BTC

BELGIAN
DEVELOPMENT AGENCY

TECHNICAL NOTE

BUDGET SUPPORT TO THE UNIVERSAL HEALTH INSURANCE POLICY

PERU

CÓDIGO DGCD : NI
CÓDIGO NAVISION : PER 09 016 11

COOPERACIÓN BELGA
PARA EL DESARROLLO .be

BASIC DATA OF THE BELGIAN CONTRIBUTION

<table>
<tr><td>Title of the programme</td><td colspan="3">Budget Support to the Universal Health Insurance Policy</td></tr>
<tr><td>Earmarking (sector/subsector/regio)</td><td colspan="3">Health sector</td></tr>
<tr><td>Country</td><td colspan="3">Peru</td></tr>
<tr><td>Calendar</td><td colspan="3">2013 – 2015</td></tr>
<tr><td rowspan="2">Financial data
(Euros)
2013-2015</td><td>Total</td><td>Belgian contribution</td><td>Donors contribution</td></tr>
<tr><td></td><td>€ 6.5 million</td><td></td></tr>
<tr><td>DAC – Code /Sector</td><td colspan="3">12110 - Health</td></tr>
<tr><td>NI - Code</td><td colspan="3"></td></tr>
<tr><td>NAV - Code</td><td colspan="3">PER 09 016 11</td></tr>
<tr><td>Date of the approval of Basic Note</td><td colspan="3">21/12/2009</td></tr>
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Calendar / Tranching in Euro

Tranching	2013	2014	2015	Total
S1	2,000,000	2,500,000	2,000,000	6,500,000
S2				

Exchange rate on 07/11/2012

1 PEN (nuevos soles) = 0.29565 EUR

1 PEN = 0.37838 USD

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List of acronyms

AECID	Agencia Española de Cooperación Internacional y Desarrollo (Spanish International Cooperation Agency)
APCI	Agencia Peruana de Cooperación Internacional (Peruvian International Cooperation Agency)
AUS	Aseguramento Universal de Salud (Universal Health Insurance)
BTC/CTB	Belgian Development Agency
CGR	Contraloría General de la República (National Auditor General's Office)
CIGS	Comité Inter-gubernamental de Salud
CNS	Consejo Nacional de Salud
CTIN	Comité Técnico Implementador Nacional (National Implementation Technical Committee)
CTIR	Comités Técnicos de Implementación Regional (Regional Technical Committees for Implementation)
DIRESA	Dirección Regional de Salud (Regional Health Directorate)
DISA	Dirección de Salud (Health Directorate)
EC	European Commission
EESS	Establecimientos de Salud (Health Institutions)
ENAHO	Encuesta Nacional de Hogares (National Household Survey)
ENAPRES	Encuesta Nacional de Programas Estratégicos (National Survey of Strategic Programmes)
ENDES	Encuesta Nacional Demográfica y de Salud Familiar (National Demographic and Health Survey)
ENESA	Encuesta Nacional de Establecimientos de Salud con Funciones Obstétricas y Neonatales (National Survey of Health Centres with Obstetrical and Neonatal Functions)
EPS	Entidades Prestadores de Salud (Private Health Service Providers)
EsSalud	Seguro Social de Salud del Perú (Peru's Health Security Fund)
EUROPAN	European Budget Support to National Nutrition Strategy
ForoSalud	Foro de la Sociedad Civil en Salud
GNP	Gross National Product
HIV/AIDS	Human Immunodeficiency Virus / Acquired Immunodeficiency Syndrome
IDB	Inter-American Development Bank
IAFAS	Instituciones Administradoras de Fondos de Aseguramiento en Salud (Health Insurance Providers)
IPRESS	Instituciones Prestadoras de Servicios en Salud (Health Service Providers)

IMF	International Monetary Fund
INEI	Instituto Nacional de Estadística e Informática
JUNTOS	Programa Nacional de Apoyo Directo a los más Pobres
LPIS	Listado Priorizado de Intervenciones Sanitarias
MCLCP	Mesa de Concertación para la Lucha contra la Pobreza
MDG	Millennium Development Goals
MEF	Ministerio de Economía y Finanzas (Ministry of Economy and Finance)
MIMP	Ministerio de la Mujer y Poblaciones Vulnerables (Ministry of Women and Vulnerable Populations)
MINSA	Ministerio de Salud (Ministry of Health)
MINTRA	Ministerio del Trabajo (Ministry of Labour)
MMM	Marco Macro-Económico Multi-anual (Multiannual Macroeconomic Framework)
OCI	Oficina de Control Institucional
ODSIS	Oficina Descontratradas del SIS (Deconcentrated SIS Office)
OIE	Oficina de Informática y Estadística (Information and Statistics Office)
PAHO	Pan American Health Organization
PAN	Programa Articulado Nutricional
PARSALUD	Programa de Apoyo a la Reforma del Sector Salud (Programme to Support Health Sector Reform)
PCM	Programa Continuo del Mejoramiento de la Gestión de Finanzas Públicas del Perú (Continuous programme of the improvement of PFM in Peru)
PEAS	Plan Esencial de Aseguramiento en Salud (Essential Plan for Health Insurance)
PEFA	Public Expenditure and Financial Accountability
PEI	Plan Estratégico Institucional (Strategic Institutional Plan)
PESEM	Plan Estratégico Sectorial Multianual de Salud (Strategic Multiannual Plan for the Health Sector)
PFM	Public Financial Management
POI	Plan Operativo Institucional (Operational Institutional Plan)
PpR	Presupuesto por Resultatdos (Budgeting for Results)
PROSIS	Programme of Financial Support to SIS
RENIEC	Registro Nacional de Identificación y Estado Civil
RO	Recursos Ordinarios (Regular Resources)
SEPS	Superintendencia de Entidades Prestadoras (Health Provision Supervisor)

SERUMS	Servicio Rural Urbano Marginal de Salud
SETEC	La Secretaria Tecnica del Comité Tecnico Implementador Nacional (National Secretariat of the Technical Implementing Committee)
SIAF	Integrated System of Financial Administration
SIS	Seguro Integral de Salud (Integral Health Insurance)
SISFOH	Sistema de Focalización de Hogares (Household Targeting System)
SUNASA	Superintendencia Nacional de Aseguramiento en Salud (National Health Insurance Supervisor)
USAID	United States Agency for International Development
UDR	Unidad Desconcentrada Regional (SIS)
USD	United States dollar
WB	World Bank

1 PROGRAMME DESCRIPTION

1.1 Description of the programme

Health care provision and financing is complex in Peru. Several parallel health insurance systems co-exist, with little collaboration among them. Such vertical integration of the health insurance systems translates into four different types of insurance: one for the formal employees (EsSalud), one for the army and police (each their own), smaller insurance providers for the wealthiest layer in society, and a subsidized insurance provider for the poor ('Seguro Integral de Salud' - SIS). In 2006 a political agreement between all political parties was signed for a progressive establishment of *a Aseguramiento Universal de Salud* (AUS).

In the framework of the current Indicative Program of Cooperation (ICP 2010-2013), an indicative allocation of € 6.5 million of budget support to AUS, with a focus on the SIS, is foreseen. External budget support in Peru is managed centrally by the Ministry of Economy and Finance (MEF) and implemented through 'budgeting-for-results' techniques in support to national strategic programs. Financial resources from the MEF are destined on the one hand, to health agencies at national level (eg. SIS) and on the other hand, to regional governments. The Ministry of Health (MINSA) holds the overall technical responsibility for strategic programs designed for the health sector. The overall focus of the policy dialogue of the Belgian budget support will be on the implementation of the AUS strategy. In this framework, the strategic program 'Salud Materno-Neonatal' will be used as a marker to appreciate the progress of the implementation of AUS and its effect on health service delivery. The complementary SIS-TEC support intervention will also feed the policy dialogue but from another perspective, since it will rather focus on the design and mechanisms of health insurance in Peru.

This budget support is thus complementary to the other health-related interventions in the Belgian portfolio (SIS-TEC, the *Becas* program, the study fund, as well as the projects of the indirect bilateral cooperation related to health).

The overall objective[1] of the budget support is 'The right of every person belonging to the poor and poorest population groups to quality health services is assured increasing the health status of the population.'

The specific objective[2] is 'By 2016, the coverage of affiliation and benefice package of the SIS is extended with guarantees of quality for men, women, children in poverty and extreme poverty according to their differentiated needs, in priority regions in Peru in the perspective of AUS.'

1.2 Summary of motivation

A well-functioning social security system – in particular, a health insurance system – serves multiple desirable social objectives. A health insurance system should:

1. Stimulate the demand for health care, which – if managed and monitored well – can lead to a better allocation of resources.
2. Protect individuals facing serious illness or injury, so that they are not condemned to poverty, but are able to receive treatment and work again when they are in good health.
3. On a more macro level, make sure that an economic downturn does not restrict access to health care for people, therefore stabilizing the health system in the longer term.

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[1] The objective as stated in the 'Ficha sobre el apoyo financiero' as sent by DGD to BTC on 16/2/2010 (D1.5/GS/2010/5420

[2] Idem

In Peru a large share of the population is barred from access to basic health care. Wide-ranged poverty, especially in the remote areas, lays at the basis of this problem. The Peruvian social security system is underfunded and unequal, and performs rather badly compared to the Latin American average[3]. Even after half a decade of important improvements in health insurance in Peru, 35% of the population does not have any form of formal health insurance according to the household survey of 2010.

In this respect the *Aseguramiento Universal de Salud* (AUS) policy has the potential to:

- Reduce the financial barrier to access the health system for the poorest. Which in turn leads to a more **equitable** health system, where the poor can enjoy partly or fully subsidized health services;
- Lead to a **more efficient** use of existing resources;
- Extend the **horizontal coverage** of health insurance. Since affiliation is compulsory under the AUS, health risks are pooled, and adverse selection reduced, hopefully leading to a premium drop;
- Offer higher **quality** health insurance to its affiliates, helped by the creation of a new sector-wide regulatory and monitoring institute, *Superintendencia Nacional de Aseguramiento de Salud* (SUNASA).

Between 2005 and 2009, the Belgian Cooperation supported the extension of public health insurance for the poor in the regions of Cajamarca, Ayacucho and Apurimac through a programme of 'Financial Support to the Comprehensive Health Insurance' (PROSIS) with a financial contribution of € 9 million. These resources were directly transferred to the SIS and executed using national rules and procedures. The innovative side of the PROSIS was the design and implementation of contracts between the SIS and regional governments promoting per capita funding through a result-based approach. This gave greater responsibility to regional governments for the organization of health service delivery and stimulated close to 100% horizontal coverage and better cost-efficiency in the regional system. The Peruvian government has built upon the successful experience of the PROSIS and is now scaling up this approach at national level and therefore operating an important shift away from the highly ineffective demand-driven reimbursement of services.

An institutional strengthening project (SIS-TEC) worth € 13.5 million has been formulated in complementarity to the SIS-FIN budget support foreseen in the ICP and is expected to kick off in the first semester of 2013. Belgium seeks a portfolio approach of its contribution to the health sector, in order to strategically align the technical support brought by the project with the policy dialogue at the Budget Support level. The Belgian Embassy took over the secretariat of the *Mesa de Salud* in July 2012 and will be working in close collaboration with MINSA on reactivating a structured dialogue between the Peruvian authorities and development partners.

1.3 General comments on the proposal

This Technical Note provides an update of the situation analysis and risk assessment carried out in 2010 during the initial formulation of the SIS-FIN budget support. Following the general elections of April 2011, a new Peruvian government came in office and endorsed a comprehensive AUS strategic plan (2011-2021) as well as a new SIS institutional strategic plan (2012-2016). However in the first year of term of the new government, the implementation of AUS under Minister of Health Alberto Tejada stalled considerably. The President reshuffled his cabinet in July 2012 and designated a new Minister of Health, Midori de Habich, who is a health economist and has worked closely on the design

[3] Strategic Plan AUS 2011-2011 (July 2011), pp.36-37.

and set-up of the AUS in her previous assignments. AUS-related priorities have now been set back on the agenda, as shown in the presentation of the new strategic axes of MINSA made in August 2012.

The Terms of Reference for the update of the Technical Note initially foresaw the earmarking of the budget support at sector level, as per the recommendations of the Technical Note submitted in December 2010 following an agreement at the Budget Support WG in March 2010. However DGD requested that BTC reconsider the option of earmarking the budget support to the SIS on the basis of a new risk analysis, as indicated in the ICP and Basic Note (2009), while analysing the option of anchoring the policy dialogue at sector level (with a particular focus on AUS). The alignment to the national procedures at the level of MEF to implement the budget support through the national strategic programs (in casu the strategic program on maternal & neonatal care being a marker of the effects of AUS on service delivery) is not in contradiction with these Terms of Reference.

The four minimum requirements for Belgium to engage in budget support, as provided in the Vademecum of 2008, are reassessed in the present Technical Note (see chapter 2.1).

1.4 Assessment of performance during the previous phase

1.4.1 Background on AUS

In 2009, MINSA started implementing the AUS strategy, which unfolded in three phases in a series of pilot zones:

- **AUS 1**: The first phase targeted three of the poorest departments, firstly Apurimac, Ayacucho and Huancavelica. Specific districts or provinces in other departments followed such as Cajamarca, Lambayeque (district of Salas), La Libertad (province of Sánchez Carrión), Piura (5 districts of El Bajo), San Martin (6 districts of the commonwealth of El Bajo Huallaga de San Martín)[4]. The designation of these pilot areas was mainly based on criteria of social exclusion, poverty and unsatisfied demand for health services.
- **AUS 2**: In 2010 the program was expanded to the districts of Junin and Cusco, the region of El Callao, and the provinces of Condorcanqui and Bagua de Amazonas.
- **AUS 3**: Still in 2010, the province of Datem del Marañón de Loreto and the Lima Metropolitan Area were included.

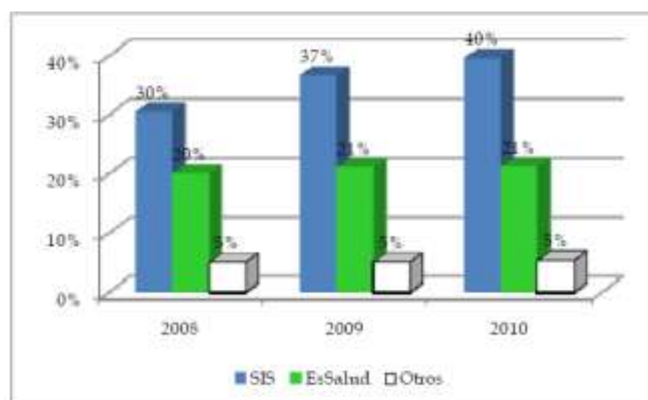
The implementation is necessarily a gradual process because of limited human, physical and financial resources.

1.4.2 Results in terms of coverage

From 2008 to 2010, the percentage of the population affiliated to some form of health insurance grew from 54% to 64%. The graph below shows that the SIS has been the main contributor in achieving this coverage, while affiliation to other insurance providers was rather stable during the same period.

[4] Note : Governmental hierarchy in Peru: Central government – Regions – Provinces – Municipalities.

Figure 1: Evolution of the insurance coverage according to type of insurance, 2008 - 2010

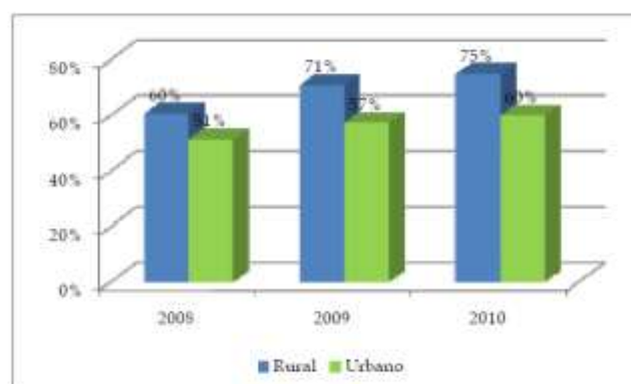


Fuente: ENAHO

It appears that the rural population has benefited the most from the increased coverage, showing a 15% jump between 2008 – 2010.

In spite of progress made, the most recent data show that an estimated 35% of the population (8 million people) in Peru do not have any form of health insurance (sources: ENAHO 2011 and SIS).

Figure 2: Evolution of the insurance coverage according to zone of residence, 2008 - 2010



Fuente: ENAHO

1.4.3 Results in terms of access and equity

One of the main purposes of AUS is to reduce the financial barriers for accessing health services. The general assumption is that the increase in horizontal coverage leads to an increase in the use of health services.

While the extension of horizontal coverage in recent years shows impressive results, the effective level of subsidy covering health care for the poor must also be considered. Between 2005 and 2009, the percentage of the poor affiliated to SIS whose health care expenses were fully covered fell from 70% to 54%. This implies that in 2009, 54% of the SIS affiliates would still have to spend money out of their pocket to complement costs incurred for the use of health services.

Data from recent household surveys have revealed that, relatively, access to health services for the insured population has decreased in recent years, while at the same time the percentage of persons without insurance who have had access to health care has been stable (from 20 to 21%) – as illustrated in the graph below.

These results can hold several explanations, one hypothesis being that the increase in the number of affiliates may not have been accompanied by a similar increase in financial resources for the provision of services. In other words, the limitations of the budget allocation to SIS could be significantly

reducing the positive effects of the insurance, therefore putting the entire AUS policy at risk (see more in chapter 2.3.3).

Figure 3: Evolution of access to health services according to insurance status, 2008 – 2010

Fuente: ENAHO

The below graphs illustrate how access to health care decreased overall among the insured population from 2008 to 2010. More specifically, this trend is more pronounced among the insured population facing higher levels of poverty.

Figure 4 : Evolution of access to health services according to poverty status, 2008 – 2010

1/ Los resultados se limitan a la población asegurada
Fuente: ENAHO

2 RISK ASSESSMENT

2.1 Minimum requirements at country level (cf. Belgian vademecum for budget support)

2.1.1 Minimum guarantees of good economic governance

Since Peru is considered a (Upper-)Middle Income Country by the World Bank (WB), its policies and economic management are not scored through the IRAI (IDA Resource Allocation Index).

Generally speaking, Peru has a good level of economic governance, with sound public sector management and institutions - see chapter 2.1.3 for the analysis of the PFM system based on the last PEFA methodology and other PFM assessments.

Conclusion: As upper Middle-Income country, Peru can be considered as having a sound level of public sector management and institutions.

2.1.2 Macro- economic stability

Peru managed to have a strong and continuous level of real economic growth between 4 and 10% during the period 2002-2012, outperforming most other Latin-American countries. Good economic performance was mainly due to the booming demand for minerals, which is an important pillar of the Peruvian economy; an increase in direct foreign investments and the development of the agro-industry in the coastal areas contributed to growth as well. Due to the global economic crisis – and the collapse of prices of raw materials that adjoined it – real GDP growth was estimated at 6% in 2012. The outlook for 2013 is for continued growth, with real GDP growth projected at 6.2%[5].

After falling at its lowest level in a decade (reaching 0.25% in 2009), inflation rates rose to 2% in 2010 and reached 4.7% in 2011, higher than the target established by the Central Reserve Bank of Peru (1-3%). This was mainly a result of supply shocks and demand pressures. The estimate is that inflation rates has decreased to 2.8% in 2012[6] and will maintain an average of 2.9% annually between 2013–2017 due to higher public spending, which is expected to fuel domestic demand [7].

Peru's per capita GDP based on power-purchasing-parity (PPP) for 2011 was estimated at 10,317 international dollars (versus 5,066 in the year 2000). In other words, average purchasing power more than doubled over the past 10 years.

The most recent IMF Article IV Consultation was led from October to December 2011 and concluded with Executive Board's endorsement of the staff appraisal, which reads:

"**The policy mix seems broadly adequate to maintain macro stability and foster growth**. The main challenge is to ensure a timely and flexible implementation of policies to confront changing domestic economic conditions in an external environment of heightened uncertainty.

The 2012 budget proposal seems appropriate. Efforts to reinvigorate public spending in the second half of 2011 are welcome as the fiscal stance was becoming somewhat tight. Still, there will be a

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[5] The Economist Intelligence Unit, Peru Country Report, December 2012

[6] ACE international consultants (for the EC), « Estudios y Matrices para análisis de situación y perspectivas macro económicas, gestión de finanzas y rendición de cuentas », Julio de 2012

[7] The Economist Intelligence Unit, Peru Country Report, December 2012

higher-than-expected surplus for 2011. The proposed 2012 budget, which aims at a surplus of 1 percent of GDP and entails a structural expansion of 0.75 percent of GDP, is broadly adequate as activity is expected to be softer. Additional short-term social spending can be accommodated within the expenditure limits established by the 2012 budget. (…)

Tax mobilization efforts will be key to the sustainability of the social agenda. Staff welcomes the authorities' plans to strengthen tax administration to increase the tax ratio to 18 percent of GDP by 2016 to provide additional resources to cover increasing social programs and public investments in the medium-term. The approval of the revised mining taxation framework, with due consideration for competitiveness in the sector, is a welcome first step. Staff also welcomes the authorities' efforts to reduce tax evasion (…)

The financial sector is strong, and the prudential framework is ahead in the implementation of proposed international standards. Peru's financial sector remains sound, profitable and well-capitalized. Most prudential regulations aligned with Basel III will be applied ahead of the internationally-agreed schedule, with banks well positioned to implement them. Monitoring corporate balance sheets, including foreign exchange and derivative positions, will be critical to assess vulnerabilities. Formalizing an institutional setup for macro-prudential policies would facilitate monitoring systemic risks more effectively, and enhance analysis and coordination across institutions.

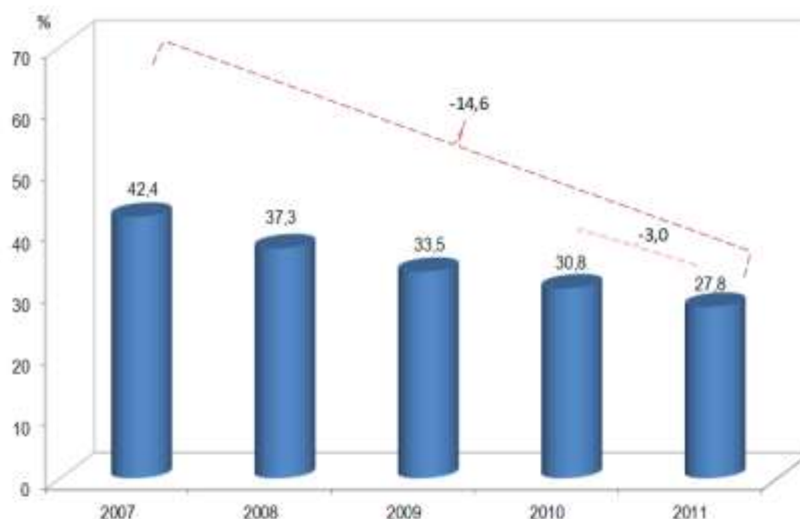
Peru's bright economic prospects will benefit from an ambitious reform agenda to maintain high potential growth. Staff concurs with the view that growth will need to be increasingly driven by higher productivity over the medium term. Key pillars to ensure high growth include: (i) enhancing competitiveness by boosting human capital and infrastructure and maintaining labor market flexibility; (ii) improving the business climate to foster investment and innovation (including enhancing formality); and (iii) further developing the local capital markets to facilitate investment and better allocate savings."

With regard to fiscal revenue, the Multiannual Macro-Economic Framework (MMM) foresees to gradually increase tax pressure to 18% of GDP by 2016 and reach a level of current revenue of the general government higher than 22.5%.

2.1.2.1 General levels of poverty and household data

Data from the latest household survey (ENAHO 2010-2011) reveal that the percentage of population living under the poverty line decreased from 42.4% to 27.8% in just four years. A technical report analyzing data from the above-mentioned survey was published in May 2012 and draws comparisons with results from previous surveys.

Figure 5: Evolution of total poverty incidence, 2007 – 2011

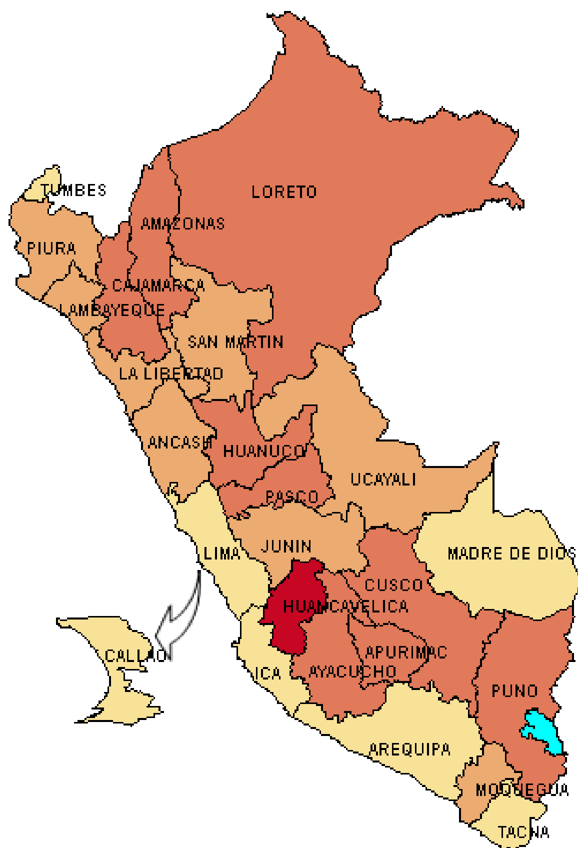


Fuente: INEI - Encuesta Nacional de Hogares (ENAHO): 2010-2011.

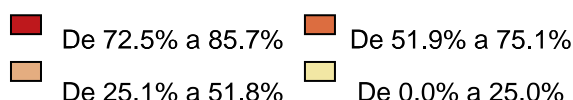
In spite of progress made in overall poverty reduction, large regional disparities still persist, as shown below, based on data from the last population census (2007). The same concern is shared in the report of the IMF staff appraisal undertaken at the end of 2011, which highlights that Peru is lagging behind other countries with comparable income level in health and education expenditure (see more in chapter 2.4). In terms of access to basic services, in 2011, out of 100 poor households, 67 had no latrines, 45 has no access to drinkable water and 27 had no access to electrical light.

On average 9.1% of household expenditure per capita is spent on health care, 11.3% on transports and communications, 16.5% on housing and fuel and 41.5% on food.

In Lima life expectancy is 78 years and one medical doctor on average serves 1,750 people; in Huancavelica life expectancy is 59 and there is one doctor for every 23,000 people.



Incidencia de Pobreza Total [8]



2.1.2.2 Total budget and medium-term projections

The total government budget for the year 2012 was defined with relative conservatism at S/. 95.5 billion in the context of an uncertain world economy. In nominal terms the budget still showed a steady increase of 8% as compared to 2011, as was the case from 2010 to 2011.

The Multiannual Macro-Economic Framework ('Marco Macroeconómico Multianual' - MMM) for 2013-2015 reaffirms the following principles as main guidelines for Peru's economic policy:

1. Greater social inclusion and poverty reduction
2. Stable growth
3. Improve productivity and competitiveness of the economy
4. Increase tax pressure
5. Improve the quality of public expenditure through Budgeting for Results

The MMM clearly spells out that the challenge with stimulating inclusive growth implies using greater permanent fiscal revenue in expanding social expenditure. The focus will be on (i) reducing rural poverty, (ii) reducing chronic malnutrition, (iii) reducing gaps in access to drinkable water, sanitation and electricity in the country's poorest districts, (iv) improving the quality of public education, (v)

[8] Population census 2007, Instituto Nacional de Estadistica e Informatica (www.inei.gob.pe)

substantially reducing the gap in access to quality health services, and (vi) articulating development policies and social inclusion with productive development policies.

Conclusion: Peru's economy has remained stable in the midst of the global economic crisis. The financial sector continues to be strong and prudent budget discipline has been observed. Therefore we can conclude that Peru shows a good level of macroeconomic stability.

2.1.3 Public Finance Management

2.1.3.1 Assessment of the overall PFM system

The first **PEFA** was carried out from September 2008 to April 2009 and was prepared jointly by the EU, the WB and the Inter-American Development Bank. The assessment covered the period 2005-2007 and its conclusions regarding the overall quality of Peru's PFM system were largely positive, with only six out of 28 high-level indicators that received a score inferior to B (see Table 1).

Three indicators got a D score however and should be highlighted, namely:

- In regards to the budget cycle:
  - Effectiveness of collection of tax payments
  - Availability of information on resources received by service delivery units
- As far as donor practices are concerned:
  - Proportion of aid that is managed by use of national procedures

The PEFA report concludes by saying that:

> "the PFM system and practices in place in Peru – analyzed according to the six dimensions of the PEFA framework – function in an adequate manner, and in line with international best practices. There are relatively few weaknesses; those have been identified and the appropriate corrective actions are either being designed or implemented. These remedial efforts should lead to a subsequent strengthening of the country's PFM system, which in turn should contribute to support economic development and poverty reduction in Peru. The leading role assumed by the national government is essential to the success of the reform program."

A political consensus exists among most political parties that PFM issues need to be addressed. The Government's PFM reforms have received direct support from the WB and IDB. In 2009, MEF established a high-level coordination forum – the **Mesa PEFA** – where donors and MEF meet to discuss the progress made in reforming the PFM system, following the PEFA framework. Belgium takes part in this Mesa PEFA, next to other donors such as the EC and the Swiss Cooperation (SECO).

The 'Mesa PEFA' is supported by a 'Grupo de Estudios' consisting of six full-time independent experts based at the MEF who monitor and support the institutional reform stipulated in the context of the PFM reform. The Study Group carries out its tasks on the basis of annual work plans approved by the MEF. One major task of this group has been its support to the preparation of a medium-term action plan named 'Programa de Mejoramiento Continuo de la Gestión de Finanzas Públicas del Perú ' (PCM) covering 2011-2015. The PCM is reviewed and updated on a regular basis (most recent version: May 2012).

Among the challenges to be addressed by the Study Group, the MEF has prioritized the following:

- Modernization of the Integrated System of Financial Administration (SIAF)
- Strengthening of the budget discipline, including the national budget system

- Analysis of the sustainability of public finances with emphasis on fiscal contingencies

According to the EC, a second national PEFA is planned to be undertaken in 2013. Meanwhile, the EC produces comprehensive reports every 6 months with an update on the implementation of the PFM reform.

A series of sub-national PEFAs have also been undertaken in six regions, of which four reports are already available and two reports are expected to be published by the end of 2012. The regions assessed were: Apurimac, Chiclayo, Cusco, Huancavelica, Puno, San Martin. The available analysis is summarized in the EC's latest PFM report (July 2012), which indicates that performance of the PFM system at regional level is substantially weaker than that of the national level and that common weaknesses are found in all regions. This implies the existence of systemic issues and requires an integrated response. The main challenges relate to frequent budgetary amendments, untidy budgetary planning, low budget execution (especially with regard to public investment), and limited internal control systems.

Table 1: Results of the national PEFA 2009

				2008
A.PFM OUTCOMES	BUDGET CREDIBILITY	PI-1	Aggregate Expenditure Out-turn Compared to Original Approved Budget	B
		PI-2	Composition of Information Included in Budget Documentation	C
		PI-3	Aggregate Revenue Out-turn Compared to Original Budget	A
		PI-4	Stock and Monitoring of Expenditure Payment Arrears	C+
B.KEY CROSS-CUTTING ISSUES	COMPREHEN-SIVENESS & TRANSPA-RANCY	PI-5	Classification of the Budget	B
		PI-6	Comprehensiveness of Information Included in Budget Documentation	A
		PI-7	Extent of Unreported Government Operations	A
		PI-8	Transparency of Inter-Governmental Fiscal Relations	A
		PI-9	Oversight of Aggregate Fiscal Risk from other Public Sector Entities	B+
		PI-10	Public Access to Key Fiscal Information	A
C.BUDGET CYCLE	POLICY-BASED BUDGETING	PI-11	Orderliness and Participation in the Annual Budget Process	A
		PI-12	Multi-Year perspective in Fiscal Planning, Expenditure Policy and Budgeting	B
	PREDIC-TABILITY & CONTROL IN BUDGET EXECUTION	PI-13	Transparency of Taxpayer obligations and liabilities	B+
		PI-14	Effectiveness of measures for taxpayers registration and tax assessment	A
		PI-15	Effectiveness in collection of tax payments	D+
		PI-16	Predictability in the availability of funds for commitment of expenditures	B+
		PI-17	Recording and management of cash balances, debt and guarantees	B+
		PI-18	Effectiveness of payroll controls	B+
		PI-19	Competition, value for money and controls in procurement	B+
		PI-20	Effectiveness of internal controls for non-salary expenditure	B+

		PI-21	Effectiveness of internal audit	C+
	ACCOUNTING	PI-22	Timeliness and regularity of accounts reconciliation	B+
		PI-23	Availability of information on resources received by service delivery units	D
		PI-24	Quality and timeliness of in-year budget reports	C+
		PI-25	Quality and timeliness of annual financial statements	A
		PI-26	Scope, nature and follow-ups of external audit	B+
		PI-27	Legislative scrutiny of the annual budget law	B+
		PI-28	Legislative scrutiny of external audit reports	C+
D.DONOR PRACTICES		D-1	Predictability of direct budget support	A
		D-2	Financial Information provided by donors for budgeting and reporting on project and program aid	C
		D-3	Proportion of aid that is managed by use of national procedures	D

2.1.3.2 Overall planning and budget cycle

The **Ministry of Finance** (MEF) plays the main role with respect to PFM. Three of its directorates are especially important to the health sector. The National Public Budget Directorate (DNPP) is the line agency of the MEF that administers the National Budget System and is responsible for the formulation, approval, execution and assessment of the budget process for all public sector entities and agencies. As far as the budgeting cycle is concerned, the responsibilities of the General Directorate of Public Debt and Treasury (DGETP) consist of allocating the government's cash, and programming and authorising payments and fund movements through its bank accounts. The General Directorate of Social and Economic Affairs (DGAES) is the line agency responsible for supervising and coordinating the Economic and Social Policy development, execution, monitoring and evaluation in the medium and long term. It also manages the Economic Programme and Multiannual Macro-economic Framework (MMM).[9]

The **fiscal year** runs from January 1st to December 31st. The budgetary preparations start with the approval of the MMM by the Council of Ministers (in May), consequently, MEF will decide on and notify the budget ceiling for each agency in the beginning of June. In practice the directives and circulars are not sent timely, effectively limiting the amount of time available for the agencies to prepare their proposals. The budget meetings and programming usually take place from the second week of July until mid-August, when the budget bill is reviewed before being submitted to Congress on the constitutionally mandated date of August 30th. Congress must approve the budget bill on November 30th at the latest.

An important policy priority for the government is to enhance the **efficiency and effectiveness of public expenditure**. In recent years the government has been implementing fiscal policies that have the objectives of improving the quality of expenditures, improving tax management systems and processes, and closely managing public debt. In line with this, **result-based budgetary techniques** were introduced by the previous government, improving the Public Expenditure Monitoring and Evaluation System, and implementing the National Public Investment System at decentralised level.

The overall objective of budgeting-for-results is to reinforce the effectiveness and equity of the public budget, to contribute to fulfill the engagement of the government towards the well-being of its

[9] PEFA 2009, p. 30

population in particular the poorest and neglected population groups. The MMM 2013 – 2015 reconfirms these ambitions and sets as objective for the MEF to have 100% of the budget formulated in programmes through a 'results logic' by the end of the term of the current government, so as to ensure the National Budget System contributes to the efficiency and effectiveness of public expenditure, with a focus on the use of performance data. This will require further strengthening of capacity for strategic planning at national and sector level.

Currently the five largest strategic programmes under implementation in support to social policies are:

- Maternal and Neonatal Care
- Chronic Malnutrition
- The population's access to identity (birth registration)
- Schooling up to the 3rd cycle
- Access of rural populations to basic social services (health, education) and opportunities of purchase of these services (mainly a program of road construction)

In regards to international development cooperation, the PCM 2011-2015 sets as a guideline that "all cooperation resources destined to the strengthening of PFM be directed mainly to the promotion of budgeting-for-results, in order to improve the quality of expenditure with targeted interventions in the subnational governments"[10].

2.1.3.3 PFM performance in other key areas[11]

The PFM reform covers all the key areas of the PFM system, of which a summary of progress and remaining challenges is drawn from the last EC report (2012) and provided here below.

Control of budget execution:

- Need to modernize the integrated information system of public financial management.
- Need to reinforce the performance evaluation system and accountability mechanisms.

Accounting, registry and information:

- Use of the General State Accounts to feed into the decision-making process should be strengthened.
- The registration of information on funds received at service delivery units (schools and health centres) has improved with the implementation of SIGA, but effective access to information on fund availability and execution should be further strengthened.

Scrutiny and external audit:

- Annual external audits are conducted by the Office of the National Auditor General (CGR) for most government administrations and agencies. These consist mainly of financial audits that report on systemic problems of treasury, staff, procurement, budget and accounting. The reports are submitted to Congress on time and there appears to be a good follow-up on the recommendations put forward in the audit reports.
- The CGR has initiated the process of strengthening the internal audit function by assimilating all the Organs of Institutional Control (OCI) that are still administratively dependent from the authorities of public entities.

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[10] MEF, PCM 2011 – 2015 (revised version of May 2012)

[11] ACE international consultants (for the EC), « Estudios y Matrices para análisis de situación y perspectivas macro económicas, gestión de finanzas y rendición de cuentas », Julio de 2012

- Deadlines for the revision of the General State Accounts have been brought forward so as to allow more time for the dissemination of information between Congress and the population before the approval of the budget law.
- Challenges remain at several levels, such as the need to: (i) strengthen the organization and capacity of the CGR for government control and internal audit, (ii) increase the number and scope of performance audits in coordination with the MEF approach to PpR, (iii) increase technical capacity within Congress to improve the revision of the General State Accounts, (iv) disseminate and use the information of the General State Accounts as a tool for social control.

Conclusion: There is a sound PFM system in Peru. Policy dialogue through the Mesa PEFA is strong and constructive and Peru welcomes the support of international development partners in the implementation of its PFM reform for further strengthening of the system.

2.1.4 Presence of a multi-donor consultation

Presently the EC provides budget support ('EUROPAN') to Peru in the framework of the result-based national *Programa Articulado Nutricional* (PAN). The PAN is one of the major nationally-owned strategic programmes and is monitored through the *Mesa de Concertación para la Lucha contra la Pobreza.* The primary counterpart of the EC is MEF (DGPP) and EUROPAN funding amounts to € 60.8 million over the period 2009 – 2013, through the release of fixed and variable tranches. Although officially the EC funds are not earmarked, MEF considers the EC budget to be additional and has used it to generate financial agreements with three agencies at central level (SIS, the civil registry RENIEC, and the social programme JUNTOS) and six regional governments[12] for transfer of the funds using a budgeting-for-results approach. The EC contribution represents only 4% of the total budget assigned to the PAN but nevertheless is considered by the MEF to be an effective tool to improve management processes and achieve results in priority areas. The future of the EC support to social sectors in Peru beyond 2013 is currently unsure.

Given that AUS covers a wide range of dimensions within the health sector, most development partners active in health are involved in the reform in some way. Dialogue on AUS has however been weak in the past couple of years but there is great interest from all donors (World Bank, Italian Cooperation, OPS-WHO, USAID) to further engage with the Peruvian government on the issue through a coordinated approach. MINSA also expressed interest in reactivating the discussion on AUS with its development partners through common spaces of dialogue.

A more detailed overview of donor support and donor coordination is provided in chapter 2.6.

Conclusion: Peru has a clear vision on how external budget support should be channelled and this modality has been successfully experimented by the EC. Moreover, many donors are active in the health sector and support the overall objective of reaching universal health insurance. Belgium is in a good position to play a key role in promoting a more structured policy dialogue on AUS and other health issues as the Embassy currently hosts the secretariat of the 'Mesa de Salud' (see more in chapter 2.6).

[12] Apurimac, Ayacucho, Huancavelica, Amazonas, Cajamarca, Huanuco.

2.2 Sector policy – sector strategy

2.2.1 Overal policy of the Ministry of Health

The ***Acuerdo Nacional*** outlines 65 lines of action, among which universal insurance, health financing, decentralization of the sector, citizen participation, access to and availability of medicines, further translated into the Plan Bicentenario: el Perú hacia el 2012.

The ***Plan Concertado de Salud 2007-2020*** was signed between 16 political parties and states eleven priority objectives with respect to the delivery of health care and another eleven for the development of the sector itself.

The policy of the Ministry of Health is based on the Process of Modernization of the Health Sector. It contains four areas of change:

- Organization: the articulation of the offer within the health system, integrated networks of services, exchange of services ('intercambio').
- Health service delivery: integrated health care, inclusion of neglected population groups.
- Management: regional and local decentralization, shared responsibility, articulation of administrative procedures.
- Financing: gradual financing through health insurance, through a payment per capita mechanism, as well as a payment per service mechanism.

2.2.2 The Universal Health Insurance Policy (AUS)

The subsidized public health insurance process in Peru started in 1997 with the creation of *the Seguro Escolar Gratuito* (SEG), a public subsidized programme targeting children of public schools in the entire national territory. One year later, the *Seguro Materno-Infantil* (SMI) was created, as another programme targeting maternal and child (up to the age of 4) population in a more reduced set of regions and localities. In 2001, the government decided to unify these programmes, which resulted in the creation of the *Seguro Integral de Salud* (SIS) in 2002.

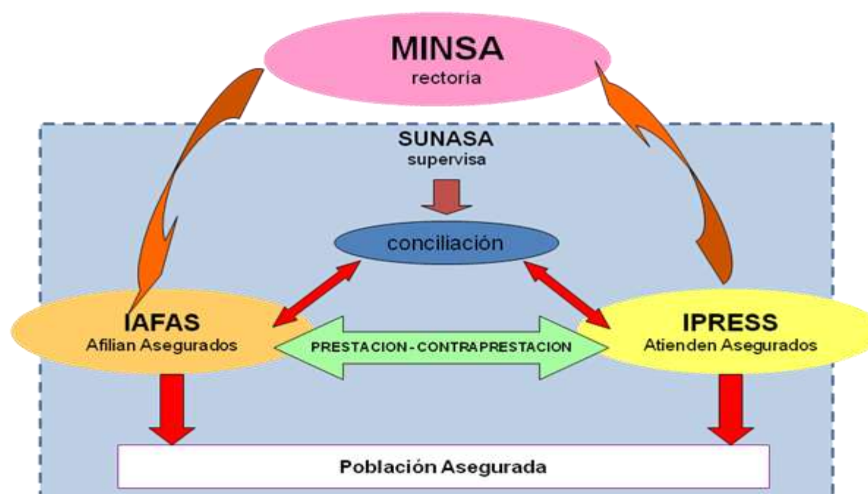
The AUS policy is – along with the decentralisation of the health sector and result-based programming and financing – the third largest structural reform that has been initiated in the past seven years.

2.2.2.1 Legal background: AUS framework law (2009)

Parliament passed the AUS framework law (Law N° 29344) on the 8th April, 2009. The new structure of the health sector as well as the responsibilities of all existing and new actors are described within. Reference is made to the minimum level of health insurance that ought to be provided to all Peruvian citizens by health insurers (be they public or private), and to the role of the health regulator, SUNASA. By involving other actors of the health sector, the law sets the basis for an understanding and future coordination, which in practice will require technical and political agreements. (see more in chapter 2.3.1.1.)

All IAFAS (insurance providers) and IPRESS (health service providers) – whether public, private or mixed – are meant to be (1) registered, (2) categorized, (3) accredited and (4) authorized by SUNASA.

Figure 6 : AUS framework



2.2.2.2 Management structure of AUS

On 20th June, 2009 three governing bodies were established by Supreme Decree 011-2009-SA for the management and coordination of the AUS implementation for a period of two years:

National Technical Implementation Committee (CTIN)

CTIN is presided by the Minister of Health and further consists of the Ministers of Defence and Interior Affairs, the chief executives of SIS and EsSalud, the president of the Association of Private Clinics, a regional president delegated by the National Assembly of Regional Governments and a representative of the '*Asociación de las Clínicas Particulares del Perú'*. It gathers every two weeks. CTIN has a management and coordination function within AUS and is responsible for:

- the organisation of the universal health insurance scheme;
- the design, coordination, management and evaluation of the general guidelines for implementation of AUS;
- approval of the Implementation Plan of AUS[13] and development of guidelines for the gradual implementation of the Plan;
- monitoring and evaluation of the progress of AUS;
- coordination with all the different actors in the health sector;
- coordination with the Regional Technical Implementation Committees

Technical Secretariat of the CTIN (SETEC)

The Secretariat is presided by the vice-minister of health and is composed of the directors of the institutions (mentioned in the previous paragraph) represented in the CTIN. SETEC is constituted of 11 (multi-sector) subcommittees: (1) Information Systems, (2) Exchange of Services, (3) Investment Coordination, (4) Beneficiary Identification System, (5) Affiliation and accreditation, (6) Medicines, (7) Emergencies, (8) Human resources, (9) Quality of services, (10) Media and (11) Financial Sustainability. The reports prepared by the subcommittees have to be submitted to the CTIN for discussion and approval.

[13]

Regional Technical Implementation Committees (CTIR)

In each of the pilot regions/districts, the first step was to set up a Regional Technical Implementation Committee. This multi-sector committee is composed of key regional actors and is responsible for planning, design, coordination and implementation of the universal health insurance policy, and for the appraisal of these processes according to the directives issued by CTIN. The DIRESA presides the committee. The frequency of gathering is every 15 days as well.

At this moment, the CTIN and SETEC temporarily have been dissolved since the law, covering its functioning for a period of two years, has not yet been renewed. However, in some regions the CTIR still functions, though informally, until the new law reinstalling these structures has been voted.

2.2.2.3 AUS health coverage plans

In the new system three types of health insurance packages exist.

- The **Essential Health Insurance Plan** (PEAS) is a prioritized list of insurable conditions and interventions that have to be insured by all health insurers, be they public, private or jointly administrated. PEAS I was approved by Supreme Decree on 29th November 2009. Overall the PEAS is more inclusive than the previous health care plan used by SIS. 140 insurable conditions and 490 medical procedures are included next to 34 guarantees regarding the quality and timeliness for health care to mothers and children. This coverage is equivalent to 65% of the disease burden and to 80% of the spontaneous demand[14].
- IAFAS are free to add **complementary plans** to the PEAS.
- If IAFAS had **specific insurance plans** offering better conditions than the PEAS, these schemes may remain in place for new affiliates too.

Additionally, there is a catastrophic fund (*Fondo Intangible Solidario de Salud* – **FISSAL**) which covers some high cost diseases for the poorest of the population.

2.2.2.4 Health insurance schemes

The Peruvian Government targets a universal coverage of the health insurance. To attain this goal it will offer three different health insurance schemes – a subsidized, a semi-subsidized and a contributory scheme – offered by different health insurance providers and specifically targeted towards each population group (see more in chapter 2.3).

The **subsidized** scheme is destined to the poor and offered by SIS. The health care for afflictions in the PEAS should be free for poor SIS affiliates. MINSA targets the poor through a twofold system: individual and collective targeting. The individual system is applied in the districts rated as income quintile 3, 4 and 5 in the Poverty Map (consisting mainly of urban areas), using a system of socio-economic evaluation for household classification. The collective targeting is applied in the districts rated as quintile 1 and 2 in the Poverty Map (mainly rural areas), affiliating all residents of these districts without making an individual socio economic evaluation – assuming that most of the population (above 60%) lives in poverty. SIS is responsible to verify the eligibility of the affiliate through the Household Targeting System (SISFOH). MEF is responsible to carry out the classification using the SISFOH.

Within the **semi-contributory** scheme affiliates pay 50% of the insurance fee tot SIS. The government envisages to reach the many workers and micro-enterprises that operate in the informal sector and are excluded from any form of social security.

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[14] It should be noted that the spontaneous demand is in itself dependent on the applicable health insurance plans.

The **contributory** scheme is offered by EsSalud, which remains unsubsidized.

2.2.2.5 AUS, strategic plan, 2011 – 2021

Strategic objectives to 2021:

1. Universal insurance coverage at national level.
2. Organization and management of health service delivery (through networks constituting of public, private and mixed health facilities).
3. Supervisory role of the MINSA.
4. Financing through an increase of the GDP share for health.
5. Financial management aiming at moving towards integration and articulation of the insurance funds.
6. Citizen participation in decisions regarding the health system and exercise of rights and duties by the insured population.

2.2.2.6 SIS, Institutional strategic plan, 2012 – 2016

Strategic lines of action of the SIS:

1. Assure Universal insurance coverage at national level.
2. Implement the functional and structural adaptation of the SIS according to the new regulation of organization.
3. Contribute to the improvement of health indicators.
4. Design mechanisms to increase the coverage of beneficiaries under the subsidized and semi-contributory schemes.
5. Be agents for the access and inclusion as rights.
6. Establish strategic alliances for national and international cooperation in critical areas.
7. Strengthen supervision and control for the efficient delivery of services.
8. Be reliable and trustworthy financers.

Strategic objectives of the SIS:

1. Reach insurance coverage of the target population at national level in the framework of AUS;
2. Contribute to the decrease of child chronic malnutrition, maternal and neonatal morbidity and mortality, risk and damage; Control of communicable and non-communicable diseases; through the insurance and opportune financing of individual health care for the population insured by the SIS;
3. Contribute to the protection of the insured and strengthen the culture of health insurance;
4. Develop and strengthen the competencies of the SIS in its role as a public IAFAS;
5. Strengthen individual health actions, through the definition of financing mechanisms for services destined to the population insured by the SIS;
6. Contribute to the strengthening of supervision for the optimization of administrative management.

2.2.2.7 SUNASA, Reinforcement plan, September 2012

Expected results of the reinforcement plan:

- The mechanisms of protection of the insured person are reinforced through the implementation of health rights;
- The IAFAS assure the coverage of qualitative health services;
- The IPRESS provide qualitative health services;
- The participation of actors involved in the process of AUS is formalized;
- Mechanisms of knowledge-management contributing to the implementation of AUS are developed;
- The institutionalization of AUS is reinforced through supervision.

2.2.3 Other relevant health sector strategies

2.2.3.1 Plan Estratégico Sectorial Multianual (PESEM), 2012 – 2016

The PESEM drafted in 2011 will be modified by the new Minister of Health. The strategic axes of MINSA presented by the new Minister of Health on 16th August, 2012 are:

1. Primary health care and improvement of access to health services.

- Strengthen primary health care by investing in 747 strategic establishments, in alliance with regional governments, by 2016

2. Access to specialized services

- Expand specialized care in regional capitals and provinces with higher demand
- Lift the legal barriers for specialists to offer and exchange services between MINSA, Regional Governments and EsSalud
- Implement the national plan on management of cancer (Plan Esperanza)
- Strengthen the capacities of the regional health staff and primary and secondary prevention of cancer

3. Improvement of Hospital Management

- Generate capacities in hospital management through a training program of public managers (100 hospital managers
- Implement a modernization program of hospital management

4. Financing of health

- Extend the signature of conventions for per capita payment for the first level of care
- Implement progressively the exchange mechanisms and purchase of services through the SIS and FISSAL for specialized services and first level of care

5. Strengthening of the institutional supervisory role of MINSA

- Adapt the organization to the new institutional roles so as to improve the performance of sector supervision
- Maximize the areas of planning and policy making, monitoring and evaluation and information analysis
- Strengthen the SIS and SUNASA

2.2.3.2 National plan of Reinforcement of the First Level of Health Care, 2011 – 2021

General objective:

To reinforce the development of the First Level of Health Care Services, allowing to link Integrated Health Care based on the family and community with quality, equity, efficiency and effectiveness.

Specific objective:

1. Improve the institutional management capacity at local level, based on identified needs.
2. Adapt the organization of health services to the needs and demands of the population.
3. Improve the health care delivery, with an emphasis on health promotion, prevention of risks, and quality of service.
4. Assure an articulated financial management (both internally and externally), in order to achieve an equitable and sustainable budget.

2.2.3.3 Strategic programmes in Health

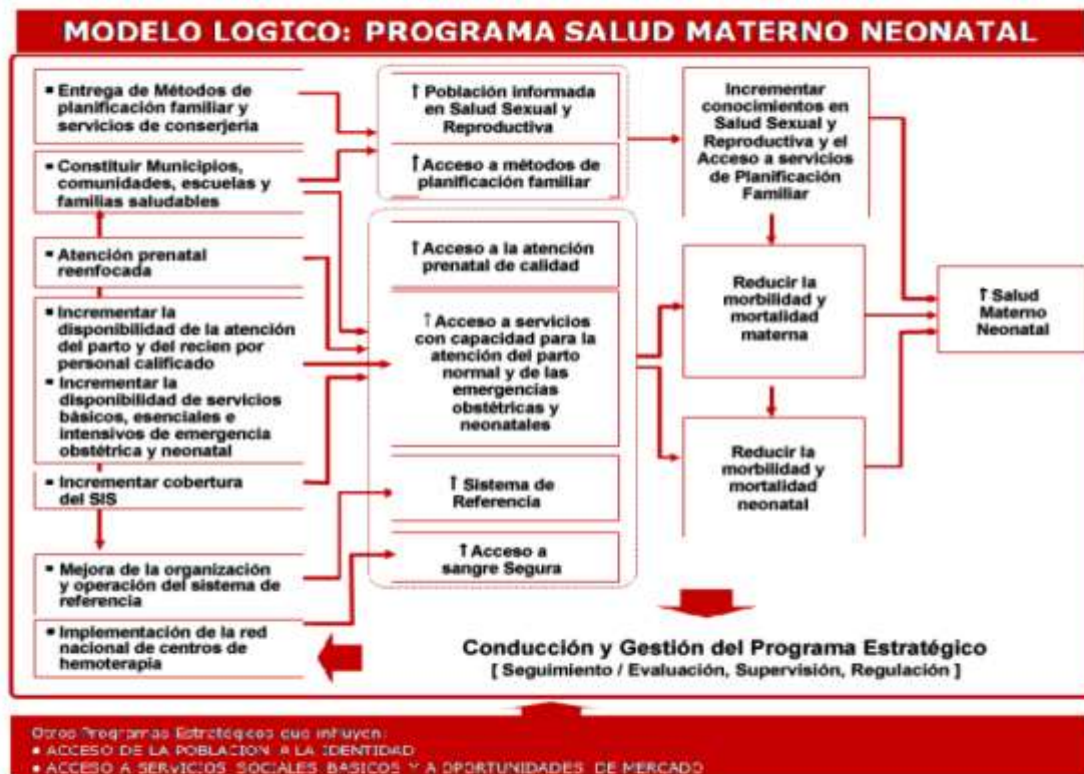
- PAN
- Salud Materno-Neonatal
- TBC-VIH/SIDA
- 'Enfermedades Metaxenicas y Zoonosis'
- 'Enfermedades no transmisibles'
- 'Prevención y Control del Cancer'

2.2.3.4 The Strategic Program on Maternal and Neonatal Care

This large strategic program started in 2008 and its scope is nationwide. The objective for the period 2011-2016 is to reduce maternal mortality by 35% and neonatal mortality by 30%. In 2012 the program budget amounted to S./ 1400 million (approximately 414 million EUR).

The program is implemented through MINSA, SIS and regional governments. While MINSA has the overall technical responsibility of the program, monitoring and budget allocation is managed by MEF.

The MEF has proposed to channel the budget support of the Belgian Cooperation to the Maternal and Neonatal Care Program. This program serves as an important marker to appreciate the progress of AUS. The design of this program is as follows:



2.2.4 General appreciation of the sector strategies related to AUS

Strengths

- The policies have a strong legal basis.
- In their design, the sector policies are inclusive and pro-poor, with disaggregated data per region showing discrepancies.
- There is an orientation towards results, particularly in the Budgeting for Result Program.
- The policies are in line with international policies and principles.
- Substantial progress has been made in the last few years. AUS implementation started successfully in three pilot regions (Apurimac, Ayacucho and Huancavelica) where the health care system was weak. The lessons learnt have been scaled-up and extended to other regions.

Weaknesses

- There is a deficit in strategic management, leading to insufficient articulation between sector policies, or even contradictions[15] amongst them.
- There still is a considerable gap between the availability of adequate policies and their implementation[16], due to insufficient financing[17] of the policy, insufficient regulation, and dysfunctional service delivery[18].

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[15] Examples: 1/ achieving a comprehensive basic package (PEAS) and at the same time focusing on specific targets (cf. Budgeting for Results Programs); 2/ the competition between the development of networks of comprehensive basic level of health and specific programs for high-tech specialized care (cf. Esperanza program against cancer).

[16] Only 31% of the persons affiliated through SIS have real access to health services (source: CIES) and only 16% have access to free medicines (source: CIES)

[17] Between 2008-2011 the number of SIS affiliates increased by 10% while the SIS budget rose by 7% meaning less money per capita.

- The culture of health insurance amongst the poorer rural population groups is still very weak[19].
- Though civil society organizations are allowed to participate in various platforms of dialogue and technical working groups, their role is principal advisory. Hence their power and impact on the policies is limited.

Opportunities

- There is a strong commitment by all political parties towards the AUS policy .
- The sector policies are embedded in a context of a fairly robust financial management system.
- The recent change at the top of the Ministry of Health shows signs of a renewed commitment towards the implementation of AUS.
- While high debt levels of SIS were formerly a great cause for concern, in 2012 it can be said that this situation has much improved with the gradual scaling-up of the implementation of advanced payments to the regions based on 'per capita' estimations at the beginning of each trimester.

Threats

- The insufficiencies in terms of infrastructure in general and the relative weak availability of resources for the social sectors in particular constitute a threat for effective implementation of the policies.
- The rotation of staff and politicians at national level constitute a threat for the continuity and consistency of policies and the effectiveness of their implementation.
- The relative fragmentation between institutions, sectors and levels (national-regional-local) hampers a smooth implementation of the policy.
- In spite of all efforts, the main problem in AUS implementation in these pilot regions has been the insufficient health care capacity to attend all affiliates in the way they are entitled to under AUS.
- Only the people holding an identity card (*Documento Nacional de Identidad*) are considered eligible for affiliation under AUS.

2.2.5 Appreciation of the Strategic Program of Maternal and Neonatal Health

The SWOT of the previous section applies here as well. But since the budget support will be channeled through this program, being an important marker for the progress towards AUS, a particular analysis is added here.

At the regional level, the regions of Huancavelica and Ayacucho have registered the most significant progress with neonatal death having decreased from 21.8 to 13.6 and 17.5 to 10 deaths for 1000 live births respectively, between 2007 and 2010[20]. Institutional deliveries in rural areas also rose from 51.6% to 61.8% (Huancavelica) and 58.3% to 86.8% (Ayacucho). Important progress was also noted in Amazonas where the coverage of institutional deliveries in rural areas increased from 36.2 to 50.7% between 2007 and 2010.

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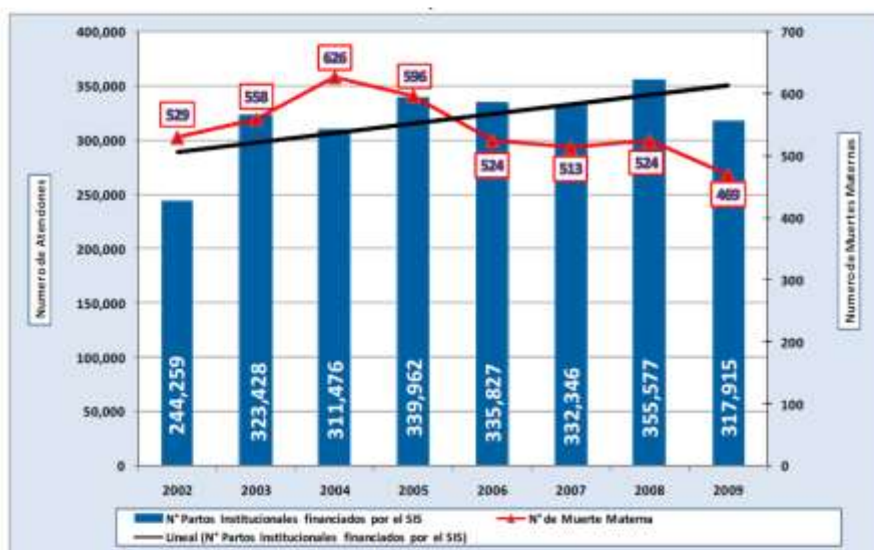
[18] The satisfaction rate of citizens towards health services is 10% with the public health services, compared to 25% with the health services run by EsSalud (source: CIES)

[19] Indicative is the low adherence to the '*regimen semi-contributivo*', which holds a potential of 5% coverage amongst the mainly rural population

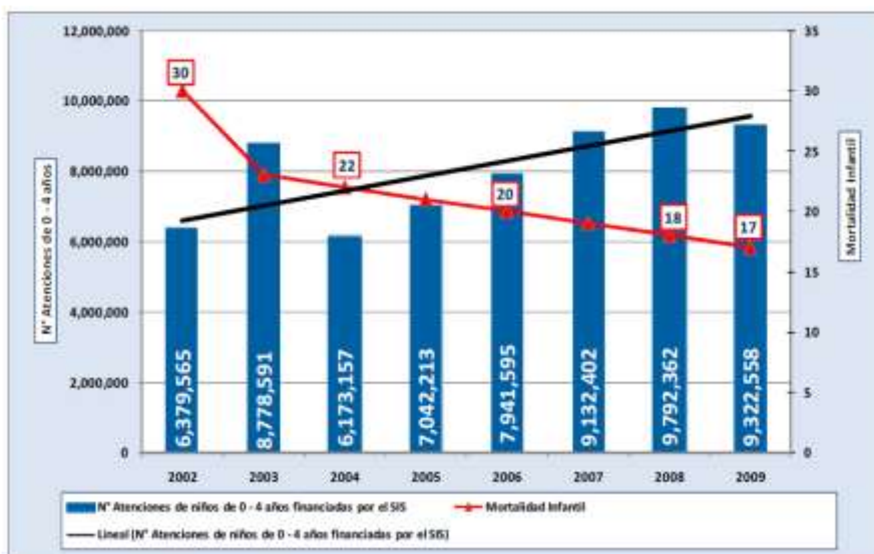
[20] Reporte de Progreso en la obtención de Resultados de los Programas Presupuestales iniciados al 2008, Avances al 2011, MEF

Figure 7: Number of institutional deliveries financed by SIS vs number of annual maternal deaths. 2002-2009



Elaborado por Gerencia de Operaciones – Seguro Integral de Salud
Fuente: Base de Datos SIASIS (SIS – Central)

Figure 8: Services delivered to children of 0 to 4 years financed by SIS vs child mortality. 2002-2009



Elaborado por: Gerencia de Operaciones
Fuente: Instituto Nacional de Estadística e Informática - Base de Datos SIASIS (SIS – Central)

Strengths

- The program has an orientation towards results with clear indicators.
- The indicators take into account regional differences and are oriented towards the poor population groups.
- The program has a clear link with AUS: it is one of the markers used in the 2011 AUS progress report of CTIN to appreciate the effects of AUS.
- The activities targeted by the program are part of the PEAS.
- The program is integrated in the strategic plan of SIS.
- The financial management of the program (coordinated by MEF) is adequate.

- The program is monitored through the working group 'Submesa Salud Materno-neonatal' which is part of the platform 'Mesa de concertación para la lucha contra la pobreza'.

Weaknesses

- The ownership and regulation by MINSA are hampered by the fact that the strategic programs are mainly managed by MEF and part of the funds are transferred directly to the regions. The division of tasks between MINSA and MEF is not always clear (for example in regard to the responsibility for the progress reports of this program.)
- The design of the logical framework lacks a holistic approach, focusing on technical aspects and clinical care, and lacking attention to social determinants of health. The strategy doesn't explicitly take into account mental health aspects in relation to maternal care[21], more sensitive themes in relation to sexual and reproductive health, as well as violence at household level.
- The vertical approach contains the risk of relatively neglecting[22] other health dimensions described in the PEAS.
- Some strategies and indicators such as on prenatal care are questionable[23] with regard to their effectiveness in relation to maternal-neonatal morbidity and mortality.

Opportunities

- The pilot experience of USAID with an inter-sector collaboration in San Martin in relation to all social programs may help to widen the perspective of Budget for Result Programs (see chapter 2.3.2.1 for more information).
- The involvement of other donors and agencies (World Bank through PARSALUD II, Italian Cooperation) in Maternal and Neonatal Care, is an opportunity for exchanging experiences.

Threats

- Regional level ownership is also fragile because of the centralized management by MEF.

2.3 Institutional capacity

2.3.1 Institutional setting

2.3.1.1 Legal framework

La Ley del Ministerio de Salud no. 27657 (2002)

This law created the SIS ('Seguro Integral de Salud') as a Public Implementing Institution and as well as a decentralized Public Institution of the Ministry of Health.

La Ley de Bases de la Descentralización no. 27783 (2002)

This law spells out the objectives and principles of the decentralization process as well as the competences of each level of government, namely: national, regional and local.

The functions of the regional government in terms of health are further described in the *Ley del Sistema Nacional Coordinado y Descentralizado de Salud no. 27813* and the *Ley Órganica de Gobiernos Regionales no. 27867* (2002). Among these: (i) formulate and implement the health policy

[21] It concerns a global mental health strategy in relation to maternal care and particular issues such as for example suicide in teen pregnancies

[22] The 2011 AUS progress report of CTIN states that the budget of the strategic programs increased by 50% between 2008-2010 compared to 7% considering the overall budget of the PEAS.

[23] Course on Maternal Health Care, Vincent De Brouwere, CIPS 2000, ITM Antwerp

of the region in line with the national policy and sector plans, (ii) formulate and carry out the 'Plan de Desarollo Regional de Salud', (iii) promote activities of promotion and prevention, (iv) organize, implement and maintain health care delivery for prevention, recovery and rehabilitation in coordination with local governments, (iv) supervise and sanction public and private health services, (v) supervise and control the production, marketing, distribution and consumption of pharmaceutical products, and (v) promote training, capacity-development and development of human resources.

La Ley Marco de Aseguramiento Universal en Salud no. 29344 (2009)

The AUS framework law mainly envisages to:

i. Provide health insurance for all, through three different insurance mechanisms: a contributory, a semi-contributory and a subsidised system.

ii. Establish a national health insurance supervisor, SUNASA, that will guard the quality of health provided, and will watch over the health insurance being provided;

iii. Break up the vertical integration of health service provision and health insurance, i.e. clients from one health insurer will in the future no longer be restricted to the health provision from the same organisation, but may also call upon a different health service provider.

Following this law some legal resolutions were passed to regulate the implementation of AUS. Important to mention are the following:

- Decreto Supremo (D.S.) no. 011-2009-SA establishes the National Technical Implementation Committee (CTIN) and the Regional Technical Implementation Committees (CTIR) and the assignment of their responsibilities.
- D.S. no. 016-2009-SA approves the Essential Health Insurance Plan (PEAS I), to which all Peruvians are entitled to according to the AUS framework law.
- D.S. 008-2010-SA provides the regulations for implementation of the AUS framework law
- Emergency Decree no. 048-2010 defines eligibility for affiliation, quality of services and efficiency of services. The role of SIS and SUNASA is being strengthened.
- Financing Law no. 29761 provides the theoretical framework for the costing of the subsidized and semi-contributory insurance schemes.
- D.S. 009-2011-SA provides the regulations for the organization and functions of SUNASA
- D.S. 007-2012-SA authorizes the SIS to replace the *Listado Priorizado de Intervenciones Sanitarias* (LPIS) by the PEAS.

La Ley de Derechos de las Personas Usuarias de los Servicios de Salud no 29414 (2010)

This law concerns the respect, the promotion and the guarantee in relation of the Right to Health. However, so far the Peruvian government has not issued the regulations, essential for the implementation of the law.

La Ley de Financiamiento de los Regimenes Subsidiado y semicontributivo del AUS no. 29761 (2011)

This law 1/ aligns financing with the increase in coverage; 2/ stipulates the coverage of fixed and variable costs of a '*prestación'* (service); 3/ makes the exchange of services ('intercambio de servicios') possible between different types of service providers (MINSA - EsSalud - private); 4/ creates the space for financing of diseases of high cost and some neglected diseases (FISSAL).

The regulations of this law are still being drafted at present time therefore many of the dispositions foreseen are still pending implementation.

2.3.1.2 Ministry of Economy and Finance (MEF)

MEF plays a key role in the health sector as it is the direct financial counterpart of most actors involved. MINSA, SIS and the regional governments all have to negotiate directly with MEF on their funding and the terms of funding. MEF is thus responsible for the monitoring of the budget execution and the compliance to the Budgeting-for-Results (PpR) contracts with all the parties involved. For more information on the role of MEF, see chapter 2.4.1.

2.3.1.3 Ministry of Health (MINSA)

MINSA is responsible[24] for the following:

- Sector planning;
- Establishment of objectives, targets and strategies for the short, medium and long term;
- Coordination of the decentralization process;
- Setting of standards and organizational models;
- Development and integration of the health sector information system;
- The promotion of rational use, access and control of supply, quality, safety of medicines and drugs;
- The financial assurance of public health and overall health of all citizens;
- The investment and financing to achieve the objectives and institutional goals;
- The training, expertise, allocation, development and quality monitoring of human resources for the health sector; and
- The logistical support of goods, services and infrastructure to the organizational units of the MINSA and its decentralized bodies.

Furthermore, MINSA is responsible for large investments in public health centers and clinics nationwide. The Ministry manages delivery of public health in the capital, as well as the provision of specialized health care, of which almost all services are based in Lima. Finally, it is responsible for research and development.

2.3.1.4 Regional Governments

Peru has 25 regions, each with its own regional government. The Regional Presidents, alongside the Regional Council, are elected every 5 years. Since 2007 the regions have gained considerable responsibilities vis-à-vis the central government. Regional governments are responsible for the formulation and implementation of regional development plans and for the coordination with municipalities.

As part of the ongoing decentralization process, 16 functions related to the delivery of primary health care[25] have been transferred to the Regional Government Health Directorates (DIRESAs), with corresponding financial resources. These functions relate to:

- Essential functions such as insurance, management of health care delivery and human resources and sector regulation
- Policy implementation, planning, institutional organization and management of investments

The DIRESAs finance the fixed costs of the health services, such as infrastructure, equipment and human resources.

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[24] Only the most relevant tasks with respect to AUS are mentioned

[25] Resolución Ministerial 1204-2006-SA

2.3.1.5 National Health Insurance Superintendence (SUNASA)

SUNASA was created by the AUS framework law on the basis of the *Superintendencia de Entidades Prestadoras de Salud* (SEPS). It monitors and supervises the health system and ensures the rights of all health care beneficiaries are respected. SUNASA's responsibility is five-fold: a recording function, an authorization function, an oversight function, a regulatory function, and a sanctioning function.

SUNASA operates under the supervision of MINSA, but will have technical, functional, administrative and financial autonomy, as stipulated in the AUS framework law. Its board of directors consists of two representatives from MINSA (one of them as President of the board), one representative from MEF, one from the Ministry of Women and Vulnerable Populations (MIMP), and one from the Ministry of Labour (MINTRA).

2.3.1.6 Health insurance providers (IAFAS)

Seguro Integral de Salud (SIS)

Next to its headquarters[26] in Lima, SIS has 33 regional offices (formerly known as ODSIS[27] but recently renamed *Unidad Deconcentrada Regional* – UDR). The chief executive of SIS is appointed by the Minister of Health. UDR are in charge of the evaluation of the health care provided to SIS affiliates, and of auditing the reports made by the DIRESAs.

The SIS holds the highest proportion of affiliates and stands out as the largest insurance provider in Peru since 2007. Previously, data on the number of affiliates were less obvious as the focus was on the number of emitted contracts by the SIS, with the possibility of several contracts per person.

EsSalud

EsSalud is the Peruvian social insurance institution that falls under the responsibility of the Ministry of Labour (MINTRA). It is fully funded by contributions of both employers and employees. This implies that only people working in the formal sector (mainly public sector employees) are affiliated to EsSalud (around 20% of the population). The insurer has a vertically integrated structure: it owns and manages health centers and hospitals across the country, and its affiliates mainly seek care in these health centers. EsSalud affiliates can in practice also go to government hospitals or health centers, or private health providers.

Others

Army and Police have their own health insurance and health facilities. These health systems fall under the responsibility of the Minister of Defense and the Minister of Interior Affairs respectively.

There are small private health insurers that target the highest income class (less than 2% of the population). Well-equipped hospitals and private health care centers (EPS) provide health services for this group of affiliates.

2.3.1.7 Health care providers (IPRESS)

Public, private and mixed health care providers all have to be approved by and registered at SUNASA, while MINSA regulates their organization and the way they function.

In practice however, a large number of the health sector actors and health service providers work outside the span of control of MINSA. The Ministry exerts very little power on the social security

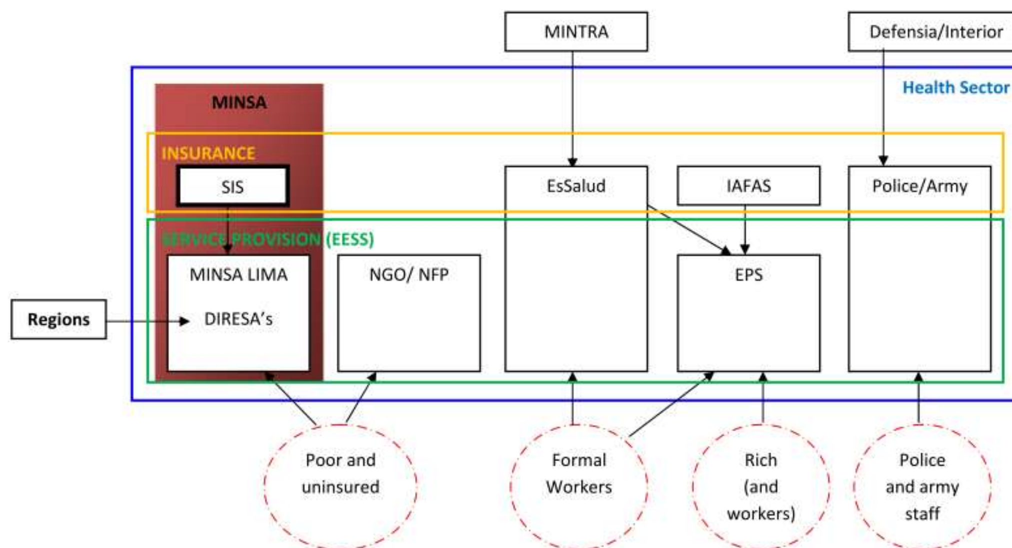
[26] Headquarters are compound by the Administration Department, Legal Department, Statistics/Informatics Department (database), Planning Department (formulation of the budget), Financing Department (responsible for making the payments to the DIRESA and its executing units), Operations Department (consolidate the affiliation and medical supervision) and Social Marketing Department.

[27] ODSIS includes an Official Representative, and Administrative Officer, a Medical Supervisor and a Responsible for Marketing and Statistics.

system (EsSalud) and over the private insurers and service providers. Its influence on the health systems of the police corps and the army is practically null.

There are as well the hospitals of SISOL ('Hospitales de la Solidaridad) which depend on the municipality of Lima.

Figure 9: Health insurance schemes and service providers in Peru



2.3.1.8 Organization of health service delivery

Health care in Peru is delivered in two separate ways, namely through the 'market' and 'non-market' providers. Currently, many health care providers do not have the capacity to offer all the services included in the PEAS. As a result, the minimal treatment of the 140 health conditions cannot be guaranteed to the insured population.

The regulation of the AUS framework law establishes the organization of integrated health service services according to **functional health networks** *('*redes funcionales de salud'*),* which could become a key mechanism addressing the lack of order among health care providers that are currently operating according to different logics. These networks ought to ensure the first and second level of care are effectively covered, and include a rational referral system. This would eventually lead to a decrease of the number of patients seeking care in hospitals of the third level (which often implies long distance travelled only to end up in overburdened facilities).

The commitment of MINSA towards the development of the First Level of Health Care Services with a focus on quality, equity, efficiency and effectiveness is reaffirmed through *the National Plan for the strengthening of primary health care*, 2011 – 2021 (cf. paragraph 2.2.3).

2.3.1.9 Human Resources

In the past, the tendency has been towards an over-specialisation and concentration of health posts in hospitals of big cities. Medical staff based at the primary health care level tend to be significantly younger, less experienced and with little or even no specialization at all compared to health professionals working at the tertiary level.

About 90% of health workers are not prepared to stay in rural areas indefinitely. Low retention capacity

remains a problem and incentives need to be put in place for an effective redistribution of health professionals in poorer and more isolated areas.

Since 2009, MINSA has substantially increased the number of health posts in AUS priority areas through initiatives such as the 'Servicio Rural y Urbano Marginal de Salud' (SERUMS). The main progress has been noted in regards to nurses and obstetricians, with a 70% coverage of the gap previously identified.

2.3.2 National spaces of dialogue and concertation

2.3.2.1 Most relevant spaces of dialogue related to Multi-sector strategic programs

The 'Mesa de Concertación para la Lucha contra la Pobreza' (MCLCP)

The 'Mesa de Concertación para la Lucha contra la Pobreza' was instituted in 2001 by Supreme Decree and provides a space for the State institutions and civil society to reach agreements and define actions to be undertaken in the fight against poverty[28]. The various sectors concerned are represented. The 'Mesa' covers and promotes actions covering a wide range of topics such as participatory budgeting, public policy and decentralization, decent work and social security, etc.

It is also the forum where strategic national programs such as the *Programa de salud materno-neonatal* are monitored and discussed on a monthly basis at central level. Regional thematic 'mesas' are also in place throughout the country.

The USAID pilot project of a regional intersectoral dialogue forum

Interesting to mention is the dynamic of the inter-sector dialogue at the level of the San Martin region, with the regional representatives of the various sectors, civil society organizations and international agencies. The aim is to integrate all social programs. The dialogue is supported by six Thematic Working Groups. The experience is in a scaling-up phase (to Cusco and Huancayo).

2.3.2.2 Most relevant spaces of dialogue between national actors of the Health sector

The 'Comisión Intergubernamental de Salud' (CIGS)

The commission was instituted in 2010 in light of the decentralization process. It is composed of the authorities of MINSA (presidency of CIGS), the 25 Regional Governments (represented by the National Assembly of Regional Governments), the Regional Directions of Health (DIRESA), and the national representatives of the Local Governments. International development partners participate as observers.

The gatherings are minimum four times per year but there are also extra-ordinary meetings The CIGS is a platform of dialogue (with decisional power) that sets the agenda of priorities related to health, harmonizes policies in relation to public health and decentralization, coordinates plans, makes executive agreements to implement and finance the agenda of priorities of the national Health Policy, and monitors and evaluates the impact of policies, plans and programs related to health.

The 'Consejo Nacional de Salud' (CNS)

The CNS in its current form was instituted in 1990. It is the consultative organ of MINSA with the objective to set priorities and provide advice regarding the National Health Policies and National Health Plan, to coordinate their implementation in an equitable way, and to facilitate the dialogue and coordination between all actors (intra- and inter-sector) concerned with health. Civil society organizations are present as well, as observers (so without direct participation). Various thematic commissions exist, such as for example on Human Resources, Medicines, Financing and Health

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[28] www.mesadeconcertacion.org.pe

Promotion. There are also regional gatherings.

The 'Vigilancia Ciudadana'

At national level there is the Forum of Civil Society in Health, Foro Salud. This association of civil society organizations concerned by health held its first national conference in 2002. Foro Salud promotes the debate around the right to health, shares and analyzes experiences, organizes studies, makes proposals, fosters consensus and engages in a dialogue with the health authorities.

At regional level, there are 16 Regional Forums. So far, they are however less organized, less strong and less independent than the National Forum.

Aside from the government, a 'Defensoria del Pueblo' exists and receives support from the Belgian Cooperation. This is a structure which deals with questions and complaints of the population.

2.3.2.3 Most relevant spaces of dialogue particularly related to AUS

The 'Comité Técnico Implementador Nacional' (CTIN) and 'Regional' (CTIR)

This has been described under 2.2.2.

Technical Working Groups of SUNASA

In its capacity as regulator and supervisor of the whole AUS system, SUNASA has created a few Technical Working Groups on specific themes in which all actors involved in AUS (including development partners) can participate, including civil society. At this moment there are groups on 'consumer rights', 'financing' and 'harmonization of information systems between institutions'. Their level of functioning however is not clear as for now.

2.3.3 Analysis of institutional capacity of AUS related structures

The analysis is made bearing in mind the objectives of the strategic plan AUS 2011-2021.

2.3.3.1 Capacity of delivery of quality health services

Strengths

- The exchange of services between the health services of MINSA and those of EsSalud has started in designated pilot regions.
- The local health networks ('redes') have been reformed into a more rational design.
- A series of emergency decrees for extra financing were passed between 2008 and 2011 to ensure the adequate investment, maintenance and equipment, especially in terms of infrastructure in AUS pilot regions. An additional 98 infrastructure projects were approved in 2012.
- Inter-sector collaboration on health issues is initiated (though still at pilot stage).

Challenges

- Access to quality health services is limited (cf. 2.2.4).
- There is a large iniquity between rural and urban health services.
- Integrated health care delivery is still a challenge, despite the reorganisation of the local health networks ('redes').

2.3.3.2 Capacity of Human Resources

Strengths

- Since 2009, MINSA has substantially increased the number of health professionals in AUS priority areas through initiatives such as the SERUMS.
- There are technical capacities (both clinical and managerial) within the sector.

Challenges

There is a need for available, motivated and competent staff, particularly in rural areas:

- The availability of health staff in rural areas is insufficient.
- The curricula at training schools do not respond sufficiently to the needs. There is a shortage of certain categories[29] of personnel.
- There is a lack of a public health institution in the country.
- The salaries and working conditions in the public sector are not attractive causing a brain-drain from rural to urban areas, from public to private services and from first line care to specialized curative care. Indicative to the problem are the long periods of strike by medical doctors (as observed in September-October 2012).

2.3.3.3 Financing capacity

Strengths

- The management of public finances is robust in general.
- Real GDP growth in Peru has remained stable in spite of the global economic downturn.

Challenges

- The budget for social sectors is insufficient: in Peru 4.6% of the national budget is spent on health care, compared to an average of 7.8% in the rest of Latin America[30].
- Despite the efforts (for example MEF through the PpR; reform first level of health care), there is an unequal distribution of resources between richer and poorer regions, and between specialized curative care and primary health care.
- The budget doesn't follow the increase in the number of people insured 'in theory' nor the health conditions covered by the actualised PEAS. The amount of available funding per capita has decreased[31] by 10% in the past year. There is a need for a comprehensive investment plan for basic health services.
- The financial capacities at the decentralized levels are insufficient, causing a centralization reflex by the national level.
- The lack of coordination within the health system and current model of care in place have resulted in insufficient levels of resources channeled to the first levels of care, leading to the emergence of: (i) centralism and concentration of resources in important cities, (ii) investment unrelated to national health objectives, (iii) disarticulation of investment, which deepens inequities and duplicates investment of the different health services providers operating in the same place.

2.3.3.4 Capacity of IAFAS

Strengths

- There is a national commitment to have more harmonized information systems and to start exchanging services between IAFA (cf. agreement between two of the IAFAS, SIS and EsSalud, in Huancavelica to start exchanging services in October 2012).
- The number of SIS affiliates has increased exponentially.

Challenges

- Despite the progress, there is still a large fragmentation between schemes constituting a barrier for patients to access services of their choice. There is insufficient intrinsic motivation of the IAFAS to move towards an integrated system of insurance.

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[29] For example: health workers trained in family medicine and community health, hospital managers, health managers with systemic and coaching skills.

[30] Strategic Plan AUS 2011-2011 (July 2011), pp.36-37.

[31] Informe de gestión – Avances del proceso AUS 2009-2011, CTIN (July 2011), p53.

- There is still a problem of filtration: 5% of the population could potentially be covered through the 'regimen semi-contributivo' but affiliation is extremely low so far.
- The SIS is concentrating on its financing role and insufficiently on his sensitizing role towards the population regarding AUS and citizens' right to health.

2.3.3.5 Regulation capacity of AUS at national level

Strengths

- There is a strong legal framework regarding AUS.
- There is a renewed political commitment towards AUS with the new Minister of Health.

Challenges

- There is a high turnover of staff at the top of MINSA, endangering the continuity in the health policies and their implementation.
- There is no longer a legal basis for the CTIN, the most important tool for strategic management in relation to AUS. This implies that for the moment there is no formal multi-actor exchange platform and decision-making structure in relation to AUS.
- Grey areas in the distribution (and separation) of roles remain: between MEF and MINSA (cf. management of the Strategic Programs for Results also known as PpR '*Programas por Resultados*'), between MINSA and SUNASA (regarding regulation), between SIS and SUNASA (SIS only as a financing tool though in practice also involved in regulation), between national and regional authorities (for example centralized management of PpR by MEF).
- The role of SUNASA, the regulating body of AUS, is clear in theory, but in practice it is perceived as a weak institution. Though it has a well-elaborated integrated vision, the institution shows too little leadership in the debate. Moreover, assuring a sanctioning role in the public sector is more complicated than in the private sector.
- The information systems amongst the various institutions within the health sector are not integrated yet.
- There is a lot of technical capacity in the sector but at the same time there is a lack of sufficient coaching capacity to articulate the various institutions.

2.3.3.6 Capacity of Implementation of AUS at the regional and local level

Strengths

- There is a strong legal framework regarding Decentralization.
- There are functional and regular spaces of dialogue between the various levels.

Challenges

- There is an insufficient level of ownership of the AUS vision and strategy, except for a few regions (for eg. Cajamarca). There is no Regional AUS Plan.
- The decentralised structures of AUS-related institutions are either weak (for eg. the UDR of SIS face shortage of staff to perform tasks such as sensitization) or non-existent (no decentralised structures of SUNASA as yet).
- MEF works in a centralised way, not only controlling the funds but also the implementation of Health Strategies such as the Strategic Programs for Results (PpR).
- The money doesn't sufficiently arrive at the operational level where the AUS policy and the health reforms have to be implemented.
- The management capacity both at the level of service delivery and demand is insufficient.

2.3.3.7 Participative Citizenship and Enforcement of Health Rights

Strengths

- There is the law '*Ley de Derechos de las personas usuarias de los servicios de salud'.*

- There are vocal national platforms such as Foro Salud (a platform of Civil Society Organizations) and the Consorcio de Investigación Económica y Social (CIES)[32].

Challenges

- The practical regulations for the implementation of the '*Ley de Derechos*….' are still not elaborated two years after the law has been passed.
- There is an insufficient flow of information to the population (especially in rural areas) regarding their health rights and AUS.
- The first line of health services is not people-centered enough, neither at the individual level nor at the community level.
- Civil society has limited direct power to act as a counterweight since it has no voice in decision-making structures and recommendations of advisory organs are not binding.
- Downward accountability is limited.
- At regional level civil society is weakly organised and politicized to a large extent.
- The 'defensorias' at regional and national level (which should treat questions and complaints by citizens, in casu in relation to health rights) have difficulties in coping with the demand despite the efforts.
- International agencies generally focus too much on the technical aspects of their support instead on concentrating more on the dimension of Health Rights.

2.4 Budget and expenditure management in the health sector

2.4.1 Planning and budgeting

Planning takes place at four different levels: at the sector level, at the regional and local levels, and at the institutional level. The health sector strategy and multi-annual planning is determined in the Ministry's Multiannual Sector Strategic Plan (PESEM). Next to the planning of the central government, the DIRESAs must formulate a multi-year planning to reach their strategic objectives in a Regional/Local Development Plan (PDRC). Based on this information, the institutions must formulate a multiannual Strategic Institutional Plan (PEI), and an Operational Institutional Plan (POI). Using this information an Institutional Budget Proposal (PIA) and an Annual Procurement and Contracting Plan can be developed (PAAC) by the institutions.

All budget entities are required to formulate their (annual) POI in accordance with their respective PEI, which in turn has to be consistent with the Ministry's Multi-year Sector Strategic Plans (PESEM). Each agency's PEI is reviewed annually by MEF and the National Budget and Financial Statements Congressional Committee (CPCG).

MEF started putting **Budgeting for Results** (PpR) into action in the health sector late 2007. This budgeting and management tool seeks to promote better informed decision-making on the allocation of scarce government resources. MEF uses PpR as a budgeting tool for regional governments as well as for parts of the MINSA and SIS budgets. Clear performance indicators have been identified and remuneration rules are the outcome of joint negotiating of the respective organizations at various levels and MEF. The effective budget allocation is thus strongly related to the institutions' performance against the indicators.

The PpR approach has brought some important consequences into the planning cycle: (1) information requirements are much higher, since MEF is no longer only interested in the input and intermediate

[32] It's a Peruvian umbrella organisation with 48 institutional members, including think tanks, research centres, NGOs, private consultancies and public agencies.

indicators, but also in the final results obtained by the counterpart institutions; (2) MEF ought to build in-house expertise to interpret these results, and to advise on the contracting with the institutions.

2.4.2 Budget allocation

Data from the 2012 World Health Statistics report[33] show that Peru has been lagging behind most other countries in the region on the level of total expenditure on health as percentage of GDP. On the other hand, we see that Peru relies very little on external assistance for health, though still slightly more than its neighbours do (except in the case of Bolivia).

Table 2: Trends in health expenditure, 2000 – 2009

	Total expenditure on health as % of gross domestic product		General government expenditure on health as % of total expenditure on health		General government expenditure on health as % of total government expenditure		External resources for health as % of total expenditure on health	
	2000	2009	2000	2009	2000	2009	2000	2009
Argentina	9.0	9.5	55.4	66.4	14.7	22.0	0	0.1
Bolivia	6.1	5.1	60.1	64.6	9.8	7.3	6.0	7.0
Brazil	7.2	8.8	40.3	43.6	4.1	5.9	0.5	0
Chile	8.3	8.4	41.6	47.6	14.1	16.2	0	0
Colombia	7.3	7.6	70.7	71.1	21.4	19.3	0.3	0.1
Ecuador	4.2	8.8	31.2	34.9	6.4	7.7	4.1	0.7
Mexico	5.1	6.5	46.6	48.3	16.6	11.9	1.0	0
Peru	4.7	5.3	58.7	57.7	14.9	15.9	1.1	1.0

Total health expenditure increased by 69.1% between 2007 and 2011 (from S/. 3,878 to S/. 6,577 million). Expenditure per capita increased from S/.135 to S/.217 (source: CIES).

The health sector budget grew by 15% between 2011 and 2012 as a result of efforts made by the new government to prioritize resources for the social sectors, partly based on to the introduction of the mining tax.

Historically, out-of-pocket expenditure[34] has been one the main sources of financing for health in Peru and was estimated at 38% of total health expenditure in 2009 (source: ENAHO). Due to the disparate expenditure patterns across income groups in MICs, which are as significant as the high proportion of out-of-pocket payments, lower income groups end up paying more toward health care as a percentage of household resources than high-income groups do.

It is important to note that although MINSA is the sector's rectory, and is responsible for the planning and strategic decision-making at the central level, its influence over the regions remains limited. As

[33] World Health Statistics Report, WHO, 2012

[34] Out-of-pocket spending consists of official fees charged by service providers; user charges for publicly provided services and consumables (eg. drugs and medical supplies); or under-the-table payments as gifts for services.

mentioned in previous chapters, MEF negotiates directly with the regions on the final budget allocation.

MINSA, together with its de-concentrated units (namely the 'Instituto Nacional de Salud', 'Instituto Nacional de Enfermedades Neoplasicas', SIS and SUNASA), constitutes the national level. With the on-going decentralization process underway, over the years a larger share of the health sector budget has been transferred from the MEF to the regional governments. **The share of the health sector budget allocated to the national level decreased from 61% to 52% between 2007 and 2011, while the allocations of the budget to the regions grew from 39% to 48% over the same period** (source: Forosalud).

The regions mainly finance wages, general services and maintenance of health infrastructure. Due to a scarcity of resources and a chronic shortage of personnel, only a very small part of resources are used for purchasing supplies and drugs, which are highly insufficient to guarantee the availability of these goods for health care provision.

Until recently, all money for SIS-related expenses transited from MEF through the central SIS agency to the regions. But with the intensification of the strategic programmes, MEF is also signing more and more agreements directly with the regions, as in the case with the EUROPAN support.

2.4.2.1 Health strategic programs: allocation vs. execution

Strategic programs are gradually absorbing a larger and larger share of budget allocations destined to the health sector. With regard to budget allocations to the strategic programs related to health, the tendency is that the majority of the budget is assigned to the 'Programa Articulado Nutricional' (41.6%) and the 'Programa Salud Materno-Neonatal' (36.7%), with a much smaller share (1.2%) attributed to Prevention and Control of Cancer, as reflected in the table below (2011 budget).

Table 3. Modified budget of the Strategic Programs in 2011(in millions of Nuevos Soles)*

PROGRAMA ESTRATEGICO	PIA2011	PIM2011
0001 PROGRAMA ARTICULADO NUTRICIONAL	928.73	1,074.93
0002 SALUD MATERNO NEONATAL	900.66	948.99
0016 TBC-VIH/SIDA	275.59	276.91
0017 ENFERMEDADES METAXENICAS Y ZOONOSIS	127.13	145.48
0018 ENFERMEDADES NO TRANSMISIBLES	98.46	106.05
0024 PREVENCION Y CONTROL DEL CANCER	30.52	30.55
TOTAL GENERAL	2,361.09	2,582.91

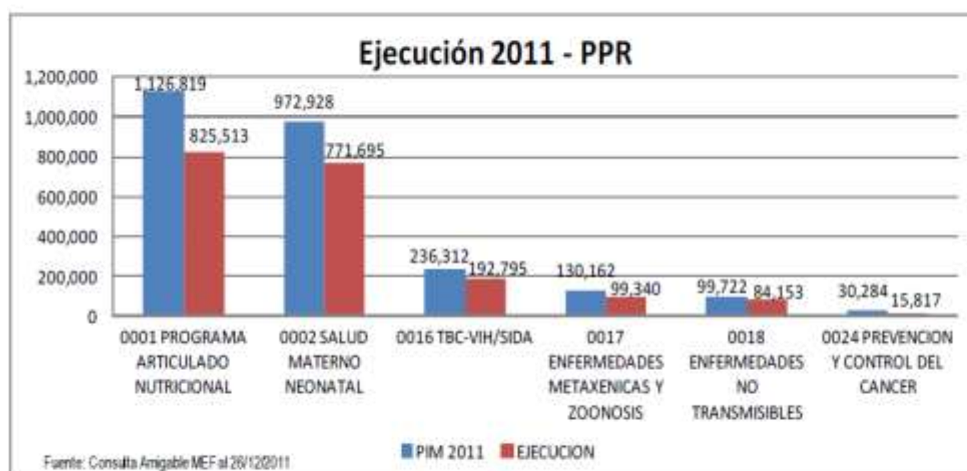
Fuente: Información del Cubo MEF

*PIA: 'Presupuesto Inicial Aprobado' - PIM: 'Presupuesto Inicial Modificado'

Some regions however still have less than 30% of their budget assigned through PpR (ie. Ancash, Apurímac, Huancavelica, Huánaco, Ica, Lambayeque, Puno, Tacna and Lima) while others assign more than 55% through this tool (Amazonas, Pasco, San Martín).

Overall budget execution of strategic programs in the year 2011 was generally quite good, reaching more than 70% of execution across all programs with the exception of the Prevention and Treatment of Cancer program, which showed the lowest score at 52.2%. The Maternal and Neonatal health executed 79.3% of its PIM, as registered at the end of December 2011.

Table 4. Budget execution of strategic budgeting-for-results programs, 2011



Disaggregation of budget allocation vs. execution per region for the 'Programa Materno Neonatal' shows high scores except for the case of Pasco (39.9%). The most relevant outputs of the program are reflected in the table below and a show good level of execution, although the output on population's access to methods of family planning still requires strengthening.

Table 5. Budget allocation and execution per level of output,

'Programa Salud Materno Neonatal' (2011)

(En miles de Nuevos Soles)

FINALIDAD	PIM	EJECUCION	AVANCE %
33172: ATENCION PRENATAL REENFOCADA	76,528	66,822	87.3
33291: POBLACION ACCEDE A METODOS DE PLANIFICACION FAMILIAR	27,612	20,194	73.1
33294: ATENCION DE LA GESTANTE CON COMPLICACIONES	54,097	48,817	90.2
33295: ATENCION DEL PARTO NORMAL	143,279	129,668	90.5
33296: ATENCION DEL PARTO COMPLICADO NO QUIRURGICO	32,142	27,865	86.7
33297: ATENCION DEL PARTO COMPLICADO QUIRURGICO	86,004	73,298	85.2
33305: ATENCION DEL RECIEN NACIDO NORMAL	58,345	49,741	85.3
33306: ATENCION DEL RECIEN NACIDO CON COMPLICACIONES	50,811	44,561	87.7

Fuente: Consulta Amigable MEF al 26/12/2011

2.4.3 Financing of AUS

The assessment provided in the AUS strategic plan indicates that the health sector budget is disconnected from health priorities and needs. Distribution of public financial resources across the territory for health services on a per capita basis remains inequitable. Most resources have been invested in hospitals and curative services, rather than in promotion and protection.

An estimated S/. 3 billion are needed to close the gap in infrastructure and equipment and respond to the increasing demand for health services[35], the departments identified as needing the largest share of support for new health infrastructure being Cajamarca, Junin, Piura, Puno and San Martin. For the piloting of AUS in priority areas a series of 'emergency decrees' were passed between 2008 and 2011 to make financial resources available in order to respond to new needs in the provision of health

[35] Elaboración del Plan Estratégico para la implementación del AUS, 2011, p. 117

services. In this context, important funds have been mobilized and transferred to regional governments (*departamentos*) for the construction of new health centers and hospitals, as well as for maintenance and equipment. The World Bank, through PARSALUD II, also supported investment projects in AUS priority areas worth S/. 43 million during the same period.

In general terms, the AUS strategic plan proposes two scenarios in regards to the overall mobilization of resources for AUS:

1) On the expectation that public expenditure on health would increase by 0.5% on an annual basis, based on steady GDP growth estimations at 5.6% until 2016. This would allow to address the gap in infrastructure, equipment and to improve training, salary schemes and distribution of HR across the territory. Substantial additional funding channelled through the SIS would lead to a significant reduction of out-of-pocket expenses by households from quintiles 1 – 3 significantly. One concern however would be wether the public sector has the capacity to execute such an increase in financial resources.
2) On the expectation that public expenditure on health would remain between 1.2 and 1.5% of GDP in the medium-term, resulting in a more modest increase. This would enable some improvements but would not be sufficient to address the major gaps in the system.

It is important to note that the regulations of the Financing Law (see chapter 2.3.1.1.) were still under preparation at the time of the mission (September 2012) therefore many of the dispositions foreseen still need to come into effect.

2.4.3.1 SIS budget and financial flows

From 2008 to 2010, public funding to health care services through the SIS increased by more than 7% (from S/. 420 million to S/. 484 million). However the number of SIS affiliates increased by a larger proportion during the AUS piloting phase between 2008 and 2010 (by more than 2 million persons). As a result, while the **average coverage subsidy per affiliate** was S/. 40.5 in 2008, in 2010 this indicator decreased to 36.2. This is an important indicator to monitor as it reflects the financial coverage that each person affiliated to SIS benefits from. It is worth highlighting that such a decrease was not observed homogeneously across the different departments of the country. In contrast, Lima and Callao were faced with an increase of their levels of subsidy per affiliate reaching S/. 80, due to the presence of higher level and more expensive health services.

Table 6. Expenditure per SIS affiliate, Peru 2004-2011

Año	Transferencias del SIS	Afiliados SIS (*)	Gasto por afiliado SIS
	Nuevos soles	miles de personas	Nuevos soles
	(1)	(2)	(3) = (1) / (2)
2004	280,366,257	4,099.7	68.39
2005	251,053,416	3,919.1	64.06
2006	266,481,036	4,000.0	66.62
2007	283,366,532	4,837.1	58.58
2008	419,586,451	8,145.5	51.51
2009	435,275,000	9,892.6	44.00
2010	448,048,343	10,755.7	41.66
2011	507,211,299	10,797.9	46.97

(*) Fuente ENAHO 2004-2011
Fuentes: Transferencias SIS: www.sis.gob.pe

In 2012, only about 4% of the SIS budget was allocated to administrative management. The rest of the budget is, by and large, used to pay health care providers for the health services given to the SIS affiliates which can be differentiated between the general emergency, basic and hospital care (59%) on the one hand, and the two largest Budgeting-for-Results strategic programs on the other hand

(35%), and to a much lesser extent for treatment of chronic diseases (0.9%). It should be noted however that much of the PpR funding is transferred directly from the MEF to the regions (and registered in the budget of regional governments) without passing through the SIS central budget.

MINSA top management are of the opinion that SIS should gradually become the 'financing arm' of the health sector and in line with this position has reallocated S/. 300 million to the SIS budget for 2013.

With the recent introduction of quarterly pre-payments implemented in the regions on the basis of per-capita estimations, calculations to readjust and reimburse the health service providers have to be done and still seem to pose quite some challenges. Health facilities report to the UDR (former ODSIS) on a monthly basis by indicating which health services have been delivered to SIS affiliates. Overall the new system provides great advantages and gives greater freedom to health providers to organize their services accordingly.

The SIS also transfers resources to the regions for the financing of variable costs (supplies and drugs) in order to assure the availability of these key elements. In the absence of SIS funding, expenses related to supplies and drugs have to be borne by citizens themselves and represent in effect an insurmountable barrier to entry for many of the country's poorest. In practice the SIS also ends up covering fixed costs related to supervision and monitoring. The expectation is that SUNASA will gradually take over these tasks, with an appropriate budget to function.

As foreseen in the legal framework on AUS, in August 2012 FISSAL was granted the status of 'Unidad Ejecutora' (implementing unit) of the SIS and given a specific budget line as well as a S/. 120 million budget for the year 2013. MINSA and SIS however share a common concern about the organizational and implementing capacity of the FISSAL.

As per the AUS financing law passed in 2011, it is expected that the budget allocated to SIS, as far as the subsidized scheme is concerned, should be equal to the value of the premium multiplied by the target of 'number of affiliates' for the subsidized scheme. In regards to the semi-contributory scheme, the coefficient of public funding (which reflects the proportion of the premium financed by the State) is added to the above-mentioned formula. By doing so, it is expected this will provide a solution to the problem that was faced from 2008 to 2010 due to the mismatch between the extension of horizontal coverage and its financing.

2.4.4 Financial monitoring

By law, budget entities transferring public funds are responsible for the monitoring and tracking of these transfers and must verify their compliance with the physical and financial objectives for which the moneys have been transferred. Monitoring is thus not only a responsibility of MINSA, but also for SIS, the DIRESAs and MEF.

Monitoring and evaluation of SIS transfers fall under the responsibility of the SIS Planning Office, with the support of the Operations and Statistics Unit. Every six months SIS publishes an evaluation report. MEF evaluates these reports annually; these evaluations feed back into the planning of the following year's budget.

2.4.5 Internal and external control

Budget agencies (eg. MINSA, SIS) each have an 'Oficina de Control Institucional' (OCI) in charge of the ex-post internal control function. OCIs have a functional relationship with the CGR (i.e. the Auditor General's Office – supreme body of the national oversight system) and their heads are appointed by the CGR itself.

At the central level, the OCIs within SIS and MINSA appear to be functioning well. OCIs annual work

plans are prepared on the basis of guidelines received by the CGR and of the human resources and finances available within their respective units.

With the majority of SIS funding ending up in the regions, the OCIs at central level are increasing efforts to work in a decentralized manner and to monitor how the resources are managed locally.

Regional governments also have OCIs that work with all the sectors but currently their capacity does not cover all of Peru's total public expenditure. The CGR has offices based at macro-regional level and plans regular internal audits in support of the local OCIs. However financial audits do not cover all accounts on a yearly basis. Whereas financial audits of central budget agencies are guaranteed to take place every year and cover all expenditures, at regional level the CGR operates on the basis of a selection made from the regional government's accounts or programmes.

External audits on strategic programmes such as the PAN or the 'Programa Salud Materno-Neonatal' are not carried out on an annual basis and depend upon the programming of the CGR.

The most recent audit exercise on the SIS (central level) was done on the financial year 2011. Three reports were issued - a short financial audit report, a long financial audit report, and a special audit report on budget information - with positive results. All three documents are annexed to this Technical Note.

2.5 Monitoring and evaluation system related to AUS

2.5.1 Description of existing mechanisms

2.5.1.1 2.5.1.1 Routine Data Collection and Processing

The flow of data from local and regional level to the central level is well organized through the regular Health Information System within the sector. The data take into account the existing inequalities. The information is disaggregated according to sex, economic status of the population and geographical differences.

Nevertheless, the different existing data collection systems are not yet fully integrated. The SIS still collects data through its own channel apart from the MINSA system, though links between them exist. This contains the risk of double work and sometimes even contradictions in information.

2.5.1.2 2.5.1.2 Survey data

Surveys fall under the responsibility of the national institute of information and statistics (www.inei.gob.pe). All data are published on the website and technical reports are of good quality, with comparisons drawn across time, and are easily accessible to the public. Household surveys (ENAHO) and Demographic and Health survey (ENDES) are carried out and updated on an annual basis. In additional to the traditional surveys, specific surveys are also foreseen in the framework of the monitoring of strategic programs. Relevant for the follow-up of the maternal-neonatal program are the National Survey of Strategic Programs (ENAPRES) and National Survey of Health centers with Obstetrical and Neonatal Functions (ENESA).ENAPRES allows follow-up of results of the PpR strategic programs and provides greater statistical precision than ENAHO as its sample population is larger (52,000 households vs. approximately 22,000).

2.5.1.3 2.5.1.3 Monitoring & Evaluation Plans

At the time the CTIN and CTIR were instituted (between 2009-2011), the process of M&E was explicit. At the regional level, the monitoring and evaluation plan was linked to the Regional Implementation Plan, and draws on the results framework which has been identified in accordance with the objectives of AUS, each goal includes a number of targets. The monitoring and evaluation was carried out in coordination with the different actors involved in the implementation of AUS: CTIR and the Regional

Health Management. At national level the CTIN and its operational secretariat SETEC monitored the progress of AUS and also produced an evaluation report (cf. *Informe de avance 2011*).

Since these structures have not yet been renewed, the AUS process as for now is piloted on the basis of the strategic and implementation plans of the institutional actors related to AUS (such as MEF, MINSA, SIS, EsSalud, Regional Governments and DIRESAs, IPRESS, SUNASA) which contain their own set of indicators. Some indicators are shared: for example the indicators of the '*Programas por Resultados*' are integrated as well in the SIS strategic plan. For these programs there is a joint M&E plan.

2.5.1.4 2.5.1.4 Relevant data for SIS-FIN support

In relation to the focus of this budget support, the following sets of indicators are particularly interesting. See chapter 3.1. for the selection of key indicators proposed for SIS-FIN follow-up.

1. <u>The AUS indicators:</u>

These indicators are mentioned in annex 2 of the 2011 CTIN report '*informe de gestión – avances del proceso de implementación del AUS*' and are monitored through a study running from 2010-2015 based on the national surveys carried out by INEI (i.e. ENAHO and ENDES):

- *Años de vida ajustados por discapacidad (AVISA)*
- *Tasa de Mortalidad Neonatal (TMN)*
- *Tasa de Mortalidad Infantil (TMI)*
- *Razón de Mortalidad Materna (RMM)*
- *Porcentaje de población asegurada*
- *Acceso Institucional por población que se percibe enferma*
- *Proporción de parto institucional*
- *Proporción de cesáreas*
- *Provisión efectiva del PEAS*
- *Asegurados con cobertura adecuada del PEAS*
- *Porcentaje de cumplimiento de garantías explicitas*
- *Cumplimiento de Guías de Práctica Clínica*
- *Porcentaje de percepción satisfactoria de la atención*
- *Gasto de Bolsillo en Salud*
- *Gasto per cápita en atención de asegurados*
- *Filtración en el régimen subsidiado*
- *Subcobertura en el régimen subsidiado*
- *Gasto catastrófico en Salud*

2. <u>The SIS indicators:</u>

The indicators mentioned in the table below come from the SIS strategic plan 2012-2016.

Strategic objective	Indicators
1. Reach insurance coverage of the target population at national level in the framework of AUS	✓ *Percentage of affiliation to the AUS* ✓ *Percentage of affiliation in zones not covered by the AUS* ✓ *Percentage of coverage reached* ✓ *Access of insured population attended to in the Health System*
2. Contribute to the decrease of child chronic malnutrition, maternal and neonatal morbidity and mortality, risk	✓ *Percentage of children from the age of 6 months to 4 years insured under the subsidized component facing a risk of malnutrition, whom have received at least 4*

and damage; Control of communicable and non-communicable diseases; through the insurance and opportune financing of individual health care for the population insured by the SIS	*nutritional counselling sessions* ✓ *Percentage of pregnant mothers controlled* ✓ *Percentage of insured women under the subsidized scheme who are screened for cervical cancer* ✓ *Percentage of health care consultations evaluated during the control process after the service delivery*
3. Contribute to the protection of the insured and strengthen the culture of health insurance	✓ *Percentage of degree of satisfaction of the insured* ✓ *Number of complaints and reclamations presented by the insured* ✓ *Number of claims cleared* ✓ *Number of 'Centro de Atención al Asegurado' implemented at national level*
4. Develop and strengthen the competencies of the SIS in its role as a public IAFAS	✓ *Percentage of achievement of the Personnel Development Plan at national level* ✓ *Number of agreements implemented* ✓ *Number of payment packages for level III* ✓ *Number of processes improved*
5. Strengthen individual health actions, through the definition of financing mechanisms for services destined to the population insured by the SIS	✓ *Number of payment mechanisms implemented* ✓ *Percentage of consults evaluated through the control process after the service delivery* ✓ *Percentage of achievement of the valorisation processes of service delivery* ✓ *Percentage of agreements with new conditionalities with service providers*
6. Contribute to the strengthening of supervision for the optimization of administrative management	✓ *Number of norms implemented* ✓ *Percentage of implementation and monitoring of Administrative Management indicators*

3. The indicators of the Strategic Program of Maternal and Neonatal Health:

- *Tasa Global de fecundidad en los 3 años anteriores a la encuesta*
- *Proporción de Mujeres en edad fértil (MEF) en unión que usa algún método de planificación familiar*
- *Proporción de mujeres en unión que usa algún método moderno de planificación familiar*
- *Proporción Parto Institucional de gestantes procedentes en zonas rurales*
- *Proporción de gestantes que dieron parto por cesárea procedentes del área rural*
- *Proporción de Partos en establecimientos de salud de gestantes procedentes de área rural*
- *Proporción de Partos atendidos por profesional de salud*
- *Proporción de recién nacidos vivos menores de 37 semanas*
- *Proporción de Mujeres en edad fértil (MEF) que conoce algún método de planificación familiar*
- *Proporción de Mujeres con demanda insatisfecha de planificación familiar*
- *Proporción de Gestantes con por lo menos un control prenatal*
- *Proporción de Gestantes con seis o más atenciones prenatales*

This program has an orientation towards results with clear indicators, related to curative, preventive and promotional care. Data collection for these indicators takes into account regional differences and is oriented towards the poor population groups. The working group *'submesa Salud Materno-neonatal'* (part of the platform 'mesa de concertación para la lucha contra la pobreza') assures the monitoring at national level. The indicators are used as major markers of the performance of the AUS strategy (cf. 2011 CTIN evaluation report on AUS).

2.5.1.5 2.5.1.5 Monitoring and Evaluation by non-state actors

A matrix of indicators for Health Monitoring by the Civil Society was elaborated in 2007 by the Health Observatory of the 'Consorcio de Investigación economica y social' (CIES) and updated in 2011. This was done in collaboration with several Civil Society Organizations, International Agencies and government institutions.

The set of indicators has two dimensions: one related to the Health Status of the population (with indicators in relation to poverty, nutritional status, sanitation, violence, vulnerability) and one related to Response both by the public health sector and civil society (with indicators on coverage by nutrition programs, financing of service delivery, regulation of the health system, 'fiscal strength' of health, social protection in rural areas, quality of public health services, AUS with a particular focus on poor population groups, availability of information to poor population groups, civil society participation in health) with a particular attention to most vulnerable population groups (in relation to poverty, rural setting and gender).

2.5.2 Challenges

2.5.2.1 2.5.2.1 Towards a more Integrated Health Information and Monitoring System

The monitoring system of the health sector is as fragmented as the health system itself. All actors producing or administering information use different information systems, resulting in duplication of efforts and incomplete information. Different health care providers are also using different codes for identical clinical processes. In 1999, the SEPS (former SUNASA) proceeded with the standardization of health data that would serve as a basis for the exchange of information among IPRESS and among IAFAS. Despite recent efforts to advance in the harmonization data systems of SIS and EsSalud, at this moment there is no coordinated M&E system or overarching M&E policy and strategy in the health sector, streamlining the collection, flow and use of health data. This includes as well a comprehensive communication strategy to make available relevant information at the correct level at the appropriate time.

At the decentralized level, data is mainly transferred to the national level and insufficiently used at the local level. The decentralized units of SIS (UDR) for example, are mainly registering information and transferring it to the central SIS. The SIS does not sufficiently analyse and use available health information to sensitize the population and defending its rights.

2.5.2.2 2.5.2.2 Use of data for Strategic management and learning in relation to AUS

The CTIN was an adequate tool for strategic management. Their evaluation report (2011) on progress in the implementation of AUS ('*Informe de de gestión – Avances del proceso de implementación del AUS 2009-2011*') was of good quality and provided orientations for future refinement of the AUS strategy. However, with the CTIN no longer being functional[36], there is a gap in the strategic management of AUS. Apart from some joint monitoring on specific topics, there is no comprehensive monitoring of AUS involving the different institutions and levels concerned by the implementation of AUS.

Apart from that, the mass of good quality data is not being analyzed and exploited in a systematic way. There is no systematic M&E feedback loop in terms of institutional learning and link with decision-making.

The new Minister of Health however appears to be committed to a strong coordination by MINSA in order to fulfill its functions of learning and accountability.

[36] The CTIN was dissolved in 2011 as foreseen by law

2.5.2.3 2.5.2.3 Tackling side-effects of the Strategic Programs (based on performance-based funding)

According to the EC's analysis, the information collected for the indicators, which is necessary to get the financing, is insufficiently trustworthy. This is an inherent risk of every program financed on the basis of results (such as the strategic program for Maternal-Neonatal Health). Similarly to any system of performance-based funding there are shortcomings which are mostly related to the fact that 'management for results' becomes 'management by results' which leads to a focus on 'quick wins', etc. It remains important to monitor and evaluate this funding mechanism further over time through independent research to mitigate possible negative side effects.

Some strategies and indicators such as the ones concerning prenatal care are questionable with regard to their effectiveness in relation to maternal-neonatal morbidity and mortality.

2.5.2.4 2.5.2.4 Increased participation of the non-governmental actors

At national level, critical analysis of data and indicators is done by the non-state actors. But access to all relevant information is complicated. The creation of the Health Observatory by CIES[37] aims at reducing this gap.

There is also limited space for these actors to hold the government accountable, specifically regarding AUS. There is an active participation of non-state actors to informal exchange fora (such as technical working groups) but their participation in the formal exchange fora (such as the 'consejo de salud') is usually limited to the status of observer. The information gathered through the 'Defensoria del Pueblo' is not exploited in an optimal way, due to other priorities as well as understaffing. Downward accountability is limited.

At the regional and local level, the level of effective participation of non-state actors is low due to limited capacity and political reasons. The upward accountability from the local and regional to the central level inside the governement structures however is strong.

2.6 Policy dialogue and donor coordination

The Government of Peru is not dependent on foreign development assistance. External financing accounts for less than 2% of the national budget.

Since 2005, the Peruvian Agency of International Cooperation (APCI) has been responsible for the organization of Donor Round Tables. An important undertaking so far has been the promotion of a division of labour between donors (still in process), based on comparative advantages, promoting sector prioritization by each donor. This should allow for a more efficient use of external resources and reducing the transaction costs.

2.6.1 External aid to the Peruvian health sector

Aside from the Belgian Cooperation, the main donors active in the health sector are the World Bank, IDB, EC, WHO (OPS), USAID and the Italian Cooperation.

- The **European Commission** (EC) provides funding to the Peruvian Government through the EUROPAN program. The EC is very active in the Mesa PEFA but has not been present in the spaces of dialogue at health sector level due to limited human resources. A small portion of the EC funding (€ 0.8 m) is used for targeted technical assistance on issues of public health and PFM.

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[37] Financed by the Belgian Cooperation

- **USAID** has a large sector support program to the health sector, containing mainly soft investment projects, worth USD 15 million over a 5-year period. The projects have targeted the following themes: governance & decentralization, health financing & health insurance, human resources, information systems and management of medicines. In the area of health insurance, USAID has offered technical support to MINSA for the implementation process of the AUS Law and carried out a considerable amount of analytical work on the theme of health insurance and health financing. A particular interesting pilot project is being conducted in San Martin in relation to inter-sector collaboration. USAID will however exit the Peruvian health sector as of 2014 and is currently focusing on the consolidation of the results achieved through its support programme.
- The **Inter-American Development Bank (IDB) and World Bank (WB)** support PARSALUD II. This is a health sector support program that aims to reduce infant and maternal morbidity and operates under MINSA. It focuses in particular on investment and infrastructure for the provision of health services to women and children and offers technical assistance in specific areas related to AUS. The Peruvian government foresees to invest € 124 million (S/. 457 million) under PARSALUD II, over the period 2009-2014.The WB and IDB each provide € 12 million (S/. 42 million) as development loans.

  The WB is also currently evaluating the first phase of the implementation of a regional initiative related to health insurance systems benefiting from a grant of the Bill Gates foundation. They expect more funding to be released to further address bottlenecks related to AUS, which they would like to implement through a concerted dialogue with other donors supporting AUS and the SIS.

  The findings of an IDB-financed study on the IT needs of SIS showed that a € 15 million investment in soft- and hardware, which includes central servers and renewal of existing hardware at the central levels and in the regions, is needed. In September 2012 IDB approved a new loan of USD 30 million of which a part will go to the SIS for the strengthening of IT systems.
- The **Italian Cooperation** provides technical support to the *Oficina de Cooperación Internacional* of MINSA to enhance areas related to aid effectiveness. It also supports the functioning of the Mesa Salud. Moreover, it provides targeted support related to the implementation of the family and community health strategic plan and is very involved in a cross-border program between Peru and neighbouring Ecuador. An important activity item addressed by the Italian Cooperation is the update of a database on all bi- or multilateral agencies as well as NGOs and other partners supporting the health sector. APCI appears to have provided such a database but it is currently outdated. Access to such information would be crucial for MINSA and all stakeholders to have an overview of the focus of each donor intervention in terms of topic and geographical coverage as well as provision of technical assistance. This would facilitate the sharing of good practices and encourage different stakeholders to join forces for analytical work or piloting (or scaling up) of initiatives where a common interest is shared.
- The support of WHO (**OPS**) to MINSA at central level is focused towards the secretariat of the *Consejo Nacional de Salud* and the Decentralization office of the Ministry. With CIDA (Canada) funding, a support program is in place in three regions (Amazonas, Cajamarca, Loreto) to address gaps in HR, health teams, and capacity of the functional health networks. With the financial support of AECID (Spain) a joint program (in collaboration with Unicef and the World Food Program) to fight malnutrition in Apurimac, Ayacucho and Huancavelica. As in the case of other donors, OPS has led analytical work on health financing. In particular, a

study on the cost of the basic package of health care in the context of AUS was picked up by the Peruvian authorities for follow-up.

Although information-sharing and regular interactions are currently limited among development partners, there is great potential and will within the group to find synergies among different interventions and build on the analytical work carried out. During the BTC mission, all donors explicitly expressed their interest and willingness to strengthen collaboration among each other through the set-up of a permanent dialogue structure, especially as staff turnover in the top management of MINSA is high. USAID in particular hopes to share lessons learned and good practices that emanated from its support to the Peruvian health sector and that achievements of its program be picked up by others after 2014.

2.6.2 Quality of dialogue between Peru and development partners

The Technical Working Groups created under the PROSIS project (BTC-SIS) to foster continuous technical dialogue between the SIS and its different development partners died out soon after the end of the intervention (2009).

The 'Mesa PEFA' was established in 2009 and is run by the MEF and development partners involved in the support to the PFM reform.

A *Carta de Intenciones* (MoU) gathering all actors of the health sector supporting AUS was signed between the outgoing government and a number of development partners early 2011. The MoU sets the tone for enhanced coordination among stakeholders. During the mission the new Vice-Minister of MINSA expressed great interest in re-launching a dialogue space ('Mesa de Salud') where a particular focus will be put on AUS.

The 'Mesa de Cooperantes en Salud' (or 'Mesa Salud") was reactivated on 2nd July 2012 (chaired by MINSA) through a very formal event where the technical secretariat was handed over to the Belgian Embassy. Since then, a new Minister of Health has come in office. A work plan for the mesa is currently under preparation, aiming at supporting two key results:

- Donor actions are more harmonized, transparent, collectively effective and based on national strategies of the health sector in Peru (harmonization and alignment)
- National actors of the health sector exert authority over their policies and strategies and coordinate actions oriented towards results, among themselves and with donors (ownership, mutual accountability and result-based management)

Some donors mentioned they have struggled to keep up with the AUS reform given the relative frequent changes in MINSA leadership and other government ministries. MINSA also recognizes that AUS was put in parenthesis during the first year of term of the new government, which partly explains the absent dialogue between Peru and development partners.

In relation to existing dialogue spaces at national level (see chapter 2.3.2) there currently is an opportunity for donors to participate (often just as observers) in fora such as the *Mesa de Concertación para la Lucha contra la Pobreza* or the CIGS which gather representatives of national and regional governments.

2.7 Summary of critical risks and mitigating measures

The main risks towards the development of a sustainable system of AUS, collected through the interviews during the formulation mission, can be summarized as follows:

1. **<u>Inequity</u>**

- There should be an increase in the financing of the social sectors, at least to a % of the GNP meeting the average of the other countries in Latin-America, and in line with the evolution of the demographic and epidemiological profile of the population.
- The distribution of resources (whether human, financial or physical resources) should be distributed in an equitable way.
- There should be geographical, financial, socio-cultural and permanent access to quality health services for all.
- Information should be available to the citizens in all regions at all levels: top-down communication and sensitization mechanisms regarding policies, strategies and schemes as well as downward accountability mechanisms should be installed.

Mitigating measures to promote equity:

Channelling the SIS-FIN budget support to the Strategic Program of Maternal & Neonatal Health with a focus on the poorest regions (in the same way as done for the EC budget support EUROPAN) reinforces (however modest) a more equitable distribution of resources.

2. A medicalized disease-centred approach

- There is a need for a sustained investment in developing the Primary Health Care services (including the first referral hospital services) and the management of the local health networks ('redes').
- There should be a re-equilibration between curative and preventive and promotional health services. The public health/community health component of the health system should be strengthened. This starts already at the level of the basic training of health professionals.
- Highly specialized medicine should not be excluded, but should be responding to the epidemiological profile of the population (also in rural areas), articulated with the needs and health services at the first level and based on the principle of cost-effectiveness and equity.
- The demand of the users and the local communities should be taken into account more explicitly in order to offer a comprehensive benefit package (with enough breadth, height and depth) of services more adapted to the needs[38] of the population at the level of each region in the country. The support to priority health programs should not lead to neglecting other health conditions.
- The working conditions for health professionals should be improved in order to allow a people-centred approach.
- The existing efforts towards a more effective inter-sector collaboration should be further strengthened, taking into account the social determinants of health.

Mitigating measures to promote a holistic, people-centred approach:

The complementary support of SIS-TEC will work both at national and decentralised level. This will allow to monitor whether the implementation of national strategies (such as the 'Plan Nacional de Fortalecimiento del Primer Nivel de Atención 2011-2021' and the strategic plan of AUS) really support people–centred care.

Since the Belgian cooperation is assuring the secretariat of the *Mesa de Salud*, this is another instrument to bring the people-centred orientation on the agenda of the policy dialogue. The participation at the 'Submesa Salud Materno-neonatal', will make it possible to monitor whether the Strategic Program on Maternal and Neonatal Health is implemented in such a way that it strengthens a

[38] Cf. comparative study (by CIES) in relation to the satisfaction rate of the population with the public health services, the health services run by Essalud, and the health services of the private sector.

model of Comprehensive Primary Health Care Services or, on the contrary, that it reinforces a strict vertical approach.

3. The implementation gap

As pointed out earlier in the document (cf. 2.2.4), there is still is a considerable gap between the policies and strategies and their implementation. In relation to AUS, the gap between nominal and real affiliation has been mentioned, the gap between the PEAS and real coverage, the gap between affiliation and real access, the gap between the law on health rights and its regulation with explicit guarantees in practice, the resource gap between rural and urban areas, the gap between the capacities at central and decentralised level among other gaps.

Reaching effective universal health coverage is a long-term effort and requires long-term political commitment along with guarantees that sufficient financial resources will be available to support the rationalization as well as delivery of adequate health services that will be generated by a higher demand. Emergency decrees passed for investment in recent years will have to be replaced by more permanent and structural measures to address the financing gap.

Mitigating measures to close the gap:

The opportunity to participate in the various spaces of dialogue allows for a regular monitoring of the implementation of policies and strategies. The dialogue should however be based on evidence. This evidence should primarily be collected at field level. The technical support in SIS-TEC as well as the possibility to mobilise punctual expertise and conduct studies in relation to specific aspects related to AUS are instruments to raise evidence, exchange experiences and reinforce local capacities.

The Belgian Cooperation has the opportunity to create a strong link between the SIS-FIN support towards the achievement of health goals and policy dialogue at macro level (eg. *Mesa PEFA*) with the MEF where issues related to resource mobilization and budget allocation for the health sector can be addressed.

4. The fragmented health system

Despite the efforts, there is still a lot of fragmentation at all levels hampering a smooth progress towards the realisation of AUS:

- Fragmentation between the different schemes of health insurance, in the first place SIS and EsSalud. The main reason is the lack of strong structures of regulation (at the level of SUNASA or MINSA).
- Fragmentation between institutions (barriers in exchange of information and services; suboptimal strategic coordination and guidance).
- Fragmentation between the national, regional and local levels (technical and political reasons complicating the decentralisation process).
- Fragmentation between sectors (vision and political will as well as practical organisation regarding inter-sector collaboration are still weak)
- Fragmentation in time (the high rotation of staff at the decision-making levels entails the risk of discontinuity of implementation of policies and strategies)

Mitigating measures:

The commitment of the international agencies in the 'Mesa de Salud' towards the implementation of AUS as well as the intention to reinforce their participation in the existing spaces of dialogue, may gradually strengthen the culture of dialogue and foster better articulation and harmonisation. The Belgian Cooperation, as current secretariat of the *Mesa de Salud*, can contribute to this process. The

current context is favourable as the new Minister of Health shows political will to strengthen its leadership regarding AUS is an opportunity.

The presence of 'Long-term International Sector Experts' in the Belgian support program, both at the level of SIS-FIN and SIS-TEC, can also facilitate the articulation between actors concerned by AUS. Building a culture of trust and exchange of information, ideas and experiences is a potential added value of this type of expertise, compared to the punctual expertise (which provides an in-depth focused technical expertise).

5. Instability due to the Decentralization reform

Decentralization possibly creates some instability and lack of continuum in terms of new responsibilities and need for capacity building at the regional and local level. For example, in the framework of the PpR absorption and implementation capacity by the regional government and heavy requirements in terms of data collection will represent new challenges.

Mitigating measures:

Closely monitor and assess the effects and needs related to the decentralization process. The Belgian Cooperation's support to specific regions in the framework of SIS-TEC and SIS-FIN will provide an opportunity to better understand bottlenecks in the system and identify areas that may need targeted support or technical assistance.

6. Weak institutional and sector learning

At the moment there is, in relation to AUS, no institutionalized learning dynamic with the participation of all concerned actors. Some important conditions for that are as follows:

- The legal basis for the CTIN (and CTIR), the most important tool for strategic management and coaching in relation to AUS, should be renewed.
- More stability at the level of the decision-makers at the top of the Ministry of Health is required to assure continuity in the health policies and their implementation.
- A comprehensive and rationalized design of (existing or new) spaces of dialogue, reflection, monitoring and evaluation of AUS should be developed under the leadership of the Ministry. This will better regulate the reflection around AUS, both at national, regional and local level and clarify the roles and expected contribution from all actors.
- The available information and analysis (cf. studies, pilot-projects, statistics….) should be exploited in a better way. Action-research at field level should be promoted and valorized.
- The information systems amongst the various institutions within the health sector need to be integrated.
- Informal networking and exchange between experts working in different institutions needs to be encouraged.
- The capacity (at strategic level) to enable constructive criticism from non-state actors at the decentralized level should be reinforced. Valorizing their contributions, formalizing their active participation in some of the exchange fora are positive signals.

Mitigating measures:

The Belgian support program to the health sector is based on complementary interventions (budget-support, technical institutional support, grant program, study fund) with an explicit focus on learning: the presence at both the central and decentralized level, the importance given to technical exchange both on the long-term and short-term as well as the focus on action-research may contribute to reinforce the dynamic of institutional learning, in particular in relation to AUS.

Given the longstanding collaboration between the Peru and Belgium in the field of AUS, the progress made in recent years, the robust financial mechanisms within the country, the commitment of the current Ministry of Health, the current lead of the Belgian Cooperation in the health sector policy dialogue between the Peruvian government and the international agencies, as well as the mitigating measures proposed in relation to the challenges in the health sector towards AUS, it can be concluded that the essential elements are in place to successfully implement a Sector Budget Support and monitor the implementation of the sector policy, throughout the various strategies.

3 PROPOSAL ON RISK MANAGEMENT – MODALITY DESIGN

3.1 Belgian focus in policy dialogue

3.1.1 The general focus

The overall focus is on a sustainable implementation of the AUS strategy, even though the budget support is earmarked to the Strategic Program of Maternal and Neonatal Health. However, this Strategic Program will be used as a marker[39] to monitor the effects of the actual process of modernization of the health sector and the implementation of AUS.

3.1.2 The specific focus

The specific focus of the policy dialogue will be linked to the critical challenges mentioned under chapter 2.7. Six key-challenges have been identified in relation to equity, people-centeredness, the closure of the implementation gap, the integrated health system (including a particular attention to the quality of interactions and coordination between all actors in the sector concerned by AUS, with a particular attention on the role of civil society in defending the right to Health), the decentralization reform, and institutional and sector learning. More specific challenges are described under each of those. The technical and policy dialogue is one of the mitigating measures to tackle these challenges.

In an effort to tackle the key-questions and boost institutional learning with regard to AUS, there will be a particular interest to capture innovative experiences (through pilot-interventions, action-research and specific studies) in the sector, either at the level of Peruvian actors, the Belgian actors or other international agencies.

Within the set of national indicators related to AUS, SIS and the Maternal and Neonatal Program (cf. 2.5.1.4), some indicators will be followed in particular. For AUS the chosen indicators are in line with the box model on Universal Health Coverage (WHO report 2010):

- the percentage of people effectively covered through AUS within the population groups living in poverty and extreme poverty (breadth of the coverage)
- the effective provision of the PEAS (depth of the coverage)
- the percentage of fulfillment of explicit guarantees (height of the coverage)
- expenses per capita made by the health system for the people who are insured
- access of the insured population attended to in the Health System

In addition, the most relevant indicators of the Maternal and Neonatal Program will be followed to monitor the effects in terms of health outcomes and health behavior resulting from the reform strategies in the health sector. Three indicators will be monitored in particular :

- “proporción mujeres en unión que usa algún método moderno de planificación familiar”
- “proporción de partos en establecimientos de salud de gestantes procedentes des área rural”
- “proporción de recién nacidos vivos menores de 37 semanas”

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[39] 2011 CTIN evaluation report on the progress of implementation of AUS

3.1.3 A dynamic process

Policy dialogue is a dynamic process that is conducted according to new opportunities and questions. Therefore the focus is likely to be adapted according to the evolution of the context and needs.

The identification of new entry points and opportunities for policy dialogue during the timeframe of the SIS-FIN support will relate to:

- The national (sub-)sector policies, strategies, plans and regulations influencing the implementation of AUS (and PpR)
- The priorities of the Peruvian government and the Ministry of Health in particular
- The conclusions and issues raised during the 'Mesa Salud', 'Mesa PEFA', Technical Working Groups and other discussion fora
- The conclusions of studies, evaluations and audits in relation to AUS, PpR and the institutions involved in their implementation
- The issues raised through experiences and action-research, particularly at decentralized level

3.1.4 Official documents of the Belgian Cooperation to back up the policy dialogue

Documents useful in the dialogue on AUS:

- The Health Policy Note of the Belgian Cooperation 'The Right to Health and Health care' (2009) and its addendum on 'Universal Health Coverage' (2012)
- The Conceptual framework of Because Health 'Investing in Health for a greater well-being (2008)

Documents useful in the dialogue on the Strategic Program of Maternal & Neonatal Care:

- The Policy note of the Belgian Cooperation 'Sexual Rights & Reproductive Health' (2007)
- The Policy note of the Belgian Cooperation 'The Belgian contribution to the international fight against HIV/AIDS' (2006)

It should be mentioned as well that the Belgian Cooperation gives specific attention to the following crosscutting/transversal themes: good governance, gender, health rights with a particular focus on children's rights and rights of indigenous people, environment and (unofficially) HIV/AIDS. During the formulation process some initial entry points for the policy dialogue were identified, particularly in relation to the Strategic Program on Maternal and Neonatal Care: pro-poor distribution of resources, gender-responsive budgeting, the mental health care aspects in relation to maternal care, progressive issues in relation to sexual and reproductive health, as well as sexual violence and violence at household level. One source of information for the latter is the final evaluation report (with lessons learnt) from the project 'El Programa Integral de Lucha contra la violencia familiar y sexual en Ayacucho' (2008-2012) supported by the Belgian cooperation.

3.1.5 International references to back up the policy dialogue

There are also important international references to back up the policy dialogue regarding AUS. To mention a few important ones:

- The World Health Reports of the WHO particularly the following:
  - 2007 - A safer future: global public health security in the 21st century
  - 2008 - Primary Health Care (Now More Than Ever) Universal Health Coverage
  - 2010 - Health systems financing: the path to universal coverage

- Declaration of Rio on Social Determinants of Health (2011)
- Communication of the European Commission on ‘Social Protection in the development cooperation of the EU’ (2012)

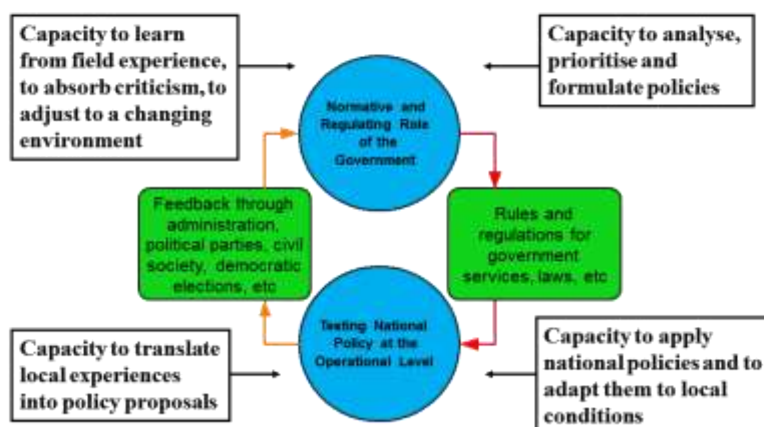
The following recommendations in relation to health financing, which are drawn from a publication of the World Bank[40] on financing health in MICs, appear to be very relevant for the case of Peru and policy dialogue around SIS-FIN:

- Efficient revenue mobilization should be a top priority for health, because funding must be sustainable and match long-term needs
- Domestic revenues and funding sources need to supply the bulk of the financing
- Increasd risk pooling is needed to improve allocative efficiency, equity and financial protection
- Health spending should be parsimonious so that coverage be expanded to more people
- Standard of minimum benefit packages should have the right mix of coverage breadth and depth
- The specific form of health insurance scheme is less important than ensuring that the scheme focuses on improving revenue collection, risk pooling, and service purchasing
- Not overlook the disparities in the health status of different populations within MICs.

3.2 Set up of policy dialogue

3.2.1 Portfolio approach of the Belgian Cooperation

One of the basic conditions to assure the quality of the policy dialogue is the link with the reality at operational level. This is essential to 1) analyze the design and the implementation of AUS in a critical way, 2) document experiences in order to generate evidence for policy, 3) contribute to a structured feedback to the decision makers at strategic level, 4) contribute to the continuous adaptation of the AUS policy and strategy in order to assure the access to quality health services responsive to the needs of the population.



[40] World Bank, “Chapter 8: Financing health in middle-income countries” in *Health financing revisited: a practitioner’s guide*, 2006.

Therefore, the support of the Belgian-Peruvian Cooperation to the health sector in Peru is composed of a **portfolio** of complementary interventions. These interventions have different entry points:

- At the level of the development partners, there is the political/policy dialogue around AUS and related policies through the Sector Budget Support SIS-FIN.

- At the central, strategic level within the SIS and in coordination with MINSA, there will be the policy/technical dialogue through the Institutional Support SIS-TEC 'Programa de apoyo a la politica de AUS en el Perú, a través del SIS'

- At the regional and local (more operational) level, there is the technical dialogue 1) through the SIS-TEC which has a strong link with ten departments (initially priority regions for the implementation of AUS) and 2) through the earmarking of the SIS-FIN budget support to the Strategic Program of Maternal and Neonatal Care in the poorest regions (based on the choice of the Peruvian partner).

- Specific needs, both at local, regional and central level, to reinforce capacities or to study particular questions, all in relation to AUS, are covered through the *Fondo de Estudios* and the *Programa de Becas* of the Belgian Cooperation.

- The dialogue at all levels is further enriched through the indirect bilateral Belgian-Peruvian Cooperation. The support projects of organizations such as FOS and CIES focus on the study and monitoring of AUS as well as on the protection of health rights in relation to AUS.

The anchorage of the portfolio at different levels stimulates unique dynamics of interaction between operational and strategic levels. It allows a consistent follow-up of results in terms of access to quality services and development of adequate policies.

3.2.2 The technical expertise mobilized by the Belgian Cooperation

The renewed strategy[41] towards MICs puts forward Cooperation for Development rather than on Development Aid. In that perspective, exchange of expertise and experiences is central. The added value of this exchange of know-how (whether at national, regional or international level) is to contribute to 1) a critical analysis by the Peruvian society of the government's policies and strategies, 2) the development of innovative ideas, 3) the resolution of complicated technical problems, and 4) a better articulation between all actors whether state or non-state actors. Within the portfolio of the Belgian-Peruvian Cooperation, different, complementary types of expertise are made available, as described in the paragraphs below.

3.2.2.1 Long-term expertise

The PROSIS support program has demonstrated the added value of a permanent expert especially in (i) identifying key-challenges and opportunities in the processes of implementation of AUS through a comprehensive understanding of the system, (ii) facilitating the articulation between different actors and levels involved in the implementation of AUS and (iii) developing innovative strategies in a participative way. This requires a relation of trust which can only be achieved by a long-term commitment. In the SIS-TEC an International Sector Expert is already foreseen, specialized in the field of Health Economics, and will focus on the functioning of SIS and its interactions with the other actors directly concerned by AUS. Through the budget support SIS-FIN a complementary long-term expertise will be mobilized. This expert should have experience with public health, public sector management and health financing.

Both experts will be working in Lima at the national level: the SIS-FIN expert having an office at the BTC representation in Lima, whereas the SIS-TEC expert will be working from the central SIS office.

[41] This renewed strategy is yet to be endorsed

However, through regular field visits and participation in dialogue spaces at regional level, they will be in close contact with the actors at decentralized level involved in the implementation of AUS.

The experts should work as a team, with exchange of information on a permanent basis. They also will brief the BTC representation on a regular basis as well as the Belgian Embassy. The experts hold an advisory role towards the Attaché in preparing the policy dialogue. As Belgium is currently assuring the secretariat of the 'Mesa Salud', the SIS-FIN expert in particular will collaborate closely with the Belgian Embassy to give a technical input to feed the policy dialogue.

The budget support expert will furthermore participate in the 'Mesa PEFA'. The experts will participate also in other exchange fora related to AUS, in close consultation with the Peruvian partner, the Belgian Embassy and the BTC representation in Lima.

3.2.2.2 Intermittent expertise

This type of expertise will mainly be mobilized through the regular external scientific support (regional/international) as described in the SISTEC intervention. This support will collaborate with local academic institutes, facilitating the identification of specific key-questions in relation to AUS, the set-up of innovative action-research related to those questions, the generation of evidence for policy and the process of capitalization of experiences. This should systematically feed into the policy dialogue. The critical challenges described under 2.7 are a starting point.

3.2.2.3 Short-term, ad hoc expertise

Both in the SIS-TEC and the SIS-FIN there is a budget to perform studies and to mobilize short-term, usually specialized technical expertise. This allows to respond to punctual needs in a flexible way. The expertise may come through specific consultancies of national, regional or international experts, but also through the exchange of experiences between the Belgian and Peruvian health insurance systems. A fair amount to be mobilized for the SIS-FIN budget support is estimated at approximately 25 000 euro/year. This budget will be managed by BTC in 'régie' and additional to the budget support funds of € 6.5 million. Part of this funding could also be used to sponsor more sub-national PEFAs in the same line as what the EC has done in the past year in complementarity to its budget support.

In that perspective, it is useful to mention that BTC has an agreement with COOPAMI[42] and with the Belgian Federal Public Service (SPF – FOD) of Public Health to mobilize specific expertise in a very flexible way in relation to AUS and public health management issues.

Additional budget in SIS-FIN will also contribute to the financing of backstopping missions (at least once per year) from the EST department of BTC Brussels. This can facilitate the exchange of experiences between different partner-countries of the Belgian Cooperation involved in the development of a national universal health insurance system.

3.2.2.4 Complementarity with expertise of other international actors

The collaboration with experts active within the indirect bilateral Belgian cooperation (mainly NGOs) is also very important. Since these actors have close relationships to local civil society and are closer to the operational level, regular exchange of information and experiences will provide a complementary perspective on AUS and will enrich the policy dialogue.

The same can be said for the collaboration with experts available at the level of other international agencies, especially those involved in the implementation of the objectives of AUS. The 'Mesa Salud', the 'Mesa PEFA' and other various existing exchange fora described in earlier chapters (cf. chapters 2.3 and 2.7) constitute excellent opportunities for this.

[42] COOPAMI is a platform of international cooperation within INAMI - RIZIV (Rijksinstituut voor Ziekte- en Invaliditeitsverzekering)

3.2.2.5 Link with exchange fora outside of Peru

Opportunities for staff of the MINSA or partner institutions involved in AUS to participate in exchange fora within the region or at international level may be facilitated through the support program of the Belgian Cooperation. It concerns particular workshops or conferences with a focus on health financing and universal health insurance. South-south exchange will be a specific point of attention.

3.3 Disbursement conditionalities and financial planning

3.3.1.1 EC EUROPAN support

The disbursement conditionalities applied by the EC for its EUROPAN support are two-fold:

- For the installment of the fixed tranches (€ 34 mio), general conditions of macro-economic stability, satisfactory progress in PFM reform and satisfactory progress in the implementation of the 'Programa Articulado Nutricional' must be met.
- For the installment of the variable tranches (€ 26 mio), the EC follows a result-based approach and looks at the performance of four indicators related to the health sector (of which three are collected monthly by SIS and one through the annual ENDES).

3.3.1.2 Belgian SIS-FIN support

With the SIS-FIN support being the first experience of the Belgian Cooperation in implementing budget support channeled through the MEF towards a strategic program, the breakdown of the financial planning proposed in the table below aims at providing a balanced support to the AUS through three disbursements throughout the duration of the SIS-FIN support.

Indicative budget (in millions of €)	2013	2014	2015	Total
Disbursements	2	2.5	2	6.5

The first disbursement (planned in 2013) should be made upon signature of the Specific Agreement taking into account the assessment made in the present Technical Note.

Conditionalities for the following disbursements should be established in conformity with the best practices as indicated in the Vademecum for Budget Support so as to guarantee a good level of predictability to the recipient country. Thus, **a disbursement in year N+1 is decided upon in year N, on the basis of the planning and budget for year N+1, financial and technical reporting on year N-1, and a positive audit on year N-2.**

The second disbursement (planned in 2014) should be made upon completion of the following requirements:

- SIS budget and POA on year 2014
- Technical and financial report of the maternal-neonatal program on year 2012 (or a more recent report if available)
- Audit report on SIS on year 2011 (or a more recent report if available)

The third disbursement (planned in 2015) should be made upon completion of the following requirements:

- SIS budget and POA on year 2015
- Technical and financial report of the maternal-neonatal program on year 2013 (or a more recent report if available)
- Audit report on SIS on year 2012 (or a more recent report if available)

If **performance audits** are planned during the duration of the SIS-FIN support, whether at the level of the SIS or of the strategic programs in health at regional or central level, these should also be taken into account.

The Specific Agreement should cover a period of 4 years, so as to allow the adequate follow-up of the last disbursement by the Belgian Cooperation.

Clear guidance from the annexes in the Vademecum on how to react upon negative audits need to be communicated and stated in the Specific Agreement. A negative opinion of the auditor (or sometimes called "Adverse") reflects a situation where the financial statements contain material misstatements or errors and the Auditor has disagreed with management and as such concludes that the financial statements do not represent a true and fair position.

Guiding principles on use of financial audits for Belgian Budget Support :

elements to be clarified in the Specific Agreement

- A provision stating that, in case of a negative audit, the donors can delay the contribution;
- The partner authority must draw up a 'management response' after every negative audit report. Both documents are sent to the donor group.
- How, in case of a possible negative audit, communication with the authority is conducted, and how the measures announced in the 'management response' will be followed up;
- What sanctions can be expected in case of serious shortcomings (repayments of funds by the national authority, or reduction of the following contribution of the donors);
- And finally, how arrangements will be made about any adaptations to the shared procedures of budget support (adaptations to the MoU, the Joint Financing Arrangement, the Vademecum of the Procedures manual)

3.4 ToR of the expert

On the basis of the context and risk analysis, and taking into account the vision of the Belgian Development Cooperation regarding the follow-up of sector budget support programs, a senior health expert will be recruited for 4 years. Since the international sector expert of the intervention SISTEC is a (health) economist, the expert of SISFIN should have a complementary profile. Moreover, in order to guarantee the technical follow-up of service delivery particularly through the indicators related to the PpR on Maternal and Neonatal care, an expertise in public health or related is essential.

In close collaboration with the Attaché for Development Cooperation at the Belgian Embassy, the budget support advisor will provide input for the health policy dialogue with the Government of Peru. The BTC expert will have to fulfill a double objective:

- The expert will be in charge of the disbursement report containing the recommendations on the release of instalments of budget support
- The expert will be in charge, with the donor group, of monitoring the sector and reporting on this monitoring. This reporting is not an end in itself. The ultimate finality is that the monitoring becomes an input into the policy dialogue, and thereby helps to make the programme be more

effective and efficient. Monitoring is the means for donors to support and assess the programme.

Tasks

1. Technical follow-up of the progress of AUS

- Follow up and analyse the implementation of AUS and related reporting done by MINSA, DIRESAs, SIS and SUNASA, with a focus on the regions supported by the Belgian Cooperation, and give technical advice to the Attaché in support of the Belgian participation in the 'Mesa de Salud'
- Follow up the effects of the implementation of AUS on service delivery, in particular by using the implementation of the maternal-neonatal program as a marker
- Participate actively in the Technical Working Groups or other exchange fora that are linked to the 'Mesa de Salud' and the 'Mesa PEFA'. Apart from the fora at national level, it may concern also participation in regional exchange fora (in regions with a particular focus of the Belgian-Peruvian Cooperation) according to the opportunity and need
- Establish, maintain and develop good working relations with MINSA, SIS, MEF, SUNASA, DIRESAs, and any other institution that becomes relevant in the implementation of AUS
- Develop, maintain and share in-depth knowledge and understanding of AUS, including through networking with local actors

2. In regards to the Belgian Cooperation

- Provide technical / policy advice to the Attaché with regards to his/her positioning on policy issues concerning AUS
- Report to the Budget Support Working Group with regards to AUS implementation and policy dialogue, as provided in the Vademecum for Budget Support
- Report on the opportunity of disbursement of the different Belgian instalments. The adviser will systematically check whether the conditions for disbursement as defined in the Specific Agreement are met. She/he will then draft a disbursement report and formulate a clear advice to the Attaché in this respect
- Support capitalization in order to feed into future Belgian interventions by documenting the implementation process and sharing experience; exchange expertise and programme results with other Belgian actors involved in the sector and / or in budget support modalities

- Develop networking and synergy with the other Belgian interventions and actors

3. In regards to the Donor Group

- Ensure follow-up and analysis of AUS implementation according to the critical challenges identified in the Technical Note SISFIN or during its implementation phase.
- Actively participate in the Technical Working Groups responsible for the programme follow-up in which the adviser can provide positive contributions
- Participate in the organisation of joint field missions
- Actively support donor coordination towards an active partnership approach to program follow-up and policy dialogue regarding AUS

4. In regards to Budget Support in the framework of AUS

- Monitor risks identified in the SIS-FIN technical note and constructively collaborate with the partner authorities within the policy dialogue to implement mitigation actions. In particular:

- Pay attention that the implementation of AUS remains focused on quality improvement, in particular using the Maternal and Neonatal Program as a marker.

- Follow the decentralization reform and issues related to PFM capacity at regional level
- Facilitate the improvement of the monitoring and evaluation system
- Contribute to institutional capacity development
- Facilitate the resolution of bottlenecks, where needed
- Support coherence and linkage of the programme with the experience and outputs of partners as well as other relevant programmes and projects from other donors
- Where possible, take initiative for research and empirical studies in the sector

Regulatory framework

The follow-up of the Belgian contribution to the BS programme will be done according to the principles and tasks set out in following official documents:

- The Management contract between the Belgian State and BTC
- Vademecum for Budget Support
- Bilateral Agreement on the contribution between Belgium and the partner country
- CMO between DGD and BTC
- MoU signed by the Development partners and partner country
- The Health Policy Note of the Belgian Cooperation 'The Right to Health and Health care' (2009) and its addendum 'Universal Health Coverage' (2012)
- The Conceptual framework of Because Health 'Investing in Health for a greater well-being (2008)
- The Policy Note of the Belgian Cooperation on 'Sexual Rights and Reproductive Health' (2007)
- The Policy note of the Belgian Cooperation 'The Belgian contribution to the international fight against HIV/AIDS' (2006)

Work modalities

In order to ensure the overall coherence of the Belgian health portfolio Work under the supervision of the Belgian BTC Resident Representative (ResRep), in functional support to the Attaché and in close collaboration with the other International Sector expert (cf. SISTEC). The BTC ResRep represents BTC and is therefore the hierarchical superior of the expert. The expert will have an office at the BTC Representation in Lima.

Profile

Degree

- A university degree or post-graduate degree in public health or related, i.e. health economics / health policy / public sector management.

Experience

- Extensive experience (at least 5 years) in supporting the Health Sector of developing and / or transition countries. Knowledge and experience in Health Sector planning is a distinctive asset;
- Experience in the design or implementation of Health Insurance Systems;
- Experience with a specific Health Sector Budget Support program and a Sector-wide Approach in Health is desirable;
- Knowledge and experience in Public Finance Management is desirable;
- Experience in Monitoring and Evaluation methodologies;
- Knowledge and experience in institutional assessment and capacity building;

- Knowledge and experience in Action Research is an asset.

Skills

- Demonstrated interpersonal, coordination, communication, negotiation and diplomatic skills;
- A high degree of questioning business as usual, drive, self-motivation and ability to work independently with minimum supervision;
- Extensive professional experience in a multicultural context;
- Experience with working in Peru and Latin America is an asset;
- Good analytical and writing skills;
- Proficiency in Spanish (speaking – writing – reading – listening)

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31. Ley Nº 27813, Ley del Sistema Nacional Coordinado y Descentralizado de Salud.
32. Ley Nº 28411, Ley General del Sistema Nacional de Presupuesto.
33. Ley Nº 27785, Ley Orgánica del Sistema Nacional de Control y de la Contraloría General de la República.
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5 ANNEXES

5.1 Annex 1: List of persons met

Embajada de Bélgica – Oficina de Cooperación al Desarrollo

- Annelies De Backer, Consejera de cooperación
- Gabriela Elgegren, Adjunta a la consejera de cooperación

Agencia Peruana de Cooperación, APCI

- Liliana La Rosa, Directora de Gestión y Negociación
- Jhonny Rengifo, responsable de la carpeta Bélgica

Unión Europea, delegación en el Perú

- Patrick Gallard, Agregado Civil Sección Cooperación al Desarrollo

Seguro Integral de Salud, SIS

- Pedro Grillo, Jefe Institucional
- Julio Acosta, Jefe adjunto institucional
- Sara Hurtado, Jefe de la Oficina de Planificación y Presupuesto
- Nilda Terrones, Gerente de riesgos y evaluación de las prestaciones
- María Antonoli, Oficina de control interno

Ministerio de Salud, MINSA

- Augusto Portocarrero, Director General Oficina General de Planeamiento y Presupuesto
- Patricia Camac, Jefe de Órgano de control institucional
- Hernán García Cabrera, Director General de la Oficina de Gestión de Recursos Humanos
- José Carlos del Carmen, Viceministro de Salud
- Hernán Roig, Oficina de Cooperación Internacional
- Gladys León, Oficina de Cooperación Internacional

Superintencia Nacional en Salud, SUNASA

- Walter Humberto Castillo Martell, Superintendente
- Mario Ríos Barrientos, Superintendente Adjunto
- Wilfredo Solís, Secretario General.
- Edson Aguilar, Asesor del Superintendente
- Rosa Díaz, Asesora de la Secretaría General
- Carlos Maldonado, Director Oficina General de Tecnologías de la Información.
- Elsa Bustamante, Intendencia de Atención al Ciudadano y Protección al Asegurado
- Henry Maquera, Intendencia de Supervisión de las Instituciones Administradoras de Fondos de Aseguramiento en Salud
- Julio Ríos, Intendencia de Supervisión de las Instituciones Prestadoras de Servicios de Salud

- Oswaldo Jave, Intendencia de Estudios y Gestión de la Información y el Conocimiento

Unidad Desconcentrada Huancavelica, UDR SIS

- Marco Antonio Arzapalo Nùñez, Representante (e)
- Wilson Cruz Sinche, Contable Administrador
- Pedro Dueñas Crispin, Médico Supervisor

Dirección de Salud de Huancavelica, DIRESA

- Enma Poma Salinas, Directora de Salud de las Personas
- Noelia Cacho Maldonado, Directora de Seguros Públicos y Privados

Ministerio de Economía y Finanzas, MEF

- Hedy Huarcaya Vasquez, Asesora coordinadora de proyectos con CT para la Dirección General de Presupuesto Público.
- Nelly Zenaida Huamaní Huamaní, Coordinadora de convenios de apoyo Presupuestario en Salud, Dirección de Presupuesto Temático, Dirección General de Presupuesto Público.

FOS

- Félix De White, representante de FOS

Organización Panamericana de la Salud-OPS

- Carlos Arósquipa Rodríguez, consultor en Recursos humanos y Cooperación Subregional Andina

Cooperación Italiana

- Chiara Ceccon, coordinadora de Programa de Asistencia Técnica al Ministerio de Salud
- Valentino Luzi, coordinador del programa binacional de integración transfronteriza en el corredor Piura- Loja

Foro de la Sociedad Civil en Salud

- Ariel Frisancho, coordinador nacional
- Stephanie Jeri, secretaria ejecutiva

Banco Mundial

- Rory Narvaez, Senior Operations Officer

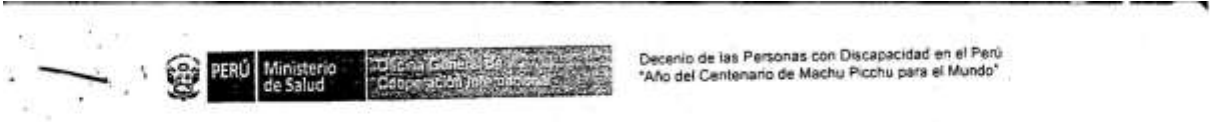
USAID

- Luis Seminario, Especialista en Gestión de Proyectos de educación y salud
- Evelyn Rodríguez, especialista en gestión de proyectos de educación y salud
- Alfredo Sobrevilla, Jefe de proyecto Políticas en Salud
- Patricia Mostajo, adjunta al jefe políticas en salud
- Rocío Mosquera, profesional en políticas en salud

PARSALUD

- Walter Vigo, coordinador general

5.2 Annex 2: Memorandum Of Understanding



CARTA DE INTENCIONES DE COOPERACION INTERNACIONAL PARA EL ASEGURAMIENTO UNIVERSAL EN SALUD

Lima, marzo de 2011

Contexto

El Aseguramiento Universal en Salud, en adelante el AUS, busca disminuir la exclusión e inequidades en salud, así como promover y proteger la salud de todos los habitantes mediante el acceso garantizado a la atención de salud con criterios de calidad y oportunidad para un conjunto de prestaciones definidas, denominado el **Plan Esencial de Aseguramiento en Salud, en adelante PEAS** en los establecimientos de salud públicos y privados.

El **AUS** es la parte central de la reforma en salud y constituye un gran esfuerzo político, producto del consenso entre los partidos políticos y la sociedad civil, liderado por el Jefe de Estado y el Ministro de Salud. Cuenta con el soporte técnico apropiado, articula las diferentes instancias y actores del Sector, configurando la normativa para que este proceso que ha comenzado en las regiones más pobres del país garantice el derecho a la salud con sus extraordinarios beneficios.

En armonía con las políticas y normas que emita el Ministerio de Salud, los Gobiernos Regionales conducen en su territorio el desarrollo del proceso de aseguramiento.

La implementación del **AUS** busca:

1. Garantizar los derechos a la atención de salud de toda la población, en términos de acceso, oportunidad, calidad y financiamiento.
2. Proteger a las familias de los riesgos de empobrecimiento asociado a eventos de enfermedad.
3. Mantener y mejorar los resultados sanitarios y así contribuir a elevar la productividad del capital humano y reducir la pobreza.

Prioridades para el **AUS**

1. Consolidar y ampliar la cobertura poblacional del **AUS**.
2. Fortalecer la oferta sectorial de servicios de salud para el otorgamiento del **PEAS.**
3. Gestionar el financiamiento ~~del~~ **AUS**
4. Fortalecer la conducción nacional, regional y local del **AUS**

Principios de Cooperación

Siendo crucial la sinergia de esfuerzos y capacidades, se formulan los siguientes principios de cooperación:

1. El Ministerio de Salud del Perú ejerce liderazgo sobre las políticas de salud, en particular sobre la política del **AUS** y las estrategias para su implementación
2. Los **Socios para el Desarrollo, en adelante SD** basan su cooperación en los lineamientos de política de Cooperación Internacional de la Agencia Peruana de Cooperación Internacional (APCI), las estrategias nacionales de salud prioritarias como el **AUS**, las instituciones y sus procedimientos.
3. Las acciones de los **SD** aumentan su eficacia cuando son concordantes y armonizadas con las políticas nacionales y se ejercen de manera transparente.
4. La gestión de los recursos de cooperación y la toma de decisiones deben estar orientadas a resultados.
5. El Perú es responsable de los resultados del **AUS** y los **SD** coadyuvan al logro de éstos.

Intenciones de las Partes

I. El gobierno nacional a través del MINSA manifiesta su intención de:

1. Coordinar la cooperación técnica y financiera para el **AUS** en Salud en el marco de los lineamientos de la APCI, promoviendo el diálogo permanente con los **SD** y fomentando la participación de los sectores e instituciones involucradas en el **AUS** (público, privado, mixto y sociedad civil).

2. Garantizar la sostenibilidad de los avances logrados en Salud Pública en el Perú y continuar haciendo esfuerzos por fortalecer este componente a fin de complementar las acciones emprendidas en la implementación del **AUS**.

3. Conducir la "Mesa Interagencial de Cooperantes para el **AUS** siendo éste un espacio creado para promover la concertación y el diálogo para la implementación de la política del **AUS** de forma eficaz y con transparencia.

4. Asegurar que las actividades asociadas al **AUS** reciban el nivel de compromiso político, un marco legal financiero y de políticas adecuado para su implementación exitosa.

5. Traducir las estrategias en programas y proyectos priorizados y orientados a resultados de acuerdo a lo expresado en la Ley Marco de **AUS** y su Reglamento y en el Plan de Implementación Nacional del **AUS.**

6. Fomentar la participación activa de los actores del **AUS** en la formulación y evaluación de los avances en la implementación de las estrategias, programas y proyectos.

7. Garantizar que los recursos recibidos de los **SD** sean invertidos en cubrir gastos asociados a los planes e implementación del **AUS** siguiendo los procedimientos y regulaciones nacionales.

8. Gestionar de manera oportuna los recursos humanos, institucionales y otros que pueden ser requeridos para la implementación del **AUS.**

9. Fomentar el buen gobierno, la rendición de cuentas e integridad, incluida la lucha contra la corrupción en la implementación de la Política de **AUS**.

10. Promover que el presupuesto y la gestión financiera a nivel nacional y regional se desarrollen con eficiencia y transparencia.

11. Promover que los Gobiernos Regionales incluyan el **AUS** entre sus prioridades

12. Incidir ante el MEF para que el financiamiento para el **AUS** esté disponible oportunamente.

13. Compartir información de los resultados de las auditorias financieras del nivel nacional ejecutadas por la Contraloría de la República con los socios de manera oportuna, en los casos que sea necesario.

14. Impulsar el fortalecimiento del Primer Nivel de Atención, en los tres niveles de gobierno, promoviendo la mejora de los procesos de gestión y organización de servicios, eficiencia de las prestaciones y alineamiento del financiamiento para asegurar los recursos e insumos que incrementen su capacidad resolutiva.

15. Promover el fortalecimiento de la articulación intersectorial y comunitaria para la implementación de las estrategias, programas y proyectos del **AUS** en el nivel Local.

16. Fortalecer el componente de regulación y supervisión de la implementación del **AUS** a través de la **Superintendencia Nacional de Aseguramiento en Salud,** en adelante **SUNASA**, quién velará por el cumplimiento de los planes ofrecidos por las **Instituciones Administradoras de Fondos de Aseguramiento en Salud - IAFAS** y por la calidad y oportunidad en los servicios que brinden las **Instituciones Prestadoras de Salud - IPRESS** a los asegurados, además de ello, la **SUNASA** fomentará la participación de los asegurados en defensa de sus derechos.

17. Fortalecer la rectoría y gobernanza global del Sistema de Salud así como la gerencia del cambio hacia un sistema de protección social de salud inclusivo, menos segmentado y de calidad que aseguren el acceso a servicios principalmente a aquellos grupos poblacionales más vulnerables.

II. Los SD manifiestan su intención de:

1. Reconocer el liderazgo del Ministerio de Salud y cooperar para el fortalecimiento de sus capacidades en el nivel nacional, regional y local.

2. Articular la ayuda y cooperación a la política **AUS** (estrategias, diálogo y programas de cooperación técnica y financiera u otros) en base a las estrategias nacionales definidas para su implementación, así como en evaluaciones de sus avances.

3. Articular las iniciativas de cooperación técnica y financiera con resultados e indicadores derivados de planes nacionales como el Plan Nacional de Implementación del **AUS** y de los Planes Regionales del **AUS**. Cada socio buscará coordinar y adecuar su apoyo en ese marco buscando la sostenibilidad.

4. En base a la disponibilidad de recursos, diseñar planes relativos a la cooperación financiera en un marco multianual para coordinar el desembolso de la ayuda o de los proyectos de asistencia técnica de manera oportuna de acuerdo al cronograma establecido en el Plan de Implementación de la Política de Aseguramiento Universal, según sea el caso y sujeto a procesos de aprobación interna.

5. Proporcionar información completa y oportuna, sujeto a aprobación interna, sobre la ejecución de los procesos y compromisos de cooperación asumidos con el objetivo de transparentar resultados y mejorar las estrategias de abordaje e intervención.

6. Promover la captación de recursos de diferentes fuentes en apoyo a la implementación del **AUS.**

7. Instruir a sus proyectos, Organismos No Gubernamentales - **ONG** y Entidades e Instituciones Extranjeras de Cooperación Técnica Internacional - **ENIEXs** relacionadas, para que participen en una Mesa de Coordinación en apoyo a la implementación del **AUS**, según sea el caso.

8. Articular los esfuerzos, capacidades y recursos en pro del diseño e implementación del Plan Nacional de Fortalecimiento del Primer Nivel de Atención en el marco del **AUS**

PERÚ Ministerio de Salud | Oficina General de Cooperación Internacional

III. El gobierno nacional a través del MINSA, y los socios para el desarrollo manifiestan su intención de:

1. **Constituir la Mesa Interagencial de Cooperación para el Aseguramiento Universal en Salud**, definir su organización, funcionamiento, apoyar la instalación de la Mesa de proyectos, **ENIEXs** y **ONG** involucradas en salud y aprobar el plan de trabajo que elaboren con productos esperados y mecanismos de verificación de logros.

2. Facilitar el fortalecimiento de las estrategias para el **AUS** y sus marcos operativos (por ej.: planificación, presupuesto y marcos de evaluación del desempeño).

3. Trabajar conjuntamente para la implementación del **AUS**; asimismo, se garantizará la transparencia, disponibilidad y el flujo de la información para el análisis y diagnóstico respectivo.

4. Facilitar el desarrollo y aplicación de mecanismos de seguimiento y evaluación de la implementación del **AUS**, incluyendo la elaboración de una línea de base.

5. Trabajar conjuntamente para promover el adiestramiento e intercambio de lecciones aprendidas y construir una comunidad de buenas prácticas.

6. Trabajar conjuntamente en enfoques participativos, rendición de cuentas y transparencia, fortaleciendo las capacidades para una gestión basada en resultados.

7. Analizar conjuntamente los resultados de los compromisos acordados sobre la eficacia de la cooperación en el **AUS** y promover la movilización de recursos de todo tipo en apoyo a la reforma.

El Ministro de Salud del Perú, la APCI y los representantes de instituciones de cooperación y desarrollo multilaterales y bilaterales, abajo firmantes, resueltos a emprender acciones de mediano y largo alcance con vistas a implementar el **AUS**, reconocen la necesidad de establecer sinergias y trabajar articuladamente para complementar eficazmente las iniciativas en salud que se vienen implementando.

Por iniciativa conjunta y estando de acuerdo en la necesidad planteada, la **"Mesa Interagencial de Cooperación para el AUS"**, se constituye como un espacio creado para el diálogo, la participación, el trabajo conjunto, armonizado y concertado con los actores de la cooperación internacional quienes se instituyen en socios estratégicos del desarrollo de esta importante reforma sanitaria.

Las instituciones firmantes dejamos explícita nuestra voluntad de facilitar el cumplimiento de estas iniciativas a fin de contribuir al éxito del **AUS**.

Las instituciones firmantes reconocen que esta carta de intenciones no obliga fondos financieros, y específicamente reconocen que esta carta de intenciones no conduce a ninguna obligación legal (financiera u otras) de parte de las instituciones firmantes, sino estrictamente la intención de trabajar juntos para alcanzar objetivos comunes.

Cualquier y todas las modificaciones de esta carta de intenciones deben ser negociadas en mutuo acuerdo.

Esta carta de intenciones entrará en vigor desde la fecha de su firma y estará vigente durante la implementación de la Política de Aseguramiento Universal en Salud en el Perú. Cualquiera de las

instituciones firmantes puede rescindir totalmente con esta carta de intenciones notificando su intención de término con 30 días de anticipación, sin tener ninguna obligación entre las partes.

LISTA DE SOCIOS PARA EL DESARROLLO DE LA SALUD

ONUSIDA

UNICEF

USAID

UNFPA
ESTEBAN CAGALLERA

Min. Relaciones Exteriores

SIS

Dr. LUIS FERNANDO LEANES
Representante OPS/OMS en Perú

MINSA - GAAD

5

5.3 Annex 3: Specific Agreement

CONVENIO ESPECÍFICO

entre

la República del Perú

y

el Reino de Bélgica

relativo al

"Programa de Apoyo a la implementación de la política de aseguramiento universal en salud, a través del SIS - Componente de Apoyo Presupuestal"

La República del Perú, citado en adelante como "Perú", por una parte

y

el Reino de Bélgica, citado en adelante como “Bélgica”, por otra

Denominados en lo sucesivo « las Partes »;

- Visto el Convenio General de Cooperación Bilateral establecido entre el Reino de Bélgica y la República del Perú firmado en Lima el día 15 de octubre de 2002.
- Vista el acta aprobada de la Comisión Mixta celebrada entre las Partes en Lima el día 24 de Septiembre 2009, Anexo 1 "Bélgica-Perú Programa Indicativo de Cooperación (PIC) 2010 - 2013".
- Vista la Carta de Intenciones de Cooperación Internacional para el Aseguramiento Universal en Salud para el seguimiento conjunto entre el Gobierno del Perú y los Socios al Desarrollo del sector salud, con respecto a los Principios de Partenariado para el Apoyo a la implementación del Aseguramiento Universal en Salud, firmado por Bélgica el día ….

disponen lo siguiente:

ARTÍCULO 1 - Definición y objeto del convenio

Mediante el presente Convenio específico, Bélgica se compromete a brindar un apoyo financiero al “programa presupuestal salud materno neonatal” para contribuir en la implementación de la política de aseguramiento universal a través del SIS. Este convenio se desarrolla como parte del Programa de Apoyo a la implementación de la política de aseguramiento universal en salud, a través del SIS - Componente de Apoyo Presupuestal

El objetivo general de este Programa de cooperación es “El derecho de toda persona en situación de pobreza y pobreza extrema a servicios de salud de calidad ha sido garantizado mejorando el nivel de salud de la población”.

El objetivo específico de este Programa de cooperación es: «Al 2016, la cobertura de afiliación y de beneficios del Seguro Integral de Salud ha sido extendida con garantías de calidad implementadas para hombres, mujeres, niños y niñas en situación de pobreza y extrema pobreza, según sus necesidades diferenciadas, en regiones priorizadas del país en el marco del Aseguramiento Universal en Salud»

ARTÍCULO 2 - Responsabilidades de las Partes

2.1 La Parte belga designa a:

2.1.1. La Dirección General de la Cooperación al Desarrollo, denominada en lo sucesivo la "DGD", del Servicio Público Federal (SPF) de "Asuntos Exteriores, Comercio Exterior y Cooperación al Desarrollo", como la entidad administrativa responsable de su contribución al Programa de Apoyo a la implementación de la política de aseguramiento universal en salud, componente ayuda presupuestal. La DGD está representada en el Perú por el Consejero/Agregado de la Cooperación al Desarrollo de la Embajada en Lima.

2.1.2 La "Cooperación Técnica Belga", sociedad anónima belga de derecho público con finalidad social, denominada en adelante la "CTB", como el órgano responsable de la participación belga en lo relativo al seguimiento de la implementación del Programa de Apoyo a la implementación de la política de aseguramiento universal en salud, componente ayuda presupuestal y de la transferencia de fondos. La CTB está representada en el Perú por su Representante Residente en Lima.

2.2 La Parte peruana designa a:

2.2.1 La Agencia Peruana de Cooperación Internacional, en adelante denominada "APCI", como la entidad peruana responsable de la coordinación con la Embajada de Bélgica en Lima.

2.2.2 El Ministerio de Economía y Finanzas, en adelante denominado "MEF", como la entidad responsable de la ejecución financiera del Apoyo Presupuestal.

2.2.3 El Seguro Integral de Salud, organismo público descentralizado del Ministerio de Salud en adelante denominado el "SIS", como la entidad peruana responsable de la supervisión, seguimiento y monitoreo del apoyo presupuestal.

ARTÍCULO 3 - Contribución de las Partes y desembolsos

3.1 El importe total de la contribución belga al apoyo presupuestales de 6.500.000 euros (seis millones y medio de euros) por un periodo total de tres años (2013-2015).

Un primer desembolso de € 2.000.000 para el presupuesto 2013 del Perú será transferido después de la entrada en vigor del Convenio Específico.

Un segundo desembolso de € 2.500.000 euros para el presupuesto 2014 del Perú será trasferido después de:

- Aprobación del presupuesto 2014 del SIS, así como del Plan Operativo Anual 2014 del SIS
- Aprobación del reporte técnico y financiero 2012 del Programa Salud Materno-Neonatal (y/o Informe de Desempeño Anual 2012)
- Presentación del reporte de auditoría positivo del SIS del 2011

Un tercer y último desembolso de € 2.000.000 euros para el presupuesto 2015 del Perú será transferido después de:

- Aprobación del presupuesto 2015 del SIS, así como del Plan Operativo Anual 2015 del SIS

- Aprobación del reporte técnico y financiero 2013 del Programa Salud Materno-Neonatal (y/o Informe de Desempeño Anual 2013)

- Presentación del reporte de auditoría positivo del SIS del 2012

Bélgica transferirá su contribución a la cuenta receptora de donaciones del Tesoro Público del MEF en la Dirección Deneral de Endeudamiento y Tesoro Público, tal y como indique el mismo ministerio.

En el lapso de un mes después de la transferencia realizada por Bélgica, el MEF informará al SIS del depósito efectuado. Por otro lado enviará un reporte del estado de cuenta emitido por la Dirección de Endeudamiento y Tesoro Público al Representante Residente de la CTB en Lima, para confirmar el importe recibido.

3.2 En caso de una auditoria negativa, se necesita una respuesta del Seguro Integral de Salud y del Ministerio de Economía y Finanzas. Un plan de acción para la implementación de la respuesta deberá ser presentado por la Parte Peruana y deberá ser aprobado por los Socios para el Desarrollo (o "los donantes principales al Aseguramiento de Salud"). Esto constituye una condición suficiente para la transferencia de los fondos.

3.3 El desembolso previsto podrá ser postergado o incluso anulado si se detectase un caso evidente de fraude, si éste no hubiese sido subsanado correctamente tras haber sido detectado y notificado. De registrarse usos graves inadecuados de la transferencia de los fondos, Bélgica se reserva el derecho de exigir de forma unilateral o conjunta, el reembolso total o parcial de los fondos.

3.4 Adicionalmente, la Parte Belga financiará y contratará a un experto senior de aseguramiento universal en salud. Este experto formará parte del personal de la Representación Residente de la CTB y será financiado directamente por la Parte Belga con fondos adicionales a la donación de seis millones y medio de euros mencionada en el artículo 3.1.

3.5 El personal contratado según el numeral anterior que fuere puesto a disposición del programa por la CTB como extranjero residente, con visa oficial otorgada por el lapso de duración del presente Convenio y que no sea de nacionalidad peruana, gozará de los privilegios e inmunidades a los que hace referencia el articulo 8 del "Convenio General de Cooperación Internacional entre el Reino de Bélgica y la República del Perú", suscrito el 15 de octubre de 2002, así como de aquellos otros beneficios que les fueran aplicables de conformidad a lo estipulado con la legislación peruana vigente sobre la materia.

3.6 La parte peruana expedirá al personal antes mencionado un carnet de identidad para extranjeros y los visados que sean necesarios, conforme a su legislación, según las modalidades vigentes para los expertos de las Naciones Unidas que desempeñan funciones en el Perú.

ARTÍCULO 4 - Implementación de la Contribución

4.1 El MEF, conjuntamente con el SIS, suscribe Convenios de Apoyo Presupuestal de cumplimientos de compromisos con los Gobiernos Regionales.

4.2 Los Gobiernos Regionales elevan su informe al SIS sobre el cumplimiento de las metas, según lo acordado en los Convenios mencionados en el punto 4.1.

4.3 El SIS es responsable de la revisión y verificación del cumplimiento de los compromisos de los Gobiernos Regionales y de informar al respecto al MEF.

4.4 El MEF autoriza las transferencias de las donaciones, previo informe del SIS, a los gobiernos regionales para que incorporen en sus presupuestos de las unidades ejecutoras comprendidas en los Convenios suscritos.

ARTÍCULO 5 - Seguimiento, control y evaluación

5.1 Las partes adoptarán todas las medidas administrativas y presupuestarias necesarias para alcanzar los objetivos del presente Convenio Específico, incluyendo controles o evaluaciones de tipo técnico, administrativo y financiero, tanto de forma conjunta como por separado. Las partes deberán informarse mutuamente acerca de los resultados y posibles recomendaciones de dichas prácticas de control y evaluación.

5.2 Una Revisión Sectorial Conjunta con el SIS será organizada como mínimo una vez al año. La misión verificará el desempeño del SIS durante el periodo anterior y se llegará a un acuerdo sobre las prioridades del SIS y la asignación de recursos para el siguiente año financiero.

5.3 La CTB es responsable de la participación belga en el seguimiento de la implementación del Programa en estrecha colaboración con el Consejero/Agregado de Cooperación de la Embajada de Bélgica en Lima. El experto técnico belga, suministrado por la CTB y establecido en Lima el cual trabajará estrechamente con los demás Socios al Desarrollo y en el marco los mecanismos de seguimiento existentes.

5.4 El punto de atención principal belga en el marco del diálogo político versará sobre los temas relacionados con la implementación del Aseguramiento Universal en Salud, el aumento del gasto per capita en el sector salud con un enfoque pro-pobre y de género, la calidad de los servicios, la coordinación de los diferentes actores bajo la rectoría del MINSA, la promoción de un enfoque de derechos humanos en el sector salud y del rol de la sociedad civil como actores claves de la vigilancia ciudadana para institucionalizar un diálogo abierto con los diferentes actores del Estado.

ARTÍCULO 6 - Duración, rescisión, modificación y conflictos.

6.1 El presente Convenio entrará en vigor en la fecha en que el Reino de Bélgica reciba notificación escrita, por parte de la República del Perú, comunicando que éste ha cumplido los procedimientos internos necesarios para tal efecto y, a partir de dicho momento tendrá una duración de 48 meses, plazo que no podrá ser ampliado.

La ejecución del programa tiene una duración de 36 meses.

6.2 Las disposiciones del presente Convenio pueden ser modificadas de mutuo acuerdo, mediante un intercambio de Notas entre las Partes.

6.3 Cualquier conflicto relativo a la aplicación o a la interpretación del presente Convenio será resuelto por vía de negociación bilateral.

6.4 El presente convenio puede ser rescindido por cada una de las Partes mediante nota verbal, con un preaviso de seis meses.

ARTÍCULO 7 - Notificaciones

Las notificaciones previstas por el presente Convenio y en particular aquellas que versen sobre su modificación o su interpretación, serán transmitidas por vía diplomática a las direcciones siguientes:

- Por la Parte belga, a:

  Oficina de Cooperación al Desarrollo

  Embajada de Bélgica

  Avenida Angamos Oeste, 380

  Miraflores, Lima 18, Perú

- Por la Parte peruana, a:

  Agencia Peruana de Cooperación Internacional – APCI

  Avenida José Pardo, 261

  Miraflores, Lima 18, Perú

Las notificaciones o la correspondencia relativa a la ejecución del presente Convenio Específico se enviarán a las siguientes instituciones:

- Por la Parte belga, a:

  Representación residente de la Agencia belga de desarrollo - CTB

  Calle Felix Olcay 389

  Miraflores, Lima 18, Perú

- Por la Parte peruana, a :

  Ministerio de Economía y Finanzas

  Dirección General de Presupuesto Público

  Jr. Junín N° 319 – 1er Piso

  Lima Cercado, Lima 1, Perú

  y

  Seguro Integral de Salud

  Calle Carlos Gonzáles Nº 212-214

  Urb. Maranga

  San Miguel, Lima 32, Perú

ARTÍCULO 8 - Disposiciones finales

En fe de lo cual, los abajo firmantes, debidamente autorizados para ello, han firmado el presente Convenio específico.

Hecho en Lima, el ……..de … …..del 2013, en cuatro (4) ejemplares, 2 (dos) en francés y 2 (dos) en español.

Por la República del Perú	***Por el Reino de Bélgica***
Ministro de Relaciones Exteriores	*Embajadora de Bélgica en Lima*

5.4 Annex 4: Budget de Convention de Mise en Œuvre

Code Budget	Description des postes budgétaires	Code Tâche	Code Secteur	Coût unitaire	Nombre	COUT TOTAL CONTRIBUTION BELGE	2013		2014		2015		2016		2017	
							1ier semestre	2ième semestre	3ième semestre	4ième semestre	5ième semestre	6ième semestre	7ième semestre	8ième semestre	9ième semestre	10ième semestre
	Prix : *Expertise*															
A_01_01	Expert(e) technique (homme habillé)	Régie		15,000	48	***720,000.00***		90,000.00	90,000.00	90,000.00	90,000.00	90,000.00	90,000.00	90,000.00	90,000.00	
A_01_02	Mission de l' expert(e)	Régie		7,922	5	***39,672.00***		6,660.00	11,292.00		9,460.00		9,460.00		2,800.00	
A_01_03	Coûts de fonctionnement	Régie		1,350	48	***64,800.00***		8,100.00	8,100.00	8,100.00	8,100.00	8,100.00	8,100.00	8,100.00	8,100.00	
A_01_04	Investissements	Régie		3,000		***3,000.00***		3,000.00								
A_01_05	Participation Review mission expert CTB	Régie		3,000	6	***18,000.00***		3,000.00		6000.00		3000.00		6,000.00		
A_01_06	Consultancy	Régie				***100,000.00***	0.00	12,500.00	25,000.00		25,000.00		25,000.00		12,500.00	
	SOUS TOTAL					***945,472.00***	**0.00**	**123,260.00**	**134,392.00**	**104,100.00**	**132,560.00**	**101,100.00**	**132,560.00**	**104,100.00**	**113,400.00**	
	Prix*: Bénéfices*					***0.00***										
	1%					***9,454.72***	0.00	1,232.60	1,343.92	1,041.00	1,325.60	1,011.00	1,325.60	1,041.00	1,134.00	
	SOUS TOTAL PRIX					***954,926.72***	***0.00***	***124,492.60***	***135,735.92***	***105,141.00***	***133,885.60***	***102,111.00***	***133,885.60***	***105,141.00***	***114,534.00***	
	Don: Contribution au "Programme"					***0.00***										
B_01_01	Art. 3 point 3.5 Convention Spécifique	Aide budgétaire				***6,500,000.00***	2,000,000.00		2,500,000.00		2,000,000.00					
	SOUS TOTAL DON					***6,500,000.00***	2,000,000.00	0.00	2,500,000.00	0.00	2,000,000.00	0.00	0.00	0.00	0.00	
	TOTAL					***7,454,926.72***	**2,000,000.00**	**124,492.60**	**2,635,735.92**	**105,141.00**	**2,133,885.60**	**102,111.00**	**133,885.60**	**105,141.00**	**114,534.00**	

5.5 Annex 4 bis : Détail budgétaire pour le fonctionnement de l'expertise (lignes A_01_02 à A_01_04)

		Montant Total	**Périodicité**	2013	2014	2015	2016	2017	**Total**
MISSIONS									
International (10 jours)		***3,860***	Annuelle	3,860	3,860	3,860	3,860		15,440
Billet d'avion + transport	2,000								
Logement	1,000								
Per diem	860								
Regional (7 jours)		***1,832***	1		1,832				1832
Billet d'avion + transport	600								
Logement	679								
Per diem	553								
National (5 jours)		***700***	8/an	2,800	5,600	5,600	5,600	2,800	22,400
Billet d'avion + transport	200			6,660	11,292.00	9,460	9,460	2800	**39,672**
Logement	333								
Per diem	167								
COÛTS DE FONCTIONNEMENT		**1350**	Mensuelle						
Téléphone	150								
Internet (10%)	50								
Loyer (10%) et bureau	225								
Services (10% eau, electricité, entretien, IT)	225								
Fournitures de bureau & imprimés	200								
Transport (taxi)	300								
Personnel RR (5% Secretaire, Comptable & Collaborateur polyvalent)	200								
INVESTISSEMENT		**3,000**	Au début						
Ordinateur	1900								
Imprimante	600								
Armoire	500								

NB: Il a été recommandé de ne pas investir dans une voiture pour l'expert international. Ceci sera compensé par un budget de mission adapté afin de permettre à l'expert de se rendre sur le terrain par les moyens les plus appropriés en fonction de la destination (transport public, location de voiture, vols nationaux).

5.6 Annex 5: Informe 007-2012-3-0186

Informe Corto de Auditoría Financiera ejercicio económico 2011

See file hereby.

5.7 Annex 6 : Informe 008-2012-3-0186

Informe 008-2012-3-0186 Informe Largo de Auditoria Financiera ejercicio económico 2011

See file hereby.

5.8 Annex 7 : 3. Informe 009 y 10-2012-3-0186

Informe 009 y 10-2012-3-0186 Informes del Examen Especial a la información presupuestaria ejercicio económico 2011

See file hereby.