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# FOSTERING PUBLIC-PRIVATE PARTNERSHIPS TO REDUCE HEALTH INEQUITIES IN PERU

**JULY 2010**

This publication was produced for review by the U.S. Agency for International Development (USAID). It was prepared by Mahesh Karra, Suneeta Sharma, and Manuel Vargas, consultant, of the Health Policy Initiative, Task Order I.

Suggested Citation: Karra, Mahesh, Suneeta Sharma, and Manuel Vargas. 2010. *Fostering Public-Private Partnerships to Reduce Health Inequities in Peru*. Washington, DC: Futures Group, Health Policy Initiative, Task Order I.

The USAID | Health Policy Initiative, Task Order I, is funded by the United States Agency for International Development (USAID) under Contract No. GPO-I-01-05-00040-00, which commenced on September 30, 2005. Task Order I is implemented by Futures Group International, in collaboration with the Centre for Development and Population Activities (CEDPA), White Ribbon Alliance for Safe Motherhood (WRA), and Futures Institute.

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The views expressed in this publication do not necessarily reflect the views of the U.S. Agency for International Development or the U.S. Government.



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## **ACKNOWLEDGMENTS**

The authors wish to thank the USAID | Health Policy Initiative, Task Order 1 teams in Washington, D.C., and Lima, Peru, as well as the regional partners and associates, for sharing their visions and experiences in forging public-private partnerships. The authors would particularly like to recognize the following key people for their ideas and insights, which are reflected in this report:

- Myra Betron, Gender Specialist and Activity Manager, Health Policy Initiative, Futures Group
- Tito Coleman, Deputy Director HIV, Health Policy Initiative, Futures Group
- Aditi Krishna, Research Associate, Health Policy Initiative, Futures Group
- Patricia Mostajo, Task Order Director, Health Policy Initiative/Peru, Futures Group
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## **EXECUTIVE SUMMARY**

The Ministry of Health is the largest provider of family planning (FP) services and contraceptives in Peru. The other public provider of services is the social security institute that provides health services to those in the formal employment sector. The private sector comprised of pharmacies, private providers, and non-governmental organizations also plays an important role. As demand for FP services increases, there needs to be a shift in how the public and private sectors respond. Promoting partnerships between the public and private sectors is a strategy for ensuring that unmet needs for services and contraceptives is satisfied, particularly among vulnerable populations in rural and remote regions.

To promote and support public-private partnerships (PPPs), the USAID | Health Policy Initiative, Task Order 1 applied a policy framework for fostering PPPs. The framework involves a multi-part process: (1) understand the policy environment and the market for FP/reproductive health (RH), (2) foster dialogue and develop consensus on health equity goals, (3) create an enabling environment for PPPs, (4) define public and private sector roles, and (5) develop PPPs. The project's activity in Peru to promote public-private partnerships was carried out from 2008 to 2010.

### **Barriers to Public-Private Partnerships**

Public-private partnerships in Peru have been predominantly limited to infrastructure and industrial development. Existing laws, health policy, current interest, and technical expertise in Peru suggests the potential for PPPs to improve the delivery of FP/RH services. Market segmentation studies not only show a shift toward the private sector but also demonstrate more diversity in terms of private sector client demand.

Despite a potentially favorable legal and policy environment, a situational analysis of national and regional health regulations revealed that key actors in both the public and private sectors were unclear about the definition and functions of PPPs. Decisionmakers often fail to understand crucial differences between PPPs and more traditional private sector provision of health services. Additionally, perceived cost disincentives dissuade the private sector from participating in public-private initiatives and limit opportunities for greater private sector contributions to health service delivery.

Contractual mechanisms for PPPs can help define the roles and responsibilities of each sector. Mechanisms, such as contracting out and voucher schemes, can be used to clarify ambiguous incentives, highlight cost reductions in service delivery, and promote investments in health systems of both sectors.

### **Public-Private Dialogue**

Senior officials of the Peruvian government and private sector representatives participated in workshops in October 2009 and January 2010. During the first workshop, PPP experts from Argentina, Brazil, and Mexico shared their views of the legal and policy framework for health partnerships and investment. Participants recognized the need for an extensive review of Peruvian laws that have bearing on PPP implementation at national, regional, and local levels. These meetings helped to clarify the objectives of public-private partnerships, present examples of contractual mechanisms for PPPs, consider long-term returns on investment, and delineate the operational scope for both sectors. Participants were optimistic about the potential for PPPs to alleviate unmet for FP/RH. Other factors contributed to their optimism: evidence of Peru's favorable legal framework, established quality standards for health service delivery, and a government that has made universal health coverage a goal.

A second workshop in January 2010 further fostered public-private dialogue and consensus about the potential role of PPPs. The workshop provided a venue for sharing information from the situational analysis and an opportunity to mobilize key private sector providers, including nongovernmental

organizations and USAID cooperative agencies. The meeting concluded with the official launching of the Health Policy Initiative and USAID/Peru's Public-Private Partnership website.

## **Outcomes**

Given the positive response from the Ministry of Health (MINSA) and other stakeholders to the promotion of PPPs, the Development Group for Public-Private Partnerships in Health was formed and officially established by MINSA in January 2010.

Members of the group, with the Health Policy Initiative's technical assistance, developed Peru's first strategic plan (roadmap)<sup>1</sup> for implementing sustainable PPPs in health. To begin implementing the roadmap, the project collaborated with MINSA and regional health directorates from the Cajamarca and Trujillo districts to design a preliminary contract for health services between public and private sector providers.

When the Health Policy Initiative's activity in Peru was designed, the overriding question from USAID was whether the conceptual framework for fostering public-private partnerships was viable and effective. It is too soon in the implementation process of PPPs to answer this question. The outcomes noted above are evidence that the first crucial steps have been taken. Assuming that MINSA and key private sector agencies continue to carry out the roadmap, it will be possible to answer this question; when depends on the progress made to implement PPPs.

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<sup>1</sup> Roadmap is the literal translation from the Spanish and is used in the Spanish documentation for this project activity.

## ABBREVIATIONS

AIDS	acquired immune deficiency syndrome
BOT	build, operate, and transfer
CDC	Center for Development Communication
CPR	contraceptive prevalence rate
CI	Clínica Internacional
DGIEM	General Manager's Office of Infrastructure, Equipment, and Maintenance
DGSP	General Manager's Office of Public Health
DIGEMID	General Manager's Office of Medicine and Pharmacy
DIGESA	General Manager's Office of Environmental Health
DIRESA	Dirección Regional de Salud Lima (Regional Directorate of Health, Lima)
DL	Legislative Decree
ENDESA	Encuesta Nacional de Salud (Demographic and Health Survey)
EsSALUD	Seguridad Social (Social Security of Peru)
FP	family planning
FP/RH	family planning/reproductive health
HIV	human immunodeficiency virus
IFPS	Innovations in Family Planning Services
INEI	Instituto Nacional de Estadística e Informática
IUD	intrauterine device
ITAP	Innovations in Family Planning Services (IFPS) II Technical Assistance Project
LGA	local government authority
MINSA	Ministerio de Salud (Ministry of Health)
NGO	nongovernmental organization
OC	oral contraceptive/over-the-counter contraceptive pill
OGAJ	General Office of Legal Consultancy
OGPP	Office of Planning and Institutional Development and the General Office of Planning and Budget
OPI	Oficina de Proyectos de Inversión, MINSA (Office of Investment Projects)
PARSALUD	Program for Health Sector Reform
PEAS	Essential Plan for Health Assurance
PPP	public-private partnership
RH	reproductive health
SIS	Seguro Integral de Salud (Integral Health Security)
SLI	standard of living index
USAID	United States Agency for International Development
WRA	women of reproductive age

## **I. INTRODUCTION**

The private sector has a critical role to play in closing healthcare gaps and reducing health inequities in Latin America. The public sector, however, must institute policies and regulations that support the private sector in providing and financing health services and products. Much of the dialogue and policy work designed to improve access to healthcare has occurred without the full and active participation of private sector representatives. Recent market studies have shown that Peru’s public sector is the largest provider (70%) of family planning (FP) services and contraceptives. However, public sector support—particularly the Ministry of Health (MINSA)—may be insufficient in the long term given the increasing demand for FP services. If the private sector in health were to be engaged as a partner with the public sector, FP service delivery could be expanded.

In 2008, USAID | Health Policy Initiative, Task Order 1 explored the private sector’s role in providing health services, particularly family planning/reproductive health (FP/RH) services in Peru (Sharma et al., 2008; Subiría, 2007). An objective of this activity was to determine if a framework for public-private partnerships (PPPs) was a viable and effective model for increasing access and availability of FP/RH services, particularly for vulnerable populations in rural and remote areas. Another objective was to address equity in the delivery of health services.

The Health Policy Initiative activity team helped to create consensus among private providers of health services [pharmacies, private providers, and nongovernmental organizations (NGOs)] and public sector providers to address the unmet need for family planning. The team assisted in developing a framework for PPPs in Peru and a strategic plan (roadmap) to guide the design and implementation of PPPs. MINSA’s Investment Committee, the Office of Investment Projects (OPI), and regional governments and private sector entities supported this work.

This report presents findings from a literature review of global and Latin American experiences with PPPs, a review of Peru’s policy and legal environment, a market analysis, key informant interviews, and national and regional dialogue from stakeholder workshops. It also describes the steps taken to implement the roadmap and the outcomes achieved.

### **Methodology**

The team conducted a literature review of PPPs in health—both globally and in the Latin American region. The review focused on health service delivery and financing. Several examples of PPPs were identified and provided useful information for Peru. The team consulted with regional stakeholders and health sector professionals, who defined the legal and policy environment for the private sector’s role in health, FP services, and financing. The team analyzed how the market was segmented among public and private sector providers using Peru’s Demographic and Health Surveys (ENDESAs). Of particular interest was service provision for poorer clients. The project team also facilitated dialogue with key informants on barriers to greater participation of the private sector. Several policy and technical workshops were held at the local, regional, and national levels to determine the best approaches to strengthen and implement PPPs in health (see Annex 1 for a timeline of the PPP activity).

## **II. A POLICY FRAMEWORK FOR FOSTERING PUBLIC-PRIVATE PARTNERSHIPS**

Supporting the private sector to become a true partner with the public sector in achieving health equity goals and meeting unmet needs for FP/RH services is a multi-step process. The Health Policy Initiative applied a policy framework for fostering PPPs. Figure 1 shows the parts of the framework that are

designed to (1) understand the policy environment and the market for FP/RH services; (2) foster dialogue and develop consensus on health equity goals; (3) create an enabling environment for PPPs; (4) define public and private sector roles; and (5) develop PPPs (Health Policy Initiative, 2009a; Sharma, 2009; Sharma and Dayaratna, 2005).

**Figure 1. A Conceptual Framework for Creating Public Private Partnerships**



The following sections elaborate on the parts of the framework and describe how it was implemented to gain support from the public sector, mobilize the private sector and promote PPP.

## Understand the Policy Environment and the Market for FP/RH

**The policy environment.** The policy environment affects the activities and priorities of the private sector in many ways. An assessment of the policy and legal environment helps to identify opportunities and barriers for both sectors and can favorably influence this environment (Cross et al., 2001). A policy environment that is well understood is part of fostering dialogue among public and private sector providers. In turn, this dialogue can shape needed policy reforms.

**The market.** An assessment of the market for FP/RH services, using market segmentation analysis, contributes to an understanding of each sector’s current and past roles in terms of the demand for and supply of health services. Demand-side analysis examines characteristics of the client base (e.g., place of residence, provider sources, and type of services used) (Suneeta and Dayaratna, 2005). Supply-side analysis assesses the market through willingness-to-pay studies that give information on providers’ sources of funding and pricing strategies. It also involves examining the public sector’s current target population and its potential niche in the future. By combining both demand- and supply-side analysis, service delivery strategies can be developed to address inefficiencies and create opportunities for greater private sector participation. Information on current and potential markets<sup>2</sup> can inform strategic planning to achieve FP/RH security in Peru, including the development of PPPs.

<sup>2</sup> The *market* for FP services includes FP/RH services and methods (particularly contraceptive methods), consumers (women of reproductive age, [WRA]), and providers. Contraceptive methods include modern methods of family planning (such as oral contraceptives, condoms, intrauterine devices, and sterilization), traditional methods (such as withdrawal and periodic abstinence), and folkloric methods (vaginal douche). *Consumers* are defined as WRA using a modern contraceptive method, and *likely consumers* are identified as those are using traditional methods or state that they intend to use FP methods in the future. *Providers* include government, private for-profit (commercial sector), and not-for-profit (NGOs) sources of FP/RH commodities and services. The manner in which these three primary components of the FP market fit together can be referred to as the *FP market structure* (Cakir and Sine, 1997).

## Foster Dialogue and Develop Consensus on Health Equity Goals

Fostering dialogue among representatives of public and private sector entities is a basis for putting PPP on the policy agenda.<sup>3</sup> Developing a communication strategy can help to create an effective dialogue and develop consensus on health equity goals and how they will be achieved. The strategy defines objectives; identifies issues to be addressed; provides information on the policy environment (including laws, policies, and regulations that enable or are barriers to service delivery through PPPs); includes demand- and supply-side analysis for FP/RH services; and touches on international and regional experiences in PPP. It also outlines channels for communication (e.g. national and regional meetings, technical workshops, and the Internet) and audiences to be reached to explain the importance of promoting PPP. The strategy can lead to advocacy for sustained public-private sector dialogue, which is needed to develop consensus on health equity goals.

There are challenges to fostering dialogue and developing consensus. Reluctance among some stakeholders to support the development of PPPs may be attributed to “past perceptions and real programmatic (policy frameworks, capacity, etc.) obstacles” (Center for Development Communication, p. 3). One major issue is the private sector’s image as a profit-driven service provider; other entities’ fear that the profit motive could undermine trust in the partnership.

There are also programmatic barriers to policy dialogue and promoting PPP, such as

- Disagreement within institutions as to the potential of PPP initiatives;
- High transactional and operational costs to implement PPP;
- Differences among public and private entities (e.g., institutional mission, objectives, strategic plans, organizational structures, culture, and operational policies)

A communication strategy can address perceptions and programmatic barriers. For example, advocacy by committed stakeholders can demonstrate the potential role of PPPs, and evidence-based arguments can illustrate how the benefits of PPP can outweigh the costs.

## Create an Enabling Environment for Public-Private Partnerships

The public sector can use several approaches to increase private sector involvement.

- **Involve the private sector as a partner in planning, decisionmaking, and resource allocation.** Policymakers often ignore the private sector in health policy formulation and planning and leave the private sector’s potential unexplored. The government can involve the private sector in many ways, such as in joint planning sessions, public-private stakeholder consultations, roundtable discussions, and policy seminars. It is crucial that the public sector ensure that the private sector is represented in key national policy committees and task forces. Such actions are essential for building public-private trust and fostering dialogue between sectors.
- **Create incentives to attract private sector participation.** Providing incentives can help increase private sector presence in the market, while also allowing private entities to effectively provide affordable services to clients. The right incentive structures also can reduce delivery and production costs, thereby encouraging providers, both public and private, to extend coverage to a broader group of clients. The public sector can offer many kinds of incentives to encourage private sector participation including the following:
  - Provide financial support to private entities that are willing to target goods and services to selected clients (e.g., low-income customers or vulnerable populations)

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<sup>3</sup> Center for Development Communication, 2008, has a detailed discussion of PPP communication strategies.

- Contract out services to the private sector
- Extend marketing strategies (public advertising, media coverage) to commercial vendors
- **Eliminate or reduce legal and regulatory barriers to private sector participation.** Government health policies and regulations are necessary for ensuring consumer protection and setting quality standards for the private sector. Such restrictions can have an adverse impact on private sector expansion. Price controls, distribution and advertising quotas, licensing requirements, and other cumbersome registration processes are barriers that can limit private sector (especially the private, for-profit commercial) participation. The goal of policies and regulations should be to enhance rather than contain the commercial sector’s ability to respond to market conditions.

## **Define Public and Private Sector Roles**

Partnerships can help both public and private sectors to reach a common objective of ensuring greater access to services. Given public-private market shares (existing and potential), different services and products, and consumer preferences, there are various roles and responsibilities for both sectors (including commercial providers). PPPs provide opportunities to capitalize on strengths, maximize the use of existing capacity, create competition, achieve economies of scale, extend service delivery networks, target the poor, and mobilize additional resources. Favorable policies, open dialogue, and direct subsidies support these endeavors.

## **Develop Public-Private Partnerships**

Developing PPPs involves an evidence-based process. It involves prioritizing needs, determining shared goals, engaging appropriate partners, developing strategic options, designing and testing appropriate models, evaluating impact, determining the costs of scaling up strategies, and ensuring sustainable financing. Government leadership and ownership are central to the process.

# **III. FINDINGS OF THE LITERATURE REVIEW**

## **Global Experiences**

The Health Policy Initiative team conducted a comprehensive literature review to identify public-private partnerships in countries around the world, particularly those in Latin America. The review aimed to

- Study the contexts and rationales used to justify implementation of PPPs in health service delivery, especially FP/RH, to vulnerable populations;
- Synthesize the challenges and barriers to PPP programs and private sector participation;
- Examine the nature of public-private contracts, particularly the mechanisms such as contracting out and social franchising schemes; and
- Identify approaches to PPP sustainability and scale-up.

Analysis of the literature confirmed that there are important benefits and potential in greater participation of PPPs in health service delivery. Both public and private sectors, which traditionally have worked separately to provide health service delivery, can work together to achieve a more efficient and higher-quality service delivery. While contracting out to the private sector through performance-based schemes continues to be a popular approach to partnerships, other mechanisms—including social marketing, vouchers, performance-based payment, and social franchising—also have been successful (Abramson, 1999; O’Hanlon, 2008; O’Sullivan et al., 2007; Savas, 2005; Ter-Minassian, 2004).

General observations drawn from the literature include the following:

- Demand for health services is increasing, and the public sector alone will not have the capacity to meet demand. Some of the increasing demand can be met by tapping into the private sector, whose role in health service delivery is growing.
- There is consensus that public and private providers work in parallel, but they could complement each other in providing services by working together.
- The public sector's main responsibility is to provide an enabling policy environment to promote PPP in health given the limited private sector participation in the past.

Common lessons from successful PPPs include the following:

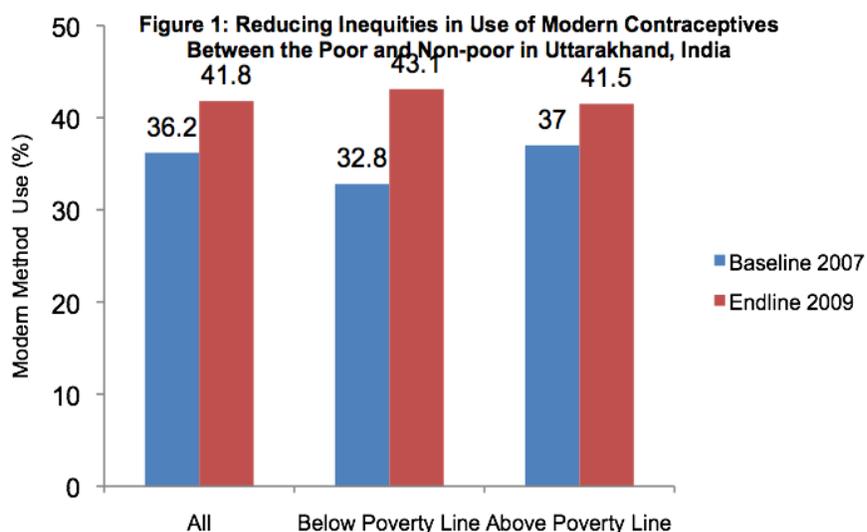
- Advocacy about the benefits and potential of PPP is needed to increase the awareness of these benefits by high-level government officials from the ministries of health, economy, and finance; relevant private sector representatives; key donors; and USAID cooperative agencies.
- All stakeholders must recognize and promote the role of the private sector in service delivery.
- The private sector needs to be involved in and committed to the PPP planning process.
- Both public and private sectors must work together to define roles and responsibilities of each and to agree on program objectives and implementation of PPP. In past efforts, poorly defined roles and responsibilities, program objectives, and implementation plans led to confusion among the partners and also impacted the privatization of services and private sector service delivery.
- Tools for improving the enabling policy environment for PPPs already exist. These include health policy frameworks from countries and particular mechanisms permitting private sector financing and service delivery.

One of the most effective public-private partnerships in health was created and implemented in India. Key features of the PPP are described in Box 1 and illustrate a useful example for a successful PPP.

### Box 1: Examples of Mechanisms for Reaching the Poor: Public-Private Partnerships in India

USAID and the Indian government have collaborated to promote PPP initiatives in FP/RH service quality and financing. As part of these efforts, USAID has developed and pilot-tested several demand-side financing schemes and partnership models that have successfully mobilized public and private sector resources, strengthened existing health systems, widened the range of access to services, reduced inequities in the use of reproductive and child health services, and improved overall service quality (Innovations Family Planning Services II ITAP, 2009, Narayana, 2009). (See Annex 2 for examples of successfully implemented PPP models in India.)

In particular, India has tested and scaled up various types of **voucher scheme** models to provide affordable reproductive and child healthcare services to poor families in the states of Uttar Pradesh, Uttarakhand, and Jharkhand. Under this scheme, families can redeem the vouchers at any selected and accredited private hospital in exchange for free RH services, including prenatal care, childbirth, postnatal care, and FP services (Donaldson et al., 2008). The hospitals then submit the vouchers to the government for reimbursement. The successful implementation of the voucher scheme pilots in Uttarakhand resulted in reduced inequities (see Figure 1) and scale-up efforts that provided coverage to more than 5.36 million people.



**Social franchising** initiatives have helped to build a network of hospitals that (1) provide RH services at a cost 35 percent to 40 percent lower than other providers and (2) follow the same set of quality standards to ensure consistency of care. The hospitals each offer the same set of services and are similarly branded so that they are easily identifiable. The franchising network covers 70 districts through two franchiser hospitals, 70 fully franchised units, 700 partially franchised units, and 10,500 community-level committees. The partial franchisees must provide a similar set of services at similar prices to those of a full franchise facility. They must also sign a contract for improving the quality of their healthcare services.

**Mobile health clinics** have been effective in bringing healthcare services directly to the villages via mobile health vans. Private companies operate the vans, and the government provides the staff, usually consisting of three doctors and one pharmacist. Villagers are notified ahead of time when the van will be in their area. Impoverished women receive RH services for free, while other women receive the services at a low, government-subsidized rate. Mobile health van initiatives have been so successful that the Uttarakhand government has scaled up operation of 13 vans across all 13 of the state's districts, thereby extending coverage to more than 10 million people. In a year, the mobile vans served 11,308 outpatients, performed 161 IUD insertions, distributed 1,203 cycles of oral contraceptives, and distributed 31,670 condoms in remote, rural, inaccessible areas.

The Uttarakhand government also **contracted out** non-clinical areas, such as laundry, sanitation, diet, and waste management services to the private service providers, so that government health service providers could focus their energies and resources on the clinical aspects of healthcare. Moreover, users and stakeholders perceived the involvement of private providers as bringing with them a system that is efficient, effective, and accountable. There has been a marked improvement in the quality of services, cleanliness in the hospitals has improved greatly, food and nutrition service standards for patients have progressed, and laundry delivery is now clean and timely. Furthermore, private service providers have a higher accountability for the quality of services rendered, compared with in-house staff. The government's "surplus" staff has been re-deployed in other areas of service delivery in which there was a perceived shortage of human resources. In this manner, the Uttarakhand health departments have been able to conserve resources by adopting a competitive tendering process.

## Latin America Experiences

Partnerships in Latin America have been developed in Bolivia, Brazil, Colombia, Ecuador, Guatemala, Mexico, and Nicaragua; for example:

- PROSALUD/Bolivia is working to integrate public and private health services, including FP/RH, to reach low- and middle-income populations in urban and peri-urban areas.
- An initiative in Colombia fostered partnerships by diversifying health insurance options and offering a wider range of public-private financing schemes to promote long-term program sustainability (Slack and Savedoff, 2000).
- Ecuador's Private Initiatives for Primary Health Care Project is designed to examine how public-private networks could deliver high-quality health services (including pharmacy services, pediatric consultations, etc.) to low-income and vulnerable populations while remaining financially viable.
- Nicaragua's PROFAMILIA clinic network is designed to deliver curative and preventative healthcare services to six towns that were hit hard by Hurricane Mitch. After only two years of operation, the network was able to recover almost 85 percent of its total costs.

Contracting out to the private sector seems to be the primary mechanism for PPP. The following two examples outline PPP outcomes in Brazil (relatively successful) and Guatemala (more problematic).

- Brazil implemented a PPP to engage NGOs in the prevention and treatment of HIV/AIDS. A key project objective was to gather information on PPP contracting mechanisms and feedback response from chief NGO and public sector participants. The resulting PPP contract successfully achieved the following:
  - A broader, more developed country strategy to fight the HIV epidemic
  - NGO participation in the project design and evaluation process
  - Emphasis on information transparency and collaboration from both sectors
  - Experience and capacity for both sectors to manage and jointly fulfill contract objectives
  - Additional infusion of donor funding and support for NGO involvement

Given the relative success of the partnership, both sectors identified several challenges that affected performance:

- Lack of adequate baseline data
  - High costs of HIV/AIDS research
  - Methodological difficulties in measuring the number of infections averted and behavior changes, such as the adoption of safe sex practices
  - Difficulty in maneuvering under an intricate and complex contracting process that may be resolved through additional capacity building and review by both sectors
  - Lack of direct support from external financial institutions (such as the World Bank) for NGO activities
- The Guatemala Ministry of Health contracted out health services to the private sector, particularly NGOs, to expand access to healthcare by the poor and isolated populations. Under a contract, private sector providers offered a basic package of subsidized services, including maternal and child healthcare services. While the level of access to services improved, several programmatic weaknesses hindered overall progress:
    - The contract lacked performance indicators and monitoring mechanisms resulting in a lower quality of service
    - Ineffective communication between the private sector and ministry representatives led to mismatches in policy objectives and failure to target under-served populations

In retrospect, the study acknowledges that clearer performance expectations, more open dialogue between public and private sectors, and stronger contractual agreements could have resolved many of the operational and programmatic problems.

## **IV. PUBLIC-PRIVATE PARTNERSHIPS IN PERU: ANALYSIS AND ACTIVITY OUTCOMES**

### **The Context**

Recent public-private partnership activities in Peru's health sector have been a part of a larger MINSAs-driven initiative to extend health coverage and improve service delivery to poorer regions. In recent years, several legal resolutions effectively paved the way for future PPP activity by focusing on universal coverage and increased private sector involvement in health (Health Policy Initiative, 2009c).

According to statistics from the 2007 National Population Census, 57 percent of Peru's population—more than 15.4 million people—were left without any form of health insurance coverage (INEI, 2007). To increase coverage and health service access, the Congress of Peru, with support from MINSAs and other regional partners, enacted the Universal Health Coverage law, Peru Resolution No. 29344. Within the framework of this resolution, health coverage will be increased by means of the Integral Health Insurance Plan;<sup>4</sup> furthermore, the law will require the implementation of a 2010 public-private program in nine regions to increase access to health services for the poorest and most excluded populations.<sup>5</sup>

In 2008, the Congress of Peru passed another resolution, Resolution No. 29320, which called for additional regional and local public investment, with increased participation from the private sector; this initiative was part of a larger series of pro-PPP oriented legal approaches, which included these ordinances:

- DL No. 1012, calling for the recognition and implementation of public-private partnerships for the generation of productive employment in manufacturing and infrastructure
- DL No. 1016, calling for a modification of the Third Transitory Complementary Disposition clause of the DL No. 1012 (this modification, in conjunction with DS No. 146-2008-EF, DS No. 015-2004-PCM, and its modifier DS No. 013-2007-PCM, effectively reinforces previous legislation, Resolution No. 28059, which stipulated the promotion of decentralized investment in infrastructure and regional development)

While these initiatives are fairly recent, they create an opportunity for MINSAs, regional governments, and local directorates to work side by side with the private sector in improving health service quality and access for the poorest populations in Peru. DL No. 1012 and its attached legislation open the way for the advancing PPP development projects in infrastructure, which includes the health sector. However, the government has achieved little in the way of implementing development projects to improve public services, particularly health services. The limited progress can be attributed to a lack of understanding and

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<sup>4</sup> This public health initiative calls for the improvement of health services, focusing particularly on clinical services offered by maternal and child health centers and hospitals at the provincial, regional, and macro-regional levels. Details of the pre-required benchmarks and compliance standards needed to define each type of health institution are outlined in the 2005 MINSAs Accordance for Health Sector Institutions and Establishments (Technical Regulation No. 021-MINSAs/DGSP V.01. Lima, Peru 2005).

<sup>5</sup> The nine preselected regions are Amazonas, Ayacucho, Huancavelica, Apurímac, Piura (Lower Piura), Lambayeque (Salas), La Libertad (Sánchez Carrión), San Martín (Lower Huallaga), and Cusco (particularly the intermediate zone between the Apurímac River Valley and the Ene River). These regions were selected through the MINSAs-sponsored Essential Plan for Health Assurance (Plan Esencial de Aseguramiento en Salud, PEAS).

awareness of PPP initiatives, uncertainty about the best approaches or mechanisms, no PPP implementation guide or programmatic precedent, and insufficient tools for monitoring PPP program development.

The Health Policy Initiative applied the PPP policy framework approach in Peru. The following sections present findings on (1) understanding the policy environment and market for FP/RH, (2) fostering dialogue and developing consensus on health equity goals, (3) creating an enabling environment for PPPs, (4) defining public and private sector roles; and (5) developing PPPs. Also presented are the outcomes from policy dialogues, diagnostic tools, and initial regional studies.

## **Understanding the Policy Environment and the Market**

### **Findings from the Legal and Policy Review**

The following four sections review laws and policies that make it possible for PPP to be implemented at the national and regional levels.

#### ***1. Current health laws and regulations that support universal health coverage***

This section introduces the initiative for universal health coverage that establishes the legal basis for investment in PPP activities.

*Universal health coverage.* Regulation No. 29344, the Universal Health Coverage law, which was approved in April 2009, defines the policy and legal process for the establishment of universal coverage. In its first Article, the law guarantees the complete and necessary right of each person to social security in health and bestows on the state the responsibility of protecting this right to high-quality policy standards, financing, benefits, and health coverage.

The law states that MINSA must fulfill its role as the supervising body by establishing and enforcing policies and norms that promote implementation of health coverage and security through linked agents and external providers, if necessary (including funding administrators, lending institutions for health services, and private donors). In this manner, MINSA can build on the foundation established by the National Superintendent of Lending Organizations in Health by appointing a National Superintendent for Health Security.

As part of the universal coverage law, MINSA approved an Essential Plan for Health Assurance (PEAS). This strategic initiative aims to

- Reduce barriers to accessing the national health system;
- Address inequities in health systems' financing across regions and populations; and
- Promote regulations that support additional health service benefits, particularly to vulnerable groups.

Under the universal health plan, the state is asked to cover the costs of implementing PEAS for those consumers in poverty. PPPs are used to subsidize costs of health services for the poor and distribute the risk shared by private and public sector financing institutions.

Furthermore, the PEAS initiative establishes minimum financing requirements and pre-determined standards for all health service providers, whether public or private, to promote higher-quality health services and guarantee coverage to all consumers, regardless of whether they can afford to pay.

In 2009, the Universal Health Coverage law was operationalized in seven regions: Ayacucho, Huancavelica, Apurímac, Piura (bajo Piura), Lambayeque (Salas), La Libertad (Sánchez Carrión), and San Martín (bajo Huallaga).

To comply with the PEAS standards, several health service centers were required to raise their health standards, particularly maternal and child health centers (Centros de Salud Materno Infantiles I–4), as well as provincial and regional hospitals (levels II and III).

## **2. Decentralization laws**

Decentralization in Peru began in 2002 under Regulation No. 27680, Ley de Reforma Constitucional del capítulo XIV del título IV. The legislation promotes decentralization as a form of democratic organization. The decentralization process was seen as a necessary and critical component of the state, and it was essential to encourage such efforts to achieve key objectives in national economic and health development.<sup>6</sup>

In 2000, the government approved others laws that endorse decentralization in Peru. These are Regulation No. 27783—Ley de Bases de la Descentralización; Regulation No. 27687—Ley Orgánica de Gobiernos Regionales; and Regulation No. 27972—Ley Orgánica de Municipalidades.

In complying with these three regulations, the national government began the process of transference by reallocating funds for social projects, poverty alleviation programs, and other initiatives to regional governments and local institutions. The Congress approved the National Plan for Transference of Competencies to Local and Regional Authorities, as stipulated in Regulation D.S. No. 049-2008-PCM. This new legislation established the functions of local authorities. The following citations call for initiatives, such as PPPs, to further the policy process:

- The necessary coordination and management of health service procurement and provision in local regional capacities, including implementing fiscal decentralization strategies (Article No. 49, Clause C)
- The organization, implementation, and management of health services for prevention, protection, recuperation, and rehabilitation in public health, in accordance and cooperation with local government authorities (LGAs) (Article No. 49, Clause G)
- Sector regulation of public health, including the supervision and financing of public and private health services (Article 49, Clause H)
- Investment in health—planning, financing, and procurement of health systems infrastructure and equipment, promoting health technology development in the regional capacity (Article 49, Clause I)

## **3. Policies that promote public investment in health**

Three recent legislative actions promote public investment in health. The first is Legislative Decree No. 059-96-PCM, Ordinance of Law that promotes and regulates private sector investment in public works, infrastructure, and services. As one of the first public-private policies in Peru, this decree supports and regulates efforts to encourage private sector participation and investment in public services, particularly in public works, infrastructure projects, and other specified public services.

The second is Regulation No. 27293, which creates a national system of public investment. Under this system of investment, public resources directed to promoting investment are allocated to public service initiatives in accordance with the particular principles, processes, methodologies, and technical norms that each project requires. In its objectives, the law states that “All projects that are implemented under the National System of Public Investment shall be governed by the guidelines that are outlined in the

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<sup>6</sup> Article 188, Regulation No. 27680—Ley de Reforma Constitucional del capítulo XIV del título IV (2002).

appropriate strategic plans (whether they be at the national, regional, or local level), the economic priorities of the State, the efficiency and efficacy of the projects themselves, and the necessary maintenance required to support project infrastructure and development.” As is described in Article 3 of this regulation, key players include the following:

- The Ministry of Economy and Finance
- Ministries and offices of program development and investment
- Relevant regional governments, LGAs, and key stakeholders

The law also highlights the creation of project funding schemes and individual project banks, which shall be regulated and monitored by the Ministry of Economy and Finance and other relevant institutions and organizations within the National System of Public Investment.

The third is Regulation No. 28509, which promotes decentralized investment and regulation, as approved by Legislative Decree No. 015-2004-PCM. A key law promoting PPP is Regulation No. 28059, which

- Establishes an investment framework for the State and its three levels of government, promoting decentralized investment as a tool for achieving optimal regional sustainability and development;
- Guarantees decentralized investment, particularly through the private sector, at the national, regional, and local levels to strengthen infrastructure, fortify public-private relations, and enhance economic performance;
- Encourages private sector involvement in the decentralization process through contracting, concessions, PPPs, joint venture initiatives, outsourcing, and other mechanisms; and
- Recognizes private agencies, such as Proinversión, that support and implement private investment at the regional and local levels of policy, particularly promoting strategic initiatives that establish decentralized private sector investment. These efforts were supported in conjunction with Regulation No. 29230, a measure calling for regional and local public investment with participation from private sector institutions.

#### **4. Regulations that specifically promote PPP**

Legislative Decree (DL) No. 1012 specifically refers to PPPs. DL No. 1012 is the key piece of legislation recognizing and approving the role of public-private partnerships as a viable and effective approach to improving productivity and achieving fundamental policy and regulatory objectives through necessary private sector investment. The decree establishes the processes and policies necessary for effective evaluation, implementation, and operation of public infrastructures and services through private sector participation and investment. As outlined in Article 4 of the decree, public-private partnerships can be classified in two ways: self-sustainable and co-financed.

Self-sustainable PPPs would be those in which

- The financial contribution from the State is minimal or non-existent (not more than 5% of the total cost of investment); and
- The non-financial contributions<sup>7</sup> have a zero or minimal probability of being demanded. This implies that if public sector resources are used for investment, they will not exceed 10 percent of the total cost of the project.

Co-financed PPP initiatives are those public-private investments that require co-financing, shared grants, or contracts using financial guarantees<sup>8</sup> that involve significant demand and use of public sector services.

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<sup>7</sup> Non-financial contributions are those non-monetary public investments and resources written into the contract.

<sup>8</sup> Financial guarantees are those endorsements approved and sustained primarily through international credit.

The supply of a public service by a private operator must be of high quality at a pre-determined cost, or of a lesser cost than if the service were to be provided and managed by a public vendor.

PPPs must take into account the financial capacity of the government to develop the contracting mechanisms needed for the partnerships. PPPs also must specify the scope and level of investment and service delivery; and these objectives must comply with national, sectoral, and regional goals and priorities.

### **Findings from the Market Segmentation Analysis<sup>9</sup>**

MINSa is the main provider of FP/RH services to the poor in Peru. Private sector clinics are rarely located in rural and other areas where the poor reside. The government provides a basic package of free services to women, children, and infants, including for HIV, tuberculosis, maternal health, and family planning.

The following sections present changes in the market share of public, private, and NGO health providers in Peru between 2000 and 2008 and profiles of clients and the use of family planning methods.

#### ***The provider market share and client profiles***

Social marketing products are distributed primarily through a large number of commercial and NGO outlets. Table 2 presents a profile of clients served by MINSa, the Social Security Institute (EsSALUD), private providers, pharmacies, and NGOs based on socioeconomic and demographic data from 2008 National Demographic and Health Survey (ENDESA).

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<sup>9</sup> See Annex 3 for a description of the market segmentation methodology.

**Table 2: Percentage of Clients Using Government, NGO, and Commercial Sectors for Family Planning Services, 2008**

	<b>MINSA</b>	<b>EsSALUD</b>	<b>Private</b>	<b>Pharmacy</b>	<b>NGO</b>	<b>Other</b>	<b>Total</b>
<b>Socioeconomic Status</b>							
Poorest	18.2%	0.9%	4.5%	0.7%	2.7%	12.1%	12.5%
Second	27.2%	7.6%	5.7%	6.6%	3.0%	12.5%	20.1%
Middle	26.1%	24.4%	19.3%	20.3%	21.0%	20.9%	24.5%
Fourth	18.0%	32.8%	23.6%	36.5%	26.8%	13.6%	22.9%
Wealthiest	10.5%	34.3%	47.0%	35.9%	46.5%	41.0%	20.0%
Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
<b>Urban-Rural Residence</b>							
Urban	60.1%	90.0%	86.9%	93.0%	94.3%	77.6%	70.8%
Rural	39.9%	10.0%	13.1%	7.0%	5.7%	22.4%	29.2%
Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
<b>Level of Education</b>							
No education	4.9%	0.6%	0.2%	0.0%	16.7%	0.3%	3.4%
Primary	40.0%	10.5%	19.7%	10.6%	17.0%	28.0%	30.5%
Secondary	41.9%	39.8%	35.8%	41.1%	41.9%	27.4%	40.9%
Higher	13.2%	49.2%	44.3%	48.4%	24.3%	44.3%	25.2%
Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
<b>Parity</b>							
0	1.8%	0.4%	2.5%	4.7%	0.0%	1.2%	2.1%
1	17.8%	11.6%	17.0%	33.8%	19.0%	7.1%	19.5%
2	23.8%	31.4%	32.4%	35.4%	25.0%	31.6%	27.2%
3	23.3%	31.3%	24.0%	18.2%	19.2%	30.9%	23.5%
4+	33.3%	25.3%	24.2%	7.9%	36.9%	29.2%	27.7%
Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
<b>Method Use</b>							
OCs	18.9%	8.1%	14.2%	14.3%	23.7%	16.4%	16.8%
IUD	5.4%	8.8%	13.0%	0.0%	24.3%	10.9%	5.5%
Injectables	41.0%	16.0%	11.5%	10.2%	10.4%	13.8%	31.0%
Condom	9.0%	15.3%	0.9%	75.6%	10.4%	16.5%	20.5%
Female Sterilization	25.0%	48.7%	55.6%	0.0%	31.2%	40.3%	25.2%
Other modern	0.7%	3.0%	4.7%	0.0%	0.0%	2.0%	1.0%
Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Note: For additional diagnostic tools and market segmentation analyses, please refer to Sharma et al., 2006, and Health Policy Initiative, 2009b.

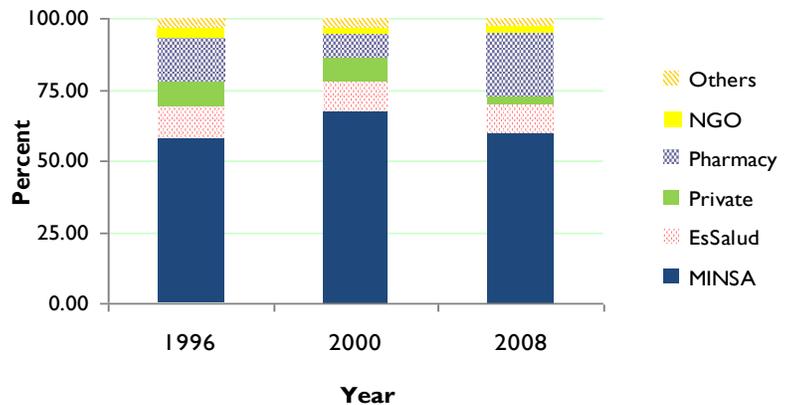
*Ministry of Health (MINSA).* MINSA is the major provider of FP/RH services and contraceptives in Peru. Between 1996 and 2000, MINSA’s share of the FP/RH services market increased from 58 percent to 67 percent but decreased to 60 percent by 2008 (see Figure 2). During the same period, the proportion of the public sector’s clientele from the two poorest quintiles that used public health services declined from about 54 percent in 1996 to 38.7 percent in 2008 (see Figure 3) (Gribble et al., 2007). In 2008, approximately 60 percent of MINSA clients lived in Metropolitan Lima and 40 percent were from rural areas. Almost 45 percent of those who relied on MINSA had no education or had attained only primary level education. More than 30 percent had 4 or more children. MINSA clients used injectables (41%), female sterilization (25%), oral contraceptives/over-the-counter pills (OCs) (19%), and intrauterine devices (IUDs) (5%).

*Social Security Institute (EsSALUD).*

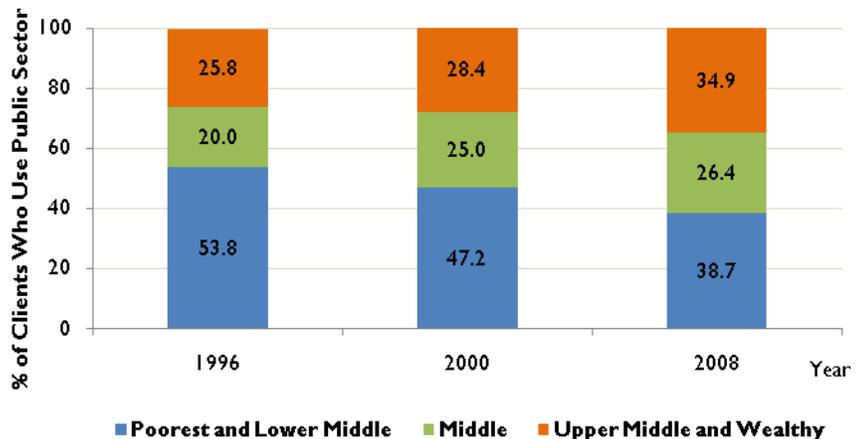
EsSALUD has consistently served about 10 percent of modern contraceptives users, providing healthcare services to those in the formal employment sector (see Figure 2). It serves as a third-party funding mechanism for healthcare and is funded through payroll taxes paid by employers. Clients covered by EsSALUD have two options when they seek healthcare—they can go either to social security clinics or private healthcare administrators that are contracted by EsSALUD and provide employers with the option of bypassing the traditional social security system. In 2008, 92 percent of EsSALUD clientele came from the middle and two highest wealth quintiles, and just over 8 percent came from the lowest two quintiles. EsSALUD clients continue to rely more on long-term contraception methods, such as female sterilization (49%), injectables (16%) and IUDs (9%). Condoms and OCs accounted for about 23 percent of the method mix.

*Private clinics and providers.* There is a small number of private doctors and nurses who work in hospitals and clinics that provide health services at affordable prices to consumers from the middle and fourth quintiles. Although always fairly small, private providers’ market share has declined even more in the last eight years. In 1996, they served 9 percent of modern method users; in 2000, they served 8.5 percent; and in 2008, they served only 3 percent. Private providers’ small market share and steady decline as a source of modern methods may be due to the difficulty of competing with the public sector since it provides contraceptives and FP/RH services free of charge. In 2008, the vast majority (90%) of clients was from the top three wealth quintiles: wealthiest

**Figure 2: Sources of Contraceptive Methods Among Current Users of Modern Methods (1996-2008)**



**Figure 3: Public Sector Client Profile by Wealth Quintiles: 1996, 2000, 2008**



(47%), fourth (24%) and middle (19%). More than 70 percent of clients relied on long-term methods, female sterilization (56%) and IUDs (13%), and 14 percent used OCs.

**Pharmacies.** Pharmacies have experienced great fluctuation in market share since 1996. From 1996 to 2000, the market share of pharmacies declined from 15 to 8 percent, but by 2008, their use rose to more than 22 percent. In 2008, almost 93 percent of pharmacy clients was from the top three wealth quintiles. More than 90 percent lived in urban areas, showing that pharmacies are concentrated in urban areas and are not very accessible or affordable to those living in rural and remote areas. More than 75 percent of clients chose condoms this method, followed by OCs (14%) and injectables (10%).

**NGOs.** NGOs traditionally have had a very small FP market share of about 5 percent, and their share has declined slightly in Peru in the last eight years. The major NGOs working in family planning in Peru are INPPARES, APROPO, APPRENDE, and MAXSALUD. Many of them have social marketing programs, generate their own resources, and serve those who can afford to pay. In 2008, about 94 percent of NGO clients came from the middle, fourth, and wealthiest quintiles. More than 90 percent of clients lived in urban areas, indicating that urban residents are the main beneficiaries of NGO-run social marketing programs. Between 1996 and 2008, modern method users obtained their contraceptives methods from the NGO sector (2–3%). Most of the NGOs have stopped receiving significant support from external donors, and their core services are largely self-sufficient. Several do receive limited support in terms of small grants and donated supplies for specific initiatives. Some—such as MAXSALUD—continue to receive donated contraceptives from USAID and provide subsidized services to under-served populations. NGO clients mainly used female sterilization methods (31%), IUDs (more than 24%), OCs (24%), and injectables (10%).

### **The consumer market**

Peru has experienced a steady increase in the overall contraceptive prevalence rate (CPR) from 64.2 percent in 1996 to 74.3 percent in 2008 (see Table 3).<sup>10</sup> While the CPR increased, there remains a significant unmet need, particularly among poorer women. In 2008, more than 15 percent of women in the poorest wealth quintile expressed a desire to space or limit the number of births but were not using contraception, and 9 percent of women in the second poorest quintile also had an unmet need for FP. By comparison, unmet need in the middle and wealthiest quintiles ranged from 5.1 to 6.5 percent.

Use of modern method increased during 1996–2000, but the proportion of Peruvian women using modern methods in recent years has remained relatively stagnant (50.4% in 2000 and 48.8% in 2008). Modern method users use a wide range of FP methods, including injectables (13%), female sterilization (11%), condoms (9%), IUDs (6%), and OCs (7%). In 2008, use of IUDs and condoms increased as wealth increased and use of injectables decreased as wealth increased. Sixteen percent of women in the lowest quintile used injectables compared with only 5 percent of women in wealthiest quintile. Conversely, almost none of the poorest women relied on IUDs compared with 10 percent of the wealthiest women. Similarly, less than 2 percent of women in the poorest quintile used condoms and women in the wealthiest quintile were almost more than 15 times likely to use. Use of other methods (Norplant, foam, jelly, and male sterilization) made up a small percentage of total method use, although those in the three highest wealth quintiles were slightly more likely to use these methods.

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<sup>10</sup> This section uses the 1996 Standard ENDESA, 2000 Standard ENDESA, and the 2004-2008 Continua ENDESA to analyze the consumer market in terms of method use, place of residence, and provider sources.

**Table 3: Method Use, Unmet Need, and CPR: 1996, 2000, and 2008**

<b>Method Use (2008 Only)</b>						
	<b>Poorest</b>	<b>Second</b>	<b>Middle</b>	<b>Fourth</b>	<b>Wealthiest</b>	<b>Total</b>
Not using	41.1	30.6	22.4	24.4	29	29.3
OCs	4.6	5.7	9.4	7.7	7.5	7
IUD	0.1	2.4	6.4	11	9.9	6.1
Injectables	16.1	17.6	15.1	9.6	5.7	13
Condom	1.6	5	9.1	13	15	8.7
Female Sterilization	5.2	11	11.6	10.8	14.4	10.6
Other modern	5.6	3.8	3.3	3.1	2.5	3.5
Traditional	25.7	23.9	22.7	20.4	16	21.8
Total	100	100	100	100	100	100
<b>Unmet Need (2008 Only)</b>						
	<b>Poorest</b>	<b>Second</b>	<b>Middle</b>	<b>Fourth</b>	<b>Wealthiest</b>	<b>Total</b>
Unmet Need (Spacing and Limiting)	15.3	9.0	5.9	5.1	6.5	8.3
<b>CPR (1996, 2000, and 2008)</b>						
	<b>1996</b>		<b>2000</b>		<b>2008</b>	
CPR (%)	64.2		68.9		74.3	
CPR – Modern Methods (%)	41.3		50.4		48.8	

Note: Other modern methods include lactational amenorrhea, male sterilization, vaginal methods, and Norplant.

### Findings from Key Informants<sup>11</sup>

Fifty-five key informant interviews were conducted in Lima, Piura, Cajamarca, San Martín, La Libertad, Junin, and Cusco districts to determine challenges for PPP. In addition, three regional meetings were held. The Health Policy Initiative team organized two meetings in Cajamarca. The first, held in October 2009, was a briefing and coordination of activities with the DIRESA (Dirección Regional de Salud Lima) Management Team for PPP activities in the region. Participants included DIRESA representatives and key regional stakeholders. The second, held in November 2009, was a technical workshop, “Meeting on Public-Private Partnership in Health—Overcoming Barriers to Improve Access to Health.” It brought together regional and local health officials, regional OPI members, DIRESA, and OPI representatives from MINSA.

The team also organized a panel discussion in La Libertad (Trujillo) in January 2010 with representatives from regional and local health ministries, regional OPIs, DIRESA, hospitals, the regional Chamber of Commerce, universities, and NGOs. By the end of the meeting, participants had signed an act establishing a Regional Platform for Promotion of Private Investment in Health for La Libertad region. Both regions are committed to defining priorities for public investment projects and establishing regulatory mechanisms to develop health services through PPPs.

<sup>11</sup> For complete details on interview methodology, measures used for data collection and evaluation, key informant responses, and other outcomes, please refer to the 2009 Health Policy Initiative Diagnostic Guide on PPP Experiences in Peru, *Diagnóstico de las experiencias de alianzas público privado en salud en el Perú*.

The following challenges for PPP were identified:

- **There is a history of PPP in other sectors in Peru, but experiences are limited and recent in the health sector.** PPP experiences have occurred mostly in other sectors, such as infrastructure. However, there are some notable experiences in the health sector:
  - Clínica Internacional (CI), a private network of clinics, competed for a bid to provide services of EsSalud, the public social security institute that provides health services and insures those who have health insurance through their employers.
  - Seguro Integral de Salud (SIS) agreed to finance an NGO in La Libertad to provide services, including FP services, under PEAS. The prices to be paid are those in the SIS-approved price list.
- **Contracting and regulatory norms and policies for PPP in health were identified as requiring development.** Because there has not been a contract between SIS or MINSA and a private entity for the provision of health services in the past, interviewees from SIS, MINSA, and CI all expressed the need for a model contract. Likewise, informants noted the need to identify regulatory concerns in each sector that would need to be addressed to implement the contract.
- **Having an agreed-on set of costs for providing health services is a key issue.** There is a general perception, particularly among SIS representatives, that costs of private sector providers exceed those of MINSA services. However, CI claims that it keeps costs low because it applies a capitation model,<sup>12</sup> wherein providers are paid a fixed amount for a given population size and pre-determined set of services. They seek to keep costs low through economies of scale and a focus on preventive health. Inefficiencies in the public sector, such as wasted materials and slow patient turnover in hospitals, may make public health services more expensive. Accurate costs need to be researched.
- **Advocacy is needed to promote the idea that the private sector can bring efficiency and decrease the cost of expanding services in the public sector.** Recommendations from stakeholders included using research and successful PPP models from other countries, and raising awareness of the benefits and efficiencies in the private sector.

## Fostering Dialogue and Developing Consensus on Health Equity Goals

The second part of the policy framework that has guided PPP development in Peru is intended to foster dialogue and develop consensus on health equity goals. The Health Policy Initiative organized two workshops for this purpose. This first workshop in October 2009 assembled high-profile public sector officials and regional government health providers from MINSA, the Agency for Promotion of Private Investment (Proinversión), and EsSalud. The second workshop in January 2010 brought together participants from the private sector (private providers, commercial entities, NGOs) and USAID cooperative agencies.

### October 2009 Workshop—Focus on the Public Sector

The workshop objectives were to

- Promote and strengthen public and private sector commitment for the development of PPPs in health;
- Share current and past experiences on PPPs in health in Latin America; and

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<sup>12</sup> Under capitation, a provider is paid an amount in exchange for a predetermined set of services and population size served. The provider receives per capita payments each month, quarter, or year, regardless of the actual demand for services. In this way, the mechanism provides strong incentives for the provider to control costs.

- Have key stakeholders and institutional representatives discuss next steps for PPP development and implementation.

The workshop provided a forum for presentations by PPP experts from Argentina, Brazil, and Mexico. They shared their assessments of the legal and policy frameworks on PPP and health investment.

Participants' conclusions from policy dialogue were the following:

- While there is a range of Latin American experiences with PPP, the objective of all these initiatives is to improve the overall health status through partnerships and risk sharing between public and private providers.
- Mexico's experience at municipal and local levels serves as a model to promote health partnerships, particularly in providing services to excluded populations.
- Brazil's vast experience with PPP, particularly in infrastructure development and investment, can help to establish alliances between private commercial and nonprofit social sectors.
- While there are still barriers to implementing PPPs, policy and programmatic actions have already been taken to promote PPP at regional and levels:
  - Passage of DL 1012 that calls for private sector participation and investment in health
  - EsSalud's decision to encourage Universal Health Insurance and coverage of poor and vulnerable populations.
  - Proinversión's preliminary legal analysis of barriers to PPP. HPI needs to support these efforts and help apply them in local and regional areas.
- More dialogue was needed to increase awareness of the issues.
- Current use and capacity of the FP/RH services in the private sector must be assessed.

Finally, participants agreed to form an advocacy group (grupo impulsor) that would develop PPPs in health at national, regional, and local levels.

### **January 2010 Workshop—Focus on the Private Sector**

Given the positive responses from MINSA and other participants to the October 2009 workshop, the Health Policy Initiative team sponsored a second workshop. The workshop objectives were to

- Continue to foster public-private dialogue;
- Share additional lessons learned from the regional programs; and
- Mobilize key private sector providers including NGOs and other USAID cooperative agencies.

Presentations from both public and commercial sector providers focused on PPP's potential contributions to the Peruvian national vision for health.

Topics of interest included

- Barriers to effective cooperation, particularly from programmatic and financial perspectives (including the crowding out of the private sector and cost subsidization of health services);
- Challenges to private sector financial investment;
- Equitable risk-sharing strategies between the private and public sectors in procurement (including contracting and joint venture opportunities);
- Lessons learned from foreign and local implementation efforts; and
- Assessment of current partnerships through monitoring and evaluation mechanisms (Junín experiences, programmatic progress in Cajamarca, and Trujillo regional studies).

Additionally, participants discussed the diagnostic guide and technical roadmap. The meeting concluded with the official launching of the Health Policy Initiative and USAID/Peru's PPP website.

## **Creating an Enabling Environment for PPP**

### **Formation of the Development Group for Public-Private Partnerships in Health**

An important outcome of the October 2009 workshop was that participants agreed to form an advocacy group (grupo impulsor) that would develop PPP in health at national, regional and local levels. The group would consist of an operations and program management team from the public and private (including NGO) sectors along with MINSA's Comité de Inversión. The Health Policy Initiative would provide technical assistance to this group. The group would develop a comprehensive roadmap to promote and implement PPPs. The roadmap would outline the steps to develop PPP and include

- Defining the roles and responsibilities of public and private participants to promote, implement, and evaluate PPPs in health;
- Creating an enabling environment that facilitates dialogue between the public and private sectors through policy analysis, advocacy, and focus group discussions; and
- Identifying and implementing pilot studies and regional activities in health under selected public-private models.

The advocacy group was the forerunner to the Development Group for Public-Private Partnerships in Health, which was officially established by MINSA in January 2010 (see Annex 4 for the official resolutions). This group consists of representatives of the public and private health sectors (see Annex 5 for a list of members). A primary objective of the group is to develop and reinforce policy actions that promote, execute, and evaluate Peruvian health sector PPPs at the national, regional, and local levels of government. These actions are to be enforced with support from MINSA, chief private sector stakeholders, and other USAID cooperative agencies. Through policy dialogue and advocacy, the group is to establish an enabling environment for the support of PPP development.

The principal actions of the group will be to

- Develop strategic analyses of chief actors and facilitators as well as policy barriers to public and private sector participation;
- Strengthen communication and facilitate dialogue among stakeholders, consumers, and policymakers;
- Generate capacity and encourage operational development (infrastructure, programmatic framework, etc.) for PPP implementation at national, regional and levels; and
- Continue searching for new alliances and support mechanisms for PPP efforts in health.

### **Development of the PPP Webpage**

The launching of the Health Policy Initiative and USAID/Peru's PPP website was an outcome of the January 2010 workshop (see Annex 6 for a preview of the PPP webpage). Website components include the following:

- A database of legal, policy, and programmatic documents on PPP
- Links to other regional, national, and international PPPs in health procurement and service delivery
- Resources and links for technical and operational assistance in PPP implementation
- Links to USAID/Peru and Health Policy Initiative websites
- Blog spaces for ongoing updates in field and program developments
- References to MINSA activities, upcoming initiatives, and future opportunities for programmatic scale-up and operational expansion

## **Developing Public-Private Partnerships**

### **Strategic Plan for Implementing PPPs**

Both public and private sector members of the Development Group for PPP in Health (with assistance from the Health Policy Initiative team) formulated a strategic plan (roadmap) in 2009 (see Annex 7). The roadmap aids in creating an enabling policy environment in which public and private sectors can collaborate to address growing demands for health goods and services and the needs of under-served populations.

The plan outlines the PPP development and implementation process. Following the policy framework for PPP, the plan identifies the steps to develop public-private collaborations:

- Create an enabling environment that facilitates dialogue between the public and private sectors through policy analysis, advocacy, and focus group discussions
- Define public and private sectors roles and responsibilities to promote, implement, and evaluate PPPs in health
- Develop and implement pilot studies and regional activities in health using public-private models

Expected results include the following:

- Active participation and support from MINSA's Comité de Inversiones in complying with DL 1012 objectives for PPP promotion in health at national, regional, and local levels
- Improved legal and policy environment for developing the role of PPP in health to improve health equity
- Information on PPPs disseminated through public and private sector channels (MINSA, Proinversión, regional governments, LGAs, Health Policy Initiative and USAID/Peru website, etc.)
- Identified mechanisms that will promote PPP in health programs
- Portfolio developed of possible PPP projects in health that can be implemented at the national, regional, and local levels (e.g., pilot studies)
- Design, development, and implementation of pilot PPPs in health

### **Regional Public-Private Pilot Studies**

Using the PPP strategic plan (roadmap), efforts are underway to initiate PPP activities in the Cajamarca and La Libertad regions. The Health Policy Initiative team has provided assistance for these activities. In November 2009, regional health ministries and LGAs coordinated a formal PPP workshop held in Cajamarca, "Reunión Técnica sobre Asociación Público Privada en Salud—Venciendo Barreras para Mejorar el Acceso a Salud." The workshop objectives were to

- Assess the current Cajamarca health infrastructure and policy framework;
- Identify barriers to PPP operation and mechanisms for effective partnerships at the regional and local levels
- Discuss PPP implementation in health infrastructure maintenance, use of medical equipment in provincial hospitals and health centers, and sustainable service delivery
- Focus on expanding access to services to poor and vulnerable populations in Cajamarca

A workshop was also held in December 2009 in Trujillo to promote a regional platform for private sector investment in health. The workshop was coordinated by La Libertad's Regional Manager's Office of Health, with participation from the Regional Agency for the Promotion of Private Investment, officials from MINSA's OPI, and representatives from Trujillo's Belén Hospital. Topics of discussion included the recent approval of a portfolio outlining prospective PPPs in health activities in La Libertad and

dissemination of results and experiences from initial exploratory PPP studies in six of the nine regions (Piura, Cajamarca, San Martín, Junín, La Libertad, and Cusco).

## **V. CONCLUSIONS**

The objective of the PPP activity in Peru was to identify and promote private, commercial, and NGO alliances with the public health sector to ensure that unmet need for FP/RH services and products can be met and that access to FP/RH services becomes more equitable by reaching vulnerable populations in rural and remote areas. The ground work has been laid that enables the public and private sectors to develop PPPs in health.

When the Health Policy Initiative activity in Peru was designed, the overriding question from USAID was whether the policy framework for promoting PPP was viable and effective. It is too soon in the implementation process of PPPs to answer this question. The outcomes noted below are evidence that the first crucial steps have been taken. Assuming that MINSA and key private sector agencies continue to follow the strategic plan (roadmap), it should be possible to answer this question; when in the future depends on the progress made in implementing PPPs.

### **Outcomes and Technical Products**

Outcomes of the PPP activity include the following:

- Normative proposals and/or modifications to the Peruvian legal framework that promote PPP as an effective and feasible strategy in the procurement of health goods and services
- The Development Group for PPP in Health, which includes key decisionmakers from both public and private sectors as well as experts and officials from local directorates and regional health ministries
- The Strategic Plan (roadmap) that outlines the PPP investment and implementation process at national, regional, and local levels. The roadmap aids in creating an enabling policy environment in which public and private sectors can collaborate to address growing demands for health goods and services and the needs of under-served populations.

Two technical products were prepared during activity implementation:

- A preliminary diagnostic guide that outlines the current policy environment for the implementation of PPPs in health, using studies of PPP at the national level and in four regions
- An analysis of the regulatory framework for PPP and the legal opportunities and barriers to PPPs in Peru's public health system.

### **Recommendations for Next Steps**

Recommendations to continue the development of PPPs in Peru include the following:

- Continue to raise awareness among political and community leaders about the role of PPP in providing FP/RH services and achieving great health equity
- Increase policy dialogue on PPP among private sector providers of FP/RH to promote their participation
- Analyze, review, and revise legal and policy frameworks to expand implementation and investment opportunities in public-private initiatives
- Adapt PPP examples from PPPs in health in India and Brazil
- Formulate guidelines to evaluate PPPs in health

- Strengthen capacities for data collection and research methodologies at the national and subnational levels
- Monitor regional workplans for effective and efficient implementation of public-private initiatives
- Extend public-private projects to the San Martín and La Libertad regions given the interest that both health directorates have shown in public-private investment
- Develop new investment opportunities with provincial private sector providers to increase districts' capacity to plan for and invest in partnership
- Continue to improve collaborative planning between regional and national partners to align budget constraints with potential investments in health service delivery
- Expand PPP to the national level through targeted policy dialogue and advocacy

## ANNEX I. PPP ACTIVITY TIMELINE

<b>2008</b>
A situation analysis of the national and Junín regional health system by the Health Policy Initiative team concluded that poor quality of reproductive health services, inadequate counseling and care, long waiting times in clinics and hospitals, inefficient schedules, insufficient response capacity and infrastructure-related equipment, and other factors act as significant barriers to access. <sup>1,2,3</sup>
<b>2009: July</b>
Upon analyzing the limitations of the public sector in meeting population healthcare needs (particularly sexual and reproductive health and family planning) and recognizing Peru's national movement toward health decentralization and universal health insurance, the Health Policy Initiative launches regional activities to promote the implementation of PPPs in health in Peru.
<b>2009: August–September</b>
Review of the Peruvian legal framework and proposal design in order to identify policies and mechanisms that promote public-private partnerships for the improvement of reproductive health services, particularly to low-income and vulnerable populations.
<b>2009: October</b>
Review and assessment of previous PPP experiences in health in Peru. Development of a national approach for implementing PPPs in six regions of the country (San Martín, Cajamarca, La Libertad, Piura, Cusco, and Junin). <i>International Meeting and Technical Workshop: Public-Private Partnerships in Health – Overcoming Barriers to Improve Access to Health Services</i> (October 28). To raise awareness among various key stakeholders on the potential for PPP in health systems strengthening, financing, service quality, and development, particularly emphasizing reproductive health service delivery and promoting national public sector engagement and/or regional public-private partnerships as a viable and effective option. At the end of the workshop, stakeholders from MINSA and other affiliates agreed to develop a technical roadmap and form a development committee that would focus exclusively on promoting and implementing PPPs in health at the policy level.
<b>2009: November</b>
<i>Meeting on Public-Private Partnerships in the Cajamarca region</i> , in which it was agreed to construct a comprehensive portfolio of potential projects that could be developed into PPP initiatives in health.
<b>2009: December</b>
<i>Meeting on Public-Private Partnerships in the La Libertad region</i> . At the regional meeting, the Regional Platform for the Promotion of Private Investment in Health was formed. The platform was responsible for (1) the preparation and delivery of key PPP proposals for the Regional Council of La Libertad's health portfolio and (2) providing the necessary resources and operative assistance in the preparation of the regional working plan and PPP technical roadmap for the promotion and implementation of PPPs in La Libertad. Additionally, MINSA committed to providing further technical assistance and support for the promotion and implementation of PPPs and private investment in health in La Libertad. <i>Meeting on Public-Private Partnerships at the Health Directorate of the Air Force of Peru</i> , whose representatives expressed interest in promoting PPPs in order to improve health infrastructure and services (e.g., upgrading provincial hospitals in Las Palmas, Chiclayo, Arequipa, and Iquitos). Briefings with officials from the regional governments and regional health bureaus of Piura and Cusco at the request of MINSA. Both regions showed no development of PPPs in health, and representatives demonstrated interest in adopting PPP as part of their respective regional health strategy.

**2010: January**

*Formation of the MINSA PPP Promoter and Development Group.*<sup>4</sup> Objectives of the development group include the promotion, implementation, and evaluation of public-private partnerships in the field of health at the national and regional levels of government, and, under the current regulations and legal framework, the creation of mechanisms to facilitate coordination between the health and development sectors and other related agents.

*Technical Roadmap for the Implementation of PPP in Health*, which aims to (1) strengthen the skills of public and private actors for the promotion, implementation, and evaluation of public-private partnerships in health, (2) create an enabling environment for constructive dialogue between public and private sector stakeholders, and (3) establish guidelines that will help in identifying and selecting pilot PPP projects in health at the national and regional levels.

*International Meeting and Technical Workshop on Public-Private Partnerships in Health (January 26).* Organized dialogue among domestic private sector institutions, as well as international and non-governmental organizations to promote active participation of the private sector in the implementation of PPPs.

Development of the MINSA-sponsored and approved Public-Private Partnerships in Health website.

**Sources**

<sup>1</sup> Sharma et al., 2008.

<sup>2</sup> Petrera, 2006.

<sup>3</sup> Subiria, 2007.

<sup>4</sup> RM N° 058-2010/MINSA 22-01- 2010 y RM N° 388-2010/MINSA.

## ANNEX 2. TABLE OF PPP MODELS AND FINANCING SCHEMES, INDIA CASE STUDY

Model Name	Model Description
Social Franchising	Type of model whereby the marketer of a product or service (the franchiser) grants exclusive rights to local independent entrepreneurs (franchisees) to conduct business in a prescribed manner over a specified period. Large-scale initiative that requires a tremendous amount of resources and networking capacity. Effective for immediate improvement for access and infrastructure development.
Branded Clinics	Chain of clinics that offer standardized, high-quality health services. These cater to slightly more financially secure clients and are useful for market segmentation. More sustainable than social franchising efforts because they can generate more income; however, these clinics need to be well promoted and sufficiently financed. Need to be able to meet demand for high-quality services at comparatively affordable prices.
Contracting In or Out to the Private Sector	Refers to a situation in which the private provider agrees to offer a defined set of healthcare services in return for a pre-negotiated remuneration. The quantity and quality of services and the duration for which they shall be provided is mutually decided upon by the partners and incorporated into the contract. <i>Contracting In</i> refers to purchasing services from an outside source for managing an internal service or workforce, whereas <i>Contracting Out</i> requires the purchase of services from an outside source to a government entity using primarily external resources/workforce.
Social Marketing	Refers to the application of marketing to solve social and health problems. For social marketing schemes to be effective, the approach must effectively combine service delivery with demand creation. Marketing approaches may include encouraging competition and brand choices, increasing availability of products in accessible retail outlets, expanding vendor networks, and targeting communication to vulnerable groups.
Build, Operate, and Transfer (BOT) Schemes	Refers to the private provider helping with the initial investment, generating profits from the facility created, and then giving the establishment to the government. It might require part-financing by the government, financial guarantees, subsidizing land and other resources, and assurance of reasonable returns on investment. These models could be useful in establishing large hospitals and ensuring quality services at reasonable rates for poor people. BOT models are particularly effective when the initial cost of investment is too high for the government to bear alone.
Joint Venture Companies	Institutions launched with shared participation of government and the private sector. Joint ventures also entail sharing an initiative's costs and risks. These arrangements are generally more useful in settings in which profit can be generated but providing the services and initial cost/expertise is a constraint.
Voucher Systems	This refers to the use of a document that can be exchanged for defined goods or services as a token of payment (tied-cash). Initiating a voucher scheme entails designing, developing, and valuing health service packages, which can be bought by people at specific intervals of time. These vouchers can then be redeemed for receiving the predefined set of services. Voucher schemes are particularly effective in providing services to those individuals/groups who cannot afford to pay. For vouchers to be successful, however, there needs to be enough demand generated to compensate for the subsidized costs, and

	sustainable voucher systems need to be monitored and evaluated for service quality and access.
Individual Donations	Many philanthropists and institutions intend to invest in societal development and improving the plight of the poor. Groups soliciting donations need to make efforts to create simple and transparent institutional mechanisms to encourage donations for helping to improve healthcare services, especially for the poor.
Partnerships with Social Clubs/Groups	Clubs and external institutions have played a significant role in promoting immunization campaigns, national health programs, and other healthcare services. These clubs have wide networks and their involvement ensures better visibility for the initiatives in which they participate. They have been proven to be useful in <ul style="list-style-type: none"> <li>• Popularizing reformed healthcare service delivery outlets and in communication campaigns</li> <li>• Organization and logistics management of camps on a large scale</li> <li>• Providing additional resources and management and technical expertise in organizing social events</li> <li>• Advocacy efforts</li> </ul>
Corporate Sector Involvement	The organized corporate sector and other business and industry associations are playing an increasingly significant role in such efforts as advocacy, funding NGOs for innovative interventions, and allowing utilization of corporate facilities.
Professional Association Partnerships	Partnering with professional health associations can be advantageous, as these groups have the technical skills and expertise to provide advice on key topics, such as setting standard protocols, quality assurance systems, and accreditation.
Public Provider Capacity-building Schemes	Capacity building can improve the technical and counseling skills of private medical practitioners, particularly rural medical practitioners, by providing them training toward improving quality of services. Since they have a huge presence in rural areas and urban slums and a significant proportion of population depend on them for services, there is a need to involve them in a significant way to ensure safer and better quality of services provided by them.
Autonomous Institutions	Giving autonomy to public institutions within the system can lead to improvement in quality, accountability, and efficiency. It also ensures greater involvement and ownership at the level of the institution, ensuring greater morale and encouragement to the workforce.
Mobile Health Vans	In regions that face a problem in geographical accessibility, private sector agencies have taken a lead in launching mobile vans. These vans go to clearly identified central points on fixed days and provide comprehensive health services. Making services available at central location reduces travel time and costs for clients.
Health Insurance	Scenario whereby community members pay a minimum insurance premium per month and get coverage against a certain level of health expenditure. This mechanism protects customers from sudden and unexpected expenditures on health. Insurance schemes are useful if <ul style="list-style-type: none"> <li>• The community is willing to participate;</li> <li>• There is a high probability of indebtedness due to healthcare expenditures; and</li> <li>• Out-of-pocket expenditures for health services are high.</li> </ul>

## **ANNEX 3. METHODOLOGY FOR MARKET SEGMENTATION ANALYSIS<sup>13</sup>**

This section presents the methodological framework used for creating the standard of living index (SLI) and analysis of market data. This includes a secondary data analysis of the 1996 and 2000 Standard Peru Demographic and Health Surveys (ENDESA 1996 and 2000) and the most recent 2004–2008 Peru ENDESA Continua.<sup>14</sup> The sample sizes were 28,951 WRA for ENDESA 1996; 27,843 WRA and 28,900 households for ENDESA 2000; and 12,455 WRA for ENDESA Continua 2004–2008.<sup>15</sup> Each household asset or amenity was assigned a factor score generated through principal component analysis. In this way, the standard of living could be defined in terms of assets, rather than income or consumption.<sup>16</sup>

Using the household data of 2000 ENDESA and 2004–2008 ENDESA Continua, the Health Policy Initiative divided the population into five SLI quintiles in which the poorest group consisted of women from households with the lowest asset index score, while the wealthiest group was composed of women from households with the greatest score. These groups were established by cut-off points for which the indicator signaled an important difference in cumulative household asset score; this method resulted in an uneven distribution of women among the five quintiles. For the 2004–2008 ENDESA Continua, however, cutoffs were determined by equally dividing households into the five quintile groups based on their weighted asset scores. In this manner, the poorest quintile represents 19 percent, the second quintile 21 percent, the middle quintile 22 percent, the fourth quintile 20 percent, and the wealthiest quintile 18 percent.

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<sup>13</sup> For a more detailed Peruvian market segmentation analysis, please refer to Sharma et al, 2006.

<sup>14</sup> For a complete discussion as to the data collection process and methodological differences between Standard and Continuous ENDESA data, see [www.measuredhs.com](http://www.measuredhs.com).

<sup>15</sup> As the ENDESA 2004–2008 sample size is not comparable to those of 1996 or 2000, conclusions on trends are made with caution.

<sup>16</sup> This method of constructing an SLI has become more popular in recent years. Refer to <http://www.worldbank.org/poverty/health/data/index.htm> for a complete technical discussion of the general approach, as well as examples from other countries, including Bangladesh, in the previous round of USAID-funded Demographic and Health Surveys. Also see Filmer and Pritchett, 2001.

# ANNEX 4. MINSA MINISTERIAL RESOLUTION—OFFICIAL RECOGNITION OF PPP DEVELOPMENT GROUP

MINISTERIO DE SALUD

No. 058-2010/MINSA



## Resolución Ministerial

Lima, 22 de ENERO del 2010

### VISTOS:

El Memorandum N° 038-2010-DVM/MINSA del 22 de enero de 2010 y las Resoluciones Supremas N° 017-2008-SA, N° 001-2009-SA y 007-2009-SA y;

### CONSIDERANDO:

Que, el artículo 2° de la Ley N° 27657, Ley del Ministerio de Salud, establece que el Ministerio de Salud es el ente rector del Sector Salud que conduce, regula y promueve la intervención del Sistema Nacional de Salud;

Que, el Decreto Legislativo N° 1012, Decreto Legislativo que aprueba la ley marco de asociaciones público - privadas para la generación de empleo productivo y dicta normas para la agilización de los procesos de promoción de la inversión privada, establece los principios, procesos y atribuciones del Sector Público para la evaluación, implementación y operación de infraestructura pública o la prestación de servicios públicos, con participación del sector privado, así como el marco general aplicable a las iniciativas privadas;

Que, de conformidad a la Resolución Suprema N° 017-2008-SA del 11 de setiembre de 2008 se creó el Comité de Inversión del Ministerio de Salud con la finalidad de evaluar los proyectos de obras públicas de infraestructura y servicios públicos que serán otorgados a los Promotores de la Inversión Privada, debiendo ejercer las funciones establecidas en el Decreto Legislativo N° 1012 y sus normas conexas;



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Que, a través de las Resoluciones Supremas N° 001-2009-SA del 14 de enero de 2009 y N° 007-2009-SA del 13 de mayo de 2009 se reconfirmó el Comité de Inversión del Ministerio de Salud;

Que, el mencionado Comité ha propuesto al Despacho Ministerial la conformación de un Grupo Impulsor de Asociaciones Público Privadas en Salud, que será el encargado de efectuar estudios respecto a la viabilidad de potenciales Asociaciones Público Privadas en el campo de la salud a nivel de Gobierno Nacional y



V. Rojas M.



Regional, en el marco de la normatividad vigente, generando mecanismos de articulación con otros sectores y agentes afines;

Que, resulta conveniente aprobar la conformación del Grupo Impulsor de Asociaciones Público Privadas en Salud;

Con el visado de la Directora General de la Oficina General de Asesoría Jurídica y del Viceministro de Salud, y;

De conformidad con lo dispuesto el literal l) del artículo 8° de la Ley 27657, Ley del Ministerio de Salud;

**SE RESUELVE:**

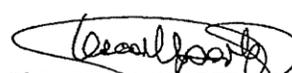
**Artículo 1°.-** Crear el Grupo Impulsor de Asociaciones Público Privadas en Salud, que será el encargado de efectuar estudios respecto a la viabilidad de potenciales Asociaciones Público Privadas en el campo de la salud a nivel de Gobierno Nacional y Regional, en el marco de la normatividad vigente, generando mecanismos de articulación con otros sectores y agentes afines.

**Artículo 2°.-** El Grupo Impulsor de Asociaciones Público Privadas en Salud estará conformado de la siguiente manera:

- Un representante del Despacho Viceministerial, quien actuará como coordinador.
- Un representante de la Oficina de Planeamiento y Gestión Institucional de la Oficina General de Planeamiento y Presupuesto - OGPP.
- Un representante de la Dirección General de Salud de las Personas - DGSP.
- Un representante de la Dirección General de Salud Ambiental - DIGESA.
- Un representante de la Dirección General de Infraestructura, Equipamiento y Mantenimiento - DGIEM.
- Un representante de la Dirección General de Medicamentos, Insumos y Drogas - DIGEMID.
- Un representante de la Oficina General de Asesoría Jurídica - OGAJ.
- Un representante del Seguro Integral de Salud - SIS.
- Un representante del Programa de Apoyo a la Reforma del Sector Salud - PARSALUD.
- Un representante de la Oficina de Proyectos de Inversión de la Oficina General de Planeamiento y Presupuesto - OGPP, quien actuará como secretario técnico.

  
M. Arce R.

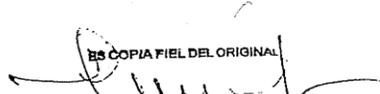
Regístrese, comuníquese y publíquese.

  
OSCAR RAÚL UGARTE VILLU  
Ministro de Salud



  
V. Rojas M.

  
D. León Ch.

  
ES COPIA FIEL DEL ORIGINAL  
CARMEN LUNA FLORES  
Fidatario de la Sede Central - MINSU.

## **ANNEX 5. MEMBERS OF THE DEVELOPMENT GROUP FOR PUBLIC-PRIVATE PARTNERSHIPS IN HEALTH**

- A representative from the Vice Ministerial Dispatch, who will act as the primary coordinator
- Representatives from the Office of Planning and Institutional Development and the General Office of Planning and Budget (OGPP)
- A representative from the General Manager's Office of Public Health (DGSP)
- A representative from the General Manager's Office of Environmental Health (DIGESA)
- A representative from the General Manager's Office of Infrastructure, Equipment, and Maintenance (DGIEM)
- A representative from the General Manager's Office of Medicine and Pharmacy (DIGEMID)
- A representative from the General Office of Legal Consultancy (OGAJ)
- A representative from SIS
- A representative from the Program for Health Sector Reform (PARSALUD)
- A representative from the Office of Projects and Investments who will act as the technical secretary for the group
- Stakeholders and representatives from private clinics, NGOs, and corporate health institutions

# ANNEX 6. PPP WEBPAGE IMAGES AND PROPOSED TEMPLATES

For further information, refer to: <http://www.minsa.gov.pe/ogpp/APP/evento2.html>.

**PERÚ** Ministerio de Salud

## Asociaciones Público-Privadas APP en Salud

Una alternativa para las inversiones en el Sector Salud

Inicio Presentación Hoja Ruta Grupo Impulsor Directorio Contáctenos

### Presentación

Las asociaciones público privadas son modalidades de participación de la inversión privada en las que se incorpora experiencia, conocimientos, equipos, tecnología, y se distribuyen riesgos y recursos, preferentemente privados, con el objeto de crear, desarrollar, mejorar, operar o mantener infraestructura pública o proveer servicios públicos. (Artículo 3º del Decreto Legislativo Nº 1012).

Modalidad que involucra: concesión, operación, gerencia, joint venture u otra en tanto concuerde con definición.

No es una APP cuando su único alcance sea la provisión de mano de obra, de oferta e instalación de equipo o de ejecución de obras públicas.

Se puede acceder a una APP ya sea por iniciativa estatal o por iniciativa privada (también regulada en el Decreto Legislativo Nº 1012), dependiendo de si el origen del proyecto está en el sector público o en el sector privado.

**Principios:** (Art. 5 del Decreto Legislativo Nº 1012)

**Valor por dinero (value for money):** mayor calidad a un determinado costo o los mismos resultados de calidad a un menor costo. Comparador Público Privado. (falta metodología)

**Transparencia.** Compatible con Ley de Transparencia y Acceso a la Información

**Competencia.** Fomentar competencia, evitar actos anticompetitivos o colusorios.

**Asignación adecuada de riesgos.** Asignar los costos a quien tiene "mayores capacidades para administrarlo a un menor costo".

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Aquí va una descripción de la foto

Portal MINSA

Portal PRO-INVERSIÓN

Portal MEF

otro a SUGERIR

Validadores W3C CSS W3C XHTML

Inicio Presentación Hoja Ruta Grupo Impulsor Directorio Contáctenos

## Normatividad

Documento	Formato	Tamaño
<ul style="list-style-type: none"> <li>Decreto Supremo N° 004-2003-SA Reglamento de la Ley del Sistema Nacional Coordinado y Descentralizado de Salud</li> </ul>		312 kb
<ul style="list-style-type: none"> <li>Ley N° 27813 Ley del Sistema Nacional Coordinador y Descentralizado de Salud</li> </ul>		442 kb

Normatividad

Bibliografía

Documentos

Pilotos

Asistencia Técnica

Eventos

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## **ANNEX 7. STRATEGIC PLAN (ROADMAP) FOR PPP IN PERU**

The technical roadmap outlines the following three primary phases of PPP development and implementation:

1. Identifying the key participants and stakeholders in the public-private initiative and informing players of the project objectives, strategies, and actions needed; resources required; intended target group(s); and current assessment of the policy and operational framework.
  - a. At this stage, key stakeholders should conduct diagnostic survey analyses of the current policy environment, including key informant and expert interviews.
2. Establishing the course of action.
  - a. This phase incorporates steps such as programmatic/operational prioritization, cost-benefit analysis, and situational analysis to identify and confront barriers to operation and performance.
  - b. After the initial assessments have been made and barriers addressed, the main steps to implementing the course of action include the following:
    - i. Project design
    - ii. Contract design for public and private sector agents
    - iii. Ensuring financial security in the form of public-private investment
    - iv. Obtaining legal and operational concurrence from relevant national and regional authorities for implementation
  - c. Initial project implementation (usually in the form of pilot studies at either the regional or national level).
3. Monitoring and evaluating project success, including the following:
  - a. Identifying indicators within the operational framework and project design that can be monitored and evaluated against project objectives
  - b. Program expansion and modification, scale-up activities, and revision of objectives

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