HEALTH FINANCING PROFILE - PERU

In the past decade, Peru has shown great success in lowering child mortality and has reached near-universal coverage of immunizations (93%) and prenatal care (95% of women have at least one prenatal visit).[1]

Despite these successes, however, Peru continues to struggle with the issue of inequality in access to health services between the relatively affluent urban districts (with 20% poverty) and poor rural districts (with 61% poverty).[2] In 2011, 85% of births in urban areas took place in health facilities and 58% in rural areas – a vast improvement from a decade earlier (24% in rural areas and 58% in urban areas), yet still a large disparity.[1]

While programs in areas such as maternal and child health, tuberculosis and malaria are generally well-funded through initiatives such as PARSALUD and other special funding sources, Peru is striving to finance its broader health system in a way that incentivizes the expansion of infrastructure and human resource capabilities into poor rural areas.

The **'Comprehensive Health Insurance' (SIS)** was introduced in 2002 to provide free or low-cost health insurance to those living in poverty and extreme poverty. This, along with the conditional cash transfer program, Juntos, has been an important step in this direction and has greatly increased coverage as well as demand for services. The primary challenge then is to increase capacity in poor districts and provide health coverage for the indigent as well as for other vulnerable groups.

Health Finance Snapshot

Total Health Expenditures (THE) in Peru have remained stagnant at 4-5% of GDP for decades (Table 1).

General Government Expenditures on Health (GGHE) remain relatively low (below 60% of THE) and include expenditures by the SIS and EsSalud (the contributory public social health insurance system) as well as other Ministry of Health (MOH) and Regional health authority expenditures to run public health facilities and vertical health programs.

Table 1. Health Finance Indicators: Peru

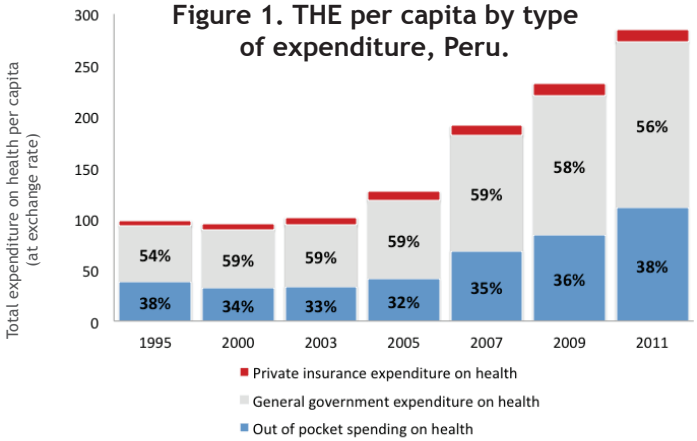
	1995	2000	2003	2005	2007	2009	2011
Population (thousands)	23,827	25,862	26,916	27,559	28,166	28,765	29,400
Total health expenditure (**THE**, in million current US$)	2,402	2,504	2,768	3,541	5,453	6,782	8,495
THE as % of GDP	4	5	5	4	5	5	5
THE per capita at exchange rate	101	97	103	128	194	236	289
General government expenditure on health (GGHE) as % of THE	54	59	59	59	59	58	56
Out of pocket spending as % of THE	38	34	33	32	35	36	38
Private insurance as % of THE	5	6	7	7	5	5	4
External resources as % of THE	1	1	2	3	1	1	1

Source: WHO, Global Health Expenditure Database; National Health Accounts, Peru

- **Out of pocket spending (OOPS)** makes up a significant portion of **THE** (Table 1, Figure 1):
  - Medical care and medications for the 28% of the population that remains uninsured
  - Co-payments for most services as well as payment for excluded complex services for beneficiaries of EsSalud and private insurance beneficiaries
    - **OOPS** does not include insurance premiums.

- Usage of private insurance remains low (approximately 3%):[1]
  - Private insurance does not substitute public coverage.
  - Some beneficiaries of **EsSalud** choose to split their payroll contribution between **EsSalud** and a private health insurer of their choice for supplementary coverage. They often then pay an additional premium to the private insurer.

Figure 1. THE per capita by type of expenditure, Peru.



Source: WHO, Global Health Expenditure Database; National Health Accounts, Peru

Health Status and the Demographic Transition

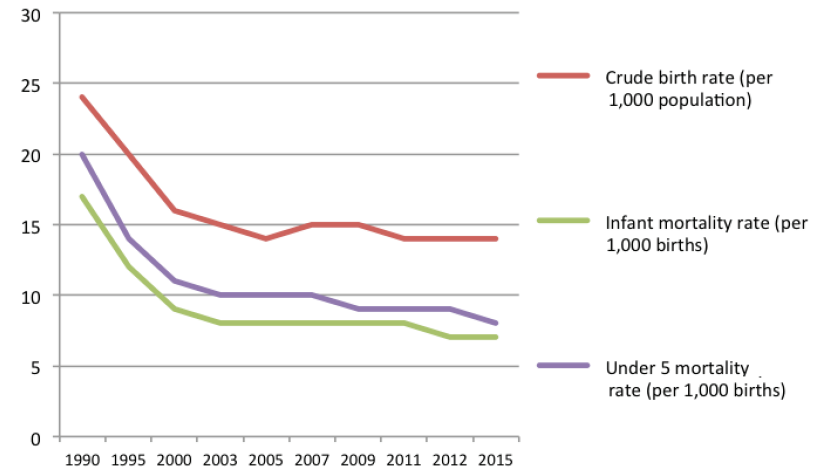
Peru is in the midst of a demographic and epidemiological transition though it is progressing more slowly than other upper middle income countries.

- Birth and mortality rates are declining relatively slowly with periods of stagnation and even regression (figure 2).
- **The total fertility rate (TFR)** has fallen from 2.6 in 1990 to 1.9 in 2012.

An uneven epidemiological transition is under way:

A. Non-communicable (chronic) illnesses have become relatively more important than communicable diseases on average (Figure 4).
B. Peru's poor rural population bears the brunt of nutritional deficiencies, maternal and perinatal death and communicable disease.
C. The relatively affluent urban population shows dramatic increases in obesity and chronic illnesses (e.g. cancer, cardiovascular diseases, and diabetes).

Figure 2. Demographic Indicators. Peru



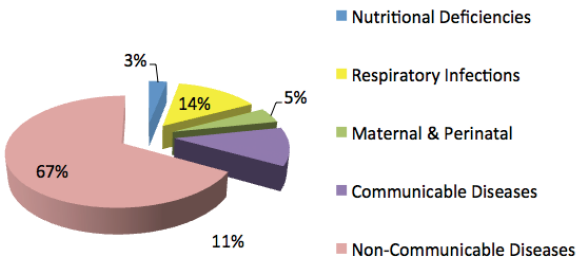
Source: United Nations Statistics Division and the Instituto Nacional de Estadisticas, Peru.

Table 2. International Comparisons, health indicators.

	Peru	Upper Middle Income Country Average	% Difference
GNI per capita (year 2000 US$)	2,005.9	1,899.0	5.6%
Prenatal service coverage	94.7	93.8	1%
Contraceptive coverage	73.2	80.5	-9.1%
Skilled birth coverage	83.8	98.0	-14.5%
Sanitation	71	73	-2.7%
TB Success	81	86	-5.8%
Infant Mortality Rate	14.9	16.5	-9.7%
<5 Mortality Rate	19.2	19.6	-2.2%
Maternal Mortality Rate	67	53.2	25.9%
Life expectancy	73.8	72.8	3.4%
THE % of GDP	5.1	6.1	-16.9%
GHE as % of THE	56	54.3	3.1%
Physician Density	0.9	1.7	-45.5%
Hospital Bed Density	1.5	3.7	-59.1%

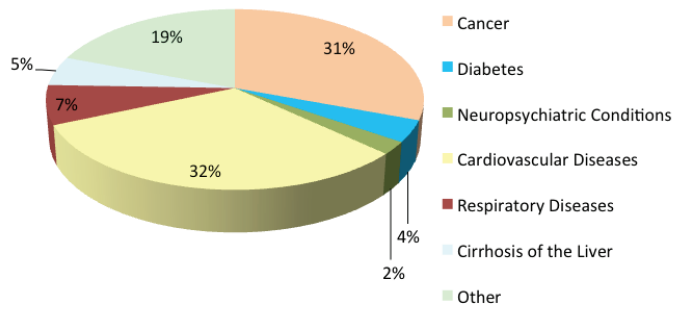
Source: Francke, Pedro. "Peru's Comprehensive Health Insurance and New Challenges for Universal Coverage", World Bank, 2013.

Figure 4. Mortality by Cause, 2008.



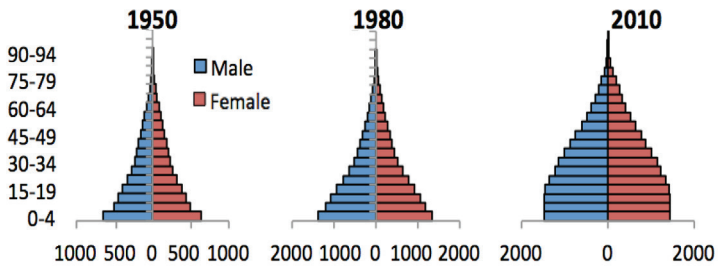
Source: WHO, Global Burden of Disease Death Estimates (2011)

Figure 5. Non-Communicable Disease Mortality, 2008.



Source: WHO, Global Burden of Disease Death Estimates (2011)

Figure 3. Population Pyramids of Peru



Source: Population Division of the Department of Economic and Social Affairs of the United Nations Secretariat, World Population Prospects: The 2010 Revision.

Health System Financing and Coverage

Peru's health system is fragmented, with a complex public component. A contributory social health insurance system for workers has been in existence since the 1940s with EsSalud being the most recent organization of this system (1999). In 2002, Peru introduced **'Comprehensive Health Insurance' (SIS)** to cover people living in poverty and extreme poverty with the **National Household Targeting System (SISFOH)** used to determine eligibility since 2011.[3] The country's health system was decentralized starting in 2004 and **Regional Health Authorities (DIRESAs)** have taken over responsibility for health facilities outside of Lima while Lima has remained under the national Ministry of Health.

Figure 6. Timeline of Peru's Health System

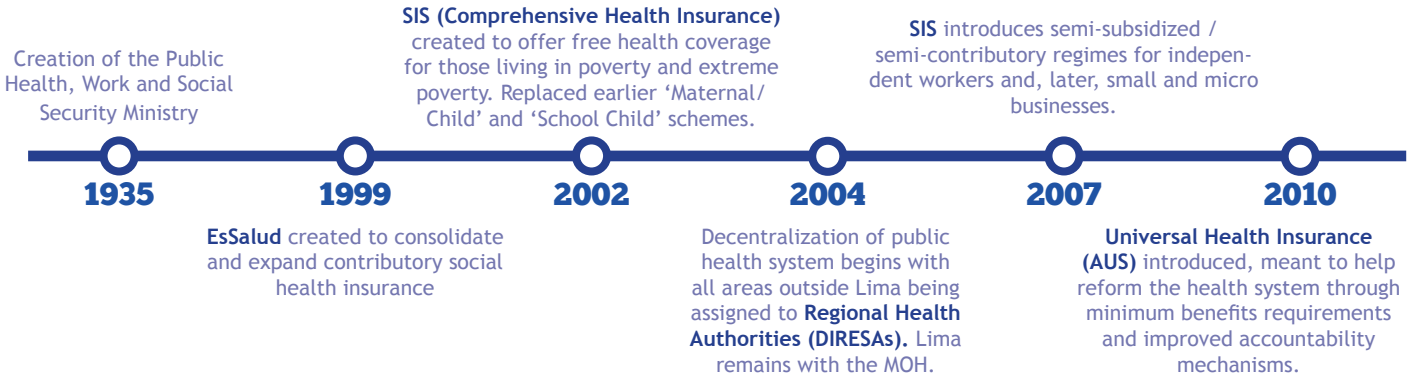


Table 3. Peru's Comprehensive Health System (SIS) and Social Health Insurance (EsSalud)

	Population Covered/Utilizing	Financing Source	Contributions	Type of Facilities
SIS Fully Subsidized	Poor and 'very poor'	National government (Ministry of Economy and Finance (MEF) and contributions for the partially subsidized schemes	--	Until mid-2012, only MOH and DIRESA facilities. (Currently expanding to some EsSalud and private facilities)
SIS Partially Subsidized	Independent Workers making up to S./1,000 per month		Premiums based on income and # of dependents (S./10 - 30/month)	
SIS Mype (Micro and Small Businesses)	Business owner must register employees of micro and small businesses		Business owner pays S./15 monthly for each employee (including dependents). Government pays S./15	
EsSalud (Social Health Insurance)	Mandatory for formal sector workers, Retirees & their dependents Voluntary for Independent Workers	Mandatory Employer contributions for active workers & MOH	9% of earnings	EsSalud-owned and operated health Facilities (mainly in urban areas)
		Mandatory Retiree contributions from eligible pension earnings & MOH	4% of pension earnings	
		Independent workers' contributions	Monthly premium between S./64 (no dependents) and S./228 (3+ dependents)	

Source: Francke, Pedro. "Peru's Comprehensive Health Insurance and New Challenges for Universal Coverage", World Bank, 2013.

The Peruvian Public Health Sector has several components (table 3):

A. **SIS (Comprehensive Health Insurance)** – 38.6% of population (2012)[4]:
- Fully subsidized regime (>99% of **SIS** beneficiaries): Covers those living in poverty and extreme poverty (determined by **SISFOH**) with no other insurance coverage. No contributions nor user fees for a basic package of priority services and since 2007, for a 'complementary package' of more complex/higher-cost services at public (**MOH** and **DIRESA**) facilities. Enrollment is required and is not automatic.
- Partially subsidized/ Semi-contributive regimes: Voluntary plan for independent workers (and dependents) who qualify under the **SISFOH**. Covers the basic package of priority services, emergency services and public health interventions. Monthly premiums apply. Beneficiaries cannot have other insurance coverage.
- **Mype (micro and small enterprises)** regime: Voluntary plan where business owner enrolls employees and pays their premiums which are partially subsidized by the national government. Beneficiaries cannot have other insurance coverage.

B. **EsSalud (Social Health Insurance)** – 33.3 % of population (2012)[5]:
- Mandatory for formal-sector workers and pensioners (covers dependents).
- Owns and operates its own health facilities for its beneficiaries.
- Independent workers may voluntarily enroll and pay monthly premiums for themselves and dependents.
- Covers most primary, secondary and tertiary (complex) care (at **EsSalud** facilities), although co-payments exist and can be significant for complex care.
- Beneficiaries may choose to also enroll in **supplementary private insurance (EPS)** and have 2.25% of their employer's contribution go towards the **EPS** with the remaining 6.75% going towards **EsSalud** (total: 9% employer contribution).

Public Facilities

- Public facilities are managed by either the **MOH (Lima only)** or the Regional authorities (**DIRESAs**). Funding for these facilities comes from the **MOH** and **DIRESA** budgets as well as from uninsured user fees and SIS payment for services.
  - **SIS** pays providers on a fee-for-service basis for variable costs (services and medications).

- **EsSalud** facilities are separate from **MOH** and **DIRESA** facilities and public funding for **EsSalud** and **SIS** are separate as well. This means that **SIS** has one single financial and risk pool and **EsSalud** has its own single financial and risk pool.

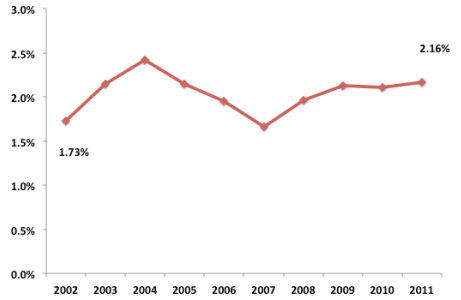
SIS Financing

- Unlike **EsSalud** and other social health insurance schemes, **SIS's** budget is fixed and does not adjust with the number of beneficiaries nor with the benefits package. It actually decreased in nominal terms from 2005-2006 (figure 7).[1] This fixed budget leads to some de facto rationing of services.

- **SIS** itself is managed by the **MOH** but its budget comes directly from the Ministry of **Economy and Finance (MEF)** which has led to issues of unfunded **MOH** initiatives.

- For example, in 2010/2011 the **MOH** established coverage of conditions representing approximately 65% of Peru's disease burden (up from coverage for 20%); however, **SIS's** budget was not expanded accordingly.

Figure 7. SIS Transfers as % of THE



Source: SIS Annual Statistics, 2002-2012 and WHO Global Health Expenditure Database, NHA Peru

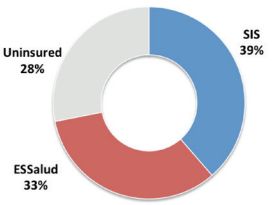
- Though **SIS** continues to target poor individuals, this lack of budgetary expansion by the MEF has led to political decisions starting in 2010 to move away from targeting the country's poorest (rural) regions and instead fo-cus on urban regions with much more advanced infrastructure and human resource levels able to provide the guaranteed benefits package.[1]

- From 2010 to 2012, the total number of SIS beneficiaries in Peru decreased by 8.2%. Following the modified regional focus beginning in 2010, the number of SIS beneficiaries in the richest districts (often urban) increased by 5.5% while the number in the poorest districts decreased by 7.5%.

- Around 28% of Peru's population was uninsured in 2012 (figure 8). These residents must pay out of pocket for services at **MOH** and **DIRESA**-run facilities and are often either unemployed, informal sector workers or rural (agricultural) workers (figure 8).

Figure 8. Population Coverage, 2012

Source: **SIS** and **EsSalud** Annual Statistics, 2012



- In spite of the challenging mandate the SIS faces to provide coverage for quality health services to the nation's indigent and low-income population, it has made important progress. Pre-2002, there were only very limited, narrowly-targeted insurance schemes for the poor (e.g. for maternal and child health). **SIS** coverage extended to 42.6% of Peru's population in 2010, the same proportion of the population that was living on less than US$5/day in that same year, an important achievement.[2,4]

Challenges and Future Agenda:[1]

- Financial mechanisms needed to attract health workers to underserved rural districts through incentives or bonuses. (Salaries are currently the same between urban and rural areas.)
- Need for a monitoring system able to identify and track **SIS** outcomes in order to qualify for more **MEF** financing which is increasingly based on results-based mechanisms.
- Clarification required in the demarcation of **MOH** and **DIRESA** responsibilities, particularly in terms of scaling-up health system capacity in poor rural areas to be able to provide services for which the **MOH** is guaranteeing coverage through **SIS** and **AUS**.
- Continued progress needed on allowing **EsSalud** facilities, with their greater capacity, to provide services to **SIS** beneficiaries.

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