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## **What does COVID-19 tell us about the Peruvian health system?**

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### **Abstract**

Peru seemed well placed to respond to the COVID-19 pandemic as a country that had achieved sustained economic growth and moved towards achieving universal health coverage. Yet, Peru has one of the highest rates of transmission and mortality worldwide. This paper analyses what the pandemic has unveiled with regards to the health system, arguing that a focus on meeting global development targets, including by promoting public-private partnerships in health, has distracted attention from the underlying structural causes of inequalities and enabled the continuation of a highly fragmented system, with access determined by income, gender, ethnicity and geography.

**Key words:** Peru, public private partnerships, Universal health coverage, SDGs and inequalities

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## **1. Introduction**

The COVID-19 pandemic has brought renewed attention to health systems and inequalities globally. Countries that were previously considered to have “successfully developed” have not been able to adequately contain the spread of the virus or address the wider societal fall-out from the virus, suggesting broader underlying structural problems. The pandemic has hit Latin America hard, as it is one of the regions most affected by COVID-19. By late June 2020, the region reported 27 per cent of global deaths from COVID-19 (Pablos-Méndez et al. 2020). While the effects of the pandemic remain uncertain, the World Bank has predicted that the region will experience a 7.2 per cent contraction in GDP this year (Horwitz et al. 2020). In recent years most countries in the region have become recognized as middle income countries after decades of being classified as poor. Yet, the devastating impact of the pandemic reveals structural problems in wealth distribution, investment in public services, and the global definition and measurement of development and health.

Within Latin America, the Peruvian case is particularly striking. Pre-COVID-19, Peru was notable for its good performance, both in macroeconomic indicators – the country had enjoyed eighteen years of sustained growth at rates above the regional average – and in the adoption of

and progress towards global development goals, in particular on universal health coverage (UHC). Theoretically, the country should have been well-placed to control COVID-19 and lessen its negative effects. In 2016, the Peruvian government incorporated the 2030 Agenda for Sustainable Development, centered around the Sustainable Development Goals (SDGs), into the Strategic Plan for National Development and implemented corresponding plans at national, regional and local levels (Gobierno del Perú and CEPLAN 2018). Yet, the reality tells a very different story. By 6 October 2020 Peru had over 830,300 confirmed cases, and more than 32,800 confirmed COVID-19 deaths (Ministerio de Salud 2020b), indicating that the country has one of the highest incidence and COVID-19 mortality rates globally (Johns Hopkins University Coronavirus Resource Center 2020). This is despite the State of Emergency declared by the government on 15 March 2020, when there were still no reported COVID-19 deaths. In fact, infections and deaths raised exponentially during the strict national lockdown (between March and June), and the disease spread across the country. Outbreaks in coastal regions of Lima, La Libertad and Lambayeque, were followed by outbreaks across the Amazon (in regions such as Iquitos and Ucayali) and in the highlands (cities as Arequipa, Cuzco, Huancayo and Puno), showing the failure of government measures to control the pandemic.

This paper analyses what the COVID-19 pandemic reveals in the case of Peru, with particular attention to the structural weaknesses of the health system, namely its fragmentation and persistent inequalities, which have undermined an effective government's response to the pandemic. The decision to focus on the health systems is deliberate, given their centrality as a core social institution, on a par with the judicial system or the democratic political system (Freedman 2006). The paper draws attention to the risks of strategies focused on making progress on global development goals, including attracting private finance to contribute to

achieve UHC, and how this has diverted attention from structural weakness of the health system. Peruvian policies to achieve the SDGs have promoted public-private partnerships (PPPs) across different sectors (Huertas 2017; Gobierno del Perú 2019a, 2019b), as reflected in several national plans including the National Plan on Competitiveness and Productivity 2019-2030 and the National Plan on Infrastructure for Competitiveness. Both plans stress the need to increase social and economic infrastructure and to use PPPs as a relevant tool.

The paper starts with a brief analysis of critical debates around the SDGs, with particular attention to their ability to address inequalities. Second, it presents the main features of the Peruvian health system and its experience in making progress towards the SDGs, including the promotion of PPPs within the health sector. Third, it provides a detailed discussion of the Peruvian case in the context of COVID-19, with a focus on the structural challenges revealed by the crisis. The final section considers what the COVID-19 pandemic reveals, not only in relation to the Peruvian case, but also wider questions raised in relation to current hegemonic approaches to development (including the SDGs).

## **2. Addressing inequalities through development goals?**

The 2030 Agenda for Sustainable Development, adopted by United Nations Member States in 2015, includes ambitious and universal commitments to improve peoples' lives and leave no one behind. The Agenda is grounded in 17 goals (SDGs) with targets that seek to end poverty, curb inequalities in outcomes and opportunities, empower women and girls, and enable all people access to quality healthcare, among others. However, the SDGs have generated considerable debate as translating complex social phenomena, such as poverty reduction or

gender equality into measurable outcomes can be extremely challenging. As critics have argued:

“[T]arget-setting can also unintentionally distort priorities by displacing attention from other objectives, disrupting ongoing initiatives and alliances, creating perverse incentives, and undermining alternative policy analyses” (Fukuda-Parr, Yamin, and Greenstein 2014, 2).

Critics have highlighted the broader context of a changing landscape of development and health finance over the past two decades, which has generated significant changes in social policy across the Global South. This reflects changing moments and forms of neoliberalism, underpinned and driven by financialisation, although these processes have proceeded unevenly (Lavinias, 2018). Two significant elements of this changing landscape are: the current “measurement obsession” in global development (Fukuda-Parr, Yamin, and Greenstein 2013; Fukuda-Parr and McNeill 2019; Davis 2020) and an increased promotion of private actors as suppliers and financiers of public services (Gideon and Unterhalter 2020).

This SDG debate can be illustrated in relation to SDG3 (good health and well-being). SDG3 has been critiqued due to its narrow overly medicalised framing of health which prioritises access to medical treatment – as evidenced in the targets relating to malaria and tuberculosis (TB) – while ignoring the underlying structural causes of poor health and health-related inequalities. Furthermore, access to healthcare is highly sensitive to policy decisions such as laws and regulations criminalizing HIV or TB transmission, denying sexual education in the schools (Gianella, Rodriguez de Assis Machado, and Gloppen 2017; Stop TB Partnership 2017) or allowing the use of healthy food labelling (Salazar 2019). Legal frameworks create parameters to key issues as permissible pollution levels, or the regulation of the price of drugs. Simultaneously, concerns were raised in relation to reinforcement of vertical approaches to

health inherent in the SDGs, which has further reinforced the neglect of more structural solutions to poor health. Critics have also challenged the use of the term UHC within the SDGs, arguing that UHC has been stripped of its links with ideas of social justice (Birn and Nervi 2019).

Another critical feature of goals, such as SDG3 on UHC, is the accompanying definition, and how indicators reduce this concept to one element. Globally, there is an increasing consensus that health coverage implies more than formal enrolment in a health insurance programme; that is, social security or insurance plans. Health systems should be able to deliver sustained, high-quality interventions to beneficiaries, ensuring that financial hardship is not suffered when these services are used (Shengelia et al. 2005; World Health Organization 2010). An evaluation of a country's health coverage, therefore, must provide information about to what extent health systems are able to deliver to the whole population, independently for example of social identity or, economic status, high-quality services to those who need them. Yet the reductionist nature of current SDG targets as well as national level indicators means that the needs of marginalized groups are often overlooked.

Importantly, the SDGs have also boosted support for an increased role of private finance in development (Gideon and Unterhalter 2020), which has become a goal in itself. Specifically, the SDGs encourage the use of PPPs as “means of implementation”. For example, SDG17 includes a call to: “encourage and promote effective public, public-private and civil society partnerships, building on the experience and resourcing strategies of partnerships” (SDG17.17). The indicator of this target seeks to measure progress on the basis of the “amount of US dollars committed to public-private and civil society partnerships” (SDG17.17.1). This has proceeded with little regard to the underlying conditions and costs under which it is secured,

and despite the ambiguous evidence of the positive development impact (Bayliss, Romero, and Van Waeyenberge, forthcoming).

### **3. The Peruvian health system**

In common with regional trends, the Peruvian health system remains highly fragmented and segmented, severely constraining state capacity to deliver quality healthcare for all (Göttems and Mollo 2020; Homedes and Ugalde 2005). This fragmentation affects different components of the system, generating dynamics among the various actors involved at different levels, and with implications for stewardship and the provision of healthcare.

The Ministry of Health (MINSA) is the sector's main stewardship body, responsible for establishing policies and standards. However, there are other institutions with decision-making power within the sector, for instance, national ministries. The Ministries of Defense and Internal Affairs are responsible for health insurance for the armed forces and the police, respectively. The Social Health Insurance system (EsSalud), attached to the Ministry of Labor and Promotion of Employment, is a public entity that enjoys technical, administrative, economic, financial, budgetary and accounting autonomy. In 2013 – as part of the healthcare system's reform – the National Health Superintendence (SUSALUD) was created to regulate Healthcare Providers (IPRESS), as well as Health Insurance Funds (IAFAS), of both public, private and mixed ownership. SUSALUD is attached to MINSA, and the superintendent is appointed by the Minister of Health. However, private insurance is regulated by the Superintendence of Banking, Insurance and Private Pension Funds (SBS).

Regarding accountability and planning, following the decentralization process initiated in early 2000s, budgets are no longer under MINSA administration. Decentralization sought to strengthen health service accountability to users, by decreasing the distance between the population and immediate managers (Göttems and Mollo 2020). One mean of achieving this was through providing regional authorities with greater financial and administrative autonomy. In parallel, central government implemented a top down policy of results-based budgeting, responding to the global development agenda, which is monitored by the Ministry of Economy and Finance (MEF). This has consequently undermined the power of MINSA, regional health authorities, or the population to determine health priorities or targets. Moreover, following decentralization, the administration of public health facilities (the largest network of health facilities in the country), as well as the capacity to implement health programs and plan public investment, were transferred from MINSA to the regional governments. This has been described as a mechanism to decrease the responsibility of national governments (Göttems and Mollo 2020).

Moreover, in contrast to countries such as Brazil or Colombia, where health reforms have shifted towards the unification of coverage of public insurance, in Peru insurance coverage remains fragmented. Legally, all residents have the right to access the Plan Esencial de Salud (PEAS – Basic Health Plan). The social security insurance system – EsSalud, also a public insurance scheme, covers additional health conditions and procedures compared to the PEAS, meaning that public health insurance coverages varies across schemes.

At the same time, health care access is also segmented. Despite attempts to enable service exchange between public health providers, this has not been implemented, and major

disparities in the distribution of health services prevail. This fragmentation and segmentation have profoundly impact access to health care, as Table 1 shows.

**Table 1: Inequalities on the access to health care**

Services availability (and quality of care)	<ul style="list-style-type: none"> <li>• A review of 251 health facilities at the secondary and tertiary levels (i.e. hospitals) across the country carried out in 2018 revealed a precarious system in which 43 per cent of the facilities examined lacked sufficient human resources to function effectively. In the case of hospital laboratories, 42 per cent did not perform basic procedures, such as immunological tests, while 42 per cent lacked the minimum equipment necessary for sample processing, delaying patient diagnoses (Contraloría General de la República 2018).</li> </ul>
Ethnic and geographic inequities in the access to insurance (by law SIS must prioritize vulnerable groups).	<ul style="list-style-type: none"> <li>• The 2018 National Household Survey reported that 19 per cent of the population, whose mother tongue is Quechua and 33 per cent of the population of the Aymara language, lack any type of insurance. Likewise, 17 per cent of the population that speaks an indigenous or native Amazonian language lack health insurance.</li> </ul>
Geographic Accessibility to health services	<ul style="list-style-type: none"> <li>• The majority of hospitals and specialized institutes are concentrated in the main coastal region cities (Gobierno del Perú and CEPLAN 2020).</li> <li>• Peru has, an average of 16 hospital beds per 10,000 inhabitants, but there are significant regional inequalities. In Lima, the capital city, the number of beds per 10,000 rises to 18.6, whereas poorer regions such as Loreto or Huancavelica report 10,6 and 10.2 beds respectively (Ministerio de Salud 2020a).</li> <li>• Rural communities in the Peruvian Amazon endure the longest travel times within Peru to reach a health facility (Carrasco-Escobar et al. 2019).</li> </ul>

Source: Authors' elaboration

### **The promotion of PPPs in health**

Following global trends in development finance, official efforts have prioritized attracting private finance as a means of promoting economic growth and improving healthcare coverage.

The World Bank Group has played an influential role in driving forward the PPP agenda in the health sector (and beyond), with other institutions like the Inter-American Development Bank

(IADB) following the same path. Health PPPs have been on the Peruvian agenda since 2008, after the creation of the Health Ministry's Investment Committee, and a new law allowing EsSalud the right to enter into long-term contracts, including PPP contracts, without obtaining prior federal approval (Zevallos, Salas and Robles, 2014). In 2015 the IADB approved a loan to strengthen the capacity of the country to implement PPPs in the health sector.<sup>1</sup> However, critics have challenged state capacity to evaluate the cost and benefits of PPP projects, and to monitor fiscal risks (Benavente and Segura 2017; Baca Tupayachi 2017; Alarco and Salazar 2019).

Additionally, bilateral relations between Peru and key governments from the Global North have also contributed to expanding healthcare business through PPPs. The UK government has actively promoted Peru as a “priority market”, which has continued despite increasing criticism of the UK's PPPs, including by the UK's National Account Office (National Audit Office 2018). In practice, the promotion of health PPPs worldwide has laid the basis for UK companies and consultancies to win contracts in Peru and other developing countries (Holden 2009; Lethbridge 2016).

The promotion of PPPs in Peru, however, has not been without controversy. Advocacy efforts from business groups have challenged the spurious nexus between private and public sector actors, and the use of PPPs as vehicles for the benefit of private sector companies. Peru – alongside 12 Latin American countries – has recently been shaken by corruption scandals, mostly in infrastructure PPP projects (The Economist 2017), further discrediting the public sector and deepening a process of “state capture” (Cabtree and Durand, 2017), that is “the mechanisms by which elites continue to control decision making and maintain their political dominance across time” (2017: 4).

The international experience with hospital PPPs also raises related concerns. Firstly, hospital PPPs tend to be more expensive than publicly financed projects, due to the high cost of private finance, profit margins and the transaction costs associated with the negotiation of complex contracts. Secondly, they are usually risky businesses for the public sector, particularly given the changing nature of health-related needs and the lack of flexibility in PPP contracts. Thirdly, there are inherent tensions in bringing the private sector into areas where there are strong social elements associated with provision. Currently, there is a strong focus on identifying ‘bankable’ projects, which limits the extent to which PPPs can proceed in areas that are at first not profitable. This means that PPPs could become a mechanism for securing revenue streams for private investors rather than contributing to high-quality and affordable healthcare (Romero and Gideon 2020).

The prioritisation of state resources within the Peruvian public health system is arguably evident in the fact that there has been a growing focus on PPP hospitals, which might detract from (public) investment in primary healthcare, prevention and community clinics. In 2018 the MINSA released the Multiannual Report of Investment in PPPs in Health 2019-2021, which proposes seven hospitals and five specialised healthcare institutions to be managed and operated by the private sector.<sup>ii</sup>

Currently, there are two PPP hospitals (in operation since 2014), and a pipeline of PPP projects which, according to the Peruvian Private Investment Promotion Agency (ProInversion), includes five PPP hospitals under negotiation and two other projects to be open for bids.<sup>iii</sup> The PPP hospitals under implementation are integrated within EsSalud and located within the greater Lima and Callao metropolitan area. These projects involve the building and clinical

operation of new hospitals, each with corresponding primary and urgent care centres. Both are managed by two consortia led by a Spanish multinational, IBT Group. Under this PPP model, EsSalud makes an annual payment for every affiliate covered by each hospital for a 30-year period, while the private consortia retain management of the hospital, including hiring of health workers. This rests on the assumption that the state has the capacity to regulate in the public interest, which has clearly been challenged by the COVID-19 pandemic.

#### **4. Peru in times of COVID-19: What the pandemic has revealed?**

To contain the spread of the virus, on 15 March 2020 the Peruvian government declared a State of Emergency, imposing a general lockdown that was extended for over 100 days. This was combined with social protection measures – mainly cash transfers and the distribution of food parcels – in an attempt to mitigate the impact of the lockdown, in a country where 70 per cent of the population works in the informal sector (Instituto Nacional de Estadística e Informática 2020).

Since COVID-19 outbreak, Peru has received considerable bilateral aid alongside several loans from international financial institutions to support the government pandemic response (Welsh 2020). Yet despite this influx of funds, and high levels of citizens' compliance with government measures, including social distancing (RPP Noticias 2020; Gestión 2020), COVID-19 has exposed, and even intensified, pre-existing weaknesses of the health system. While it can be argued that the capacity of countries to control COVID-19 is multifactorial, including the strategy employed in response to the crisis, structural problems, such as fragmentation and persistent inequalities, have jeopardised the government's ability to respond to the health crisis effectively and protect the most vulnerable. In this section we highlight several key issues.

COVID-19 has raised doubts about the “transformative” capacity of the SDGs, including its focus on an increased role of the private sector, and prompted questions around the extent to which they have diverted attention away from health inequalities, thus exacerbating the effects of the pandemic. As elsewhere, the impact of COVID-19 in Peru has been unevenly spread among the population, given the centrality of the social health determinants in the transmission and impact of the virus (Horton 2020; Marmot and Allen 2020). Mortality has been higher in certain regions (Ica, Lima and Callao, Moquegua, Arequipa) (@rparrawong 2020a), despite good performance in development indicators (Table 2). Data also shows significant differences in the number of cases and mortality rates (@rparrawong 2020b; Carrasco-Escobar and Ñopo 2020). For instance, in Metropolitan Lima statistics reveal the highest death rates in poorer districts. Wealthy districts, with a large percentage of senior citizens (which are population at risk), have recorded lower mortality rates than poor districts with younger populations (Carrasco-Escobar and Ñopo 2020).

Table 2: Ranking of the top seven regions with highest COVID 19 mortality rate (as of September 23<sup>rd</sup> 2020)

	Covid 19 Mortality per million inhabitants	Ceplan Vulnerability index.* National= 34.3	Human development Index (2019) National = 0.6	UHC coverage (%)
Ica	6,678	22	0.6	88
Lima Metropolitan area	6,617 (data includes Callao)	24	0.72	93
Moquegua	6,426	18	0.65	91
Arequipa	6,395	22	0.64	89
Tumbes	5,672	33	0.55	92
Ancash	5,619	34	0.51	98
Madre de Dios	5,088	39	0.61	93
* Defined as the unmet needs that threaten the well-being of the population from a socio-economic and multidimensional point of view and as consequence limits them to reach their potential. Scores go from 0 to 100. Higher the score, higher the vulnerability.				
Sources: @rparrawong (2020a) Gobierno del Perú and CEPLAN (2020)				

Other issues including ethnicity, historical marginalization and State neglect are also important variables when determining the impact of COVID-19 on the population. Within Peru, the indigenous peoples in the Amazon region are among those who have suffered most from the epidemic. The lack of access to health services, water and sanitation, as well as the high rates of poverty and child malnutrition, once again placed these ethnic groups in a situation of greater vulnerability. According to data from the MINSA, by mid-August 2020, 21,921 members of the Amazonian indigenous population had been identified as infected by COVID-19 (Red Investigativa Regional 2020). At that time, the number of cases among the Amazonian indigenous population represented 4 per cent of reported COVID-19 cases at national level, although these ethnic groups only account for 0.91 per cent of the total population (Instituto Nacional de Estadística e Informática 2018). COVID-19 has indeed revealed the poor access to health care among indigenous communities (Carrillo et al. 2020).

COVID-19 has also exposed the high cost of access to care at public health facilities (Defensoría del Pueblo 2020; Tenorio-Mucha et al. 2020). Despite assurances of financial protection being an integral part of UHC, catastrophic health expenditures have remained high in Peru. Even before COVID-19 out of pocket expenditure was increasing (Kanavos et al. 2019). Given the limited supplies of oxygen within public hospitals, relatives of COVID-19 patients have been forced to buy oxygen on the open market, sometimes paying over US\$1000 (Collins 2020b) and further exacerbating the economic impact of the disease on families.

Moreover, COVID-19 has exposed the state's weak capacity to deliver services in the public interest and ensure inequalities are effectively addressed. Although Peru developed a national plan to respond to COVID-19, following the WHO declaration of the pandemic, there have

been serious challenges regarding management, regulation and coordination between the central (MINSA) and regional governments, some of which can be linked to the fragmentation of the health system. Central government's inability to supervise and enforce regulation by regional health authorities has been evident in the dramatic situation in Arequipa, Peru's second city with one million inhabitants. In Arequipa, confirmed cases rose from 3,726 and 71 deaths in early June, to 43,206 and 853 deaths by mid-July, leading to widespread protests by medical staff and relatives of COVID-19 patients, ending with the announcement of an emergency decree that wrested control from the regional government and placed it with the Ministry of Health (Collyns 2020a).

## **5. Conclusions**

The COVID-19 pandemic has exposed, and even intensified, pre-existing weaknesses of the Peruvian health system, such as fragmentation and inequalities, which have undermined the government's ability to respond to the health crisis effectively and protect the most vulnerable. Our analysis shows that neither the current development model, nor mechanisms for global health reporting have been able to prevent the crisis generated by COVID-19 in Peru. The lack of health infrastructure forced the government to implement drastic measures, such as a mandatory lockdown, that have profoundly impacted on individuals and their families. Despite this, cities with poorer and weaker health systems soon collapsed, and the national government performed poorly in terms of management, coordination and regulation of private providers. The situation in Peru calls for an urgent reassessment of the means of determining successful development.

Moreover, the pandemic has starkly shown that the need to effectively address inequalities must be firmly placed at the center of future endeavors. As Alston (2020) argued in his final report as United Nations Special Rapporteur on extreme poverty and human rights, the needs of the poor and vulnerable have been “lost in the fog of an overriding focus on Public-Private Partnerships with troubling track records” (UN Special Rapporteur on extreme poverty and human rights 2020, 12). As this analysis has argued, there is very little evidence that PPPs are able to deliver on the universal access to quality healthcare. Given the deeply embedded inequalities within the Peruvian health system, questions must be asked about the promotion of PPPs and its implications for public finances, equity considerations and the effectiveness of the wider health system.

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<sup>i</sup> See the 2015 loan PE-L1169 "Improving Management for Universal Health Coverage Program I".

<sup>ii</sup> Minsa planea 12 proyectos vía APP para hospitales de Lima," 12 December 2018, <http://www.diariomedico.pe/?p=12657>; Ministerio de Salud, "Resolución Ministerial," 1 August 2018, [https://www.mef.gob.pe/contenidos/inv\\_privada/app/IMIAPP\\_MINSA\\_2018.pdf](https://www.mef.gob.pe/contenidos/inv_privada/app/IMIAPP_MINSA_2018.pdf)

<sup>iii</sup> See:

<https://www.proyectosapp.pe/modulos/JER/PlantillaProyectosResumenes.aspx?are=0&prf=2&jer=5680&sec=22> (accessed on 9 October 2020).