Policies, regulations, and programmatic actions taken by regional and national governments and health authorities regarding health human resources

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Acronyms

PHC	Primary health care
UHI	Universal Health Insurance
CAFME	Commission for Medical School Accreditation
CGP	Civil Service Managers
CPV	Population and Household Census
CONAREME	National Medical Residency Committee
CONEAU	National Council for the Evaluation, Accreditation, and Certification of Quality University Education
DGGDRH	Department of Human Resources Development Management
DIRESA	Regional Department of Health
EBS	Basic Health Team
ESSALUD	Peruvian social security health system
FESP	Essential Functions of Public Health
RG's	Regional governments
IPRESS	Institutions that provide public health services
MoH	Ministry of Health
MDG's	Millennium Development Goals
ILO	International Labor Organization
WHO	World Health Organization
PAHO	Pan American Health Organization
PCM	Presidency of the Council of Ministers
PEAS	Basic Health Insurance Plan
PLANSALUD	2010 – 2014 Decentralized Plan of Health Capacity Building at the sectoral level
PROSALUD	National Program for Staffing and Human Resources Capacity Building for Universal Health Insurance - PROSALUD
HHR	Health Human Resources
SERUM	Intern Service in Rural and Marginal Urban Areas
SERVIR	National Civil Service Authority
SGD-RHUS	Decentralized Management System for Health Human Resources
SINEACE	National System for Educational Quality Evaluation, Accreditation, and

	Certification
SNIP	National Public Investment System
SNP	Non-Personal Services
REMSAA	Meeting of Ministers of Health of the Andean Area
TUO	Amended text of the Civil Service Law
USAID	United States Agency for International Development

Executive Summary

The development of explicit human resources policies is a crucial step in achieving the expected results of health policy implementation. In that sense, it is necessary to: a) move away from traditional staff management to human resources management, b) give greater importance to the integrated, interdependent, and systemic nature of the different components of human resource management when designing and implementing health policies, c) develop a more proactive attitude in human resources managers and policy makers, and d) promote that all professionals and sectors commit to each component of the human resources management system.

While there are health human resources management policies in Peru, these are not properly implemented.

Moreover, as a means of meeting the Millennium Development Goals (MDG's), 2006 - 2015 was declared the "Decade of Health Human Resources for the Americas" and, as such, five challenges facing that field were established. Similarly, health human resources management must meet the principles established by the International Labor Organization, such as: a) decent work, b) social dialogue, c) social protection, and d) labor rights.

At the country level, the National Civil Service Authority (SERVIR) was named the governing body of the Human Resources Management System in June 2008 and thus made responsible for defining the public sector human resources management system model. Furthermore, the National System of Educational Quality Evaluation, Accreditation, and Certification (SINEACE) was created in May 2006 for certifying professionals and accrediting training institutions; for the health and education sectors, it is a mandatory system.

Improving people's health means making the health system capable of ensuring equitable access to quality and efficient health services; one important factor is to place skilled, committed, and motivated human resources in areas that need them most. Achieving this requires an operable human resources management system that provides for: a) recruiting and hiring the best workers based on merit, b) placing the best health workers where they are needed, c) defining their competency profiles, d) periodically evaluating their performance, e) drawing up individual development plans, f) establishing career paths, g) defining fair and equitable salaries and incentives, h) maintaining staff morale, and i) maintaining good interpersonal relationships at all levels.

The USAID | Peru | Health Policies project is working with SERVIR, SINEACE, the MoH, and regional governments to support national and regional strategy design and implementation for improving health human resources operations in order to address health priorities.

This document presents current issues in health human resources and the strategies in place to tackle them.

Resumen Ejecutivo

El desarrollo de políticas explícitas de los recursos humanos es un eslabón crucial para lograr los resultados esperados con la implementación de las políticas de salud. En ese sentido, se hace necesario: a) Pasar de la administración tradicional de personal a la gestión de recursos humanos; b) Dar mayor importancia a la naturaleza integrada, interdependiente y sistémica de los diferentes componentes de la gestión de recursos humanos en la preparación y ejecución de la política; c) Fomentar una actitud más proactiva de los gerentes y hacedores de políticas de recursos humanos; d) Promover el compromiso pleno de todos los profesionales y los sectores en todas las fases del proceso.

En el Perú contamos con políticas para la gestión y desarrollo de recursos humanos en salud, que todavía no logran implementarse adecuadamente.

Por otro lado, en el marco de los Objetivos de Desarrollo del Milenio se declaró al decenio 2006 – 2015 como la “Década de los Recursos Humanos en Salud para Las Américas” y se establecieron cinco desafíos en el campo de los recursos humanos en salud (RHUS). Además, la gestión de los recursos humanos en salud debe responder a los principios establecidos por la Organización Internacional del Trabajo, como son: a) trabajo decente, b) diálogo social, c) protección social; e) derechos laborales.

En el nivel nacional, desde junio del 2008 se crea la Autoridad Nacional del Servicio Civil (SERVIR) como ente rector del Sistema Administrativo de Recursos Humanos, responsable de definir el modelo de gestión de recursos humanos para el sector público. Por otro lado, en mayo del 2006 se crea el Sistema Nacional de Evaluación, Acreditación y Certificación de la Calidad Educativa (SINEACE), responsable de los procesos de certificación profesional y acreditación de instituciones formadoras, a implementarse de manera obligatoria para los sectores salud y educación.

Mejorar la salud de la población, significa que el sistema de salud tiene que ser capaz de garantizar el acceso equitativo a servicios de salud de calidad y eficientes; un factor para ello es dotar de recursos humanos competentes, comprometidos y motivados a las zonas de mayor necesidad. Lograr esto, requiere del funcionamiento de un buen sistema de gestión de recursos humanos que permita reclutar a los mejores trabajadores; seleccionar personal en base al mérito; ubicarlos donde más se les necesita; definir sus perfiles de competencias; evaluar periódicamente su desempeño; definir planes de desarrollo individualizados; establecer líneas de carrera; definir remuneraciones e incentivos justos y equitativos; mantener la motivación del personal y las buenas relaciones interpersonales en todos los niveles; etc.

El proyecto USAID|Perú|Políticas en Salud está trabajando con SERVIR, SINEACE, MINSA y los Gobiernos Regionales, apoyando el diseño e implementación de estrategias nacionales y regionales que permitan mejorar el desempeño de los recursos humanos en salud para la solución de sus prioridades sanitarias.

El presente documento presenta la problemática actual en el campo de los recursos humanos en salud así como las estrategias en marcha para controlarlas.

1. Introduction

The success of the implementation of health reform, plans, policies, projects, or programs, depends mainly on the quality of human resources, it means the capacities they have and especially their motivation for doing well the tasks they have to do.

We are now at the midpoint of the "Decade of Health Human Resources" [1] and in this framework, in Peru we have approved the "National Policy Guidelines for Health Human Resources Development", [2] but, we have not done enough in its implementation.

In the last five year period, the MoH has made progress on improving the relationship with training institutions, particularly in creating and distributing posts in the SERUM's, internships, and residencies, in an attempt to respond more effectively to the country's needs. However, there are still serious problems regarding human resources performance, both with health service managers and health service providers.

In the framework of decentralization, the MoH has transferred a set of new functions to the Regional Governments (RGs), but neither their institutional capacities nor minimum competencies for adequately fulfilling those functions have been developed. Moreover, to put into practice Peru's Universal Health Insurance (UHI), or any type of health insurance, implies having the right amount of human resources placed where they are needed most and guaranteeing that they provide quality healthcare.

In conclusion, this report will describe the international and national legal frameworks that support actions in Peru towards health human resources management and development. It will, furthermore, feature an analysis of the progress and perspectives on each one of the components of the field of health human resources at the national and regional levels. Lastly, it will discuss the project's contributions to developing national and regional health human resources strategies.

[1] 7th Regional Meeting of the Observatory of Human Resources in Health, in Toronto, 2005, established that 2006-2015 would be the "Decade of Health Human Resources in the Americas"
[2] Ministerial Resolution #1007-2005/MINSA, dated 30 December, 2005

2. International Commitments in the Field of Health Human Resources

In this chapter we will discuss the international commitments that are the framework around which current policies and strategies in the field of health human resources in Peru are being developed.

However, before beginning this discussion, it is necessary to explain what is meant by "The Field of Health Human Resources".

1.1 The Field of Health Human Resources

To Bourdieu (1990), the notion of field is the setting of social interaction (hence every field is a place of struggle and conflict) that operates according to determined rules of organization and institutions of social legitimization (or hierarchy).

The field of health human resources (HHR) considers the following:

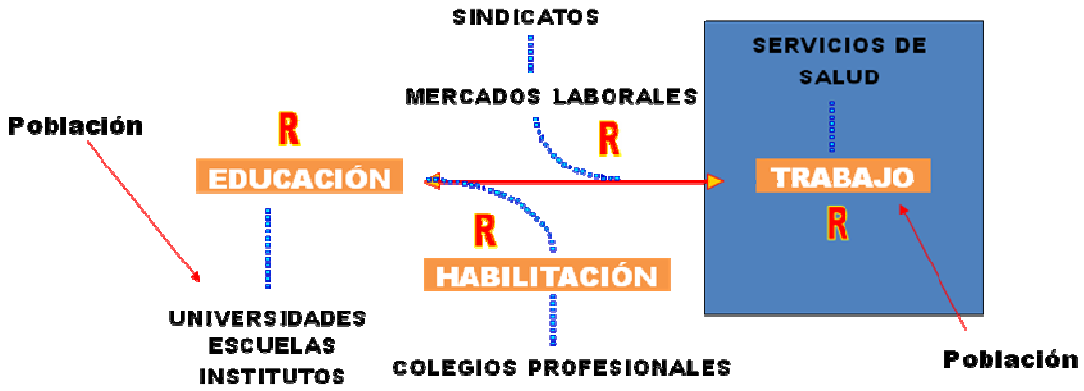
- The definition of social stakeholders related to human resources management and development: The field of HHR is a social field in which these stakeholders interact, in accordance with their interests, capacities, and possibilities.
- The characteristics of the health system and the way in which health services are organized: The type of interactions among stakeholders depends on the type of health system. A divided health system will make this interaction more difficult.
- The boundaries of the field and its components which are not clear-cut or fixed. For example, it is not possible to determine how much autonomy universities have in clinical fields located in health facilities.

PAHO proposes two HHR components: education and work. To understand the HR interactions in Peru, it is necessary to add a third setting: professional habilitation, which is concerned with guaranteeing that professionals adhere to a code of ethics. Thus, the proposed HHR settings are:

- Education: where training institutions educate future health workers.
- Work: where "health workers" perform their activities technically and socially.
- Professional: where professional associations provide habilitation to professional practice and certify that their members fulfill codes of ethics and deontology.

The following represents an adaptation of a PAHO chart that shows the vision of the field of health human resources.

THE FIELD OF HUMAN RESOURCES DEVELOPMENT



The variable **R** shows the areas in which regulatory policies must be applied:

- In education: through accrediting schools and institutes for guaranteeing quality professional and technical training, in accordance with national health needs and priorities. This setting should regulate the operation of "clinical fields" and the creation of new training institutions.
- In professional practice: through habilitation and periodic certification, thereby demanding minimum competencies for guaranteeing the quality of that practice. Professional associations are in charge of Habilitation and Certification processes and are autonomous to impose behavioral standards on their members and to obtain special regimes for defending their interests.
- In the labor market: through establishing the rules and regulations for management and health career paths that will govern entry into the labor market.
- In the work environment: through human resource management policies, the application of which will contribute to retaining competent personnel and to compensating them fairly.

Universities, schools, institutes, and health services must be able to respond to the needs of the population that ultimately engage in three types of interactions: a) demanding these types of services (training and delivery), b) being users of these services and c) replicating health practices.

The segmentation and division that characterizes our health system creates different forms of HR management with different labor regimes and compensation. This, in turn, causes an imbalance, primarily in the public sector, and problems with human resource performance.

Another difficulty facing proper interaction in the field of HHR is the fragmentation of our health system which obstructs: a) better rationale for investments, b) improved health oversight that would contribute to compliance with regulations in health, c) a culture of strategic planning of human resources and d) a clear definition of each institution's responsibilities and functions at each level. Furthermore, most institutions are still centralized, like EsSalud and the Army Health Department.

In addition, the lack of stewardship of the health system does not allow suitable national HR policy and a sectoral HR planning that considers training needs and HR needs for delivering health services.

In health, it is impossible to examine HR issues from just one of these settings without linking the other two, since the solution to HHR problems requires intervention strategies that connect all three.

Actions undertaken in the HHR field, therefore, are bound within ILO and PAHO international agreements.

1.2 The International Labor Organization

The ILO is a global institution responsible for creating and supervising international labor laws. It is the only tripartite U.N. agency with government, employer, and worker representatives that work together to draft its policies and programs and *to promote decent work for all*.

ILO main objectives are: i) promoting rights at work, ii) encouraging greater opportunities for men and women to decent employment and income, iii) enhancing the coverage and effectiveness of social protection for all, and iv) strengthening tripartism and social dialogue on work-related issues.

The commitments and agreements assumed by countries are expressed in ILO recommendations, and the issue of human resource management is the subject of ILO Recommendation 195.

1.2.1 ILO Recommendation 195: human resources development: education, training, and lifelong learning

During the 2004 General Conference of the ILO in Geneva, Switzerland, the Organization issued Recommendation 195 in which it calls upon members to define human resources, education, training, and lifelong learning policies, among other items, and emphasizes the development of competencies, promotion of decent work, [3] job retention, social development, social inclusion, and poverty reduction. Similarly, it recognizes the responsibility of government for education and pre-employment training.

As for development and certification of competencies, [4] the Recommendation appeals to members to "promote, with the involvement of the social partners, the ongoing identification of trends in the competencies needed by individuals, enterprises, the economy, and society as a whole" and promote workplace learning and training. In this aspect, the General Conference emphasized equal opportunity policies for work and training so that people would be able to balance their work, family, and lifelong learning interests. It was also

[3] Decent work sums up the aspirations of people in their working lives. It involves opportunities for work that is productive and delivers a fair income, security in the workplace and social protection for families, better prospects for personal development and social integration, freedom for people to express their concerns, organize and participate in the decisions that affect their lives and equality of opportunity and treatment for all women and men. (ILO)

[4] The term **competencies** covers the knowledge, skills, and know-how applied and mastered in a specific context (ILO R195)

agreed that research into human resource development would be conducted in order to identify, measure, and forecast the trends in supply and demand for competencies and qualifications in the labor market. It likewise promoted the development, implementation, and financing of transparent mechanisms for the assessment, certification, and recognition of skills, including experience. For this, methodologies of competency assessment should be objective, non-discriminatory and linked to performance standards.

In terms of international and technical cooperation, it was agreed to implement strategies to strengthen human resources development systems in developing countries as a means of mitigating the adverse impact on the loss of skilled people through migration.

> In fulfillment of this Recommendation and to improve the quality of training and professional practice, the Peruvian government enacted the National System for Educational Quality Evaluation, Accreditation, and Certification Act in May 2006, whereby it created the National Council for the Evaluation, Accreditation, and Certification of University Education Quality (CONEAU). In health, CONEAU is responsible for laying out criteria, indicators, and standards for accrediting training institutions and for leading the professional competency certification process through authorized professional associations.

1.2.2 The Millennium Development Goals and Decent Work

During the September 2000 UN Millennium Summit, delegates approved the Millennium Declaration for jointly working on constructing a safer, more prosperous and equitable world. Eight measureable goals were proposed to be met by 2015, collectively known as the Millennium Development Goals (MDG's). The MDG's establish targets for poverty and hunger, education, gender equality, child and maternal health, HIV/AIDS, environmental sustainability, and a global partnership

In 2005, a new target (1.B) was included in the MDG's: "Achieve full and productive employment and decent work for all, including women and young people" as recognition that employment and decent work are the primary way to leave poverty.

As reported in the analysis papers on the Millennium Development Goals drafted by the UN task force member agencies, [5] social protection is essential for sustainable and equitable economic growth and for poverty reduction. However, only 20% of the world's population enjoys adequate social protection, and more than half do not have any protection. Coverage is strongly related to the portion of workers in the formal economy and the total number of employed workers. In developed economies, nearly 85% of employees are wage workers, a fact that does not occur in the rest of the world (20% in South Asia and Sub-Sahara Africa, less than 40% in Southeast Asia and the Pacific, somewhat greater than 40% in East Asia, and close to 60% in North Africa, the Middle East, and Latin America and the Caribbean).

[5] Thematic Paper on MDG 1. Eradicate extreme poverty and hunger, 2010

When social protection is well designed, it plays a vital role in alleviating social problems – particularly in times of crisis – and that it injects resources into the economy to stimulate demand. The total expenditure on social protection as a share in the GDP is often well above 20% in developed economies. In many developing countries with mostly informal economies, however, the formal regimes for social security are not available to the great majority of the economically active population. This problem worsens in countries that are seriously affected by HIV/AIDS.

One major problem happening in the midst of the global financial and economic crisis is the lack of basic social security packages for workers in the developing world. Leaders of multi-lateral organizations have included in the set of nine Joint Crisis Initiatives something called a Social Protection Floor, which consists of access to essential public services and a basic set of social transferences. This would establish a minimum income level and health for all.

Peru's HHR management and development policies, programs, and strategies should take into account decent work and social dialogue as a means of fulfilling MDG commitments the country has pledged to uphold.

Within this framework, work competencies are vital for job growth and productivity. Therefore, capacity building should become flexible and far reaching in order to take full advantage of the possibilities of achieving the anticipated success of employability and productivity.

1.3 Pan American Health Organization (PAHO)

1.3.1 Toronto Call to Action: critical challenges that face health human resources

In October 2005, PAHO promoted the 7th Regional Meeting of the Observatory of Human Resources in Health in order to draft policies and to formulate interventions for developing human resources as a way to meet the MDG's in the context of the "**Decade of Human Resources in Health in the Americas (2006 – 2015)**". The outcome was a document titled the "**Toronto Call to Action**".

In response to that call to action, the efforts of countries should be based on the following guiding principles:

- Human resources are the foundation of the health system
- The work in health is a public service and demands a social responsibility
- Health workers are the key players in their own development

Although the challenges and problems facing the HR field are multiple, they were grouped into five critical areas:

1. Define long-range **policies and plans** to better adapt the workforce so it will be prepared to meet expected changes in the health systems and to better develop the institutional capacity for defining these policies and revising them periodically.

2. Place the **right people** in the right places by deploying the appropriate personnel into the right positions and into the most suitable areas of the countries, so as to achieve an equitable distribution of quantity and skill set of health workers in the different regions so that they match the specific health needs of those populations.

3. Regulate the **migration** and displacement of health workers so as to ensure access to health care for all the population.

4. Generate **labor relationships** between workers and the health organizations that promote healthy work environments and foster commitment to the institutional mission to guarantee quality health services for all the population.

5. Develop mechanisms of **cooperation between training institutions** (universities and schools) **and the health services institutions** so that it is possible to adapt the education of the health workers to a universal and equitable model of providing quality care to meet the health needs of the entire population.

To meet those challenges, the document lays out a set of actions for the countries to follow, which should be supported by international cooperation:

- Strengthen institutional support for HHR development.
- Defending and promoting health worker value.
- Financing health worker development.
- Improving the technical capacity for human resources management and training.
- Expanding the bases of information and evidence in Human Resources.

2. National Institutions in the Field of Health Human Resources

This chapter will discuss important government actions towards managing human resources in the public sector, such as creating: a) the National Human Resources Management System and the National Civil Service Authority (SERVIR) and b) the National System for Educational Quality Evaluation, Accreditation, and Certification (SINEACE).

In regards to SERVIR, the project entered into an agreement with SERVIR on August 5, 2011, for establishing a framework of collaboration for driving public sector health human resource management systems. To that end, both parties have attended coordination meetings in which the project addressed progress made on designing methodologies and on implementing proposals for improving health human resource performance, the latter having received feedback from SERVIR officers who also provided useful information that has allowed the project to adjust its designs.

In terms of the SINEACE, the project was invited to participate as an expert member of the National Committee for Professional Certification, whose purpose is to review functional maps produced by different health professional associations and to propose management, research, and teaching competencies. The project is supporting the sub-commission in charge of defining health management competencies.

The following sections will discuss the scope and progress of these two institutions.

2.1 National Civil Service Authority (SERVIR)

Given that human resources are the essential element in public services and in order to improve the work carried out by current public servants, having established merit as a principle and the source of rights, the National Civil Service Authority was created through Legislative Decree 1023 of June 2008 as the governing body of the National Human Resources Management System under the Presidency of the Council of Ministers (PCM), granting to it the status of a legal entity and national level competence.

The law defines civil service as “the set of institutional measures that unite and manage public servants, thereby harmonizing the interests of society and the rights of government workers.”

It furthermore establishes that HR offices in state-owned companies and government agencies are the decentralized level responsible for implementing the management system’s norms, principles, methods, procedures, and techniques.

SERVIR’s main duties are:

- Develop HR offices that act as strategic partners in close proximity with the people.
- Support the modernization of regional and local government.
- Implement and manage the Public Service Manager Corps (CGP).
- Provide technical opinions on matters of its competence.

- Establish guidelines for training public servants, for improving their performance, and for making public services more efficient.
- Develop an evaluation and information system.
- Carry out pilot evaluation programs to guarantee methods to be used according to the different types of entities and types of tasks each public servant engages in.
- Propose a compensation policy that includes performance-based monetary and non-monetary incentives.
- Progressively resolve individual conflicts in matters related to entering the civil service, payment of salaries, career evaluation and progress, disciplinary regime, and job termination, doing thus through the Civil Service Court, which will be the final administrative option for such issues.

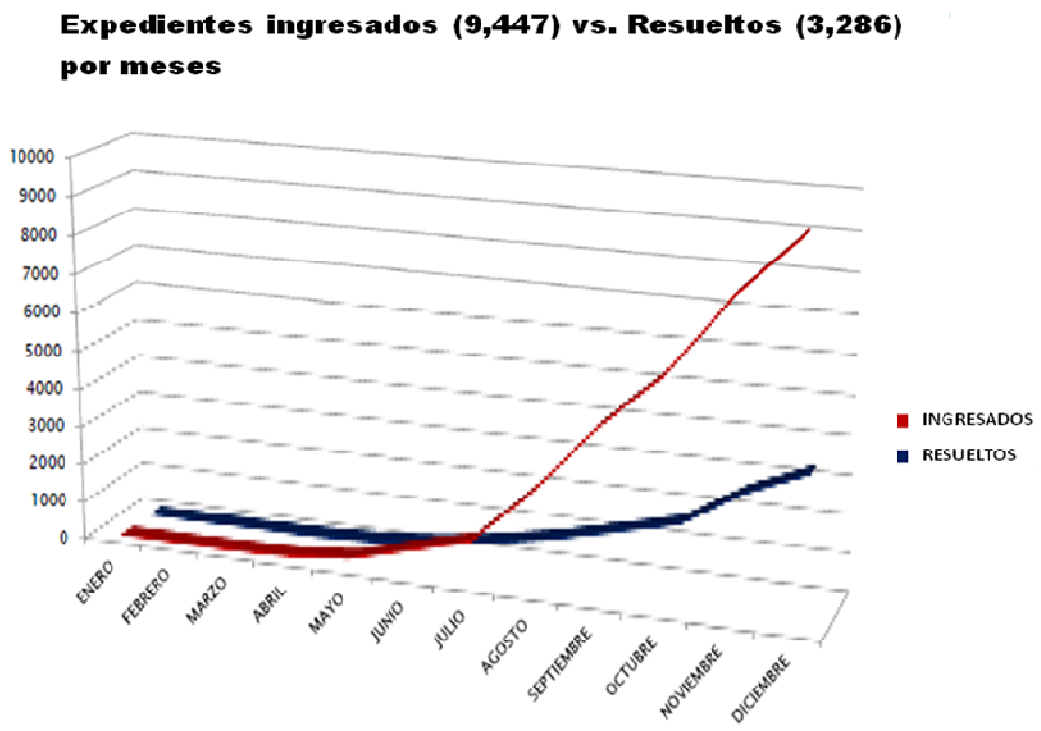
Currently, more than 1.3 million people work for the government, and each year approximately 400,000 new workers enter the civil service, according to the National Household Survey. Most of these enter without passing through a merit-based selection process, and each entity defines its own management process for employment, compensation, performance, development, etc.

SERVIR's progress to date is the following:

- Approval of the National Civil Service Policy (Supreme Decree # 086-2010-PCM)
- Design and approval of the amended text of the Civil Service Regulations (Supreme Decree # 007-2010-PCM)
- Support for government institutions with more than 1000 technical opinions and more than 3500 answers concerning public sector human resources management, all carried out through its website.
- The Civil Service Manager Corps (CGP) seeks to guarantee high quality management in strategic positions in the government. It was created through Legislative Decree 1024, and has been operating at the national and regional government levels. The CGP selects candidates to place in management positions through transparent public processes that are based upon an individual's merit. Its members have a regime and a special salary scale that is co-funded by SERVIR and the entity in which the chosen candidate is placed. Its most remarkable characteristic is that it demands that the chosen managers meet concrete goals and indicators as a requirement for remaining in their assigned post. To date, it has assigned 61 civil service managers to 23 entities at the three levels of government. There are 143 people in the CGP, all of which had to pass through a rigorous selection process.
- As for the Human Resources System, it has a) twenty Human Resource Management Networks, nine of which are at the regional government level; b) a diagnostic of human resources management offices, and c) the National Civil Service Registry.
- Specific profiles per competency have been defined for all crosscutting positions in the government and for all National Public Investment System operators.

- At the three levels of government, the performance of public servants working in the administrative systems for public investment and procurement has been assessed.
- It has been charged with formulating the Government Workers Development Plan (PDP).
- The Civil Service Court (TSC) has also been created as part of SERVIR, yet it does enjoy functional autonomy. Its mission is to guarantee proper application of the legal framework and the protection of workers' rights. The TSC has a Technical Secretariat, whose main duties are to manage the process, through which files to be voted on by its members pass, and to provide technical and administrative support for the court's correct operation. To date, it has made close to 8000 rulings that have produced jurisprudence on different controversial topics on matters dealing with its competence.

The following charts reveal certain results:



SOURCE: SERVIR

Most controversies are related to salary payment (86%) and the disciplinary regime (13%)

Source: SERVIR

Education (49%) and health (40%) are the sectors that have consulted SERVIR the most and hence have had the greatest number of controversies settled.

According to Longo (2001), the greatest challenge to civil service is related to leadership promotion, i.e. developing public sector managerial capacities through identifying potential, training, and providing incentives. "…the strengthening public sector professionalism promotes ethical behavior, fights corruption, and consolidates values according to public service in new types of organization. In that sense, it implies joint effort on different fronts: developing laws, transparency, fostering a civically active and watchful society, internal and external oversight systems, codes of conduct, and teaching ethical administration."

For this, it is important to know whether our civil service will value meritocracy, or will we continue to define managerial positions in a flexible manner based on trust, or will we

employ a combination of both: merit and flexibility.

These aspects are important for constructing HHR management models, which will be aligned to SERVIR procedures.

Similarly, SERVIR has already stated for the health sector, that it will fix normative guidelines for a health career path with the understanding that health workers directly involved in providing services should focus a career path on a balance among workers' rights, the population's needs, and sectoral policies, strategies and priorities.

The project has supported the MoH in systematizing discussion on the topic, in gathering information of the legal framework dealing with the current career in health sector, and in comparatively analyzing health career paths in selected Latin American countries.

2.2 National System for Educational Quality Evaluation, Accreditation, and Certification (SINEACE)

Law N° 28740 was signed on May 19, 2006, which created the National System for Educational Quality Evaluation, Accreditation, and Certification (SINEACE); on July 9, 2007, its regulations were approved through Supreme Decree # 018-2007-ED.

The SINEACE's purpose is to guarantee Peru's society that public and private schools offer quality education; promotes self- and external assessments for optimizing factors that have an influence on learning and on skill and competency development for improving professional qualification and labor performance levels.

The National Council for the Evaluation, Accreditation, and Certification of University Educational Quality (CONEAU) is one of the SINEACE's operational branches, whose jurisdiction is the university level. Some of its primary functions are defining evaluation criteria and indicators for the accreditation and certification process universities and their programs must undergo, approving rules that govern the authorization and operation of accreditation and certification agencies, fostering a culture of evaluation in universities, and publishing the results of evaluations, accreditations, and certifications.

In Peru, the implementation of the Professional certification process based on competencies has been moving forward through the combined efforts of the CONEAU, professional associations, academic institutions, and hiring institutions. One of the most important aspects in this process is having a set of technical regulatory documents that unify criteria and that guide the work of the certifying agencies.

Professional certification process is a delegated regulation: in this case, CONEAU has delegated it to professional schools.

This process incorporates contributions from international experiences, but mostly from self-regulation experiences carried out by health professional associations: mainly physicians, nurses, obstetricians, and pharmacists.

USAID, through its projects USAID|Promoting the Health of Peruvians at risk and USAID|Peru|Health Policies Initiative have provided support for the legislative initiative as well as technical assistance to professional associations in defining their professional

competencies and in implementing pilot assessment experiences of them. These processes have been useful for designing the national certification process.

The SINEACE Law stipulates that certification is compulsory for health and education professionals. In case of health professions, they are defined in Law N° 23536, 28456, and 23728; education professions are defined in Law N°28198. Certification is voluntary for all other professions.

Therefore, health professionals included in these laws are:

- Physicians
- Dentists
- Pharmacists
- Obstetricians
- Nurses
- Veterinarians
- Biologists
- Psychologists
- Nutritionists
- Health engineers
- Social workers
- Medical technicians
- Chemists

Presently, the following certification-related documents have been drafted:

- The Procedural Handbook for Authorization and Registry of Certifying Agency.
- The Procedural Handbook for Professional Certification
- The Procedural Handbook for Professional Competency Assessment for Professional Certification
- Guidelines for Identifying and Standardizing Professional Competencies
- Operational Guidelines for Professional Competency Assessment Centers
- Evaluator's Code of Ethics
- Professional Competency Evaluator Training Modules

Competency-based professional certification opens a new setting and creates new challenges for professional associations since the process demands that their members demonstrate they possess the knowledge, skills, and abilities needed for proper performance in an actual work environment. This entails that the associations ought to a) build or create competency-based management capacities (identification, standardization, evaluation, certification, and competency-based training), b) have qualified and recognized evaluators, and c) have evaluation centers.

On August 18, 2011, the National Committee on Competency Certification was created and charged with uniting efforts by professional associations, training institutions, and employers for defining national competencies. Both USAID (through the project) and PAHO have one representative on the committee acting in an advisory capacity. The committee has, furthermore, formed different task forces.

The project representative sits on the Health Management Task Force, which is responsible for creating a competency map and for drafting management competency standards for all health professions.

Professional associations have defined profession-specific competencies that are related to direct health service delivery; these competencies are being used in the professional certification process.

One of the primary difficulties confronting this process is the large number of health professionals that are not providing health care and instead are working as managers, professors and researchers. As a result, competencies establish by professional association do not apply for assessing professionals at work in other areas. Moreover, management, teaching, and research-related competencies cut across all professional groups. Therefore, task forces, whose members come from all professional associations and that are supported technically by USAID and PAHO, have been set up to define these cross cutting competencies.

3. Progress and Perspectives on Managing and Developing Health Human Resources in Peru

This chapter will cover information related to the current situation in the field of health human resources and discuss its progress and perspectives. Additionally, as part of the HR situational analysis, it will discuss progress towards fulfillment of the goals of the five critical challenges facing the Decade of Health Human Resources in the Americas.

3.1 Issues in Health Human Resources

The population of Peru is 29 million people, and 34% of them live in dispersed rural areas in the mountains and jungle.

Of the 8531 health facilities in our health system, 86% belong to the MoH/RG public sub-sector, 4% to the social security network (EsSalud), 4% to the Army and Police Health Departments, and 7% are private clinics. Services are provided in health centers and posts which make up 89% of all health facilities. 68% of health workers in the public sub-sector work for the MoH/RG's, and the majority of the professional groups are physicians and nurses (15.2% and 15.6% respectively).

Table 3.1.1: Total human resources in public sub-sectors per type of occupation – Peru 2009

Region	MoH/ RG's	EsSalud	Police	Army	Total	
					n	(%)
Physician	17,130	8,505	552	1,085	27,272	15.2%
Nurse	17,126	8,904	780	1,307	28,117	15.6%
Obstetrician	8,259	1,074	157	65	9,555	5.3%
Dentist	2,321	694	209	346	3,570	2.0%
Biologist	888	99	55	21	1,063	0.6%
Health Engineer	15				15	0.0%
Nutritianist	809	313	12	28	1,162	0.6%
Psychologist	994	300	68	190	1,552	0.9%
Pharmacist	1,227	393	110	92	1,822	1.0%
Medical Technician	1,391	1,728	191	191	3,501	1.9%
Veterinarian	126	1		101	228	0.1%
Social worker	1,351	437	40	82	1,910	1.1%
Other health professionals	868	2,946		43	3,857	2.1%
Pharmacist	59				59	0.0%
Technical health worker	35,696	7,410	23	1,713	44,842	24.9%
Assistant health worker	6,788	990	3,111	1,215	12,104	6.7%
Administrative technician	16,575	4,526	13	49	21,163	11.8%
Administrative assistant	7,619	418	1,085	25	9,147	5.1%
Administrative Professional	3,228	1,473	46	10	4,757	2.6%
Other administrators	823	2,443	151	310	3,727	2.1%
Unspecified	370				370	0.2%
Total	**123,483**	**42,761**	**6,603**	**6,873**	**179,720**	
	68.7%	23.8%	3.7%	3.8%		

In terms of HR distribution per region, Lima and Callao possess the greatest percentage of public sub-sector health providers (48%), whereas Madre de Dios the lowest at just 0.6%.

Table 3.1.2: Total human resources in public sub-sectors per region – Peru 2009

Region	MoH/RG's	EsSalud	Police	Army	Total	
					n	(%)
Amazonas	1,898	266	44	0	2,208	(1.2)
Ancash	4,406	1,088	116	0	5,610	(3.1)
Apurimac	2,740	351	34	0	3,125	(1.7)
Arequipa	5,050	3,071	380	538	9,039	(5.0)
Ayacucho	3,415	372	52	0	3,839	(2.1)
Cajamarca	4,289	379	99	0	4,767	(2.7)
Cusco	4,081	1,202	104	19	5,406	(3.0)
Huancavelica	1,630	220	8	0	1,858	(1.0)
Huanuco	2,575	584	54	0	3,213	(1.8)
Ica	3,023	1,472	195	22	4,712	(2.6)
Junin	4,425	1,288	142	2	5,857	(3.3)
La Libertad	4,807	2,115	158	0	7,080	(3.9)
Lambayeque	3,116	2,763	259	424	6,562	(3.7)
Lima y Callao	53,956	21,627	4,556	5,667	85,806	47.7)
Loreto	3,695	574	52	146	4,467	(2.5)
Madre de Dios	884	140	9	2	1,035	(0.6)
Moquegua	1,281	442	13	0	1,736	(1.0)
Pasco	1,042	649	8	0	1,699	(0.9)
Piura	5,109	1,615	113	46	6,883	(3.8)
Puno	4,352	922	54	0	5,328	(3.0)
San Martin	2,922	517	52	3	3,494	(1.9)
Tacna	1,875	605	52	2	2,534	(1.4)
Tumbes	1,001	193	28	0	1,222	(0.7)
Ucayali	1,911	306	21	2	2,240	(1.2)
Total	**123,483**	**42,761**	**6,603**	**6,873**	**179,720**	**(100)**

Source: National Human Resources Observatory

By examining the HR distribution between Lima and the rest of the country, it is clear that more personnel work outside Lima region (56%), whereas the other health providers concentrate their human resources in Lima, especially the Army, which has 82% of its staff operating in Lima and Callao.

Table 3.1.3: Human resources distribution in public sub-sectors between Lima and the rest of the country – Peru 2009

Provider	Rest of the country		Lima and Callao		Total	
	n	(%)	n	(%)	n	(%)
MoH/RG's	69,707	(56)	53,956	(44)	123,663	(100)
EsSalud	21,134	(49)	21,627	(51)	42,761	(100)
Police	2,047	(31)	4,556	(69)	6,603	(100)
Army	1,206	(18)	5,667	(82)	6,873	(100)
Total	**94,094**	**(52)**	**85,806**	**(48)**	**179,900**	**(100)**

Source: National Human Resources Observatory

The gap in HR investment does not allow for implementing development or incentive programs and, moreover, the former requires setting up career paths based upon competencies demonstrated by workers.

One of the pending problems is **the lack of specialists** in certain regions of the country. In 2009, 77% of specialists were concentrated in Lima and Callao, and the region with the lowest percentage was Amazonas (0.38%). 76% of specialists are permanent workers, which means that in many cases they cannot be easily moved according to sector needs. In 2010, 70% of specialists were working in Lima and Callao.

This distribution constitutes greater evidence of the inequality in the health system since specialists are not distributed in a way that responds to the population's health needs.

Table 3.1.4a: Specialists in 48 hospitals nationwide - Peru 2009

#	Location	SPECIALISTS				
		Permanent 276	Hired 276	CAS Hired	Total	%
1	Amazonas	9	3	1	13	0.38%
2	Ancash	101	0	1	102	2.97%
3	Apurimac I	3	0	0	3	0.09%
4	Arequipa	20	6	0	26	0.76%
5	Cajamarca I	52	5	0	57	1.66%
6	Callao	288	0	75	363	10.58%
7	Huancavelica	17	5	3	25	0.73%
8	Huanuco	12	2	2	16	0.47%
9	Ica	61	31	12	104	3.03%
10	La Libertad	98	6	0	104	3.03%
11	Lambayeque	83	12	0	95	2.77%
12	Lima	127	0	67	194	5.65%
13	Lima Ciudad	1266	12	357	1635	47.64%
14	Lima Este	294	2	156	452	13.17%
15	Loreto	53	14	2	69	2.01%
16	Madre de Dios	8	2	0	10	0.29%

#	Location	SPECIALISTS				
		Permanent 276	Hired 276	CAS Hired	Total	%
17	Moquegua	21	8	0	29	0.84%
18	Pasco	20	4	1	25	0.73%
19	San Martin	33	2	0	35	1.02%
20	Tumbes	31	0	2	33	0.96%
21	Ucayali	30	6	6	42	1.22%
	Total	**2627**	**120**	**685**	**3432**	100.00%
		76.54%	3.50%	19.96%		

Source: National Human Resources Observatory. MoH Department of Human Resources. Data gathered on specialists from 48 hospitals in 2009.

Table 3.1.4b: MoH specialists in Lima/Callao and the rest of the country – Peru 2010

Location	Total	
	n	(%)
Lima Region	444	(7)
Province of Lima	3,402	(56)
Province of Callao	405	(7)
Total Lima and Callao	**4,251**	**(70)**
Rest of the country	1,823	(30)
Total Perú	**6,074**	**(100)**

Source: Study into the Needs of MoH Specialists. By the National Human Resources Observatory

An examination of the distribution between MoH/RG's and EsSalud specialists reveals even greater disparity. While fewer people are EsSalud beneficiaries, when compared to the MoH/RG's network, the majority of specialties in the former system have more specialists working in them.

Table 3.1.5: National Gap in Specialists – Peru 2009

Specialties	MoH/RG's	EsSalud	Total	Need	Gap
Pediatrics	637	408	1045	1917	-872
Gynecology/ Obstetrics	538	285	823	1480	-657
Surgery	0	362	362	1004	-642
ENT	82	89	171	658	-487
Cardiology	89	137	226	710	-484
Ophthalmology	138	138	276	694	-418
Gastroenterology	68	87	155	559	-404
Anesthesiology	196	329	525	911	-386
Clinical oncology	27	30	57	442	-385
Internal medicine	319	404	723	1103	-380

Specialties	MoH/RG's	EsSalud	Total	Need	Gap
Pulmonology	52	51	103	447	-344
Endocrinology	38	46	84	423	-339
Neurology	86	63	149	473	-324
Urology	60	98	158	447	-289
Psychiatry	163	63	226	498	-272
Pathology	98	55	153	356	-203
Radiology	115	111	226	421	-195
Neonatology	25	34	59	210	-151
Geriatrics	9	17	26	112	-86
Total	**2,740**	**2,807**	**5,547**	**12,865**	**-7,318**

Source: Nuñez, M. Migración en la Región Andina, Presentación Lima, March 2009

To reduce the gap between the current need for specialists and the training of new ones, the MoH has determined the specialties the country requires and is committed to executing the Medical Residency Program as a means of meeting the established priorities. Having this priority list in mind is important since it lays out the course to follow in defining specific health workers' occupational competencies, and it also informs the medical association on the primary concern for defining professional competencies that are subject to periodic certification. The following chart provides the list of 25 priority specialties for the country's public health system in order of importance.

Table 3.1.6: 25 top medical specialties in terms of training – Peru 2009

#	SPECIALTY	#	SPECIALTY
1	Family and community medicine	14	Health management and administration
2	Gynecology/ Obstetrics	15	Physical Medicine and Rehabilitation
3	Pediatrics	16	Cardiology
4	Anesthesiology	17	Gastroenterology
5	Internal medicine	18	Pulmonology
6	Surgery	19	Neurology
7	Clinical pathology	20	Neurosurgery
8	Neonatology	21	Ophthalmology
9	Orthopedics and traumatology	22	Geriatrics
10	Emergency and disaster medicine	23	Infectious and tropical diseases
11	Radiology	24	Urology
12	Intensive care medicine	25	Endocrinology
13	Psychiatry		

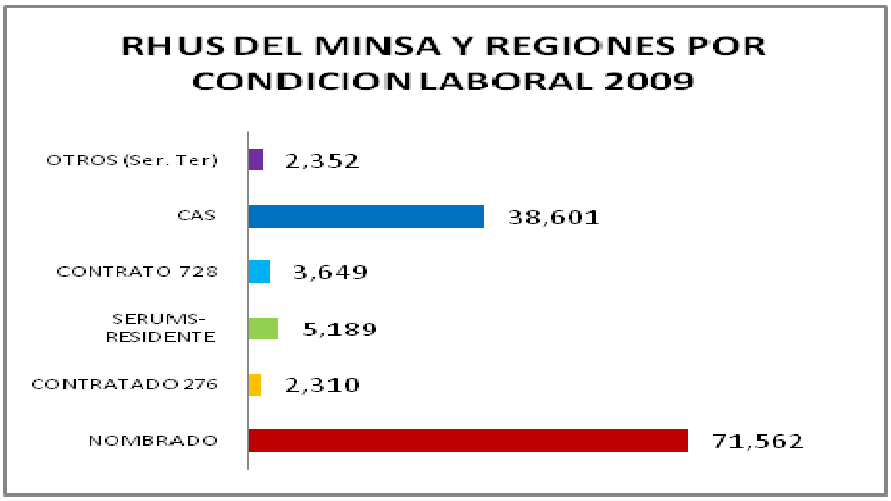
Source: National Human Resources Observatory. MoH Department of Human Resources

As shown in the chart, family and community medicine is the number one priority, and the MoH is promoting the development of a Basic Health Team (EBS) concept in which other health science professionals build their capacities in family health and primary health care. Consequently, the MoH has determined that the EBS will be comprised of a physician,

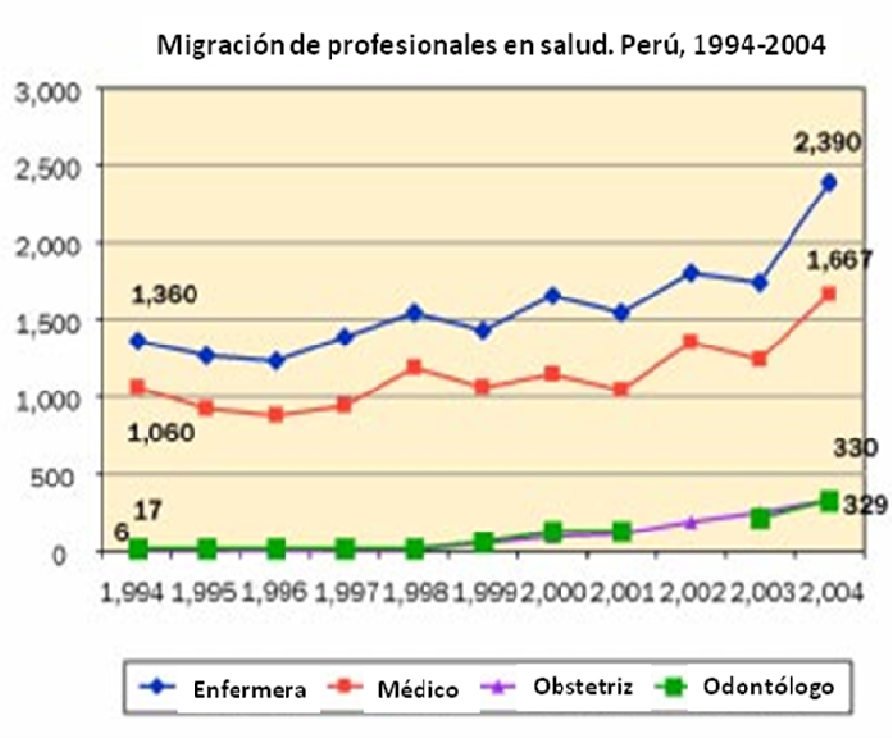
nurse, obstetrician, and a health technician with the understanding that other health professionals could form part of the team according to the needs of the local health situation.

One other important aspect involved is salary policies. As previously mentioned, there are different salary scales. It is assumed that, “same job, same pay”, but unfortunately there are large discrepancies among health organizations of the health system. Since 2009, Peru has instituted a new form of hiring (CAS) that provides some benefits to workers. However, there is still much to be done in the search for fairer and more equitable compensation models.

It is not enough to have competent human resources if they are not given legal tools, infrastructure, equipment, and minimum working conditions for them to properly conduct their professional practice. On the other hand, it is not enough to have infrastructure, equipment, and human resources if there are no guarantees that they possess the required competencies for providing quality health care.



As for migration of health professionals, the occupational group that has shown the greatest trend in migration from 1994 to 2004 has been nurses, from 1360 to 2390, according to statistics from the Department of Immigration and Naturalization. The rising trend in migration is alarming since other countries are reaping the benefits of Peruvian government investment in training these specialists. It is therefore urgent to produce job retention policies for qualified human resources and to improve working conditions through applying motivational and incentive packages.



3.2 Progress on the 5 Challenges Facing the Decade of Health Human Resources

In addition to what was previously mentioned, it is important to analyze country progress towards fulfilling commitments regarding the 5 Challenges Facing the Decade of Health Human Resources.

As to those challenges, Member States have decided upon a set of goals that should be met by 2015 plus a set of indicators to monitor their progress. [6] The following sections will discuss Peru's results in these indicators.

3.2.1 CHALLENGE 1: Defining long-range policies and plans to better adapt the workforce so it will be prepared to meet expected changes in the health systems and to better develop the institutional capacity for defining these policies and revising them periodically.

Goal 1: All countries of the Region will have achieved a human resources density ratio level of 25 professionals per 10,000 inhabitants.

[6] Handbook for Measurement and Monitoring indicators of the Regional Goals for Human Resources in Health 2007 – 2015

Though the goal may not be the ideal, it is what the countries have pledged to meet by 2015. Furthermore, it says nothing about team distribution, only pointing out an expected ratio of 25 health professionals per every 10,000 inhabitants.

Table 4.2.1 covers the years 2007 and 2010 and generally indicates that the national level gap is closing, Peru still lacks 2.71 health professionals per 10,000 inhabitants to reach the goal.

Table 3.2.1: Health human resources density – Peru 2007 and 2010

PROFESSIONALS	2007	2010
Physicians	23,554	27,272
Nurses	23,411	28,117
Obstetricians	7,994	9,555
TOTAL	54,959	64,944
Population	28,220,765	29,132,013
HHR density/10,000	19.47	22.29
2015 goal	25.00	25.00
Gap vis-à-vis goal	-5.53	-2.71
% of progress	**78%**	**89%**

Source: National Human Resources Observatory, (*) Presentation by Dr. Nuñez during the 2010 REMSAA

Presently, there is no precise information concerning the distribution of the population per sub-sector, but it is safe to say that nearly 8 million people are beneficiaries of the social security system, which indicates that the HHR density is 23, a figure very close to what PAHO has set.

Table 3.2.2: Health human resources density per sector – Peru 2010

Professionals	MoH/RG's	ESSALUD	Police	Army	TOTAL
Physicians	17,130	8,505	552	1,085	27,272
Nurses	17,126	8,904	780	1,307	28,117
Obstetricians	8,259	1,074	157	65	9,555
TOTAL	42,515	18,483	1,489	2,457	64,944
2009 Population					29,132,013
HHR density/10,000					**22.29**
2015 goal					25
Gap vis-à-vis goal					-2.71
% of progress					**89%**

Source: Presentation by Dr. Nuñez during the 2010 REMSAA

While the results are noteworthy, there is still much to be done to close the HR density gap. Lately, professional SERUM posts (a one year of civil service work in rural and marginal urban areas) have increased in health facilities located in MoH-prioritized areas as a way of implementing the Universal Health Insurance Act. It would seem that there are no problems

with the number of HHR simply by reading the averages, but what is actually happening is a large centralization of positions in cities and capitals of departments.

The project has laid out a methodology for estimate the gap in primary health care human resources. This information was used to draft a population density proposal that considers the population's level of rurality.

The project has worked with the MoH and the San Martin DIRESA on defining a methodology for figuring out the gap of HHR in primary health care based on health needs and according to rurality. With this information, a population density proposal was drafted, one particularly for PHC needs. For cities, the population density is supposed to be 25 professionals for every 12,000 inhabitants and in rural zones 30 for every 9000. These estimates were made under the following standards: the population's health needs, actual time available for service delivery, regional prevalence, adjustment rates for rurality, time allocated by each type of provider for each of the procedures involved in PHC delivery. [7]

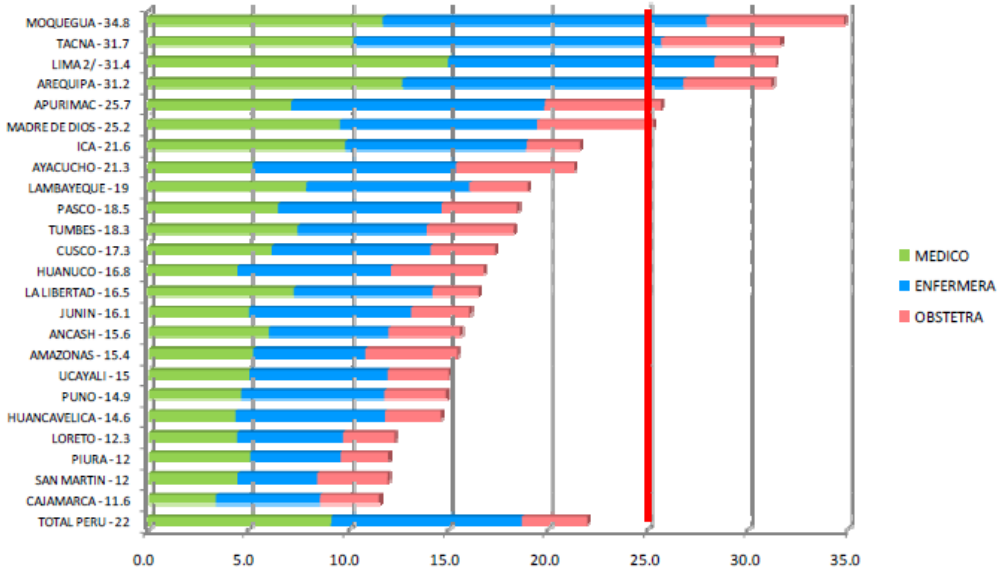
Proposed population density for PHC professionals - USAID|PERU|Health Policy project

	Urban	Rural
Population	12,000	9,000
Surgeon	10	10
Nurse	10	10
Obstetrician	5	10
Total	**25**	**30**

The following graph shows the HR density in different regions around the country for 2009. Moquegua, Tacna, Lima and Arequipa have met the 25/10,000 density goal; on the other hand, the regions with the lowest density, close to 12/10,000, were Loreto, Piura, San Martin, and Cajamarca. The country can report progress on this goal, but it is necessary to take into account the evidence of this unequal distribution

[7] This information was produced together with the MoH to determine the cost of the Basic Health Insurance Plan (PEAS).

Table 3.2.3: Health Human Resources Density – Peru 2009 (25/10,000)



Source: ONRHUS - DGGDRH - MoH 2009 National Human Resources Database

Goal 2: The regional and sub-regional proportions of primary health care physicians will exceed 40% of the total medical workforce.

The goal is to have at least 40% of the total medical workforce in the primary health care. For 2007, the proportion of these was just 29%, it means there is a large gap of more than 10% to be closed in order to meet the goal.

Table 3.2.4: Proportion of PHC physicians – Peru 2007 - 2009

Professionals	2007	2009
Total # of physicians	22,366	27,272
# of primary health care physicians	6,594	7,922
% of primary health care physicians	**29.48%**	**29.05%**
2015 goal	**>40.00%**	**>40.00%**
% of progress	**73.71%**	**72.62%**

Source: Data from: 2007 MoH DISA's and DIRESA's, 2007 EsSalud, 2007 PNP, and the MoH presentation during the 2010 REMSAA.

The above table reveals a slight decrease in progress towards the indicator, but overall progress to the goal is just above 70%.

The following table shows that while 37% of MoH physicians worked in primary health care, only 15% of EsSalud and 15% of the army physicians did.

Table 3.2.5: Proportion of PHC physicians per sub-sector – Peru 2009

Professionals	MoH/RG's	ESSALUD	Police	Army	TOTAL
Total # of physicians	17,130	8,505	552	1,085	27,272
# of primary health care physicians	6,323	1,288	149	162	7,922
% of primary health care physicians	36.91%	15.14%	26.99%	14.93%	29.05%
2015 goal	40.00%	40.00%	40.00%	40.00%	40.00%
% of progress	**92.28%**	**37.86%**	**67.48%**	**37.33%**	**72.62%**

Source: Presentation by Dr. Nuñez during the 2010 REMSAA

Health facilities that provide primary health care are covered by temporary personnel, a situation that does not guarantee continuity of the strategies being implemented. Most health centers and posts do not have physicians on staff and, in the best scenario, health facilities are run by nurse auxiliaries and health technicians.

As shown in the next table, there were no major changes in the percentage of primary health care facilities (94% in the entire sector and 98% under the MoH) from 2002 – 2009. Hence, in 90% of the health facilities, physicians constituted only 29% of the total staff.

Table 3.2.6: Health sector and MoH facilities by type – Peru 2002-2009

Year	Health Sector				MoH/RG's			
	Total	Hospital	Health Center	Health Post	Total	Hospital	Health Center	Health Post
2002	8,077	482	2,055	5,540	6,732	138	1,179	5,415
2003	8,064	452	1,784	5,828	6,892	142	1,202	5,548
2004	7,958	441	1,926	5,591	6,722	141	1,188	5,393
2005	8,055	453	1,932	5,670	6,821	146	1,203	5,472
2006	8,237	463	1,972	5,802	6,997	147	1,246	5,604
2007	8,295	470	1,990	5,835	7,049	151	1,261	5,637
2008	8,544	485	2,049	6,010	7,267	154	1,295	5,818
2009	8,955	469	2,321	6,165	7,382	155	1,321	5,906
2007	100%	6%	24%	70%	100%	2%	18%	80%
2009	100%	5%	26%	69%	100%	2%	18%	80%

Source: MoH health facilities database. Department of Statistics and Informatics.

Goal 3: All countries will have developed primary health care teams with a broad range of competencies that will systematically include community health workers to improve access, reach out to vulnerable groups, and mobilize community networks

PAHO set forth seven evaluation criteria for measuring this indicator in the Handbook for Measurement and Monitoring indicators of the Regional Goals for Human Resources in Health. Highest score is **70**.

As stated by experts who were consulted by the MoH, in 2007 Peru had advanced 60% of all the criteria. The two criteria with the lowest percentage were the existence of PHC community network and the low coverage by PHC health teams. [8]

Evaluation Criteria

Evaluation Criteria	2007 Score	Expected Score	% of progress
1. Is there a policy or program with respect to primary health care teams?	5.6	10	56.0%
2. What percentage of the country's total population is covered by the primary health care teams? (Less than 20%)	5.5	10	55.0%
3. Does the primary health care program utilize community networks?	0.6	10	6.0%
4. Does the program cover vulnerable populations?	10	10	100.0%
5. Which of the following populations are covered by primary health care teams? pregnant women; children; elderly; handicapped; mentally ill; ethnic groups; religious groups; cultural groups; impoverished, language.	4.4	10	44.0%
6. Which professional groups are generally included in primary health care teams? (physicians; nurses; midwives; community health workers, nurse auxiliaries and health technicians)	7.9	10	79.0%
7. What broad competencies are currently required of the primary health care teams?	8.1	10	81.0%
SCORE	**42.1**	**70**	**60.1%**

Source: Data from: 2007 MoH DISA's and DIRESA's, 2007 EsSalud, 2007 PNP, and the MoH presentation during the 2010 REMSAA.

Results presented by the MoH at the 2010 REMSAA were 42.68, or 61% of progress towards goal fulfillment. This slight improvement in the indicator is owed to the fact that there is now a PHC team training program.

Goal 4: The ratio of qualified nurses to physicians will reach at least 1:1 in all countries of the Region

What is expected is that each country will have a ratio of 1 physician to every 4 nurses (1/4). Countries agreed to a 1/1 ratio to stress with greater clarity the human resources gap.

[8] According to the handbook, a community network refers to a system of inter-related, informed, coordinated, community-based groups and contacts that are linked to community issues, resources and services.

Table 3.2.7: Ratio of physicians/nurses – Peru 2007 - 2009

Professional	2007		2009	
	#	Ratio	#	Ratio
Physician	23,553	1.00	27,272	1.00
Nurse	23,411	0.99	28,117	1.03
Physician/nurse ratio		**100/99**		**100/103**

Source: Data from: 2007 MoH DISA's and DIRESA's, 2007 EsSalud, 2007 PNP, and the MoH presentation during the 2010 REMSAA.

As per official data, the 2007 ratio was 100/99, or there were 100 physicians to every 99 nurses. There was a slight nationwide increase in nurses in 2009 with 100 physicians to every 103 nurses. Even though the country has somewhat advanced towards the goal, it is still rather far from the adequate ratio of 100/400.

Analyzing the ratio by sub-sector, MoH's ratio was 100/100, while for example Police health facilities had a ratio of 100/140. In spite of this, none of them come close to the ideal relation.

Table 3.2.8: Ratio of physicians/nurses by sub-sector – Peru 2009

Professionals	MoH/RG's		ESSALUD		Police		Army		TOTAL	
	#	R	#	R	#	R	#	R	#	R
Physicians	17,130	1.0	8,505	1.00	552	1.0	1,085	1.0	27,272	1.00
Nurses	17,126	1.0	8,904	1.05	780	1.4	1,307	1.2	28,117	1.03
P/N Ratio	**100/100**		**100/105**		**100/140**		**100/120**		**100/103**	

Source: Presentation during the 2010 REMSAA.

Goal 5: All countries of the Region will have established a strategic direction of human resources for health (HHR) responsible for the development of HHR policies and negotiation with other sectors, level of governments, and stakeholders.

This indicator is measured only when the country has a HHR Unit. Peruvian MoH has a Unit in charge of the HR management and development.

What is expected is the evidence of the importance that governments are granting to HR management. That evidence is represented by having a HHR unit and by changing that unit's role from personnel administration to HHR management and development.

The indicator is measured through key informant interviews, whose answers are scored at a maximum of 6 points. The answers for all key informants are averaged. The first question is not included in the averaged score since it asks whether there is an HHR Unit. If the answer is yes, then the interview moves on to the rest of the questions.

The following table shows Peru's results.

Table 3.2.9: Goal 5 assessment results

Evaluation criteria	Actual averaged score	Expected score	% or progress
Q.1 Does an HHR Unit exist?			
Q.2 What is the hierarchy level of the HHR Unit within the MoH organization? Close to the Minister of Health, as an advisory role to the Minister, functioning as part of the stewardship team, and/or providing national strategic direction?	0.75	1	75.0%
Q.3 Does HHR unit develop HHR policies at the national level?	0.75	1	75.0%
Q.4 Does the HHR unit plan the number and type of required human resources for the country?	0.7	1	70.0%
Q.5 Does the HRH unit lead a strategic management of health human resources; in-service training and the approach towards problems and determinants for the health system?	0.7	1	70.0%
Q.6 Does a dedicated HHR unit have an updated information system which consider the inventory of HRH (numbers, types, locations and educational levels)?	0.5	1	50.0%
Q.7 Does a dedicated HHR unit use the negotiation for inter-sectoral relationships with education, employee and union sectors?	0.75	1	75.0%
2007 Score	**4.15**	**6**	**69.2%**
2009 Score	**4.30**	**6**	**71.1%**

Source: Department of Human Resources Development Management – 2007 MoH; PAHO.

Despite of Peru has a HHR Unit, it has only progressed 69% in reaching its full operability, with the lack of an updated information system being its greatest weakness.

The MoH results during the 2010 REMSAA did not vary greatly because the 2009 assessment score was 4.3 nationally, representing 71.7% progress towards the goal.

One other issue is that HHR Unit Teams do not possess the needed capacities for managing Regional Departments of Health

The project is supporting the MoH in defining a human resources management base architecture; it is, furthermore, supporting the Ayacucho, San Martin, Ucayali, and Huanuco Departments of Health on building basic HR management capacities.

3.2.2 CHALLENGE 2: Place the right people in the right places by deploying the appropriate personnel into the right positions and into the most suitable areas of the countries, so as to achieve an equitable distribution of quantity and skill of health workers in the different regions so that they match the specific health needs of those population.

Goal 6: The gap in the distribution of health personnel between urban and rural areas will have been reduced by half in 2015

This goal is expected to measure the degree of supply shortage of competent human resources in rural areas, particularly in the context of renewed PHC, such that steps will be taken to improve the rural population's access to health services.

As reported by the National Human Resources Observatory, the 2007 human resource density ratio between rural and urban areas was 10/14, or for every 10 health professionals in rural areas, there were 14 in urban ones, translating into a gap of 4 in favor of the latter. The 2015 goal is to reduce the gap in half; thus, the expected rural/urban ratio in Peru would drop from 10/14 to 10/12.

Results comparison between 2007 and 2009 reveals that the gap has been increasing rather than closing since the urban density ratio rose by 10 points.

Table 3.2.10: Rural/Urban human resources ratio – Peru 2007 - 2009

Area	2007		2009	
	HHR density	Ratio	HHR density	Ratio
Rural	10.2	1.0	10.93	1.0
Urban	14	1.4	26.11	2.4
Rural / Urban ratio	10/14		10/24	
2015 goal	10/12			

Presentation during the 2010 REMSAA.

This increase in professionals working in urban areas is primarily due to the concentration of specialists in the largest cities.

Goal 7: At least 70% of primary health care workers will have demonstrable public health and intercultural competencies

To achieve positive results in the health of the population, it is necessary to guarantee that PHC human resources have the minimum competencies for clinically dealing with prevalent diseases as well as health knowledge.

The MoH has made progress on defining PHC competencies, using, as a reference, progress on the matter that different regions have made through USAID-funded projects.

The country had not, as of 2007, defined public and intercultural health competencies, but with PAHO support, all Latin American countries have received the task of define competencies for the Essential Public Health Functions (FESP). To date, there are no training programs in place for these competencies.

In 2007, the MoH reported progress of 38.6% due to the fact that regions that received technical assistance from USAID projects drafted their PHC competencies.

Results presented by the MoH at the 2010 REMSAA revealed progress towards the goal at 40.8%, or, from the point of view of experts, 40.8% of Peru's PHC health workers are competent in the areas of public health and interculturality. [9]

Goal 8: Seventy percent of nurses, nurse auxiliaries and health technicians including community health workers, will have upgraded their skills and competencies appropriate to the complexities of their functions

Professionals listed in this goal, form part of the Basic Health Team in PHC health facilities. They are the gateway of the health system, and should work within multi-disciplinary teams connected to community-based agents.

The expectations are that countries will develop training programs for these groups in order to build their capacities jointly. It is expected that in the scenario of scarce resources, when these health team members demonstrate competencies, new roles could be assigned to them. It is, therefore, necessary to guarantee the required capacities for their proper job performance.

The following table features MoH reported results:

Indicator	2007		2009	
	Result	% of progress	Result	% of progress
Percentage of nurses that will have upgraded their skills and competencies appropriate to the complexities of their functions	14.90%	21%	14.70%	21%
Percentage of health technicians that will have upgraded their skills and competencies appropriate to the complexities of their functions	40.50%	58%	50.40%	72%
2015 goal	70%			

Source: National Human Resources Observatory

From 2007 to 2009, there was an increase in the percentage of health technicians trained on their new functions, in accordance with community health needs. Yet there was less progress made in training nurses.

A previous task should be the definition of required competencies based on the functions that each member of the team ought to be responsible. These competencies will become the basis for designing training programs.

Goal 9: Thirty percent of health workers in primary health care settings will have been recruited from their own communities

[9] The PAHO handbook states that evaluator must verify whether health workers possess this indicator's 9 proposed competencies.

The scarcity of human resources in rural areas is the consequence of not having enough incentives to recruit, attract, or retain health workers. One strategy might be to recruit workers that live in the geographical setting where the health facilities operates; in that way, they would already be part of the population they would be serving and know the culture, therefore making it easier for them to stay in their position.

As reported by the MoH during the March 2009 REMSAA, Peru did not have this information.

3.2.3 CHALLENGE 3: Regulate the migrations and displacements of health workers for countries affected by migration to retain their health workers and avoid personnel deficits so as to ensure access to health care for all the population.

Goal 10: All countries of the Region will adopt the WHO Internationa Code on Mgration of Health Workers.

Goal 11: The receiving countries of the Region will produce the human resources to satisfy their own needs.

Goal 12: All subregions will have developed mutual agreements and mechanisms for the recognition of foreign-trained professionals.

As stated in a PAHO report, health worker migration is a rising trend in the Americas. It is caused by factors within the country of origin that persuade people to migrate, such as low salaries, unsatisfactory working conditions in rural areas, etc. As a consequence, the increase in migration of competent health workers from the country in which they were trained to another may affect the former's capacity to respond to health needs of its own population.

During the XXXII REMSAA held on April 1st, 2010, Andean area health ministers agreed to strengthen HR planning and management, migration management, and careers in public health management as well as the implementation of the WHO code of practice on the international recruitment of health personnel.

This important step forward will enable Andean countries to produce staffing and health personnel retention strategies as well as to meet the health demands and needs of the population.

In that context, countries in the Americas have raised the alarm concerning the impact of migration on their health care systems, and some have pointed out their difficulty in retaining professionals. PAHO has received the mandate from governments to "promote national and international initiatives for developing countries to retain their health workers and avoid personnel deficits" and therefore drafted, with the countries, three explicit goals for achieving this target by the next decade: 10, 11, and 12. [10]

In this context, internal and external migration is a highly troublesome factor for Peru's health system sustainability and operation, and there is evidence of high mobility from the MoH to the EsSalud over a short period of time, mainly in the form of specialists and professionals with ample experience and due primarily to the significant differences in working conditions between these two public institutions. From October 2007 to May 2008, a total of 688 physicians and nurses left the MoH to go to work in EsSalud, a figure based

[10] PAHO CSP27/10; 19 July 2007. Health migration in countries of the Americas.

upon data gathered from fifty-two second and third level health facilities. If the MoH and RG's do not execute human resource retention policies, this situation will only continue, and they will lose more response capacity in their health facilities.

Table 3.2.11: Internal human resources migration: from the MoH/RG's to EsSalud – Peru 2008

Health facilities	# of Physicians	# of Nurses	Total for 8 months	Anticipated total for 12 months
INEN	14	63	77	116
Hospital Hipolito Unanue	22	40	62	93
Hospital Chancay	33	7	40	60
Hospital Huacho	27	8	35	53
Hospital San Bartolome	13	16	29	44
Hospital Sergio Bernales	23	6	29	44
IMP	12	16	28	42
Hospital Apoyo Sullana	12	15	27	41
Hospital Dos de Mayo	0	24	24	36
Hospital Arzobispo Loayza	6	16	22	33
Hospital Honorio Delgado	19	2	21	32
Hospital Daniel A Carrion	5	15	20	30
Others	200	74	274	411
Total	**289**	**302**	**688**	**1032**

Source: National Human Resources Observatory; 2008

Specifically for Peru, the trend in physicians and nurses migrating to other countries is on the rise, especially to Spain. For example, 29.03% of health professionals who took Spain's MIR exam (Resident Medical Intern) were Peruvian.

Over the past two years, the MoH has applied different strategies to minimize migration, including:

- Modifying the way in which it assigns professionals and provides them incentives in the SERUMS, prioritizing the quintile of highest poverty.
- Proposing a new decentralized training mechanism for medical specialists in medium complexity hospitals in mid-sized cities.

There is still much work to accomplish. Salary scales are not reasonable or equitable, which is why it is not possible to keep human resources in the settings that most need them.

In addition, REMSAA agreements will open the doors to producing staffing and health personnel retention strategies as well as to meet the health demands and needs of the population.

3.2.4 CHALLENGE 4: Generate labor relationships between the workers and the health organizations that promote healthy work environments and foster commitment to the institutional mission to guarantee quality health services to all the population

Goal 13: The proportion of precarious, unprotected employment for health service providers will have been reduced by half in all countries

Having satisfied health workers contributes to improve the quality of healthcare. One of the frequent cause of dissatisfaction is related to unsecure and unhealthy work conditions Job insecurity is a result of part time work, low wage jobs, and jobs with unclear and uncertain prospects for the future. Thus, countries should consider strategies for improving health workers' job conditions.

In 2007, the MoH had hired 34,705 workers under the "non personal service" arrangement through which these people were expected to perform ongoing functions without any social benefits whatsoever. This means working in precarious situations. The other health sub-sectors do not keep records of this type of working arrangement.

Based upon this data, the MoH set the level of precarious jobs at 30.5%, so that percentage would have to drop to 15.25% in order to meet the 2015 goal.

Table 4.2.12: Health workers in precarious job – Peru 2007 - 2009

Precarious job	2007	2009
# of health workers in precarious job	34,705	43,253
Total of health workers in precarious job	113,787	179,900
% of health workers in precarious job	**30.5%**	**24.0%**
2015 goal	15.25%	
Gap	15.2%	8.8%

Source: Author's own creation; National Human Resources Observatory.

Compared to 2007 data, the 2009 situation had improved, but 43,253 health workers still needed their working conditions improved, given that they did not enjoy social benefits.

A new hiring system came online in 2010: CAS or the Service Administration Contract, which gives some benefits to public sector workers. It will substantially help improve progress reached thus far on the goal.

Goal 14: Eighty percent of the countries of the region will have in place a health and safety policy for health workers, including the support of programs to reduce work-related accidents and diseases.

It is expected that countries will implement health and safety programs according to specific workplace demands. As a means of increasing worker satisfaction, it should improve employee performance and grant them greater stability through lower rates of worker absenteeism, turnover, and attrition.

As of 2007, Peru has had a national workplace safety policy that was being implemented in 51.7% of all settings, as reported by the DIGESA and presented at the 2009 REMSAA.

Peru reported the following statistics for the 2011 REMSAA:

Table 3.2.13: Workplace Health and Safety Policy – Peru 2009

Indicator	Result
The MoH has a national health and safety policy.	1.0
The policy covers:	
Updated and repaired equipment	0.57
Healthy and risk free environments	0.57
Structurally safe work areas	0.57
Training in safety and security	0.57
Health insurance coverage and provision of health care services	0.11
Score	**3.39**

Source: National Human Resources Observatory

REEMSA Peru's report is based upon expert judgment that concluded the current policy is being implemented. It also reported that the 3.39 score is equal to 56.6% implementation. The score was obtained from weighing results from among the main health providers. EsSalud did not submit 2009 data, so it is not included with the rest.

Table 3.2.14: Workplace Health and Safety Policy by provider – Peru 2009

Indicator	MoH	PNP	FFAA	Total
The MoH has a current health and safety policy.	1.0	1	0.8	
The policy covers:				
Updated and repaired equipment	0.5	1	1	
Healthy and risk free environments	0.5	1	1	
Structurally safe work areas	0.5	1	1	
Training in safety and security	0.5	1	0.8	
Health insurance coverage and provision of health care services	0	1	0.8	
Score	**3**	**6**	**5.5**	**3.39**

Source: National Human Resources Observatory

Goal 15: At least 60% of health services and program managers will fulfill specific requirements for public health and management competencies, including ethics

The purpose of the goal is to professionalize health service management in order to make health facilities more efficient. Its indicator is the proportion of managers who have a formal training certification and that the training includes aspects dealing with health services management.

Unfortunately, Peru's health system does not gather and maintain this type of information. Also, most managerial posts are "positions of trust" that do not require any type of management degree.

The first step in complying with this indicator is to lay out minimum competencies for managerial positions and then to establish the percentage of positions of trust, with the remainder having to be filled through a selection process based upon those competencies. In that way, health services would have suitable managers who would guarantee positive administrative results.

The project supported the San Martin Regional Department of Health in defining administrative competencies for all its management posts. These are being used in competency-based selection processes of critical administrative positions in the DIRESA's, health networks, and hospitals.

Since health services have been decentralized to the regional governments, the RG's have the freedom to choose how they recruit and select professionals. In this sense, San Martin RG has decided to carry out a selection process for critical managerial positions in the Regional Department of Health (including the General Manager), networks, and two regional hospitals, and the competencies that will be used were identified with technical assistance of the project and are drafted in the "Dictionary of Competencies".

Peru did not present any results for this indicator during the 2009 and 2011 REMSAA.

Goal 16: One hundred percent of the countries of the Region will have in place effective negotiation mechanisms and legislation to prevent, mitigate, or resolve labor conflicts and ensure essential services, if they happen.

The provision of health services is an essential part of people's lives, and any disruption in their delivery due to labor conflicts should be avoided. Thus, countries must have mechanisms for monitoring the workplace atmosphere, for negotiating and settling disputes, and for avoiding conflicts that obstruct health service delivery.

As the MoH reported during the 2007 and 2009 REMSAA, Peru does have laws that avoid essential health service disruption as well as formal negotiation mechanisms.

The MoH has implemented round tables at which union leaders and authorities can conclude agreements that are signed in the respective records. Along these lines, EsSalud has set up a negotiation system for reaching collective bargaining agreements.

3.2.5 Challenge 5: Develop mechanisms of cooperation between training institutions (universities and schools) and health services institutions so that it is possible to adapt the education of the health workers to a universal and equitable model of providing quality care to meet the health needs of the entire population.

Goal 17: Eighty percent of clinical health sciences will have reoriented their education towards primary health care and community health needs and adopted interprofessional training strategies

Regional countries have pledged to fuel PHC and should reorient their human resources training accordingly. In 2007, 36.4% of health sciences schools had already included PHC-related contents in their courses, and that figure rose to 46.5% in 2009.

Table 3.2.15: Health sciences schools that include PHC contents in their courses – Peru 2009

# of schools	UNMSM	UPCH	UNFV	USMP	UNPRG	UNSAAC	Total
# of schools that have reoriented their education	4	1	4	9	1	1	20
Total # of health sciences schools	5	2	4	30	1	1	43

Source: National Human Resources Observatory

Goal 18: Eighty percent of schools in clinical health sciences will have adopted specific programs to recruit and train students from underserved populations with, when appropriate, a special emphasis on indigenous, or First Nations, communities.

The purpose of this goal is to lower the inequality in accessing educational opportunities under the assumption that everyone has equal rights to quality education. The result should be that training institutions produce strategies for underserved groups so they can fully participate in the benefits of education.

In 2007, no health sciences school in Peru had adopted specific programs for attracting and educating underserved groups. Furthermore, out of the thirty-eight programs that were being offered in 2009, only the San Antonio Abad University in Cusco offered specific programs for such populations.

Goal 19: Attrition rates in schools of nursing and medical will not exceed 20%.

It is important to measure nursing and medical schools' ability to retain students as an indirect indicator of the quality of professional training. Some studies show that rates in countries around the region are greater than 50%.

In terms of Peru, 2009 data revealed the medical school attrition rate to be 24.4%, which implies the necessity to establish mechanisms for having research to discover the reasons behind student attrition and then, from their results, executing improvements to curricula and training methodologies accordingly. Peruvian institutions with the highest attrition rates are the Federico Villarreal University and the San Martin de Porres University.

Table 3.2.16: Medical school attrition rates – Peru 2009

# of schools	UPCH	UNFV	USMP	UNAS	UNPRG	UNSAAC	Total
# of medical students who entered in 2009	120	156	487	95	60	60	978
# of medical students who graduated in 2009	116	98	327	88	56	54	739
# of dropouts	**4**	**58**	**160**	**7**	**4**	**6**	**239**
% of attrition	**3.3%**	**37.2%**	**32.9%**	**7.4%**	**6.7%**	**10.0%**	**24.4%**

Source: National Human Resources Observatory

Goal 20: Seventy percent of schools of clinical health sciences and public health will be duly accredited by a recognized accreditation body.

One way of guaranteeing quality education is to have health sciences schools fulfill minimum standards and receive the respective accreditation.

Only Peruvian medical schools have implemented an accreditation process, and there was an oversight body for it: the Commission for Medical School Accreditation (CAFME).

In 1991, the government passed Law 27154 creating the CAFME. In 2000, its regulations were approved under Supreme Decree 005-2000-SA. In 2001, the minimum standards for medical school accreditation were approved through Supreme Resolution 013-2001-SA.

That accreditation process officially began in 1999 with enactment of Law 27154, which made it a normal practice. The law a) guarantees medical school and community-based health care quality and suitability, b) created the CAFME and its structure and assigned it the functions of formulating minimum accreditation standards and of continuously managing, supervising, and evaluating the process, c) halted the creation of new medical schools, d) set up the process through which medical schools that failed to meet the minimum accreditation standards must pass, e) established the CAFME within the MoH structure, f) granted it technical and administrative autonomy, and g) gave it 120 days to draft a proposal for establishing minimum accreditation standards. The CAFME is comprised of MoH representatives plus one from each of these institutions: Ministry of Education, National Assembly of Rectors - ANR, National Council for the Authorization of University Operations (CONAFU), and the Peruvian Medical Association.

In accordance with the law, the system should evaluate different areas: academic structure, curriculum, admission procedures, teaching faculty, health risk prevention, acquired competencies, testing methodologies, learning assessment, administrative structure, complementary academic services, physical infrastructure, and equipment.

As of 2006, these were the results:

Medical school accreditation process results – Peru 2006

Medical schools that had graduated students
• 7 (4 public and 3 private) were complying with all minimum standards • 11 had not met the standards and needed to raise objections before the deadline
Medical schools that had not graduated students
• 6 were complying with the standards and would be accredited after graduating their first group of graduates. • 3 were adapting themselves to the standards • 1 was not complying. The CAFME requested that the ANR suspend entrance of new students.

Source: Ministry of Education University Coordination Unit.

Since enactment of the SINEACE Law in May 2006, CAFME operations were suspended.

Moreover, the SINEACE is now designing a health sciences school accreditation process, and CAFME is no longer operating. The last CAFME report revealed the following:

Table 3.2.17: Accredited health sciences schools – Peru 2007

Type of health sciences school	Accredited	Total # of schools	%
Medical	25	29	86.2%
Nursing	0	45	0%
Obstetrics	0	25	0%
Total	**25**	**99**	**25%**

Source: CAFME – 2007

As the results of progress towards fulfilling the five critical challenges have shown, there is still much work to be done:

- The health human resources density ratio is less than the PAHO benchmark (25/10,000), and there are regional distribution irregularities.
- Nationwide, only 29% of all physicians work in primary health care, yet close to 90% of health facilities offers this service.
- PHC programs do not include community networks and do not lay out PHC team competencies.
- The MoH does have an HHR unit, but it does not have an updated information system that registers health workers at all levels.
- Health professionals are concentrated in specific geographic areas, mainly physicians in urban settings.
- There are no mechanisms for guaranteeing PHC competency development and maintenance.
- In rural areas, there are no means of recruiting health workers from their own communities.
- There is no plan for retaining qualified professionals as evidenced by the increase in their external migration and in their internal migration from the MoH to the EsSalud.
- 30% of health workers perform their duties under precarious working conditions.
- The country has workplace health and safety policies, but these are under-implemented.
- At national level, Peru has not identified competencies for managerial positions. But, the project has assisted San Martin DIRESA in the definition of managerial competencies to all its managerial positions, and these can be a model for the rest of the regions.

- Peru does not have a health sciences school accreditation system.
- The project has supported the MoH in designing a decentralized HHR management model.
- The project worked with the San Martin DIRESA on defining a methodology for figuring out the gap in primary health care human resources.

4. Progress and Perspectives on Health Human Resources Training in Peru

Public and private universities in Peru enjoy complete autonomy. What is more, the past thirty years have seen uncontrolled growth in the number of universities and students, particularly between 1980 and 2000, when the percentage of private universities ballooned by 450% and student attendance increased by 162% in all universities (see table 5.4). Over the past decade, the university growth rate was 134% with the largest share being private institutions (149%). An important aspect to keep in mind is that these figures do not include extension campuses private universities have established nationwide.

Table 4.1: Universities - Peru 1980 - 2010

	1980	2000	2006 (a)	2010	Dif 2010 – 2000 # (%)
# of universities					
Total	**35**	**76**	**82**	**102**	**26 (134)**
Public	25	31	35	35	4 (113)
Private	10	45	47	67	22 (149)
# of students	**257,220**	**415,465**			

Source: 2010 Country Report and GRADE (a)

Table 4.2: Increase in the number of universities – Peru 1980 - 2000

	1980	2000	% Variation
# of universities			
Total	**35**	**76**	**(217)**
Public	25	31	(124)
Private	10	45	(450)
# of students	**257,220**	**415,465**	**(162)**

Source: 2010 Country Report

Regrettably, the rise in the number of universities has not gone hand in hand with higher quality teaching and increased production of scientific studies. Along these lines, public university growth has not been accompanied by greater budgets, and professor salaries are rather low.

Just 14% of university professors held doctorate degrees in 2006.

In 2000, Peru published 228 studies, whereas Colombia 734, Chile 2282, and Brasil 12,895. (Institute for Scientific Information, Science citation Index)

As reported by GRADE in 2006, the ANR functions as a coordination body. Since there are no higher education policies, universities are isolated from each other, and each institution decides on its own what careers it will offer and the corresponding curriculum.

The issues pointed out about universities in general are not far off from those that affect careers in health. The number of health sciences schools has also skyrocketed (presently there are 28 medical schools), and these are dealing with the subsequent uniformity, loss of quality, and lack of guiding principles.

In terms of HHR training, the number of health sciences schools has increased enormously due mainly to the passage of Law 882 enacted in 1996 "Education Investment Promotion Act", which opened the floodgates and facilitated this growth. For example, in 1960, Peru had 3 medical schools, but in 2002 the number jumped to 22. Nursing schools experienced even greater growth over the same time period: from 2 to 42.

Table 4.3: Number of regions with a health sciences school – Peru 2009

Type of health sciences school	Regions	
	#	(%)
Medical	15	(60)
Nursing	22	(88)
Obstetrics	18	(72)
Dentistry	12	(48)

Of the twenty-five regions in Peru, 60% have medical schools, 88% have nursing schools, 72% have obstetrics schools, and 48% have dentistry schools.

There are more private schools than public ones for each discipline, and it is recommended that no new schools be created in universities or in setting where there are neither teachers nor trained personnel to teach students.

The problem, however, is not only one of a growing number of health sciences schools, but also of curriculum contents that do not meet the population's health needs. This is why the sector needs to define the human resources competencies required for each profession since these can then be used as the basis of corresponding curricula contents.

The MoH should determine required critical competencies for health worker so universities can design their courses accordingly.

Along related lines, the increase in health sciences schools has meant an increase in the numbers of graduating medical, nursing, and obstetrics students. From 1993 – 2003, the rate jumped 130%, and that trend seems to be on the rise.

Table 4.4: Health sciences school graduates – Peru – 1993 - 2003

Type of health sciences school	# of graduates		
	1993	2003	Difference # (%)
Medical	951	1238	287 (130)
Nursing	1402	1760	358 (126)
Obstetrics	2374	2916	542 (123)

Source: GRADE, 2006. Author's own creation

Most graduates prefer to work in Lima or other regional capitals, which causes a surplus in those places and a shortage in rural settings. The surplus, in turn, generates precarious working conditions for those professionals. The 2005 PAHO Country Report stated that 1) a large group of professionals are underemployed, 2) each new graduating class has trouble finding jobs, 3) multiple employment is expanding, 4) there is job insecurity, the constant search for new opportunities, and migration, etc.

Table 4.5: Health sciences schools – Peru 2002

Health sciences school	#
Medical	28
Nursing	42
Obstetrics	25
Dentistry	21

Source: National Assembly of University Presidents

One significant aspect for HHR training is clinical fields. All health sciences schools have entered into pre-service training agreements with health facilities, yet now that there are more universities offering careers in health and more students studying those careers, there are not enough clinical fields and the capacities of existing ones are stretched thin, which is negatively affecting their education. This aspect has not yet been considered as an area that requires regulation.

Progress to date has been the creation of different coordination offices:

- COPREME (Undergraduate Medical School Committee). [11] The MoH is the President of COPREME. In this Committee, the number of MoH clinical fields is agreed to. There are neither clear assignment criteria nor procedures for all training clinical fields.
- SINAPRES (National System for Coordinating Teaching and Research in Undergraduate Health-related Careers). [12] This office coordinates between MoH health facilities and university medical schools. It has the following organs:
    - National Committee for Undergraduate Health Science Majors (CONAPRES). Presiding institution rotates every other year between the MoH and ASPEFAM.
    - Regional Committees for Undergraduate Health Science Careers
    - Executive Secretariat
- Health Educators Cooperation Agreements among the MoH, RG's, and universities with schools of health sciences. [13]
- CONAREME (National Medical Residency Committee). Created by Supreme Decree 055-75-SA, regulated by Supreme Decree 009-88-SA, and amended by Supreme Resolutions 018-2004-SA and 002-2006-SA. It used to be headed up by the ASPEFAM,

[11] Minister of Health Resolution 804-2004-MINSA, dated August 13, 2004
[12] Supreme Decree 021-2005-SA, dated October 21, 2005
[13] Supreme Resolution 032-2005-SA, dated December 1, 2006

but the MoH took over in July 2011, under protest by the former. This committee was in charge of approving available job openings at each institution for each specialty in an attempt to reach consensus with the MoH to orient specialist training, in accordance with the country's needs.

In conclusion, the critical issues surrounding HHR training are:

- Curricula are not focused on the country's needs. The MoH does not have a clear job profile that lines up with the population's needs.
- The accreditation process for health sciences schools is limited to mainly considering structural standards; there is little or practically nothing related to process and results standards.
- Undergraduate studies focus on medical specialties rather than PHC or public health. Undergraduates are not sufficiently sensitized to view the population and its needs.
- University professors are not able to dedicate themselves solely to teaching but must also work in their private practices.
- Universities are not active participants in MoH activities.
- Universities educate students according to the needs of other countries and not to Peru's needs.

5. Progress and Perspectives on a Decentralized Management of Health Human Resources based on competencies

Human Resources are intangible assets for the national development. The more competent workers are, the greater their contribution to sustainable development will be. Yet, competence is not just about the combination e interaction of knowledge (knowing how to do, how to learn, and how to be), but also about proper working conditions that allow people to show off their competencies.

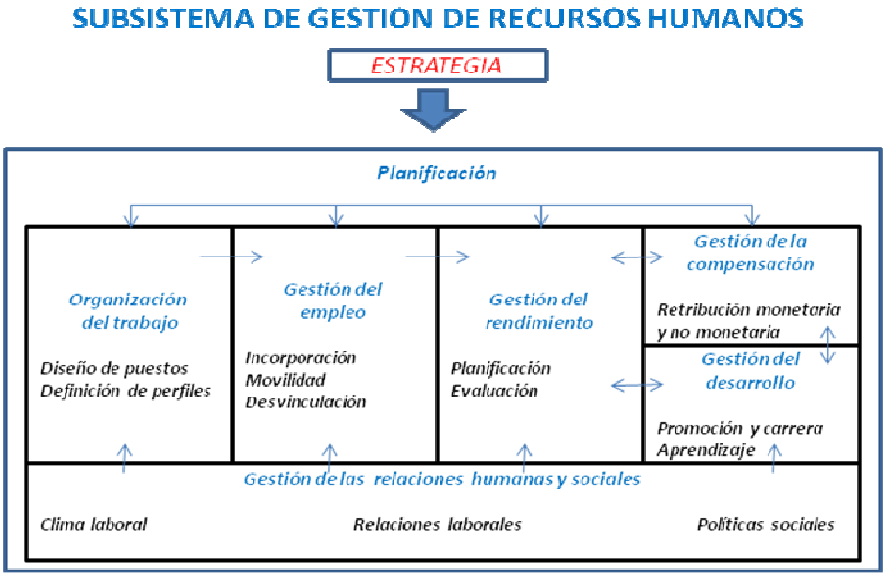
This chapter will discuss the current MoH proposal for decentralized human resources management and the strategies already underway.

5.1 Decentralized Health Human Resources Management System

If human resources management is "having the right workers with the right training in the right place doing their jobs well" (adapted from the 2006 World Health Report), then this entails carrying out a series of interrelated and interdependent processes.

The project has worked with the MoH on creating the structure and processes of the decentralized HHR management system.

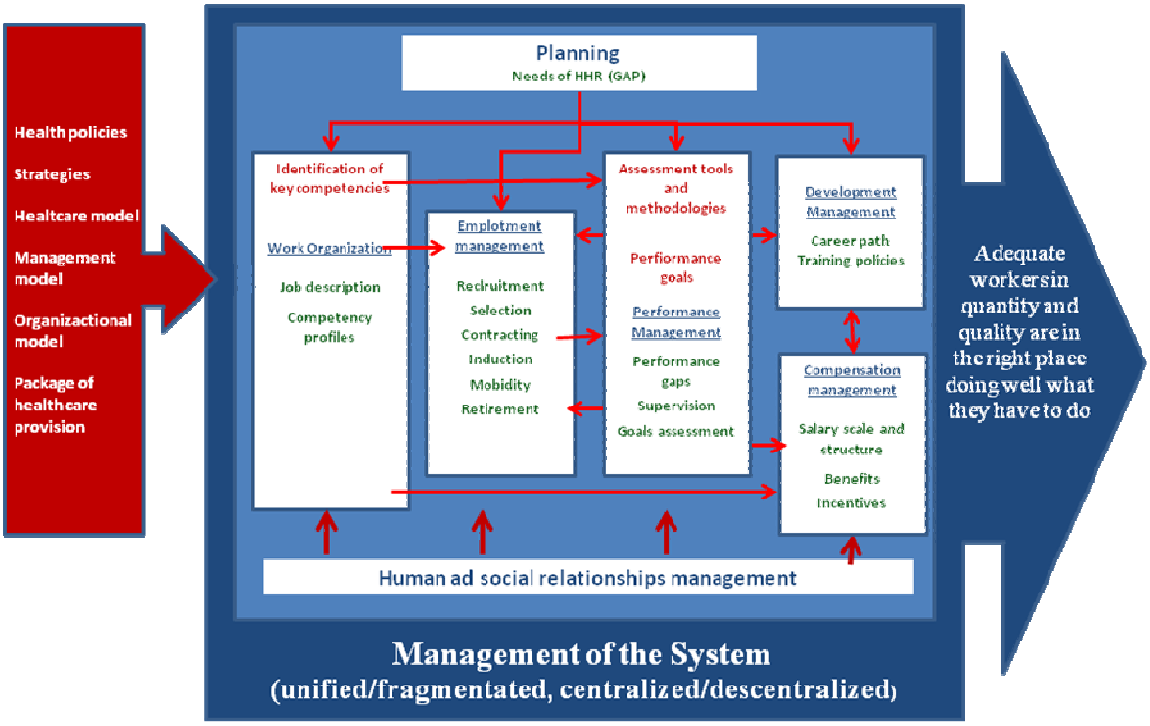
SERVIR is responsible for leading the Human Resources Management System at national level and used the Longo proposal as a reference to set up its sub-systems. [14]



[14] Francisco Longo Martinez. Law degree from the University of Barcelona. Professor in the Department of People Management and Organization. Associate Professor at the University of Ramon Llull. Staff Meeting President. Director of the Institute of Public Governance and Management

The MoH has taken this model and created the basic architecture of the Decentralized Health Human Resources Management System (DHHRMS). The following flowchart illustrates that architecture:

Chart 5.1: Decentralized Health Human Resources Management System - MoH



There are eight subsystems in the model:

- **Health Human Resources Planning Subsystem**: If HHR planning is "estimating the number of persons and the kinds of knowledge, skills, and attitudes they need to achieve predetermined health targets and ultimately health status objectives" (Hall, T.L. Health manpower planning: principles, methods, issues, Geneva, WHO; 1979), then the problem in Peru is that no one has defined the type and number of health providers managers that are actually needed. This has occurred because there are no properly defined models for the most suitable health care and health service management and organization, especially since Peru has a rural, scattered, multicultural population. Without these models, there is no way of knowing how many management levels are required. Another difficulty is the lack of a clear management career path that allows qualified people to occupy positions based upon merit rather than on trust.

  This subsystem refers to defining quantitative and qualitative, short, medium, and long range human resources needs contrasted against internal capacities; likewise, it includes actions that should be started to close the identified gaps. Its main processes are: a) human resources information management and b) Formulation of policies and plans for closing HHR gaps.

- **Jobs Structure Subsystem**: A parallel process is deciding upon the jobs structure, i.e. positions needed for meeting the organization's goals. This field requires that human resources managers are capable of defining job competency profiles and management position requirements. If the desired type of organization and health service management is not made evident, it will be very difficult to describe the characteristics of managerial posts.

  This subsystem includes the set of DHHRMS policies and practices that will be used for describing and classifying jobs, lays out requirements and competencies for each job, and records staff distribution within the organization in order to guarantee the most effective use of work time and existing resources and the expected quality and health worker performance results. Its processes include: a) job descriptions and b) competency profile.

- **Employment Management Subsystem**: This subsystem primarily deals with staff entry, permanence, and exit. Health managers are not hired through a transparent selection process; generally, the head of an organization (at any given level) places people in management positions based on trust. Therefore, whenever there is any change in directors or managers of health, these new managers change all the positions below him/her, which does not allow continuing with some progress made, so progress made is lost, based upon the attitude that what the former management did was wrong so it is not worth reviewing, just halting. Another obstacle is high staff turnover. Many times, the organization invests in training its providers and managers, some of which afterwards receive better job offers and so leave. The other main problem is that many of the managers are excellent clinicians, and so they moonlight, working as administrators and physicians at the same time. They are not dedicated to just managing.

  This subsystem includes all personnel policies and practices designed to manage the processes and procedures by which individuals enter, move in and out of the organization, with a profile of competencies required to perform a particular function, such way that allows the achievement of health objectives in the sector. The processes include are: a) recruitment, b) selection, c) hiring, d) orientation / induction, e) displacement, f) staff action, and g) resignation and termination.

- **Performance Management Subsystem**: Without clear competencies and performance standards, there is no possibility of properly assessing performance. It may be easier to do for non-management positions since managers do not accept being periodically reviewed. One way of assessing performance may be through defining measurable goals that can become part of management agreements or contracts. Unfortunately, this component is something new in Peru, and the country is just now undergoing the process of applying results-based budgets.

  This subsystem defines staff performance goals and competency standards for maintaining them at the highest possible level through processes that continually improve health worker performance. Its processes include: a) performance planning, b) active performance follow up, c) performance assessment, and d) results feedback.

- **Management Compensation Subsystem**: In Peru, salary and wage determination is more of a political issue than a technical one. The payment discrepancies between the MoH and EsSalud workers are huge, being one of the main causes of health worker migration from the MoH to the EsSalud. It is difficult for management teams can continually be in management, and to assume these positions often means stop receiving certain bonuses that have the caregiver (mainly by guards). There are no monetary or non-monetary incentives that can retain or attract competent staff

  This subsystem has to do with the way in which organizations pay their workers. Its processes include: a) salary structure and compensation system design, b) payroll management, c) benefits and bonuses management, and d) incentives management.

- **Development Management Subsystem**: There is no health career path, much less one for management that guarantees that professionals who fill these positions have the managerial capacities for doing so. A university education is not preparing individuals for the challenges they will face as managers, especially those in the public sector. The MoH, moreover, does not have a management capacity building program for producing a critical mass or pool of health managers.

  This subsystem defines practices for developing professionals and staff according to their skill, offering education and career paths that line up with an organization's dynamic and structure. Its processes include: a) job advancement, b) capacity building, and c) clinical field regulation.

- **Social and Human Relations Management Subsystem**: The organizational climate is an important factor for the trained worker to feel motivated to perform well. This subsystem is to regulate and harmonize the interactions between individuals, with emphasis on collective dimension and the organization, based on policies and practices related to Organizational Climate, Labour Relations, Welfare and Safety at Work. This subsystem is related to and supports all the above processes, as ensuring the conditions for a productive and positive performance. The processes included are: a) Management of Organizational Climate; b) Managing the Labour Relations c) Safety and Security at work.

These different subsystems are necessary for improving health worker performance and, consequently, that of the organization in which they work, whether it is a health facilities, micro-network, network, or department of health. Not all subsystems are active in one single organ of a health institution so, in light of this division, it is necessary to assign DHHRMS management functions to just one unit. In other words, someone must be responsible for the proper operation of the DHHRMS processes and subsystems, yet it is more important to have one team in charge of maintaining the needed interrelationships and of keeping the interdependencies moving without mishap. The main processes that should be coordinated are: a) management system oversight, b) HHR policy and strategy creation, c) HHR information management and organization, d) HHR funding analysis, and e) budget and operations planning.

Main problems facing Peru in terms of HHR management:

- Unsuitable staffing and human resources distribution in general; a workforce centralized in large cities without the capacity to respond to the population's health needs, culture, and geographical distribution.
- Rising migration of qualified professionals: internal (from the rural to the urban) and external (abroad).
- Incipient regulatory mechanisms that guarantee quality in schools of health professionals (accreditation) and ongoing professional development (periodical certification)
- Lack of a health career path that is based on merit, applies a transparent selection process, offers fair salaries linked to performance, and provides non-monetary incentives centered around performance assessment.
- Health worker training is not oriented to closing the gaps in their performance. Both clinical and administrative levels suffer from these gaps.
- There are no incentives for recruiting the top management candidates.
- Neither universities nor the MoH are educating professionals to meet the actual needs that decentralization is demanding.
- Management positions are not filled using a transparent selection process.
- Insufficient budgets are assigned for implementing decentralized HHR management policies.
- The USAID project has supported the design of a HHR management model and is supporting a competency approach to management selection.

5.2 Health Career Path

Peru's current labor regime concerning public servants is laid out in Legislative Decree 276 on the Basic Precepts for the Administrative Career Path and Public Sector Salaries, which states that "the administrative career path is the group of principles, regulations, and processes that regulate the income, rights, and duties of full time public servants who work in Public Administration." Its article 4 establishes these principles: a) equal opportunities, b) job stability, c) a guarantee of earned level, and d) a fair and equitable salary, regulated by a uniform system. The law also touches upon such labor rights provided in the Peruvian political constitution as social benefits, vacation time; leaves of absence; pension; equal treatment; merit without political, religious, economic, racial, gender, or any other kind of discrimination; collective rights, and the right to strike. All rights under this law are inalienable.

Health work typically establishes a close bond between the service provider and service user. Furthermore, one of the objectives of every health system is meeting the population's

health needs, which are influenced by the quality of care they receive in a health facility that is ultimately the responsibility of the workers.

In that regards, a health career path should encompass aspects that are not found in a public or administrative career path since it is not only about producing better working conditions that will generate improved worker performance and about guaranteeing their rights and interests, but it also essentially deals with meeting the population's needs and institution's policies and goals.

The question to ask is why a health career path is needed. The answer is manifold: Peru has labor laws for each health professional group resulting from union negotiations; the system has limited capacity for retaining qualified health professionals; there are no career paths; job entry and advancement are not specifically based on merit; performance evaluations are subjective; an unmotivated, dissatisfied staff will not deliver high quality health care; etc.

However, the most critical problem is located in the PHC, the level at which 80% of Peru's health facilities operate and where there is no policy for generating conditions that stop health professionals from migrating to other levels, other health institutions, or other countries. There is still a permanent gap in qualified human resources for rural areas and for places where poverty and want abound and development is limited.

Hence, it is necessary to create rules for solving these issues that should form part of the legal framework for a health career path and that, due to their nature, should be born out of social dialoguing and agreement among all stakeholders. In that way, the health career path will be made legitimate and sustainable.

There is no clear, definite plan on how to set up this career path in Peru, yet some progress has been made on including the topic on the health agenda and acknowledging that it should be a health policy instrument. What is left, though, are plenty of questions to answer:

- What does a health career path imply? What should it respond to?
- What principles should govern it?
- Which human resources management aspects does it solve? Which one does it not?
- Who should it cover? Administrative staff? Managers? Should there be a specific career path for health managers?
- Should it apply to the entire public sector: MoH, EsSalud, and the Army and Police Health Departments?
- Is it possible to talk about a PHC career path? In other words, can we enhance PHC, make it more attractive, establish job promotion and professional development strategies, or define specialists in PHC?

Participants of the 5th National Health Human Resources Meeting raised interesting questions concerning this topic:

1. How will ensue that workers identify with health policies? How will it tackle the existing salary gap between health managers and health providers?
2. It seems strange to question whether we should include health technicians in a health career path, and even managers should be incorporated in the corresponding law. There is no room for doubt. The debate needs to move outside the room where the commission meets and encompass all interested parties so they can discuss their concerns and proposals.
3. What is the underlying principle of the proposed career path and why was it chosen?
4. How will all health professionals participate in the career path, particularly in regards to management specifications? Is it possible for a non health-related professional to reach a management position in the health system?
5. Under current labor regimes (DL 276, DL 1057, and DL 728), the salary gap should be unified into one system.

There is still much to do and to learn. Moreover, "no proposed health career path will be feasible if there is no human resource management system, if its governance has not been planned, with health facilities managers trained in human resources management, this is, a system where rules 'take on a life of their own' and work effectively. Therefore, we need to reform human resources management within the health sector to go along with this structural reform." [15]

From the civil society point of view, we need "to listen to the opinions of those who will benefit from the processes of merit-based employment, career path structure, and professional development, so these do not remain simply as bureaucratic and internal facts; instead, we think all citizens should be involved." [16]

5.3 Strategies underway for health human resources management

To tackle the abovementioned issues, the MoH Department of Human Resource Development Management has established the following set of strategies:

5.3.1 National Staffing and Human Resources Capacity Building Program for Universal Health Insurance - PROSALUD

Through Supreme Decree 003-2011-SA of March 29, 2011, PROSALUD was created as part of the Universal Health Insurance implementation process and placed under MoH jurisdiction in order to guarantee human resources provision, distribution, and development by way of a Basic Health Team and renewed Primary Health Care approach.

Its objectives are:

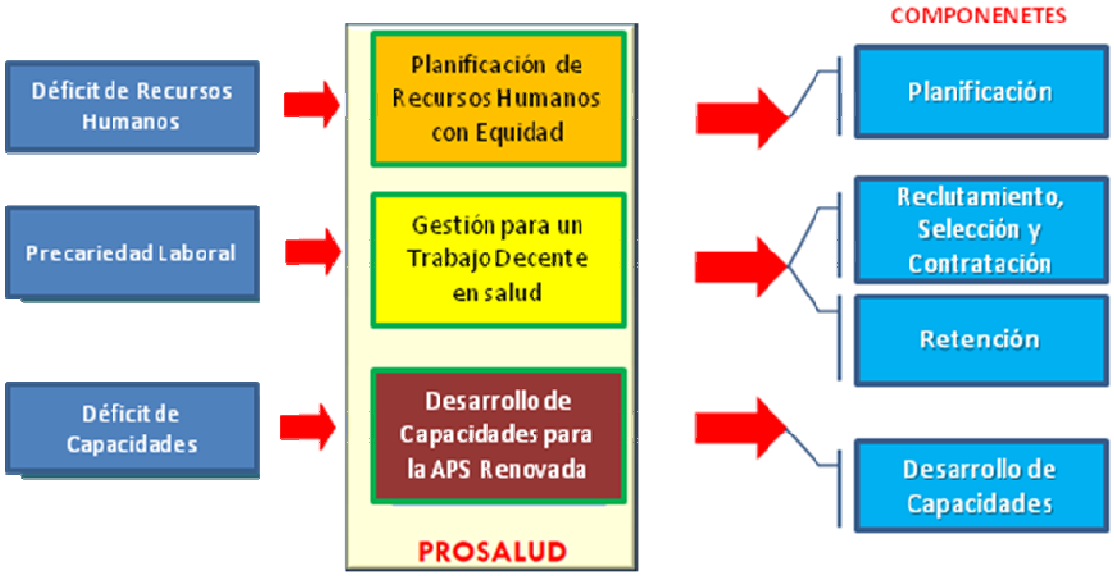
[15] Dr. Guillermo Miranda, President of the Sectoral Task Force on the Health Sciences Career Path – 5th National Health Human Resources Meeting, July 2011
[16] Dr. Mario Rios, President of the Health Forum – 5th National Health Human Resources Meeting, July 2011

a) Guarantee the availability of Basic Health Teams (BHT), formed by professionals in health sciences, with emphasis on areas where the poverty rate is high and accessibility is low.

b) Improve PHC working conditions for EBS's; this should increase recruiting capacity and impartial retention.

c) Strengthen EBS capacities for implementing the comprehensive health care model.

PROSALUD Components



Its components are:

1. Planning: For determining EBS composition at micro-network level (physician, nurse, obstetrician, and medical technician) using criteria "established by the national authority".

2. Recruiting, selecting, and hiring: Through a "national recruiting and selection process" based on merit, experience, and competencies.

3. Retention: CAS contracts for new staff will feature salaries based on criteria that take into account the quintile of poverty and geographic accessibility. "Salaries will be determined by the national government in coordination with the RG's."

4. Capacity building: Mainly for PEAS implementation through ongoing health education. Development of a Family and Community Health training program will be fostered.

The MoH is the implementing agent, and funding will come from "institutional budgets from organizations involved in UHI implementation."

This program is under the umbrella of the Health Human Resource Management System.

Pilot regions for the Operational Handbook design are: Ayacucho, Huancavelica, and Apurimac.

The Operational Handbook is still being validated, so implementation is on hold.

As stipulated in the supreme decree, this seems to be a program where key decisions are centralized in the MoH. PROSALUD success will depend on the extent it manages to involve the regional governments.

5.3.2 Agreed and Decentralized Sectoral Health Capacity Building Plan - PLANSALUD

Through Ministerial Resolution 184-2011/MINSA of March 15, 2011, PLANSALUD was approved to "guide and to generate regional institutional capacity building plans to be implemented according to the social, economic, and cultural context of the corresponding governmental level."

Its strategic action lines are:

a) Health management and government: It includes the processes that were decentralized to the RG's.

b) Comprehensive health care under renewed PHC, where PEAS conditions are established as capacity building areas.

c) Health Human Resources Development Management: It includes the transferred human resources management powers.

Its components are:

a) Technical assistance, characterized by support for a specific job or operational problem.

b) Training (courses, workshops, etc.) for new sustainable development approaches. PLANSALUD proposes to develop a problematization methodology.

c) Education and health partnership: This component is related to creating dialogue, consensus building, and cooperation mechanisms between health schools and institutions that provide health services in order to educate qualified and competent health professionals, according to the population's needs and for the purpose of meeting health sector goals. Thus, this partnership purposes to improve the quality of health services and their users' satisfaction.

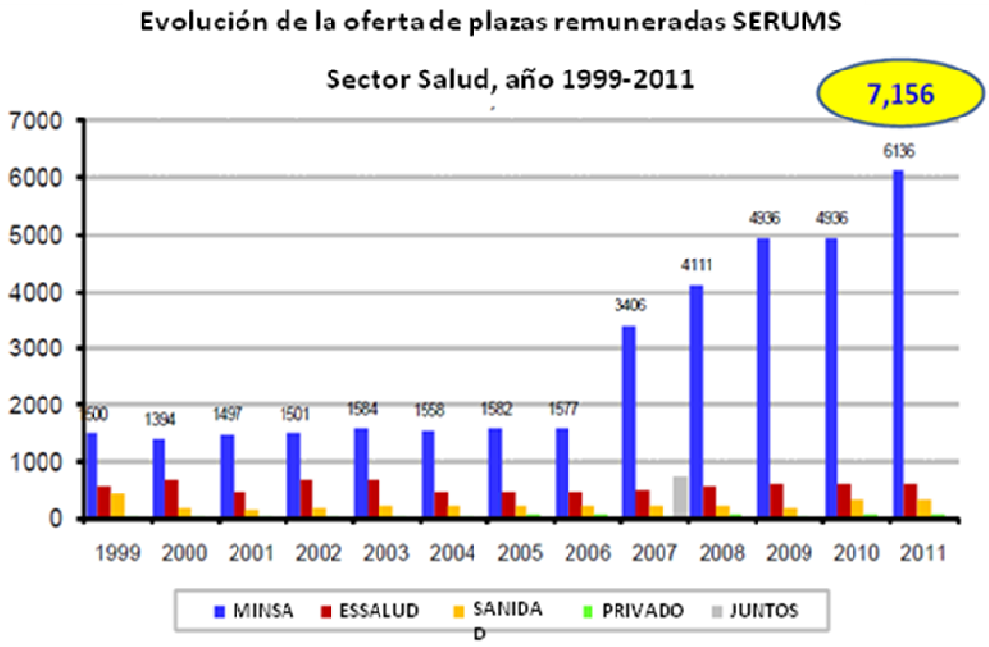
5.3.3 Primary health care Human Resources Staffing: Intern Service in Rural and Marginal Urban Areas – SERUM's

One strategy for providing human resources in poverty stricken areas was increasing the SERUMS' budget, the positions of which are allocated as per the quintiles of poverty.

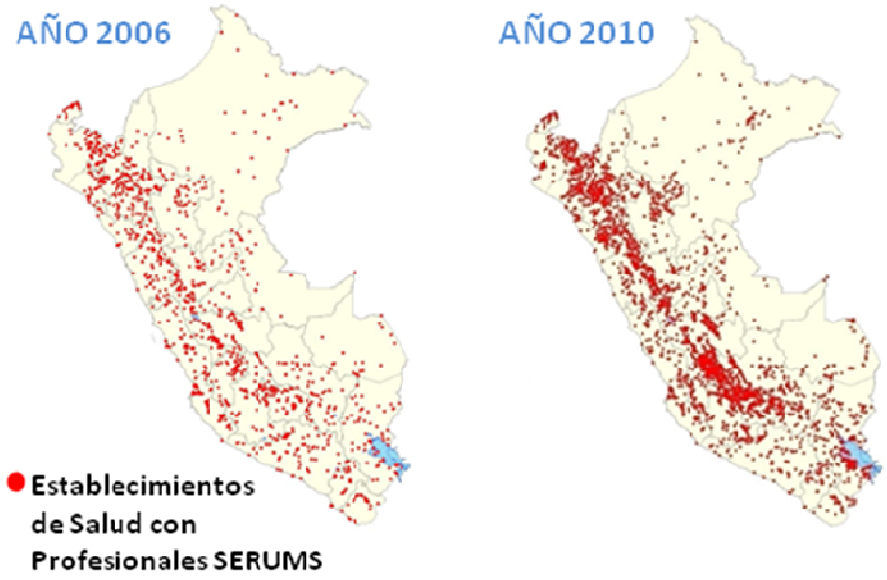
Part of the strategy was to modify the assignment criteria, especially for physicians who did not feel they were getting anything out of the experience and left before completing the one year service term.

Criteria	Past	Present
Assignment	By lot	By merit (medicine)
Bonus	Up to 0.9/100 points on the medical residency Up to 15% bonus during selection processes	Up to 10/100 on the medical residency Up to 15% bonus during selection processes
Assignment Criteria	Categorization 1997 (A, B, C, D) Altitude, distance, road	Per poverty levels (FONCODES) Priority: Quintile I and II

In this way, HHR staffing was improved in areas with high poverty rates, from 1394 postings in 2000 to 7156 in 2011, as shown in the following chart:



Likewise, human resources density is improving in the country's highland areas, as seen in the following maps:



5.3.4 Staffing specialists throughout the entire country

One of the problems in health service delivery is the lack of specialists in hospitals that depend upon Regional Departments of Health. While regional EsSalud hospitals do have teams of specialists, these were not allowed to work for short periods of time to support health care in MoH hospitals. Likewise, RG's were offering salaries well above the national and regional average to recruit and to retain physicians, without success.

Against this backdrop, the MoH posed the following group of strategies:

a) Setting priorities for funding education: Ministerial Resolution 167-2009/MINSA of March 20, 2009, prioritized medical specialties and sub-specialties in education that are being used in offering positions under the free model and by "a year job commission" modality for admission to Peru's National Medical Residency System. It also set up a new application procedure to the residency system through "Captive Placement" in RG, it led the MoH and RG which increased the number of positions from 25 in 2007 to 341 in 2010 for physicians appointed in Peru (233 were accepted) who will return to their Region in 3 years as specialists.

Table 5.1: Increase in the number of vacancies in the medical residency admission process

Year	Applicants	Admitted physicians	
		#	(%)
2006	116	33	(28)
2007	75	25	(33)
2008	349	135	(39)
2009	482	229	(48)
2010	297	233	(78)

b) Supplemental services among the MoH, RG's, EsSalud, and Army and Police Health Departments: The MoH, faced with a critical shortage of physicians where the UHI is being implemented. MoH has promoted the Supreme Decree 015-211-SA, the Urgent Decree 022-211 Regulations, which authorizes supplemental services to guarantee and to broaden UHI coverage and to reduce the discrepancy between national health service supply and demand. The UHI, consequently, authorizes physicians and/or specialist under any type of labor regime and the special regime regulated by Legislative Decree 1057 to provide supplemental services to the following public health institutions: the MoH and institutions within its structure, RG's, EsSalud, and the Army and Police Health Departments.

   These services may be provided after completing a full day of work or during his day off, according to current law. They are likewise purchased by one public health institution from another, when the former requires them and the latter agrees and has the corresponding professional available. Once these details have been hammered out, supplemental services will be scheduled for the department/ facilities that require them. Similarly, a public health institution may request supplemental services from within its own pool of physicians, following the same legal stipulations as above and guaranteeing that it has the budget to pay for the service.

c) Brigades of specialist in the VRAE: As mentioned in previous chapters, Peru suffers from a significant gap in specialists, mainly in the departments of the Apurimac and Ene Rivers Valley (VRAE), where it is estimated to be 1374. This strategy was launched in August 2009 in PHC and level II health facilities in UHI pilot settings. The brigades visited 19 health facilities in nine departments: Ayacucho, Amazonas, Apurimac, Huancavelica, Junin, La Libertad, Lambayeque, Loreto, and San Martin. Each brigade was made up of 1-4 physicians from 21 specialties: anatomic pathology, anesthesiology, cardiology, general surgery, emergency and natural disasters, endocrinology, gastroenterology, geriatrics, gynecology and obstetrics, family and community medicine, internal medicine, pneumologist, neurosurgery, neurology, ophthalmology, otorhino laryngology, clinical pathology, pediatrics, psychiatrics, traumatology, and urology.

   From August 2009 to November 2010, 52 specialists took part in 222 visits. They traveled by air, land, and river. There were serious communication problems, and in some places there were no telephones. Apurimac saw the greatest number of visits: 45.5%. Each professional worked 15 days/tour, Monday - Saturday, 8 hours/day, having signed a professional services contract. According to how remote the area was, the salary was either S/.5300.00 or S/.8,000.00 (Table 5.2). And while the national government was the employer, the regional and local governments were in charge of paying for room and board.

   In regards to the number and types of interventions, the brigades performed 32,470 in total, 12% of which were anatomic pathological in nature, 57% were outpatient, and 81% were complex diagnoses.

Some difficulties encountered were: a) limited coordination among the three levels of the government, b) lack of a work plan and clear goals, c) lack of resources, materials, and basic equipment, d) low salaries, and e) uncertainty on the lasting of the strategy. The biggest obstacle was the lack of human and technological resources, with many of the specialists having to use their own equipment. There were severe deficiencies in health workers such as lack of required competencies; lack of motivation; problems in management and supervision.

Most participating professionals agreed with the employment regime but suggested that salaries be increased and health facilities outfitted with proper equipment.

It will be necessary to assess this strategy further and to prioritize the specialties. Its outcomes should not be measured in relation to the number of interventions but to the impact it had on contributing to solving the population's health problems. Lastly, it should be placed within a referral and counter-referral system.

Table 5.2: Cost of the VRAE Specialist Brigades Strategy - Peru 2010 (PEN)

Departamento (EESS)	Especialidad	Total actividades	Estimación de costos			
			Sueldo 15 d	Número de salidas	Costo total	Costo / actividad
Ayacucho (H. R. Ayacucho)	Psiquiatría	687	5 300	7	37 100	41,83
	Neurología	453	5 300	2	10 600	23,40
	Oftalmología	686	5 300	4	21 200	30,95
	Medicina interna	436	5 300	2	10 600	24,31
	Traumatología	321	5 300	2	10 600	33,02
	Geriatría	326	5 300	2	10 600	32,52
	Endocrinología	342	5 300	2	10 600	30,99
Apurímac (C.S.Z. Chincheros)	Cirugía general	1 303	5 300	9	47 700	36,61
	Medicina interna	1 793	5 300	8	42 400	23,65
	Ginecología y obstetricia	533	5 300	2	10 600	19,89
	Pediatría	1 127	5 300	8	42 400	37,62
Huancavelica (H.D. Huancavelica)	Anat.Patológica	480	5 300	5	26 500	55,21
	Medicina interna	282	5 300	2	10 600	37,59
	Oftalmología	545	5 300	7	37 100	68,07
	Neurocirugía	95	5 300	2	10 600	111,58
	Neurología	133	5 300	1	5 300	39,85
	Urología	172	5 300	5	26 500	154,07
	Neumología	138	5 300	2	10 600	76,81
	Patología clínica	0*	5 300	2	10 600	
	Cardiología	76	5 300	2	10 600	139,47
Apurímac (Guillermo Díaz de la Vega)	Medicina interna	631	5 300	3	15 900	25,20
	Cirugía general	206	5 300	2	10 600	51,46
	Endocrinología	1 781	5 300	10	53 000	29,76
	Geriatría	1 075	5 300	7	37 100	34,51
	Anat.Patológica	91	5 300	1	5 300	58,24
	Patología clínica	1 316	5 300	9	47 700	36,25
	Anestesiología	68	5 300	2	10 600	155,88
Apurímac (H. Hugo Pesce)	Traumatología	1 654	5 300	11	58 300	35,25
	Anat.Patológica	682	5 300	8	42 400	62,17
	Cirugía general	198	5 300	2	10 600	53,54
	Otorrinolaring.	419	5 300	2	10 600	25,30
	Psiquiatría	565	5 300	6	31 800	56,28
	Pediatría	1 868	5 300	9	47 700	25,54
	Gastroenterología	122	5 300	1	5 300	43,44
Tarapoto (H. de Apoyo II Tarapoto)	Patología clínica	70	5 300	1	5 300	75,71
	Anat.Patológica	2 262	5 300	5	26 500	11,72
	Oftalmología	296	5 300	3	15 900	53,72
	Gastroenterología	288	5 300	3	15 900	55,21
	Emergencia	76	5 300	1	5 300	69,74
	Endocrinología	359	5 300	5	26 500	73,82
Lambayeque (Mr Salas)	Ginecología y obstetricia	590	5 300	4	21 200	35,93
	Pediatría	382	5 300	2	10 600	27,75
San Martín (H. Moyobamba)	Patología clínica	96	5 300	1	5 300	55,21
Apurímac (Lab. Diresa)	Anat.Patológica	480	5 300	1	5 300	11,04
Amazonas (H. Gustavo Lanata)	Medicina interna	703	5 300	3	15 900	22,62
	Cirugía general	511	5 300	6	31 800	62,23
	Ginecología y obstetricia	966	5 300	5	26 500	27,43
	Pediatría	254	5 300	1	5 300	20,87
Amazonas (H. Santa María de Nieva)	Medicina familiar y comunitaria	781	5 300	4	21 200	27,14
Amazonas (C.S. Nieva)	Medicina familiar y comunitaria	819	5 300	4	21 200	25,89
San Martín (C.S. Barranquita)	Medicina familiar y comunitaria	469	5 300	4	21 200	45,20
San Martín (C.S. Huimbayoc)	Medicina familiar y comunitaria	76	5 300	2	10 600	139,47
San Martín (C.S. Pongo de C.)	Medicina familiar y comunitaria	272	5 300	2	10 600	38,97
La Libertad (H. Leoncio Prado)	Cirugía general	289	5 300	2	10 600	36,68
Ayacucho (H. de Campaña por la Paz del Vrae)	Ginecología y obstetricia	352	8 000	2	16 000	45,45
	Cirugía general	170	8 000	3	24 000	141,18
	Anestesiología	117	8 000	3	24 000	205,13
	Traumatología	172	8 000	2	16 000	93,02
Loreto (C.S. San Lorenzo)	Medicina familiar y comunitaria	572	5 900	3	17 700	30,94
Junín (H. San Martín de Pangoa)	Cirugía general	245	5 300	1	5 300	21,63
Total		32 470		222	1 205 400	37,12

Source: study by Violeta Barzola

6. Conclusions and Recommendations

For Dussault (2003), the absence of suitable human resources policies in many countries is the reason for flaws in human resources quality and distribution, as well as the lack of coordination between HR management actions and the needs addressed in health policies.

The characteristics of Peru's HHR field are:

- 68% of health workers are employed by the MoH and DIRESA's.
- 15% of health workers are physicians and close to 16% are nurses, so there is almost a 1:1 ratio between them.
- 48% of all health providers are concentrated in Lima-Callao, and only 0.06% work in Madre de Dios.
- In 2010, 70% of specialists were based in Lima. More specialists work in the EsSalud than the MoH.
- The national human resources density ratio is 22/10,000 inhabitants, in Moquegua is 34.8/10,000, while in Cajamarca, San Martin, Piura, and Loreto are 12/10,000. The goal is 25/10,000 inhabitants.
- 90% of Peru's health facilities provide PHC, but only 29% of all physicians work in them.
- Health professionals are concentrated in urban areas. For every 10 health professionals working in rural areas, there are 24 in cities. There are not enough incentives for recruiting and retaining qualified staff in rural areas.
- Health professional migration to foreign countries is on the rise; there is internal migration from the MoH to the EsSalud.
- Peru has a workplace safety policy, but it is not being implemented.
- Health managers' designation still does not meet specific competency profiles for their positions.
- There is no salary or incentive policy. Neither there is a regional selection process; each executive unit of budget establishes its own posts to be covered through Administrative Services Contracts and sets the salaries, which generates inequality and, consequently, staff discontent.
- From 1980 to 2000, the number of universities increased by 217%; private universities alone recorded the greatest amount of growth in that same period: 450%.
- For 2009, just 46% of health schools and faculties incorporated PHC contents.

- 60% of Peru's regions have at least one medical school. From 1993 to 2003, the number of graduates increased by 130%, and in 2009, the attrition rate was 24%. "Clinical fields" are unregulated.
- Professional certification is mandatory for health professionals, and the role of certification is being filled by accredited professional associations. Unfortunately, the MoH was not part of the discussions concerning the certification process, so it is not linked to human resources management. In other words, professional association certifications are not a requirement for being hired and promoted or for receiving incentives and, as a result, members do not feel the need for such certification.

MoH strategies to tackle these issues:

- The National Staffing and Human Resources Capacity Building Program for Universal Health Insurance – PROSALUD. Its purpose is to set criteria for a) hiring members of micro-network basic health care teams, b) recruiting processes, c) staff selection and hiring with monetary incentives, and d) PHC training. The new management team is reviewing the Operational Handbook before putting the program into practice.
- The Agreed and Decentralized Sectoral Health Capacity Building Plan – PLANSALUD, with three strategic action lines: 1) management and government, 2) comprehensive health care, and 3) human resources management. The MoH is currently supporting the regions on formulating their own regional capacity building plans.
- Expanding SERUM's (Intern Service in Rural and Marginal Urban Areas): The Ministry of Economy and Finance approved a larger budget for financing more SERUMS posts, and assignment criteria were modified such that a 413% increase in positions in rural poverty-stricken settings was recorded: from 1394 in 2000 to 7156 in 2011.
- Assigning more specialists to health facilities nationwide: 1) creating a set of medical residency openings through "Captive Placement" just for physicians assigned to the regions who will afterwards return to their place of origin, 2) authorizing specialists to offer supplemental services to public health institutions other than the one at which they are working, and 3) deploying specialist brigades in the Apurimac and Ene Rivers Valleys (VRAE).

Pending tasks:

- Continue discussions on the health career path.
- Establish methods for estimating human resources gaps at the three levels of health care and for creating comprehensive, sustainable strategies to close them.
- Set equitable salary policies and/or scales which shall at least include these criteria: rurality, poverty, specialization, and level of responsibility.
- Define required competences for assuming new, decentralized functions; must be agreed by the MoH and RG's.

- Establishment of non-monetary incentives to retain skilled health care workers in places where they are necessary.

The USAID | Peru | Health Policy project is working with SERVIR, SINEACE, the MoH, and regional governments to support national and regional strategy design and implementation for improving health human resources operations in order to address health priorities.

7. Bibliography

BARZOLA, Violeta; Llamosas, Ena; Echegaray, Ciro; Cuzco, María; Peralta, Felipe. Experiencia del Ministerio de Salud en la implementación de las brigadas de médicos especialistas en las zonas de aseguramiento universal en Perú, 2009-2010. Rev Peru Med Exp Salud Pública. 2011; 28(2): 352-61.

BOURDIEU, Pierre. O Poder Simbólico. São Paulo: Difel, 1990.

GRADE; Estudio sobre los Recursos Humanos en Salud en Perú: Gestión, Distribución, Normatividad, Regulación, Condiciones laborales y salariales y Formación. Agosto, 2006

LONGO, F. (2001): La Reforma del Servicio Civil en las democracias avanzadas: mérito y flexibilidad. Documento de Trabajo, BID, Washington

LONGO, F. (2001): Modernizar la gestión pública de las personas: desafíos de la flexibilidad. Publicado en la Revista del CLAD Reforma y Democracia. No. 19 (Feb. 2001). Caracas.

LONGO, F. (2002): Marco analítico para el diagnóstico institucional de sistemas de servicio civil.

OIT (2004). Recomendación 195 sobre el desarrollo de los recursos humanos.

OMS (2006). Working together for health. The World Health Report 2006

OPS (2005). Llamado a la Acción de Toronto, 2006 – 2015 Hacia una Década de Recursos Humanos en Salud para las Américas.

OPS (2007). Manual de Medición de Línea de Base de los Indicadores de las Metas Regionales de Recursos Humanos en Salud 2007 – 2015

SERVIR (2011) Mejorando la calidad del Servicio Civil: Avances y desafíos del proceso de reforma del Servicio Civil, Mayo 2011. http://www.servir.gob.pe

UNITED NATIONS DEVELOPMENT GROUP (2010). Thematic Papers on the Millenium Development Goals.
http://www.ilo.org/public/english/bureau/pardev/download/mdg/2010/mdg1_2010.pdf

WEBB, R.; Valencia, S: Los Recursos Humanos en la Salud y la Educación Públicas del Perú, en el Informe del Banco Mundial “Un nuevo contrato social para el Perú: ¿Cómo lograr un país más educado, saludable y solidario?”.