Overview

Peru is a middle-income country of more than 31 million people, around three fourths of whom live in urban areas. The Peruvian health care system is a four-tier system, including the following: public (Ministry of Health and district facilities, police and armed forces facilities); the social insurance system (EsSalud); and private for-profit and private not-for-profit (nongovernmental organization and religious) facilities.

Primary health care (PHC) is provided through a doctor-supported infrastructure comprising over 10 200 health centres and health posts. These facilities are free for beneficiaries of the public Integral Health Insurance (Seguro Integral de Salud, SIS). The PHC system and the conditional cash transfer programme (Juntos) have made significant progress in maternal, child and sexual and reproductive health. Significant progress has also been observed in combating tuberculosis (with over 30 000 people assisted), malaria and other vector-borne diseases, sexually transmitted infections, HIV (with antiretroviral therapy provided to over 64 000 people), and mother-to-child transmission of HIV. In parallel, PHC is also provided by private, fee-for-service general practitioners, as well as traditional healers.

Progress in provision of PHC has been achieved in Peru since the 1990s with an increase in the number of public PHC facilities and the implementation of the initial public health insurance (free school insurance and mother-child insurance), facilitated by the economic growth and political stability over the last 15 years.

Peru reported a slow decline in the Gini coefficient from 0.492 in 2004 to 0.436 in 2014, and 0.35 in 2015. In the health sector, these inequalities are visible as stark differences between two realities: a well-resourced, insurance-based private sector serving only 32% of the population, but consuming around 70% the total funds flowing through the health sector in the country; and the tax-funded, public health system providing care for the remaining 68%.

The Peruvian burden of disease study of 2013 found that the greatest number of healthy life-years lost were due to neuropsychiatric diseases (26%), unintentional injuries (13%), perinatal conditions (10%) and cardiovascular diseases (8%). The main causes of healthy life-years lost are traffic accidents, lower tract respiratory infections, alcohol abuse, low birthweight, depression, chronic childhood malnutrition, osteoarthritis, neonatal asphyxia, diabetes mellitus and cerebrovascular accidents.

There is still general consensus that public PHC facilities provide low quality of health care, with inadequate provision of drugs and supplies, together with a very low proportion of gross national income spent on health (5.5% of gross domestic product (GDP), or 60.6% of health expenditure for the public sector), leading to expectations that health outcomes will be poor.

Table 1 summarizes demographic and health indicators for Peru.

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Three periods are identified in the development of the PHC strategy in Peru, dating back to the 1960s (Figure 1). The first period, from the 1960s to the 1980s, mainly focused on a theoretical analysis of the scope of PHC. The second period, following the Alma Ata Declaration on Primary Health Care (1978), involved some development of PHC experiences, though these were characterized by being generally selective and localized in specific areas of the country, sponsored by international cooperation. Some of these initiatives included the Rural Medicine Programme (Programa de Medicina Rural) in Puno; the Primary Health Care Project in Loreto (Red Barnet and Cayetano Heredia Peruvian University, 1992–1998); the Primary Health Care and Basic Sanitation Project (Proyecto de Atención Primaria de Salud y Saneamiento Básico in Cajamarca, APRISABAC), 1991–2000; Project 2000 (1993–2002); the Basic Health and Nutrition Project (Proyecto Salud y Nutrición Básica), 1994–2000; the New

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<thead>
<tr>
<th>Indicator</th>
<th>Results</th>
<th>Sources of information</th>
<th>Year</th>
<th>Source links</th>
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<tr>
<td>Total population of country</td>
<td>31,151,643</td>
<td>INEI</td>
<td>2015</td>
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<td>Population growth rate (% annual)</td>
<td>1.1</td>
<td>INEI</td>
<td>2015</td>
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<td>Population density (people/sq km)</td>
<td>24.2</td>
<td>INEI</td>
<td>2015</td>
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<tr>
<td>Distribution of population (rural/urban)</td>
<td>0.3037622</td>
<td>INEI</td>
<td>2015</td>
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<tr>
<td>GDP per capita</td>
<td>15,501 Peruvian Sol</td>
<td>INEI</td>
<td>2015</td>
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<td>Income or wealth inequality (Gini coefficient)</td>
<td>0.35</td>
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<td>2015</td>
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<tr>
<td>Life expectancy at birth (years)</td>
<td>75.1</td>
<td>INEI</td>
<td>2015</td>
<td><a href="https://www.inei.gob.pe/media/MenuRecursivo/">https://www.inei.gob.pe/media/MenuRecursivo/</a></td>
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<tr>
<td>Infant mortality rate</td>
<td>15.3 Per 1000 live births</td>
<td>INEI</td>
<td>2015</td>
<td><a href="http://proyectos.inei.gob.pe/endes/ppr.asp">http://proyectos.inei.gob.pe/endes/ppr.asp</a></td>
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<tr>
<td>Under-5 mortality rate</td>
<td>18 Per 1000 live births</td>
<td>INEI</td>
<td>2015</td>
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<tr>
<td>Maternal mortality rate</td>
<td>93 Per 100,000 live births</td>
<td>INEI</td>
<td>2004–2010</td>
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<tr>
<td>Immunization coverage under 1 year (including pneumococcal &amp; rotavirus)</td>
<td>69.4%</td>
<td>INEI</td>
<td>2015</td>
<td><a href="https://www.inei.gob.pe/">https://www.inei.gob.pe/</a></td>
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<tr>
<td>Total health expenditure as proportion of GDP</td>
<td>5.5%</td>
<td>World Bank</td>
<td>2014</td>
<td><a href="http://datos.bancomundial.org/indicador/SH.XPD.TOTL.ZS">http://datos.bancomundial.org/indicador/SH.XPD.TOTL.ZS</a></td>
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<tr>
<td>Public expenditure on health as proportion of total expenditure on health</td>
<td>60.6%</td>
<td>World Bank</td>
<td>2014</td>
<td><a href="http://data.worldbank.org/indicator/SH.XPD.PUBL">http://data.worldbank.org/indicator/SH.XPD.PUBL</a></td>
</tr>
<tr>
<td>Out-of-pocket payments as proportion of total expenditure on health</td>
<td>72.7%</td>
<td>World Bank</td>
<td>2014</td>
<td><a href="http://data.worldbank.org/indicator/SH.XPD.OOPC.ZS">http://data.worldbank.org/indicator/SH.XPD.OOPC.ZS</a></td>
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<tr>
<td>Number of physicians per 1000 population</td>
<td>2.17</td>
<td>INEI</td>
<td>2015</td>
<td><a href="https://www.inei.gob.pe/media/MenuRecursivo/">https://www.inei.gob.pe/media/MenuRecursivo/</a></td>
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<tr>
<td>Number of nurses per 1000 population</td>
<td>2.51</td>
<td>INEI</td>
<td>2015</td>
<td><a href="https://www.inei.gob.pe/media/MenuRecursivo/">https://www.inei.gob.pe/media/MenuRecursivo/</a></td>
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INEI: National Institute of Statistics and Informatics (Instituto Nacional de Estadística e Informática).
Initiative Project (Proyecto Una Nueva Iniciativa); the Basic Health for All Programme (Programa Salud Básica para Todos), 1992–2000; and the Local Health Administration Committees (Comités Locales de Administración de Salud, CLAS) project, 1994–2006.

The third period has evolved during the new century. In 2003, the Ministry of Health formulated and formalized, through Ministerial Resolution No. 729–2003-SA/DM, the Comprehensive Health Care Model (Modelo de Atención Integral de Salud, MAIS), which signified a fundamental reform of public health. MAIS introduced a new approach that focuses on health needs to guide the way health services are organized and run. The most important changes and advances of this period are the incorporation of forms of extramural care provided by basic health teams; mobile health solutions for dispersed populations (with itinerant teams or brigades providing comprehensive health care); the definition and approval of care norms by each stage of life; and formation of networks and micro-networks for provision of health services by the Ministry of Health. Parallel to the development of PHC, other strategies have been introduced alongside significant changes in governmental organization and modes of administration, such as decentralization of health services and implementation of budgeting for results (presupuesto por resultados); targeting universal health coverage and insurance; the Programme for Strengthening the First Level of Health Care; and establishment of the National Health Strategy for Family Health. Together, these measures have resulted in a progressive improvement of health indicators, particularly with regard to the reduction of maternal and child mortality.

However, in the first decade of MAIS implementation was limited, due to the predominance of actions in the health sector that were centred on individuals and fragmented by stage of life, with a comparative neglect of other actions in the family, community and environment spheres, and a lack of cross-sectoral activities. Consequently, these elements have been integrated since 2011 into the axes of the new Comprehensive Health Care Model based on Family and Community (Modelo de Atención Integral de Salud basado en Familia y Comunidad, MAIS-BFC). In summary, the adjustments in the MAIS-BFC can be grouped into two fundamental components: (a) the reform of the care model away from a family medicine approach with a welfare paradigm towards a more comprehensive family health approach, based on the family and the community; and (b) several initiatives to strengthen the first-care level in such areas as equipment, medicines, training and work incentives, and the development of integrated health services networks.

Figure 1. Evolution of primary health care in Peru


1978 Alma Ata Declaration
1980
1990
1978
1991 PHC & basic sanitation Cajamarca (APRISABAC)
1991
1993 Project 2000
1993
1994 Basic Health and Nutrition Project and CLAS
1994
1996 Healthy Municipalities & Communities
1996
1991
1992 Basic Health for All
1992
1991
1993
1996
2000
2000
2001 Law 27783. Bases of Decentralization Law
2001
2002 Dirección de Promoción de la Salud - MoH
2002
2003 Comprehensive Health Care Model
2003
2005 Health Promotion Guidelines
2005
2010 Law 29344. Framework Law on Universal Health Insurance
2010
2011 Comprehensive Health Care Model based on Family and Community
2011
2013 Law 1166 Approving the formation and operation of integrated PHC networks
2013
Peru Case Study

Governance and administration architecture

At the national level, all the political parties and civil society organizations have defined non-binding agreements for State policies, including health policies, through the National Agreement (Acuerdo Nacional). Focusing on the health sector, the National Health Council (Consejo Nacional de Salud) is the advisory body of the Ministry of Health and has responsibility for the Coordinated and Decentralized National Health System (Sistema Nacional Coordinado y Descentralizado de Salud, SNCDS). The SNCDS aims to coordinate the implementation process of the National Health Policy, promoting its concerted, decentralized implementation and coordinating the plans and programmes of all the institutions of the sector in order to achieve comprehensive health care for all Peruvians, and move towards universal social security in health.

Currently, the Peruvian health care system is a four-tier system, including the following: public (Ministry of Health and district facilities, police and armed forces facilities); the social insurance system (EsSalud); and private for-profit and private not-for-profit (nongovernmental organization and religious) facilities. There are three categories of facilities that provide PHC, namely primary facilities (I-1 to I-4), secondary facilities (II-1 and II-2) and tertiary facilities. PHC is provided through a doctor-supported infrastructure; only facilities in category I-1 are supported by nurses, midwives or health technicians.

In Peru's decentralized health system, it is the national level that sets overall policies and frameworks, and the regional and local authorities are responsible for implementation.

Under the Ministry of Health, the head of the regional health authority, called the regional health directorate (dirección regional de salud, Diresa) or regional health management (gerencia regional de salud, Geresa), is designated by the governor and has the main responsibility for service delivery, including PHC and environmental health services. On the other hand, regional or equivalent health authorities of the police and armed forces and social insurance subsystem (EsSalud) are designated by the national-level authority.

In practice, there is limited coordination between the different entities involved in the regulatory processes or in health services provision. For example, coordination could be improved between the Peruvian National Institute of Health and the General Directorate of Medicines, Supplies and Drugs (Dirección General de Medicamentos, Insumos y Drogas, DIGEMID) for approval of medicines and import authorization in clinical trials; and between all public institutions for procurement of medicines nationwide, in order to facilitate cost reductions arising from economies of scale.

Figure 2 provides a summary of the official health system architecture and governance mechanisms.
The National Superintendence of Health (Superintendencia Nacional de Salud, SUSALUD) is the institution responsible for protecting the health rights of each Peruvian, and empowering citizens as the central focus of the national health system, regardless of their personal or insurance status. SUSALUD has the authority to regulate all the health service provider institutions (instituciones prestadoras de servicios de salud, IPRESS) as well as the public, private and mixed institutions administering health insurance funds (instituciones administradoras de fondos de aseguramiento en salud, IAFAS) of the country.
Financing

Between 1995 and 2014 health expenditure increased from 4.46% to 5.47% of GDP. In real terms, this has involved an increase from US$ 96.63 (around 328.54 Peruvian sols) per capita in 1995 to US$ 358.58 (around 1219.17 Peruvian sols) per capita in 2014, which represents an increase of 271%. In Peru, health expenditures include public expenses from general taxes and private expenses, both insurance expenses and out-of-pocket expenses. This increase is related to the increase in the coverage of SIS, which involves contracting more human resources, the creation of strategic centres (first-level health care facilities), and the expansion of HAART and anti-tuberculosis therapy.

Government public revenues are collected at the national level through general taxes and redistributed to regions based on size of population, population dispersion and accessibility to services. Within the health budget, some funds cannot be modified or redirected, such as vaccine funds and funds for other treatment schemes. There are several ways to affiliate to EsSalud: regular insurance, optional or independent insurance, agricultural insurance, supplementary risk insurance, and accident insurance. Further information on several of those categories follows:

- **Regular insurance** provides coverage for health care and social welfare, work and occupational diseases of the holder and their beneficiaries. Employers affiliate their workers in the system, fully assuming 9% payment for the regular insurance of all workers who are on the payroll and have opted for this service.
- **Agricultural insurance** is a special scheme that provides health, economic and social benefits to dependent and independent workers. For dependent agricultural workers, the contribution is borne by the employer and equals 4% of the monthly remuneration, which cannot be less than 994.80 Peruvian sols; while for independent workers, the contribution is borne by the workers themselves and is equivalent to 4% of the minimum vital remuneration in force.
- **Personal accident insurance** grants compensation in case of death or total or partial permanent disability as a result of an accident. Its coverage is backed by a consortium of two private insurance companies – La Positiva Insurance and Mapfre Peru Vida Insurance Company.

Private sector financing flows through a fragmented system of 83 individual medical plans. In addition, there are institutions providing health services (IPRESS), previously called health care entities (entidades prestadoras de salud). IPRESS were created under Law 26790, which allows them to complement the health care services provided by EsSalud to the contributory regime. IPRESS are private companies that provide health care services, with their own infrastructure and third parties, subject to the regulation of SUSALUD. Companies by law provide 9% of the payroll to EsSalud so that their workers are covered in the event of any illness that they may present, without distinction, for all simple diagnoses (more frequent and less complicated care, mainly ambulatory, usually linked to first-level health care services) and those that are more complex (cases of greater severity). When choosing IAFAS, the 9% of company contribution to EsSalud is divided into 2.25% for the chosen IAFAS and 6.75% retained by EsSalud.

In general, donor funds and international cooperation account for a small proportion of the total budget – less than 10% of total public health sector expenditure. However, they have a significant presence in national health strategies (previously called vertical programmes), such as those for tuberculosis, HIV/AIDS and sexually transmitted infections, which represent one third of the expenditure. Public PHC services are free at the point of use for the SIS- and EsSalud-insured population; however, they are not always provided, for example when there is a lack of drug distribution. The percentage of family spending on health in relation to total expenditure increased on average from 5.0% in 2004 to 5.8% in 2012, in a context of economic growth. This percentage increased in all quintiles, though quintiles 1 and 2 showed the lowest increase in family spending, with 0.14 and 0.69 percentage points, respectively.

SIS coverage is estimated to include 39.0% of the population while EsSalud coverage is 24.6%, with only 5.4% of the population covered by other insurance. However, the financing rate for each subsystem is inversely proportional to the population coverage. Therefore, for some interviewees, private insurance has more financing and professional human resources in relation to its population coverage, while SIS has fewer financing and professional human resources proportional to its population coverage (almost 8 times greater than for private insurance).
Human resources

According to the Directorate-General for Human Resources Development Management (Dirección General de Gestión del Desarrollo de Recursos Humanos) of the Ministry of Health, there are in Peru 38,065 physicians (general practitioners and specialists), 39,979 nurses, 14,445 obstetricians, and 5,754 dentists. In addition, there are smaller numbers of other professionals, including pharmacists, psychologists, medical technologists, biologists, and entomologists. The availability of health professionals by population (number of personnel in a given year per 10,000 inhabitants) shows 12.2 physicians and 12.8 nurses per 10,000 inhabitants at the national level, with large disparities at the regional and subregional levels. Thus, in 2015 some regions had double the national average while others reported less than half the national average. Within the regions, capital cities reported greater availability of human resources. In addition, medical professionals were concentrated in first- and third-level facilities, with 40.5% and 35.2% respectively.

In regions with lower population density, technicians and nursing assistants persist as the backbone of PHC. The National Family and Community Health Training Programme (PROFAM) was implemented to train human resources for PHC. During 2009 and 2010, the Ministry of Health, in partnership with local universities, implemented the programme with ministerial funds and technical and financial support from the Pan American Health Organization (PAHO) and Italian Cooperation; nearly 150 health workers from six regions were trained. In 2011 and 2012, PROFAM received financial and technical support from PAHO, Medicus Mundi, and Salud Sin Límites (a nongovernmental organization), and a diploma was implemented with the attendance of 346 participants from nine regions. The Ministry of Health seeks to strengthen the delivery and management of health services through the development of programmes such as the Comprehensive Health Care Programme (for all health personnel of the first level of care, including nursing technicians and assistants), together with specialization in the areas of family health (directed to any professional) and family medicine, formerly called Comprehensive Medicine and Health Management (aimed at medical professionals).
The diploma is a short academic programme (six modules) with a pedagogical approach to problem solving. It aims to generate competencies to critically address on-the-ground issues and contribute to the solution of problems facing populations. On the other hand, a survey in a sample of universities showed, in 2012, that only 60% of health science schools had reoriented their training towards PHC and included PHC content in the curriculum, with curricular change most evident in the schools of nursing and obstetrics.

There are major inequalities in personnel distribution between the public and private sectors. Of the total number of physicians registered in the Directorate-General for Human Resources Development Management of the Ministry of Health, just over half (54.7%) work in the public sector.

All health professionals are regulated by their own professional colleges, and by the Ministry of Health as the governing body of health and its own health institutions. The consensus is that, in spite of many proposals and the work of many teams, there is still a lack of connection between health needs and policies focused on PHC and an approach that takes account of the social determinants of health. A consequence of this is the continued orientation of health professional training towards biomedical areas, focusing on disease diagnosis and treatment and hospital work.

The last census of health facilities reported a total of 10,860 health facilities, of which 71.1% were health posts, 23.2% were health centres and the rest were hospitals or specialized institutes.

The analysis of administrative databases showed that 53.1% of health facilities had at least 85% of adequate equipment for pregnant women and children aged under 5 years. Likewise, the analysis showed variability between regions, with Ancash, Madre de Dios and Ucayali regions reporting the lowest percentage of health facilities with adequate equipment. In addition, within each region, health facilities located in the districts of quintiles 1 and 2 reported – before the implementation of the Performance Stimulus Fund (a payment-for-performance mechanism) – the lowest percentage of health facilities with adequate equipment.

Only 13% of the identified pregnant women received an integrated package for pregnant women (prenatal care, iron and folic acid supplementation and tests for urinary tract infection and HIV), and only 13% of children aged under 1 year received the integrated package, including micronutrient supplementation according to age, growth and development, and vaccination against pneumococcus and rotavirus. As expected, the analysis showed variability across regions; Lima, Piura, Ica, La Libertad and Tumbes regions reported in 2015 less coverage of children aged under 1 year with the integrated package; also, Lima, Cusco, Junin, Madre de Dios and Pasco regions reported, in the same period, less coverage of pregnant women with the integrated package. In addition, the analysis within each region showed that health facilities located in the districts of quintiles 1 and 2 reported, before the implementation of the Performance Stimulus Fund, less coverage of pregnant women and children aged under 1 year with the integrated package, at 7% and 1% respectively.

Another problem identified in different interviews with staff at central level and in the regions is the quality of certification of health facilities, especially those in the public sector. This limitation makes difficult references and counter-referrals, and interchange of provisions between IPRESS and IAFAS.

As the 40th anniversary of the Alma Ata Declaration approaches, it is evident that its goal of Health for All by the year 2000 has not been met, due to a lack of medical, political and ideological will, resulting in an even greater sanitary gap than existed in 1978, and the creation of divergent health systems – for the lower classes, the State subsidy is often deficient, and for economically wealthy classes, the private alternative is often followed. As was expressed by some interviewees, the Ministry of Health seems more like the “ministry of disease” given its strongly biomedical approach.

Historically, PHC activities have been supported by the active participation of community health workers (previously called health promoters), initially in preventive and promotional activities, without recognition or benefit for the exercise of their functions, and with almost no participation of civil society and transparency of first-level health facilities. Subsequently, the Shared Administration Programme (Programa de Administracion Compartida,
PAC), created by the Ministry of Health in 1994, promoted the formation of non-profit civil associations called local health administration committees (comités locales de administración de salud, CLAS) with the aim of improving the coverage and quality of services in the first level of care through the strategy of co-management with the community. Thus, CLAS would be in charge of administering health centres or posts (first-level health facilities). According to the latest report of the Health Promotion Directorate of the Ministry of Health, the number of community health workers in the country decreased by up to 30% in the short period 2013–2016.

There is a recognized need for greater participation and empowerment of civil society to address the problems of PHC and the social determinants in health, allowing a patient-centred approach to articulate intersectoral and intergovernmental activities.

**Planning and implementation**

In 2013, the National Health Council and the special guests of the President of the Republic, in compliance with the mandate given by Supreme Resolution No. 001–2013-SA, established health sector reform guidelines and arrangements to improve the health status of Peruvians (since health is a fundamental right and the State must ensure health protection for all people, without any discrimination, at all stages of life), with priority given to establishing a future inclusive and universal health insurance model.

Each health subsystem is currently developing its initiatives to create financial organizations, the IAFAS (Instituciones Administradoras de Fondos de Aseguramiento en Salud) and provisional organizations, the IPRESS (Instituciones Prestadoras de Servicios de salud) for PHC strengthening. At the Ministry of Health, the National Strategy for Family Health was created to aid implementation of national PHC policy, in accordance with Ministerial Resolution 464 of 2011. The strategy defined the MAIS-BFC, which takes the definition of PHC in the Alma-Ata Declaration as its starting point, and outlined the principles, values and strategies of a renewed PHC system. In summary, the adjustments in the MAIS-BFC can be grouped into two fundamental components: (a) the reform of the care model away from a family medicine approach with a welfare paradigm towards a more comprehensive family health approach, based on the family and the community; and (b) several initiatives to strengthen the first-care level in such areas as equipment, medicines, training and work incentives, and the development of integrated health services networks. However, the National Strategy for Family Health has disappeared with the new proposals for regulation of the organization and functions of the Ministry of Health, and the implemented developments of the MAIS-BFC have been gradually deactivated.

Frameworks for financial and performance accountability are provided nationally, and include systems of budgeting, planning and accounting, including reporting on a set of core national indicators. Moreover, in some metropolitan areas, district authorities also provide clinic-based PHC in parallel to that provided by the regional health authority. In order to improve the quality of PHC services and the referral system, creation of a number of strategic health
facilities is planned. The initial plan is to create around 700 facilities nationwide; however, since 2010 only around 5% of them are under construction.

A PHC strategy is explicitly included in both EsSalud’s strategic plans and in the description of its care model, which is in accordance with the Alma-Ata Declaration of primary health care: “Primary health care is essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination.” The portfolio of services delivered by the first level of care is defined as primary care, based on MAIS, with a strong orientation towards health promotion and disease prevention in the individual and family environment. To this end, two strategies are being developed: the Basic Unit of Primary Care (Unidad Básica de Atención Primaria, UBAP) programme, and a new health care delivery model: the Model of Standardized and Progressive Health Care.

The Basic Unit of Primary Care (UBAP) is a management and organization model of the First Level of Care designed by EsSalud, where the implementation process involves the functioning of a supply of outpatient, primary healthcare services that delivers opportune and accessible integral care to an insured population residing in a defined geographic area. The UBAP will develop health promotion, disease prevention, recovery and basic rehabilitation activities, corresponding to the First Level of Healthcare, according to the Primary Health Care Services portfolio of EsSalud.2

“The UBAP (a) will provide integral outpatient healthcare; (b) will carry out health promotion and disease prevention activities through the essential healthcare packages and ambulatory, recuperative and rehabilitation care corresponding to the first level of healthcare; (c) UBAP’s health facilities will be located in the health sector where the assigned insured population is located; (d) The performance evaluation will be based on the health results obtained by the UBAP, the level of accessibility to healthcare services, health benefits coverage granted to the insured population, and the degree of user satisfaction; and (e) The payment system is per capita. The implementation of the UBAP is being carried out through the following schemes: Agreement with public entities – Municipalities, Contracts with private entities, and Fixed Offering of services of EsSalud.”

On the other hand, the Model of Standardized and Progressive Health Care (Spanish acronym – MOCEPS) is a governable, efficient, user-oriented, human, ethical / transparent, and articulated representation; of the set of institutional resources EsSalud counts with, expressed by the service system, its structure and processes; its purpose is to respond to the health needs of the insured, while being responsibly self-sustaining.3

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2 http://www.essalud.gob.pe/unidad-basica-de-atencion-primaria-ubap/
Monitoring and evaluation

In the case of the Ministry of Health, the information system for health care services provided by first-level health facilities is found in two databases: the Health Information System and SIS, each of them with strengths and weaknesses in terms of validity, reliability, accessibility and representativeness. There are other databases – for health facilities there is the National Registry of Health Establishments and Medical Support Services (Registro Nacional de Establecimientos de Salud y Servicios Médicos de Apoyo, RENAES), while other databases exist for strategic inputs, human resources, equipment and epidemiological surveillance. There is, however, limited effort to articulate and align the various databases in order to have timely information for decision-making at national and subnational levels. EsSalud also has several databases of administrative, welfare, epidemiological and medical rest certificates (called medical certificates of temporary inability to work). The health sector of the police and armed forces and private health facilities also store data. Ministry of Health data sources and other sources (surveillance, population surveys, management information) are being integrated into a National Repository of Health Information (Repositorio Único Nacional de Información en Salud, REUNIS). The database contains reports with differentiated access that are made available to the general public, or with a password and restricted access for staff working at the Ministry’s headquarters and in the regional health directorates. Health care outcomes in all the national subsystems must be reported to SUSALUD, which consolidates this information into annual periodic reports.

Among the limitations of information systems is their low capability to collect information on preventive, promotional and extramural activities. There is also limited interoperability of the various databases within and among the different subsystems of the health sector, which creates difficulties in decision-making at the national and subnational levels, limits articulated exchange of supplies, and impedes development of a spatial approach to the promotion of healthy communities. There has been limited research in the health sector due to the shortcomings of the administrative databases, and limited development of robust evaluations of the various interventions implemented nationwide.

4 http://www.minsa.gob.pe/reunis/
Way forward and policy considerations

Going forward, the main priorities for primary health care in Peru are:

• to address the significant burden of disease through a more focused approach to health promotion and well-being and to undertake concerted action on associated factors, including national and subnational intersectoral action on the social determinants of health;

• related to this, to recognize the need to build the capacity of communities to engage meaningfully with the health sector through formal and informal mechanisms for citizens’ participation and improved community services, accompanied by transparent mechanisms at the national and local levels;

• to consolidate the process undertaken by the State to reach universal coverage of health, through a territorial approach that allows articulated work between the various entities of the health sector within a patient-centred approach, so as to guarantee continuity of treatment;

• to strengthen the human resources base of PHC, including by ensuring that training curricula for professionals and technicians are reoriented towards PHC, revising and developing mid-level human resources policies, enhancing the managerial and leadership capacity of top-level managers, reactivating the work of community health workers, and analysing the various formalization mechanisms that can improve community work;

• to support better systems of accountability to communities, in the areas of performance and resource use, at all levels;

• to strengthen relationship between the health sector, academia and civil society in order to take advantage of advances in information technology, including with regard to electronic medical records, appointment reminder systems, treatments, controls, and adequate referral and counter-referral systems.
This case study was developed by the Alliance for Health Policy and Systems Research, an international partnership hosted by the World Health Organization, as part of the Primary Health Care Systems (PRIMASYS) initiative. PRIMASYS is funded by the Bill & Melinda Gates Foundation, and aims to advance the science of primary health care in low- and middle-income countries in order to support efforts to strengthen primary health care systems and improve the implementation, effectiveness and efficiency of primary health care interventions worldwide. The PRIMASYS case studies cover key aspects of primary health care systems, including policy development and implementation, financing, integration of primary health care into comprehensive health systems, scope, quality and coverage of care, governance and organization, and monitoring and evaluation of system performance. The Alliance has developed full and abridged versions of the 20 PRIMASYS case studies. The abridged version provides an overview of the primary health care system, tailored to a primary audience of policy-makers and global health stakeholders interested in understanding the key entry points to strengthen primary health care systems. The comprehensive case study provides an in-depth assessment of the system for an audience of researchers and stakeholders who wish to gain deeper insight into the determinants and performance of primary health care systems in selected low- and middle-income countries.