**Peru: When the Expansion of Public Insurance and a Robust Normative Framework is Not Sufficient to Respond to the Public Health Crisis**

*Introduction*

Peru is an upper middle-income country in Latin America with over 32 million inhabitants. [ref] The majority (79%) of the population lives in urban areas, with over 30% living around the capital, Lima.[ref] It is administratively divided into 26 departments, with important health and wealth disparities. Life expectancy at birth in 2020 in the more affluent, mainly urban departments, such as Lima, was estimated at 78 years, compared to 71 years in the poorest, mainly rural departments, such as Huancavelica.[ref] In 2019, 20% of the population lived below the poverty line, with large disparities by residency status; 40% of the rural population lived below the poverty line compared to 15% of the urban population. [ref] In 2019, 73% of the working population of Peru was in informal working arrangements [ref] with large disparities by department, ranging from 92% of working people in the department of Huancavelica to 60% in Lima. The largest informal sectors are fishing and agriculture and commerce. Women make up a disproportionate share of the informal workforce (76% of women vs 70% of men).[ref]

*Overview of the healthcare system and progress towards UHC*

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The Peruvian healthcare system is decentralized and includes both public and private services and providers.[ref] The Ministry of Health (MoH) is by far the largest insurer and provider. About 44% of the population are insured by Segura Integral de Salud (SIS, Integral Health Insurance), a government-subsidized healthcare. [ref] The services provided by the MoH are further decentralized into national, regional and municipal levels.

The introduction of SIS signified a remarkable growth in health coverage, particularly primary care coverage and reduction in out-of-pocket expenditures.[ref] EsSalud, is the second largest body, with 25% affiliated. EsSalud services are regulated and operated by the Department of Labor and Employment, and provides mandatory health coverage for all people employed in the formal sector through their employers. Finally, 6% of the population are affiliated to the Armed Forces, the National Police, and the private sector, combined.[ref]

UHC is promoted under a legal framework in Peru. the Universal Health Insurance Law (Ley Marco del Aseguramiento Universal en Salud), adopted in 2009, stipulates universal health coverage, as well as defines the basic package of services.[ref] Since then, the government has enacted multiple other decrees to continue expanding SIS in efforts to achieve universal health coverage, including expanding SIS inclusion criteria and the essential package of services that are available free of charge to reduce out-of-pocket expenditures, regardless of poverty level.

As a result, between 2009 and 2017, healthcare coverage increased significantly from 60.5% to 76.4%.[ref]

An analysis by the civil society alliance to end poverty, identified three main weakness in the healthcare system 1) fragmentation; 2) low overall health investments which limits response capacity; and 3) underfunded primary health care, with most investment going to second and tertiary care levels.[ref]

The healthcare system in Peru includes 20,000 healthcare establishments, including over 600 hospitals. However, distribution is uneven, with roughly 67% of hospitals located in Lima. Total health expenditure, including private and public, in Peru represent 5.5% of its gross domestic product on health, which is an improvement from below 3% of GDP until the healthcare reform of 2013. However, these levels are below the Latin American average of 7.7% and below those of most high-income countries.[ref] Healthcare expenditures are shared by the government, employers, and households, although, as of 2019, 60% of health expenditures were in the public sector.[ref] As of 2010, all insurance schemes must cover an essential care package, as regulated by the *Plan Esencial de Aseguramiento Universal*.[ref] However, because the healthcare system is fractured and not all services are covered or available from each insurer, most households incur in out-of-pocket expenses for monthly subscription fees or fee-for-services for non-basic services. As a result, premature death attributed to NCDs remains as a key issue [ref] High informality in labor markets and the new waves of migrants from Venezuela exacerbated the number of vulnerable populations despite country’s effort on expansion of care.[ref] As a result, their progress towards SDG 3 target has been slow in the past few years. Peruvian government, in response to this, recently aligned their overall government agenda to the SDG 2010 targets and has been publishing annual report on its strategic focus and progress.[ref]

*Pandemic preparedness and response capacity*

Coordinated by the MoH’s National Center for Epidemiology, Prevention and Control of Disease (Centro Nacional de Epidemiologia, Prevencion y Control de Enfermedades), Peru has a robust surveillance system, with protocols in place for monitoring and mandatory reporting of infectious and non-infectious diseases. [ref] Over 20 diseases and conditions, including infectious diseases that are endemic to some regions of Peru, such as malaria and dengue, as well as for tracking health indictors, such as maternal mortality, are collected by the system. Epidemiologic surveillance of respiratory infections has been included in the system since 2015.[ref]

Despite the robust surveillance system, Peru’s recent surge in dengue cases demonstrates the country’s suboptimal response capacity

against infectious disease outbreaks. The country’s existing burden of arboviral diseases, including dengue, chikungunya, and zika virus disease, surpassed the country’s medical and public health capacity even before the pandemic. Peru is the third country in Americas with the highest dengue-attributed mortality.[ref] Rapidly changing climate in the region accelerated the spread of mosquito vectors to the areas previously unaffected by the diseases.[ref] The most recent dengue outbreak, started in October 2019 and has spread to 17 regions by the beginning of the COVID-19 pandemic, continues to spread as the current report is being drafted.[ref] Early response to this outbreak included the deployment of military force for the fumigation and vector control activities in remote areas due to the shortage of medical workforce. However, this only resulted in short-term decrease in number of cases, which was followed by the re-surge and the declaration of health emergency accordingly.[ref] Unless the preparedness and response capacity is further bolstered, the burden of infectious disease is likely to severely hamper Peru’s progress on population health as number of other mosquito-borne diseases, including zika and chikungunya, are also steadily increasing.[ref] Industrial development and deforestation can potentially alter the arbovirus disease dynamics with further complexity, which should be anticipated by the strong preparedness capacity.[ref]

*Response to COVID-19*

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, an imported case with travel history to Europe,ported[ref][ref][ref], such as and . the country’s to expand the healthcare coverage in the past decades.[ref]At the beginning of the COVID-19 pandemic, only 2000 beds in intensive care units were available nationally.[ref] That is 2.9 beds per 100,000 people, which is lower than the regional average of 9.4 beds per 100,000.[ref] The government acted relatively quickly in response to the COVID-19 pandemic, declaring a national health emergency on March 15, 2020, only a few days after the detection of the first case.[ref] Yet, from the emergency declaration until May 25, 2020, all primary care provision was closed, creating an immense access barrier to everyone including those who are insured. [ref] COVID-19 pandemic hit the toll on the vulnerable populations in Peru. As of June 2021, the government has officially recognized the death of 559 medical staff between March and December 2020 while providing care for COVID. [ref] As of May 2021, there was an increase 43% in maternal deaths, with COVID-19 being the leading cause.[ref] In response to the increase in maternal death, government launched a hybrid service model in May 2020 and provided over 10,500 teleconsultations to pregnant women. [ref]

Investment on the public health sector was reinforced, with an emergency budget approved for COVID-19 activities, such as surveillance, testing and tracing, and purchase of ICU beds, and personal protective equipment, among others. Healthcare workers involved in the COVID-19 response received monetary incentives. It also instituted mandatory reporting of COVID-19 cases.[ref] On April 16, 2021, the government launched the national COVID-19 vaccination plan, initially for people over 80 years old, which has been progressively extending to younger people and people at high risk for severe COVID-19 throughout the country.[ref] As of June 14, 2021, over 5 million people had received at least one dose of the vaccine.[ref] In order to counter the limited access to necessary cares during the pandemic, Peruvian government passed an emergency measure to allow more people to affiliate to SIS, “SIS para todos” (SIS for all). The permitted having more than one types of insurers, expanded the types of services covered, including for treatment for COVID-19, and allowed flexibility in which establishments to visit.[ref] As a result, official statistics as of October 2020 showed that 95.2% of the population was insured, reducing the uninsured to 5% of the population. [ref]

Aside from the public health measures, including the social distancing, lock-downs, and border closure, the government has issued around 100 decrees related to the economy and labor, education, transportation, rights, and health to prevent and curtail the adverse effects of the pandemic. [ref] An early analysis of the impact of the COVID-19 pandemic in Peru, suggested that close to 30% of the population would be living in poverty as a result of the economic impact of COVID-19.[ref] To mitigate the impact, the government issued monetary incentives to households in poverty. In addition, special efforts have been made to contain the impact of the pandemic on hard-to-reach areas in the Amazon rainforest through the Plan de Intervención para Comunidades Indígenas y Centros Poblados Rurales de la Amazonía frente a la emergencia de la COVID-19. [ref]

*Conclusions*

Peru’s strength in its health system can be summarized as the expansive health insurance coverage, close to achieving UHC, and the robust normative framework to ensure the system’s resilience to crises. This served as a solid backbone that enabled the country to adapt to the pandemic with agility and flexibility. Their successful expansion of the government-funded insurance scheme and the expansion of telehealth to address the urgent maternal health gap during the early pandemic mitigated, to some degree, the harmful public health consequences of the access barrier caused by COVID-19. The same success, however, was not achieved in controlling other simultaneous infectious disease outbreaks. Despite the country’s commitment and success in achieving universal healthcare coverage leveraging both the public and private scheme, the country’s toll on COVID-19 pandemic was severe. The damage was disproportionately allocated to the vulnerable population, such as those in hard-to-reach area, workers in informal employment, and pregnant women. Peru serves as a good example to signify the importance of the balance between 1) resilient health system with universal coverage, 2) equitable access to health care that is inclusive to the vulnerable population, and 3) the country’s strong emergency preparedness, which includes surveillance, sufficient volume of trained medical and public health workforce, as well as the laboratory capacity. In January 2021, Peruvian government issued a decree to refine the definition of telehealth and its purpose, aiming to continue expanding the telehealth model and its associated legal frameworks beyond pandemic, following its success in tackling the maternal health issue.[ref] Next steps for Peru post pandemic would be to continue expanding the telehealth model to tackle some of the key challenges surfaced during the pandemic, including strengthening linkages with secondary and primary care, reducing the disparity in access to care for the vulnerable population, and to build resilient health care system against public health crises.

*Take-aways*

* Peru’s strength in health system can be attributed to their quick action to expand the public health insurance during the pandemic to achieve universal health coverage. These was only possible with the strong foundation of the previous 10 year’s achievement in increasing access to health care. Peru’s expanded coverage close to UHC was an essential enabler to promoting access to life-saving procedures.
* Peru’s robust legal framework on health system enabled the government to be resilient to the public health crisis. The country continued strengthening of this normative and legal framework during COVID-19, allowed healthcare institutions to reorganize services.
* Peru demonstrated the potential of telehealth services beyond the pandemic. As demonstrated by their success story in tackling maternal health, telehealth is a promising strategy to replace in-person visits, while still providing life-saving services and prevent infections among providers and healthcare users.

However, Peru’s failure to effectively control the COVID-19 pandemic stems two main factors:

1. The weak response capacity to infectious disease outbreaks, including the shortage of staff, insufficient geographical coverage of public health and medical services, and the suboptimal laboratory capacity.
2. Rapidly changing population and disease dynamics due to the highly volatile labor market, migration, and climate change, whose speed is difficult to catch even for the agile government.

* Net, Peru serves as a good example to signify the importance of the balance between 1) resilient health system with universal coverage, 2) equitable access to health care that is inclusive to the vulnerable population, and 3) the country’s strong emergency preparedness.