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HEALTH SYSTEMS 20/20 PERU FINAL REPORT

(November, 2009)

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Mission

The Health Systems 20/20 **cooperative agreement**, funded by the U.S. Agency for International Development (USAID) for the period 2006-2011, helps USAID-supported countries address health system barriers to the use of life-saving priority health services. Health Systems 20/20 works to strengthen health systems through integrated approaches to improving financing, governance, and operations, and building sustainable capacity of local institutions.

Date

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ACRONYMS

ACRES	Software application to estimate Regional Health Accounts
ASEGURA	Software application to estimate financial requirements of PEAS
CIES	Economic and Social Research Consortium
CTB	Belgium Technical Cooperation
CTIR	Regional Technical Committees for the Implementation of the Universal Health Insurance
DISA	Health Directorate (in Lima)
ENAHO	National Household Survey
GalenHos	Hospital Management Information System
HRG	Healthcare Resource Groups
HS 20/20	Health Systems 20/20 project
LOF	Law of Organization and Functions
LOPE	Organic Law of the Executive Power
MED Salud	Monitoring and Evaluation of Health Decentralization tool
MOF	Ministry of Finance
MOH	Ministry of Health
ODSIS	Deconcentrated Offices of the Integrated Health Insurance
OGPP	General Planning and Budgeting Office
OSCE	Supervisory Office of State Procurement
PCM	Prime Minister Office
PEAS	Essential Health Insurance Plan
PHRplus	Partners for Health Reform plus
PRAC Salud	Regional Anticorruption Plan in Health
RHA	Regional Health Account
RHD	Regional Health Directorate
ROF	By-law of Organization and Functions
SEPS	Superintendence of Private Provider Entities
SERVIR	National Authority of Civil Service
SIS	Integrated Health Insurance
SUNASA	Superintendence of Health
USAID	United States Agency for International Development

I. EXPECTED RESULTS

From April to October 2009, the Health System 20/20 (HS 20/20) project was requested by the USAID Peru Mission to provide technical assistance to the MOH and selected Regional Governments to plan the implementation of the universal health insurance law, which was approved by Congress in March, 2009. Additionally, HS 20/20 continued some of the activities related to health decentralization and insurance which had been developed by the USAID/Promoting Alliances and Strategies which ended in March 2009.

In order to do so, the project opened offices in seven regions, six of which had been selected by the MOH as pilot regions for the implementation of the health insurance reform:

- Ayacucho
- Apurimac
- Cajamarca (not a pilot zone)
- Huancavelica
- Lambayeque
- La Libertad
- San Martin

The expected results for this 7 month period are shown below.

TABLE I: EXPECTED RESULTS AND DELIVERABLES

Component	Expected Results (April – November 2009)	Deliverables I/
Advocacy of health reform	--	National and regional political parties agreements
	--	International experience in health financing
Health decentralization	PCM and MOH have approved matrix of distribution of health functions by government levels	Matrix of distribution of health functions between government levels
		Guidelines to define sector functions matrixes
	MOH, Northern and Southern Macro Regions are building consensus regarding health reform agenda and its implementation	Road Map of Health Decentralization 2010-2014
	MOH and Regional Governments have approved monitoring and evaluation systems of health decentralization	Publication of Module I of MED-regional level
		Legal norm for the approval of MED-regional level
	Proposal of Module II of MED-regional	

Component	Expected Results (April – November 2009)	Deliverables 1/	
		level	
		Regional capacity plans	
		Proposal of MED-local level	
	Regional and Local Governments exercise decentralized health functions		Regional Health Directorate ROF ROF networks and micro networks
			Participatory Regional Health Plan
			Guidelines or the design of local health decentralization design
			Design of the local health decentralization pilot experience – Celendin
			Systematization of experiences of local health decentralization
	Implementation strategies for anti corruption plans in health for three regions		Publication of Anticorruption Plans
			Systematization of experiences of implementation of anti corruption measures
Health Financing and Insurance Reform	MOH approves quality and opportunity indicators for maternal and child conditions covered by the insurance program	Health Insurance Benefit Plan	
	MOH has approved by-law of SUNASA	By-law of the Superintendence	
	SIS has developed capacities to design and implement new payment mechanisms for health insurance	Training reports of SIS personnel	
	Regional Governments are conducting and implementing the health insurance reform		Health Insurance implementation plans
			Stakeholder mapping
			Methodological guidelines to develop multiannual investment plan
	--		Publication of Burden of Disease study
			Update of ASEGURA
			Update of GalenHos
			Regional Health Accounts reports
Other		Update of ACRES	
		Project reports	

1/ Included in attached CD.

2. ADVOCACY FOR HEALTH SECTOR REFORM

2.1 PURPOSE OF THE COMPONENT

During the period April-November the project continued the facilitation of the political dialogue among national parties. Specifically during in this stage the health topic chosen by the political parties was: “financing of the universal health reform”. The objective was to facilitate a political agreement regarding a policy proposal to introduce mechanisms that will allow a more predictable flow of financial resources for the expansion of health insurance. Currently, the Law of Universal Health Insurance lacks guidelines for the establishment of clear financing rules and the allocation of public funds is subject to the discretion of the Ministry of Finance (MOF).

At the regional level, a new deliberation and consensus building cycle on health topics was promoted among regional political movements. To this end, the project assisted the constitution of Regional Dialogue Promoter Groups that could act as facilitators of the deliberation on regional health issues, during the pre-election phase.

2.2 RESULTS

2.2.1 NATIONAL LEVEL

The facilitation of political dialogue regarding health reform was initiated in 2005 by the project PHRplus. During the USAID/Promoting Alliances and Strategies this program continued by i) training of young political members in political parties and health sector reform; and ii) facilitating a second political agreement regarding the stewardship role of the MOH. The representatives of the political parties also participated actively in the approval of the Law of Universal Health Insurance by informing and motivating their Congress members to support the passing of the law.

In order to strengthen the capacity of the participating parties, the HS 20/20 project promoted the constitution of a Coordination Committee selected by the political parties, so as to directly engage them in the organization of the program. The project has facilitated the meetings of the Coordination Committee, processed and disseminated health information, facilitated the deliberation sessions and systematized the different positions of the political parties.

The Coordination Committee has maintained communication with the MOH and has presented the progress of the deliberations to the Technical Secretariat of the National Agreement (Acuerdo Nacional). The participation of the political parties has been constant thus contributing to the consolidation of technical expertise on health reform within the political parties, as well as to strengthen thrust relationships between them. In this stage 14 political parties have participated as shown in the following table. It is important to note that two political parties that had not participated previously: Cambio 90 and the Partido Nacionalista del Peru have actively joined the group.

TABLE 2: NATIONAL POLITICAL PARTIES PARTICIPATING IN HEALTH DIALOGUE

1. Partido Acción Popular	8. Partido Alianza para el Progreso
2. Avanza País - Partido de Integración Social	9. Partido Cambio 90
3. Partido Movimiento Nueva Izquierda	10. Partido Aprista Peruano
4. Partido Descentralista Fuerza Social	11. Partido Humanista Peruano
5. Partido Popular Cristiano	12. Partido Socialista
6. Partido Perú Posible	13. Partido Restauración Nacional
7. Partido Solidaridad Nacional	14. Partido Nacionalista del Perú

In this period the main topic of discussion has been the alternatives for financing the universal health insurance reform. The process followed these following steps:

1. Analysis of health financing in Peru
2. Analysis of international experiences and alternatives
3. Presentation of the proposals of the political parties
4. Identification of points of consensus

Due to the technical nature of the selected topic, in the first step several introductory sessions were held to standardize understanding of concepts and update knowledge and diverse experts presented the Peruvian situation regarding health financing. In the second step, the project elaborated a comparative study of international experiences on health insurance financing, which proved useful to increase familiarity of the participants on financing alternatives. The cases of Chile, Colombia, Germany, Canada, France and United Kingdom were analyzed. On this basis a basic discussion guide was elaborated containing the following topics:

TABLE 3: HEALTH FINANCING TOPICS FOR DISCUSSION IN NATIONAL DIALOGUE

General	Subsidized regime	Semi-Contributory regime	Semi contributory regime
Eligibility criteria	Public financing	Administration of the regime	Stability of the contributions
	Resource allocation mechanisms	Co-payments	Solidarity contributions
	Provider payment mechanisms		Risk management
	Provider autonomy for financial management		Insurance plans contracting

The political parties carried out an internal work to develop their proposals, which were presented in two sessions and systematized by the project. The final step of consensus building will be facilitated by the Belgium Technical Cooperation (CTB) and the Economic and Social Research Consortium (CIES); the expected product is a document containing consensus based guidelines for a health financing policy which will be submitted to the MOH and Congress.

2.2.2 REGIONAL LEVEL

At the regional level the project has promoted political dialogue on regional health topics in Ayacucho, Cajamarca and San Martin. Efforts were made to organize similar work in Lambayeque and La Libertad, but political movements have not been fully defined yet. In total, 25 political movements have participated, as shown below.

TABLE 4: REGIONAL POLITICAL PARTIES PARTICIPATING IN HEALTH DIALOGUE

Ayacucho	Cajamarca	San Martín
Frente Regional Ayacucho	Movimiento Político Tierra y Libertad	Movimiento Nueva Izquierda
Somos Perú	Alianza Para el Progreso	Grupo Ideas
Partido Perú Posible	Movimiento Independiente Regional	Partido Nacionalista Peruano
Partido Nacionalista Peruano	Frente Independiente Regional	Partido Aprista Peruano
Qatun Tarpúy	Partido Popular Cristiano	Partido Popular Cristiano
Partido Bien Peruano	Partido Aprista Peruano	Alianza Para el Progreso
Partido Acción Popular	Movimiento Regional Fuerza Social	Acción Popular
Agrupación Juntos Sí Podemos	Acción Popular	Partido Socialista
		Partido Perú Posible

The Regional Dialogue Promoter Groups were integrated by respected regional organizations and institutions, such as Regional Health Councils, universities, professional associations, NGOs, etc. In all the cases, these groups were trained by the project in facilitating skills and were accepted as neutral facilitators by the political parties.

It is important to note that the majority of the members of the regional political parties lack information about the health sector. Therefore, the presentation made by health authorities and managers about the situation of the regional health system, progress made and key issues has been very important in the three regions to place the health sector in the political agenda.

In all the cases, there has been an introductory session, followed by the prioritization by the political parties of the health issues to be discussed. In the case of San Martin, the political movements decided to simultaneously discuss the health and education sectors. The following table shows the specific topics selected in each region.

TABLE 5: HEALTH TOPICS FOR DISCUSSION IN REGIONAL DIALOGUE

Ayacucho	Cajamarca	San Martín	
Health		Education	
Progress, limitations and challenges of the regional health agenda		Progress, limitations and challenges of the regional education agenda	
Health investment policies	Health financing	Health financing	Education financing
Health Human Resources policies	Regional Health Priorities	Regional Health Priorities	Access of children under 5 years of age to the education system
Health insurance	Health insurance	Environmental Health and Sanitation	Improvement of basic education: effective strategies
Citizen participation and inter sector responsibility			

In the regions of Cajamarca and San Martin the political parties have presented their proposals regarding the prioritized topics. Both Regional Dialogue Promoter Groups will continue the program till the consensus building stage. The project has provided the methodology on the basis of the experience developed by PHRplus and USAID/Promoting Alliances and Strategies during 2005, 2006 y 2008-09 at the regional and national levels. In the case of Ayacucho, the political parties have completed the program, establishing a regional agreement regarding the four prioritized topics. This agreement will be presented to regional authorities and representatives of public and private organizations in the near future.

In general terms, there is a need to strengthen the capacities of the political organizations at the regional level, due to the lack of information and ability which has evidenced in the discussion meetings. Capacity building programs at the national level are not enough due to the particular political structure in the country by which national parties have limited influence in regional and local elections.

3. HEALTH SECTOR DECENTRALIZATION

3.1 PURPOSE OF THE COMPONENT

In this component, the project had the purpose of continuing some of the activities that had been initiated during the USAID/Promoting Alliances and Strategies, such as:

- Providing technical assistance to the MOH and the Prime Minister's Office (PCM) to conclude the stage of definition of the sector's functions at the national level which was pending after the approval of the Organic Law of the Executive Power (LOPE) on December, 2007.
- Providing technical assistance to the MOH and Regional Governments to collect a base line of health decentralization, upon the completion of the transfer of health functions to the regional level in 2008. On the basis of this base line assessment, capacity building plans were developed at the regional level taking into account prioritized health functions.
- Continue supporting Regional Governments of Cajamarca, La Libertad, Lambayeque and San Martin in the process of reorganization of the Regional Health Directorates (RHD), according to the newly transferred functions. From April to November, efforts were made to develop the by-laws of organization and functions (ROF) at the RHD level and the health network levels, as well as necessary support documentation to enable the approval of the reorganization.
- Assist the Regional Governments of Lambayeque, La Libertad y San Martin to initiate the implementation of the local health decentralization pilot experiences. In the case of Cajamarca, the project supported the regional government in the process of selection of the pilot site as well as in the participatory design of the pilot experience.
- Initiate the implementation of the Regional Health Anti Corruption Plans of Lambayeque, La Libertad y San Martin, which were approved by the end of 2008.

3.2 RESULTS

3.2.1 LAW OF ORGANIZATION AND FUNCTIONS OF THE MOH

Upon the approval of the Organic Law of the Executive Power (LOPE) - Law N° 29158 which established the basic norms of organization, competencies and functions of the Executive Power, each ministry was required to elaborate a proposal of their Organization and Functions Law (LOF). The MOH formulated a proposal, which was sent to Congress for approval.

In April, the Decentralization Committee of Congress and the Public Management Secretariat of the Prime Minister Office (PCM) assessed the progress in the implementation of the Organic Law of the Executive Power and established the need to strengthen the process. Technical assistance was requested to USAID to develop a health sector map of the MOH functions in the framework of the definition of its Organization and Functions Law. In order to comply with this request, the project

developed a methodology based on 9 steps to define the sector's core competencies and essential processes. This methodology was developed in close coordination with the Public Management Secretariat and the Decentralization Secretariat of the PCM. A work group was set up that revised the function matrixes developed by the MOH, distinguishing the stewardship functions from the health services management functions. On the basis of the separation of functions, the project assisted PCM to develop the proposal of matrix of functions of the MOH which was presented to the Minister of Health and the LOF Committee of the MOH.

The MOH has shown some resistance regarding the separation of functions between the stewardship/regulation of health markets and the health service provision related functions. This can partly be explained due to the fact that the health decentralization process in yet to be completed as the transfer of the health provision functions of MOH to the Region of Metropolitan Lima is still pending, due to a lack of political will of the Metropolitan Lima Municipality. While this situation persists the MOH will still need to devote efforts to the management of hospitals and health service networks in Lima, instead of focusing on developing capacities for the stewardship and regulatory functions.

On the basis of the work done by the project, the PCM requested the development of a methodological guideline to be applied to other sectors and ministries which shared national-regional functions, such as the Ministry of Women and Social Development, Ministry of Education, Ministry of Agriculture and Ministry of Housing and Sanitation. The project also trained the sector experts of PCM in the use of the guideline.

3.2.2 HEALTH DECENTRALIZATION ROADMAP

Since the beginning of the decentralization process, two health decentralization road maps had been developed which established the steps needed for the transfer of health functions from the national level to the Regional Governments. With the "decentralization shock" mandated by the new administration in 2006, the transfer of functions was accelerated and in the health sector they concluded in 2008, thus completing the Medium Term Transference Plan developed in 2006 (with the exception of Lima metropolitan region, as noted above).

In this context it was necessary to plan the next stage of the decentralization process. To this end, the Decentralization Office of the MOH carried out, with the project's technical assistance and facilitation, a process of discussion with Regional Governments to establish a new health sector decentralization road map. The project worked closely with the MOH facilitating dialogue with the Regional Governments through the macro regional meetings in the northern, central and southern regions of the country.

In May, in the Northern Macro Regional Meeting, that took place in Cajamarca, the Decentralization Office of MOH presented the initiative and the scope of the process that would lead to an agreement regarding priorities to advance the decentralization process in the health sector. The Regional Health Directors and Regional Managers of Social Development designated a committee that has received technical assistance from the project. Similar committees were designated in the macro regions of the south and center, promoted by the Decentralization Office of MOH.

Finally, in September a national decentralization meeting was held, in which the regions and the MOH offices and directorates agreed upon a final road map for 2010-2014. The approved road map contains 8 policy areas, for which specific topics, activities, time frames and responsibilities have been established.

TABLE 6: POLICY AREAS OF THE NEW HEALTH DECENTRALIZATION ROAD MAP 2010-14

1. Strengthening of the national health authority and intergovernmental articulation
2. Strengthening of regional health authorities and interregional articulation
3. Local health decentralization
4. Monitoring and evaluation of the health decentralization process and capacity building at the national, regional and local levels
5. Human resources in health
6. Public health sector financing
7. Citizen participation
8. Universal health insurance

See annex A for complete description.

The MOH will develop a Supreme Decree to formalize this road map, so as to lay the ground for the institutionalization of this agenda and its continuation by the next government starting in 2011.

3.2.3 HEALTH DECENTRALIZATION MONITORING AND EVALUATION (M&E) SYSTEM

With the purpose of monitoring and evaluating the compliance of Regional Governments regarding the exercise of decentralized functions, two norms were issued in the year 2007: the Supreme Decree N° 010-2007-PCM, that mandates that ministries will execute the decentralization monitoring and evaluation system; and the Supreme Decree N° 027-2007-PCM, that establishes that the Decentralization Secretariat of the Prime Minister’s Office will supervise this system.

In this context, the USAID/Promoting Alliances and Strategies project developed the analytical framework and the initial M&E tool (“MED Salud Regional” Volume I) to assess the exercise of transferred functions to the regional level. Project HS 20/20 published the “MED Salud Regional” Volume I for its use in self assessment workshops carried out in all the regions of the country under MOH guidance. In November, 2009 the MOH issued the Ministerial Resolution 739-2009/MINSA by which the “MED Salud Regional” was approved and future periodical monitoring of progress in the exercise of regional health functions was made mandatory.

Technical assistance was provided to the Regional Governments of Cajamarca, Lambayeque, La Libertad and San Martin to develop capacity building plans based on the results and analysis of the self assessment of the “MED Salud Regional” Volume I. The following table shows the prioritized areas for improvement selected in each region.

TABLE 7: FUNCTION AREAS OF THE REGIONAL CAPACITY BUILDING PLANS

Prioritized functional areas	Cajamarca	La Libertad	Lambayeque	San Martin
• Management of public insurance		x	X	X
• Institutional organization	X		X	X
• Management of health investment	X			X
• Management of health information	X		X	X
• Institutional management of human resources	X		X	X
• Sector regulation of human resources		x		
• Organization and management of	X	x		

Prioritized functional areas	Cajamarca	La Libertad	Lambayeque	San Martin
health services				
• Sector regulation of health services		x		
• Strategic and operational planning		x		
• Management of risks and disasters		x		

On the basis of these plans, the project developed a general manual for the formulation of capacity building plans, which was submitted to the Decentralization Office and will be applied to other regions during 2010.

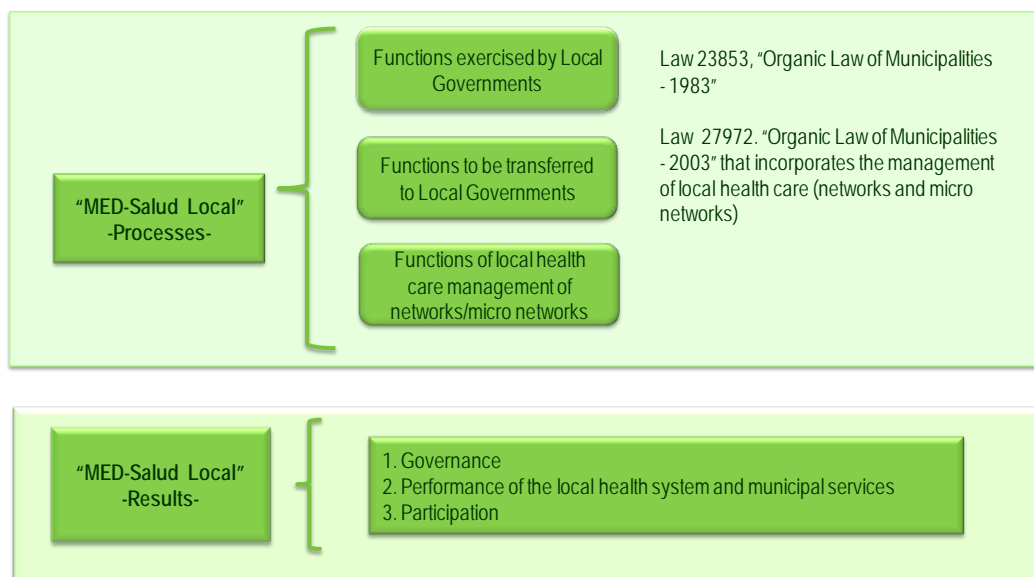
Additionally, the project has worked closely with the Decentralization Office of the MOH to develop proposals for two complementary tools to complete the M&E system, as established by the Health Decentralization Road Map:

1. Assessment of results and impact of regional health decentralization (“MED Salud Regional” Vol. 2).
2. Assessment of local health decentralization (“MED Salud Local”)

Regarding the “MED Salud Regional” Volume 2, the proposal contains indicators regarding results and impacts of the decentralization process to the regional level, on the basis of currently available information sources. This tool has been validated with the MOH officials and needs to be validated with regional officials, prior to its application nationwide in 2010. Upon completion of this, the country will have a fully estimated base line of regional decentralization with indicators of processes, results and impacts.

The “MED Salud Local” has been developed following the same structure that the “MED Salud Regional”, taking into account the health functions defined for Local Governments. The proposal has been validated in one local area and needs to be further validated at provincial and district scope –both at the municipal and health network level-, as well as with the MOH and PCM officials. It is expected that the “MED Salud Local” can be used a tool to monitor and accredit local health functions prior to their transference to the municipalities.

FIGURE I: CONTENTS OF “MED SALUD LOCAL”



3.2.4 EXERCISE OF REGIONAL AND LOCAL HEALTH FUNCTIONS

3.2.4.1 BY LAWS OF REGIONAL HEALTH DIRECTORATES AND HEALTH NETWORKS

The project has continued to assist the Regional Governments of Cajamarca, Lambayeque, La Libertad and San Martín to advance their processes of institutional redesign. In this stage the by-laws (Reglamento de Organización y Funciones - ROF) of the Regional Health Directorates (RHD) were developed. The ROF are technical and legal documents that formalize the organizational structure, establishing general and specific functions and main organic units. In the four cases, the project supported the technical teams of the Regional Health Directorates and facilitated the approval of the ROF by the Regional Councils (regional legislative bodies) of the Regional Governments.

The ROF that have been developed clearly establish the separation of functions between regional regulatory functions and health service provision functions. On the one hand, this change reinforces the condition of Regional Health Authority of the Regional Health Directorates; and on the other paves the way to progressive deconcentration of health service provision functions to the networks and micro networks. In the case of three Regional Health Directorates, ROFs of health networks have also been developed to complete the map of institutional redesign at the regional level. To this end, work groups were established and ample workshops were organized with the participation of public health providers.

3.2.4.2 PARTICIPATORY REGIONAL HEALTH PLAN

In the region of Cajamarca, the project assisted the regional technical team in the formulation of the Regional Participatory Health Plan, on the basis of previously selected health priorities:

1. Chronic Malnutrition in children below 5 years
2. Maternal and perinatal mortality
3. Low educational level of the population
4. Reduced capacity of the health facilities

The project facilitated the analysis of the health strategies and the development of the plan, identifying objectives, goals and indicators for each priority. The Regional Participatory Health Plan contains intermediate results that will allow health authorities and managers to link the strategic plan to the annual operational plans and budgets. The plan has been approved by Regional Resolution 913-2009 GR.CAJ/DRS.

3.2.4.3 LOCAL HEALTH DECENTRALIZATION

The process of local decentralization was initiated with the Supreme Decree 077-2006-PCM, which established the stages and mechanisms for the transfer of the management functions of primary health care to local governments. This decree determined the criteria for the definition of the pilot zones, including the requisite of a concerted selection between the regional and local levels.

Within this legal framework, USAID/Promoting Alliances and Strategies assisted the Regional Governments of La Libertad, Lambayeque and San Martín in the definition of the pilot sites and in the design of the pilot experience projects for their approval by the Regional Councils. During HS 20/20 further assistance was provided to initiate the implementation of the pilot experiences in district of

Salas, Lambayeque; the province of Sanchez Carrion, La Libertad; and the Commonwealth (mancomunidad) of Bajo Huallaga, San Martin. In the first two cases, Local Health Boards have been constituted with the formal incorporation of representatives of the Local Governments, the Regional Health Directorate and civil society. To designate the members of civil society, election processes were organized with ample participation at the district level. These Local Health Boards have been assisted to define their by-law and their work plans for 2010. In the case of Cajamarca the project assisted the regional and local authorities to define and design the pilot experience in the province of Celendin.

As shown in the table below, currently the scope of local health decentralization is limited. In most of the cases, the process has not progressed beyond the initial dissemination/motivation stage. Only in the case of the sites assisted by USAID, the pilots have completed the design phase and are being implemented. In the case of Cajamarca, the design of the pilot experience has been completed in only 4 months.

TABLE 8: SCOPE OF THE LOCAL DECENTRALIZATION PILOT EXPERIENCES

Regional Government	Phase	N° Pilots	Name	Type	Micro Network	N° Micro Network	N° Districts
AMAZONAS	DISSEMINATION	3	ARAMANGO	DISTRITAL	ARAMANGO	6	8
	DISSEMINATION		CAJARURO	DISTRITAL	CAJARURO ALTO AMAZONAS NARANJITOS		
	DISSEMINATION		RODRIGUEZ DE MENDOZA	PROVINCIAL	RODRIGUEZ DE MENDOZA TOTORA		
APURIMAC	DESIGN	3	AYMARAES	PROVINCIAL	CHALHUANCA SANTA ROSA	4	19
	DESIGN		CURAHUASI	DISTRITAL	CURAHUASI		
	DESIGN		SAN JERONIMO	DISTRITAL	SAN JERONIMO		
PIURA	DISSEMINATION	3	CATACAOS	MANCOMUNIDAD	CATACAOS	3	11
	DISSEMINATION		BAJO MORROPON CHULUCANAS	MANCOMUNIDAD	CHALACO		
	DISSEMINATION		TALARA	MANCOMUNIDAD	LOS ORGANOS		
HUANUCO	DISSEMINATION	2	AMBO	PROVINCIAL	AMBO	2	8
	DISSEMINATION		AUCAYACU	DISTRITAL	AUCAYACU		
PASCO	DISSEMINATION	3	PAUCARTAMBO	DISTRITAL	PAUCARTAMBO	3	3
	DISSEMINATION		POZUZO	DISTRITAL	POZUZO		
	DISSEMINATION		VILLA RICA	DISTRITAL	VILLA RICA		
AYACUCHO	DISSEMINATION	2	RIO PAMPAS	MANCOMUNIDAD	POMABAMBA	2	5
	DISSEMINATION		JESUS NAZARENO	MANCOMUNIDAD	NAZARENAS		
HUANCAVELICA	DISSEMINATION	5	ACOBAMBA	PROVINCIAL	ACOBAMBA PAUCARA	6	25
	DISSEMINATION		TAYACAJA	PROVINCIAL	PAMPAS		
	DISSEMINATION		YAULI	DISTRITAL	YAULI		
	DISSEMINATION		HUANDO	DISTRITAL	HUANDO		
	DISSEMINATION		HUANCAVELICA	PROVINCIAL	ASCENSION		
SAN MARTIN I/	IMPLEMENTATION	3	BAJO HUALLAGA Y CAYNARACHI	MANCOMUNIDAD	BARRANQUITA HUIMBAYOC CAYANARACHI	5	12
	DISSEMINATION		JEPELACIO	DISTRITAL	JEPELACIO		
	DISSEMINATION		TOCACHE	PROVINCIAL	TOCACHE		
MADRE DE DIOS	DISSEMINATION	2	MADRE DE DIOS	DISTRITAL	COLORADO	2	2
	DISSEMINATION		LAS PIEDRAS	DISTRITAL	PLANCHON		
CAJAMARCA I/	DESIGN	2	CELENDIN	DISTRITAL	CELENDIN	3	8
	DISSEMINATION		CAJABAMBA	PROVINCIAL	CAJABAMBA MALCAS		
ICA	DISSEMINATION	2	NAZCA	PROVINCIAL	NAZCA	2	10
	DISSEMINATION		PALPA	PROVINCIAL	PALPA		
AREQUIPA	DISSEMINATION	3	CONDESAYOS	PROVINCIAL	CHUQUIBAMBA	4	18
	DISSEMINATION		LA UNION	PROVINCIAL	ALCA COTAHUASI		
	DISSEMINATION		PAMPACOLCA	DISTRITAL	PAMPACOLCA		
LAMBAYEQUE I/	IMPLEMENTATION	3	SALAS	DISTRITAL	SALAS	4	8
	DISSEMINATION		KANARIS	DISTRITAL	KANARIS		

Regional Government	Phase	N° Pilots	Name	Type	Micro Network	N° Micro Network	N° Districts
	DISSEMINATION		CIRCUITO MUCHIK	MANCOMUNIDAD	REQUE MONSEFU PIMENTEL PUERTO ETEN CIUDAD ETEN SANTA ROSA		
TUMBES	DISSEMINATION	1	ZORRITOS	PROVINCIAL	CORRALES	1	3
LA LIBERTAD I/	IMPLEMENTATION	1	RED SANCHEZ CARRION	PROVINCIAL	CHUGAY EL PALLAR CURGOS SANCHEZ CARRION	4	8
UCAYALI	DISSEMINATION	2	ATALAYA	DISTRITAL	ATALAYA	2	2

I/ Assisted by USAID.

The Decentralization Office of the MOH has announced a relaunching of the local health decentralization policy during 2010, in order to expand the number of pilot experiences in the country. The general purpose is to articulate the local health decentralization process to the expansion of universal health insurance. To this end the project developed a manual for the design of local health decentralization pilots which is being incorporated by the MOH as a key tool.

3.2.5 IMPLEMENTATION OF ANTICORRUPTION PLANS IN HEALTH

During USAID/Promoting Alliances and Strategies, the Regional Governments of La Libertad, Lambayeque and San Martin formulated and approved Health Anti Corruption Plans. HS 20/20 provided technical support for the initiation of the implementation of these plans, according to the identification of key actions in each region. In the table below, the diversity of these actions are shown.

TABLE 9: IMPLEMENTATION OF ANTICORRUPTION PLANS

Regions	Implementation Actions
La Libertad	<ul style="list-style-type: none"> Promotion of mechanisms of citizen surveillance of the anticorruption measures through volunteers called “avales ciudadanos”. Training of “avales ciudadanos” Designation of “avales ciudadanos” in the pilot zone.
Lambayeque	<ul style="list-style-type: none"> Creation, training and functioning of the Surveillance Unit of the Regional Health Council Promotion of the creation of the Surveillance Unit in the pilot zone
San Martín	<ul style="list-style-type: none"> Strengthening of the Patient Ombudsman Office in the Hospital of Tarapoto. Strengthening of transparency and Access to information through the update of the web page

In La Libertad the project revised and adjusted the pre-existing program of “avales ciudadanos” (citizen volunteers that carry out surveillance of health services). The selection procedures of the “avales” and the surveillance tools were improved, on request by the Regional Health Directorate. A training program was carried out for the expansion of the “avales” to the region, particularly to the province of Sanchez Carrion, which is the local health and universal insurance pilot site.

In Lambayeque, the project trained the Surveillance Unit particularly to strengthen their capacities to oversee the processes of hiring of new staff and the contracting of goods and services, particularly pharmaceuticals, by the Regional Health Directorate. To this end, checklists have been developed according to current approved procedures. In the case of selection of human resources, the check list was developed with the participation of the National Authority of Civil Service (SERVIR), while for the acquisition of pharmaceuticals, assistance of the Supervisory Office of State Procurement (Oficina Supervisor de Contrataciones del Estado -OSCE) was coordinated. These tools were disseminated also in the regions of San Martin y La Libertad. Additionally, the Unit has developed a work plan which includes creating a Local Surveillance Unit in the pilot zone of Salas.

In San Martin the project facilitated workshops with the Regional Health Directorate to establish a work plan for the implementation of the processes of acquisitions and measures of transparency and participation, in accordance to the anticorruption plan. The project provided assistance to redesign the web page so as to include information regarding anticorruption indicators (<http://www.minsa-sm.gob.pe>). This was institutionalized through the approval of the Directorial Resolution 160-2009 DG - DIRES /SM. In the case of the Hospital of Tarapoto a proposal to constitute a Patient Ombudsman Office was developed and a by law was approved accordingly (Directorial Resolution 704-2009-DIRES-SM/DEDIC).

During the short period in which the project has assisted the implementation of the anticorruption plans, the basic emphasis has been on strengthening the role of external surveillance agents. Nevertheless in the future this strategy needs to be reinforced with direct actions to introduce behavior change in public officials and workers.

4. HEALTH FINANCING AND INSURANCE REFORM

4.1 PURPOSE OF THE COMPONENT

Following the approval of the Universal Health Insurance Law, the MOH considered a priority the design of a strategy for the implementation of the health insurance reform in selected pilot regions. This strategy involved the definition of a normative and operative set of activities that were identified as imperative for the initial launching of the reform. Considering the complex nature of this task and taking into account previous technical background developed by USAID/Promoting Alliances and Strategies, HS 20/20 was asked to advance the definition of an action plan for the Universal Health Insurance implementation considering a time span of six months. This agenda included the following issues:

- Update of the Health Benefit Plan of the Essential Health Insurance Plan (PEAS), including the opportunities and quality guarantees for maternal and child care
- Design of a by-law proposal for the National Health Superintendence (SUNASA) in accordance with the Universal Health Insurance Law
- Generation of capacities at the Integral Health Insurance (SIS) for the design of new payment mechanisms
- Development of universal health implementation plans for six pilot regions selected by the MOH

4.2 RESULTS

4.2.1 DEFINITION OF EXPLICIT GUARANTEES OF PEAS

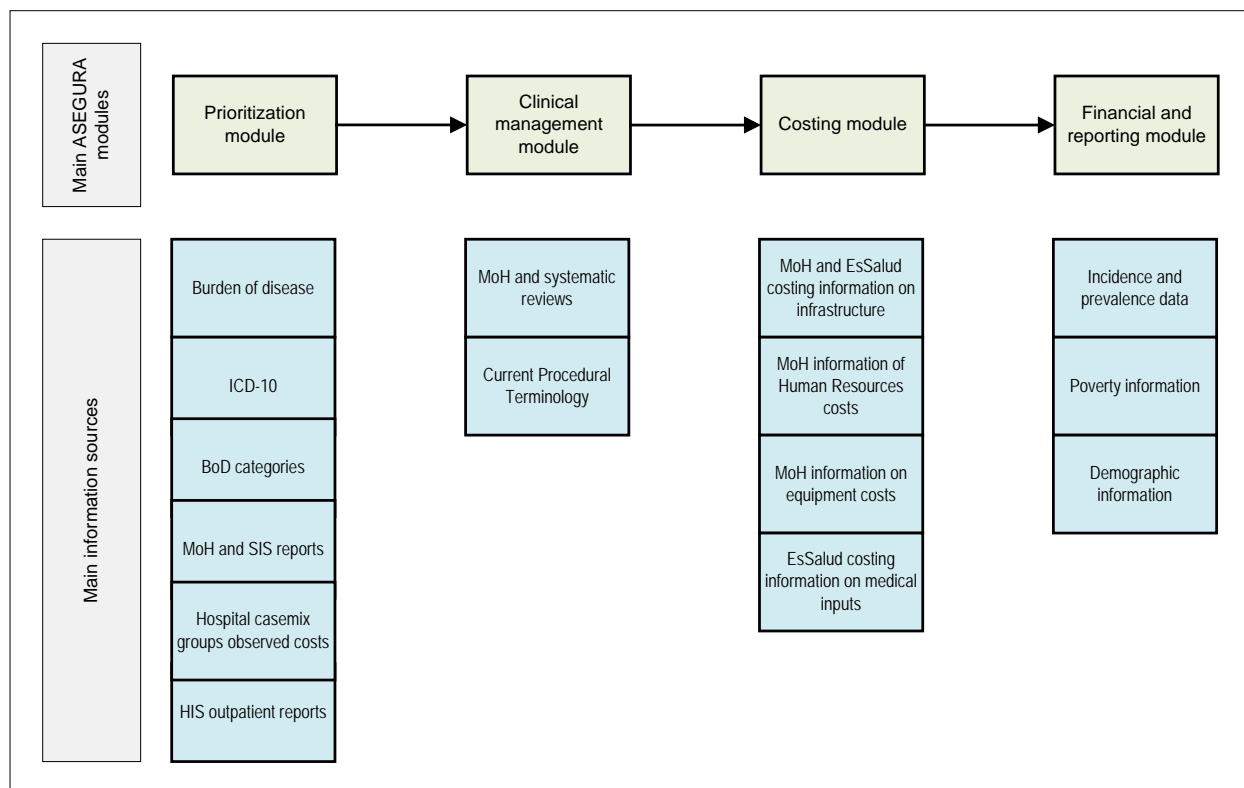
HS 20/20 and the MOH worked closely together to define the opportunity and quality guarantees to be included in the Essential Health Insurance Plan (Plan Esencial de Aseguramiento Universal-PEAS). A methodology was defined to identify the critical points in the process flow of care for 54 conditions. Thus, quality and opportunity guarantees were designed for an initial set of 54 conditions; nevertheless the MOH decided to start by focusing on 11 conditions. This decision was based mainly on the perception the existence of severe provider restrictions in the pilot regions. In particular, the MOH felt that the opportunity guarantees identified for life-threatening maternal and child conditions (and variants) set performance standards impossible to be attained considering the current non availability of specialized medical staff at the pilot regions.

By the end of the project a Supreme Decree of the PEAS has been developed and is pending of approval by the Executive Power.

4.2.2 DEVELOPMENT OF ASEGURA

The complex nature of the design of a health insurance package is related to the varied sources of information that have to be collected and processed. These pieces of information need a multidisciplinary approach in order to be correctly used for the financial planning process. Considering that the time needed for the design of the first version of PEAS took around two years of a continuous and intense work, the project developed a software application to be used for rapid updating of health insurance financial estimates. ASEGURA was developed using information from the Burden of Disease Study, standard costing, integral health management schemes and the incidence and prevalence data for insurable conditions. The general functioning of ASEGURA is shown in figure 1, and a sample report screen is shown in figure 2.

FIGURE 2: GENERAL ORGANIZATION OF ASEGURA DATA INPUTS



ASEGURA served to update the estimations of financial requirements for PEAS implementation. This update was necessary due to changes in the PEAS that arose as a consequence of the consultation that the MOH opened to receive input from civil society representatives and health sector officials. This activity served to update information on pharmaceuticals and salaries, as well as the poverty rate.

The resulting effect of these changes was variable: the simplification of the list of medical drugs for PEAS contributed to the elimination of most costly clinical variants; the reduction of the poverty level -from an initial 39.3% of the Peruvian population to 36.2%- reduced overall financial requirements; while on the

contrary, the update of salaries increased costs. Thus, the per capita cost for PEAS rose from NS/ 280 to NS / 285, but the overall requirements decreased from NS/. 3.1 billion to NS/. 2.9 billion due mainly to the significant reduction of the poverty level.

FIGURE 3: MAIN SCREEN OF ASEGURA: ADMINISTRATOR PROFILE

Nro	Código	Denominación	Probabilidad	Criterio	Poblac.Prior	C.U	Estimac
1.	A010001	Recién nacido sano Grupo de riesgo Sífilis congénita.	0.000110	1.00	1,119.09	6.96	7
2.	A010003	Recién nacido sano Grupo de riesgo Malaria congénita	0.006064	1.00	81,949.59	4.21	260
3.	A010004	Recién nacido sano Grupo de riesgo Tripanosomiasis americana	0.001761	1.00	17,985.37	4.21	75
4.	A010005	Recién nacido sano Grupo de riesgo Diabetes mellitus medición Glucosa cuantitativa en sangre	0.000264	1.00	2,697.80	3.46	9
5.	A010006	Recién nacido sano Grupo de riesgo Diabetes mellitus medición de Glucosa por tira reactiva	0.000264	1.00	2,697.80	2.25	6
6.	A010101	Recién nacido sano	0.019561	1.00	199,837.39	127.77	25,533
7.	A020001	Niño sano Grupo de riesgo Menores de 1 año	0.015649	1.00	159,869.92	140.89	22,523
8.	A020002	Niño sano Grupo de riesgo de 1 año	0.017881	1.00	180,825.69	95.58	17,445
9.	A020003	Niño sano Grupo de riesgo de 2 a 3 años	0.018887	1.00	192,949.98	74.98	14,467
10.	A020004	Niño sano Grupo de riesgo de 3 a 4 años	0.009599	1.00	98,062.18	80.73	7,916
11.	A020005	Niño sano Grupo de riesgo de 5 a 9 años	0.026408	1.00	269,786.20	85.86	23,162
12.	A030000	Adolescente sano. Sin actividad sexual	0.014819	1.00	151,390.59	182.81	27,676
13.	A030001	Adolescente sano Grupo de riesgo Mujer Método anticonceptivo oral	0.000407	1.00	4,154.46	125.79	522
14.	A030002	Adolescente sano Grupo de riesgo Mujer Método anticonceptivo DIU	0.000156	1.00	1,597.87	5.83	9
15.	A030003	Adolescente sano Grupo de riesgo Mujer Método anticonceptivo inyectable	0.001095	1.00	11,185.08	32.43	362
16.	A030004	Adolescente sano Grupo de riesgo Mujer Método anticonceptivo de barrera	0.000313	1.00	3,195.74	9.83	31
17.	A030006	Adolescente sano Grupo de riesgo	0.148191	1.00	1,513,905.86	10.38	15,709
18.	A040001	Adulto sano Grupo de riesgo Mujer Método anticonceptivo oral	0.023576	1.00	240,847.17	249.89	60,184
19.	A040002	Adulto sano Grupo de riesgo Mujer Método anticonceptivo DIU.	0.009068	1.00	92,633.53	118.40	10,967
20.	A040003	Adulto sano Grupo de riesgo Mujer Método anticonceptivo inyectable	0.063473	1.00	648,434.70	126.60	82,091
21.	A040004	Adulto sano Grupo de riesgo Mujer Método anticonceptivo de barrera	0.018135	1.00	185,267.06	122.40	22,676
22.	A040005	Adulto sano Grupo de riesgo Mujer AQV	0.001814	1.00	18,526.71	271.98	5,038
23.	A040006	Adulto sano Grupo de riesgo Varón menor de 50 años	0.052859	1.00	540,003.18	101.04	54,561
24.	A040007	Adulto sano Grupo de riesgo Varón mayor de 50 años	0.013015	1.00	132,963.41	104.73	13,925
25.	A040008	Adulto sano Grupo de riesgo Varón AQV menores de 50 años	0.000144	1.00	1,468.81	277.21	407
26.	A040009	Adulto sano Grupo de riesgo Varón AQV mayores de 50 años	0.000035	1.00	361.66	280.90	101
27.	A040010	Adulto sano no inmunizado previamente	0.039966	1.00	408,287.59	19.54	7,978
28.	A040011	Adulto sano en riesgo	0.022806	1.00	232,987.90	6.96	1,622
29.	A050001	Adulto Mayor hombre	0.002984	1.00	30,486.33	114.43	3,488
30.	A050002	Adulto Mayor mujer	0.003172	1.00	32,402.01	110.74	3,588
31.	A050003	Adulto Mayor no inmunizado	0.004145	1.00	42,341.46	17.63	746
32.	A050004	Adulto Mayor en riesgo	0.000272	1.00	2,782.08	6.96	19
33.	B010101	Aborto incompleto Sin complicaciones	0.010390	1.00	106,144.19	291.62	30,953
34.	B010102	Aborto incompleto Con complicaciones	0.002083	1.00	21,279.81	54.87	1,167
35.	B020101	Aborto complicado con infección Paciente estable Legrado Uterino Clindamicina + Ceftriaxona	0.000531	0.25	1,356.32	924.47	1,253
36.	B020102	Aborto complicado con infección Paciente estable Legrado Uterino Ampicilina + Gentamicina	0.000531	0.25	1,356.32	656.41	890
37.	B020103	Aborto complicado con infección Paciente estable Histerectomía Clindamicina + Ceftriaxona +	0.000094	0.50	478.70	4,749.00	2,273

4.2.3 PROPOSAL OF BY-LAW OF SUNASA

The Universal Health Insurance Law mandates the transformation of the current Superintendence of Private Provider Entities (SEPS) into a National Health Superintendence (SUNASA). HS 20/20 prepared a proposal of the by-law that implies a major reform of the organization of the current SEPS, based on the new functions mandated by the law. Among the main advantages posed by the proposal, the following can be mentioned:

- Executive offices are specialized following the current segmentation of health insurance markets, in this way, specialization is attained in areas in which market failures may arise
- Increasing levels of specialization for each type of entity under supervision of the Superintendence
- Lowering of costs of coordination across functional areas contributing to an improvement in the decision making process
- Overall orientation towards the insuree so as to facilitate the adoption of decisions across every institution under the mandate of the Superintendence

- Vertical and horizontal coordination between the different levels of management units of the Superintendence

The technical proposal prepared by HS 20/20 was submitted to a MOH task group comprised by representatives of SEPS, Integrated Health Insurance (Seguro Integral de Salud – SIS), General Office of Legal Advisory (OGAJ), and PARSALUD (MOH-World Bank-IDB project). This group analyzed the document, providing comments and suggestions. It has to be mentioned that the task group shows resistance to change the current organizational design of the Superintendence, on the assumption that it is adequate for the functions to be exercised. On the contrary, it is the opinion of the project that important changes are needed for adequate SUNASA functioning, based on the scaling up of the operations that the Superintendence will have to carry out. Currently the SEPS is supervising only 2% of the global universe of provision entities whereas under the evolution into SUNASA it will have to supervise 100% of provision entities.

MOH has adopted the proposal made by HS 20/20 regarding the nature of the supervision to be implemented, the functions of the Superintendence, the constitution of the Governing Board and the sanctions regime (see box 1). It remains to be confirmed the organizational design that SUNASA will have.

BOX 1: SELECTED ARTICLES OF THE PROPOSAL OF BY-LAW OF SUNASA

Article 8. Competency of the Superintendence

The Superintendence exerts the functions mentioned in the General Health Insurance Law, this by-law and other sector regulations.

The following entities are under the competence of SUNASA: all public, private and mixed institutions that are linked to the implementation of the universal health insurance, and those linked under Chapter II of the General Health Insurance Law, nationwide.

Article 9. General objective

The SUNASA has as a general objective the registration, authorization, regulation, supervision, sanctioning and other functions defined by the corresponding normative framework, within its competencies reach, so as to guarantee full and progressive access for the individual to the health social security, and that the latter is based on the guiding principles of universality, solidarity, unity, integrality, equity, irreversibility and participation.

Article 13. Requirements to be a member of the Board

- 1) To be a professional with more than 10 years of experience
- 2) To have relevant competencies and expertise, that is, a) more than 3 year-experience in executive positions in public, private or international entities, b) more than 5 year-experience in the issues that are under SUNASA competencies
- 3) Prove the fulfillment of at least a Masters degree in topics concerning the legal, regulative, economic, administrative or technical analysis of issues under the SUNASA competence

Article 83. Registration of penalties

SUNASA will have a register of penalties applied so as to elaborate statistic reports, communicate to the general public, and for identifying relapsing cases. This register will be on the public domain and updated information will be published in the institutional web page of SUNASA.

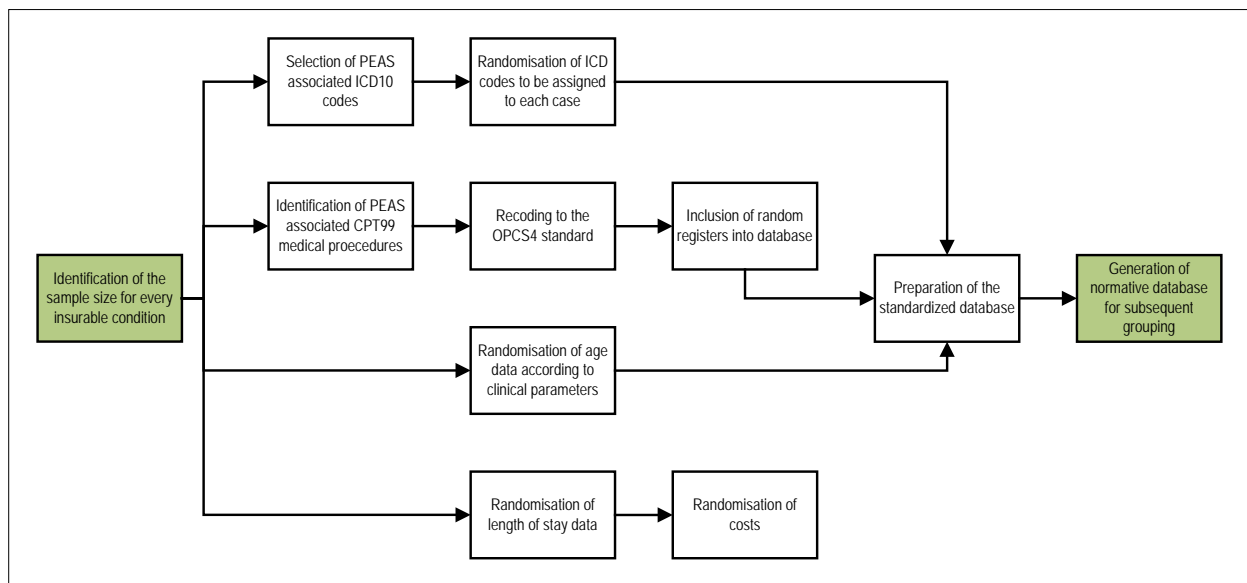
4.2.4 GENERATION OF KEY CAPACITIES FOR THE SIS

4.2.4.1 DESIGN OF NEW PAYMENT MECHANISMS FOR INPATIENT CARE

HS 20/20 received a request by SIS to provide the technical guidance for the design and implementation of Healthcare Resource Groups (HRGs) as a method for reforming the payment for public hospitals. In accordance to this demand, a training program was defined and executed from August to October 2009. Attendants were selected from the operations, planning, financing and statistics offices of SIS. The program allowed the reproduction of the general process to be followed in order to define an inpatient care fee-schedule based on HRGs and linked to PEAS. That is: a) Identification of the information requirements for the technical work, b) Identification of data inputs from PEAS working documents, c) Use of HRG grouper v 3.5, d) Generation of the HRG fee-schedule.

The generation of a normative database originated in clinical and economic data from PEAS, allows the definition of a minimum fee schedule that can be implemented for buying inpatient hospital outputs. This schedule has to be compared with observed costs at the same facilities in order to negotiate and determine a fair fee schedule that neither introduces financial risks to the provider nor to SIS. Figure 4 shows the general process for the generation of the normative HRGs database based on PEAS

FIGURE 4: PROCESS FOLLOWED FOR THE GENERATION OF A NORMATIVE HRG DATABASE ORIGINATED ON PEAS DATA



4.2.4.2 TRAINING IN CLINICAL AUDITING

SIS made a second request of technical support regarding the training of operations staff in clinical auditing. For this purpose, four universities were invited to participate in the selection process: a) San Marcos University, b) Cayetano Heredia University, c) Applied Sciences University and d) San Martin de Porres University. San Martin University was selected and developed a training program that comprised the following modules:

- Internal control
- Government auditing
- Evidence based medicine and evidence based auditing
- Normative, legal and ethical issues in health organizations

25 attendants were involved in this training, including the participants of ODSIS (Regional SIS Offices) from all universal health insurance pilot regions. The program has been certified by San Martin University and course credits are recognized as valid for the application to a diploma in the regular health auditing program. The overall rating of the course was satisfactory. SIS operations management office is committed to the immediate application of the training received by means of the formulation and execution of clinical auditing plans.

4.2.5 REGIONAL HEALTH INSURANCE IMPLEMENTATION PLANS

One of the most important tasks faced by HS 20/20 was the provision of technical assistance to six Regional Governments for the design of their corresponding health insurance implementation plans. The project's contribution to this process consisted in the following issues:

- Formulation of the methodology to be applied in the regions to develop the Regional Health Insurance Implementation Plan. The proposal was presented to the MOH and adjusted according to suggestions.
- Design of the overall planning approach to be used in the definition of the implementation plan. This step involved motivating the Regional Health Directorates and Regional Governments on the need of the nomination and the support for the regular functioning of the Regional Technical Committees for the Implementation of the Universal Health Insurance (CTIR). Seven CTIR were created in six pilot regions (Aurimac had two CTIR –Abancay and Andahuaylas- because of local rivalries between both cities). In some regions, the CTIR was constituted on the basis of the Regional Health Councils. In general terms, after a short start up period, the CTIRs showed a regular activity that favored the elaboration and monitoring of their regional implementation plans within their own expectations. This step also included the dissemination of the Law of Universal Health Insurance as well as of information regarding the health insurance policy as established by the MOH.
- Diagnosis on the current coverage of public and private health insurance systems in each region. A diagnosis was made regarding the current coverage of health insurance under the different insurance regimes: subsidized, contributory and semi contributory. Administrative data were contrasted with information retrieved from the national household survey (ENAHO). Systematically, administrative data provided higher estimates in comparison to ENAHO. ENAHO may contain more reliable information for diagnostic purposes, since there is double counting in EsSalud registers (for instance double affiliation of children arising from father-and-mother's affiliated status to EsSalud). However, CTIRs relied on their local registries for establishing the official health insurance diagnosis.
- Diagnosis on the current financial status of public insurance system in each region. Using information from SIAF and the local information provided by ODSIS, diagnosis were made for all six pilot regions. The analysis revealed very strong disparities of financing between regions, as can be seen in Table 10: the range of per capita expenditure can be as low as NS/ 74 per capita in Sanchez Carrion,

contrasting with NS/ 190 in Ayacucho.

TABLE 10: FINANCIAL DIAGNOSIS OF THE PUBLIC HEALTH INSURANCE

Region	Local pilot	Affiliated 2009 1/		Affiliation target 2010 2/		Expendit. 2009 3/	Expend. per capita 2009
		%	Pop	%	Pop	S/.	S/.
Lambayeque	Salas county	100%	13,326	100%	13,499	996,547	75
La Libertad	Sanchez Carrión province	71%	92,082	80%	105,479	6,823,443	74
San Martín	Bajo Huallaga cluster of counties	83%	18,662	100%	23,071	2,483,110	133
Piura	Bajo Piura cluster of counties	n.d.	n.d.	n.d.	n.d.	n.d.	n.d.
VRAE		n.d.	n.d.	n.d.	n.d.	n.d.	n.d.
Huancavelica		74%	309,060	85%	356,173	32,547,161	105
Ayacucho		93%	429,460	95%	440,276	81,445,775	190
Apurímac		78%	302,977	82%	322,251	38,445,728	127
			1,165,567		1,260,750	162,741,764	140

1/ Affiliation data revised by Technical Secretaries of CTIR

2/ Affiliation goals set by Technical Secretaries of CTIR

3/ Estimates by Technical Secretaries of CTIR regarding executed funds in individual health by all sources (Regional Government, MoH, SIS): SIAF

- Definition of an implementation strategy for the health insurance reform based on a balanced scorecard approach. Based on the financial, coverage and benefit plan information, goals were discussed for the short and medium term for population coverage, health benefit coverage and degree of implementation of quality and opportunity guarantees. Generally speaking, expectations of higher levels of funding were ameliorated by taking into consideration likely moderate funding increases that the MOF might approve. Besides, the analysis of guarantees showed the multiplicity of areas that have to be involved in order to make feasible their full implementation. These pieces of information provided a useful insight on the needed changes to be started at the regional level. Accordingly, strategies were identified using a comprehensive framework that involved the following perspectives: 1) users, 2) processes, 3) institutional growth and 4) physical and financial resources.
- Definition of first year implementation plans with their corresponding activities and monitoring indicators. For each strategy an expected result was identified, and the relevant actions were scheduled in their execution.

Additionally, the Regional Government of Callao requested technical assistance as an agreement was reached with the MOH to include a district of this region as a new pilot zone. Due to time limitation, the project worked with Callao's technical team to estimate the gaps in insurance in the three regimens and the financial gaps according to different coverage scenarios. In the case of Cajamarca, the project trained three officials in the planning methodology as this region is negotiating with the MOH its inclusion as a pilot zone for 2010.

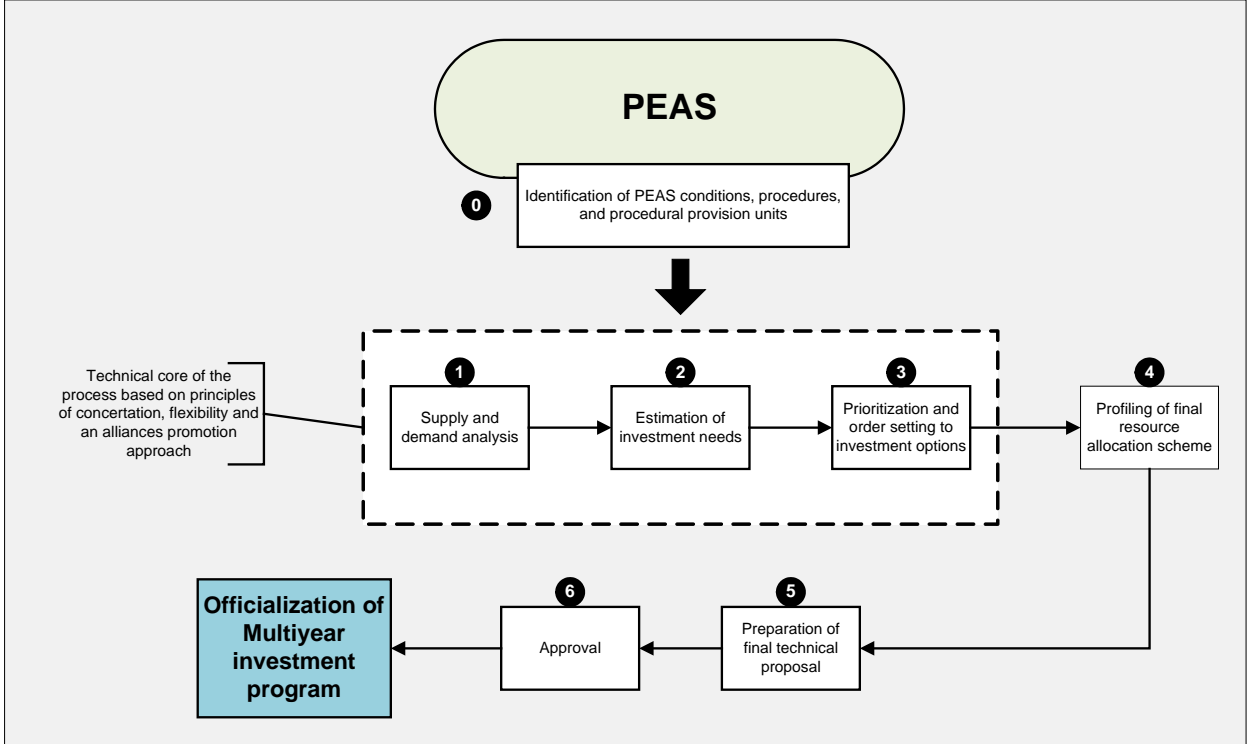
4.2.6 METHODOLOGICAL GUIDELINES TO DEVELOP A MULTIANNUAL INVESTMENT PLAN

A generalized perception among the six CTIR was that there was a wide operational gap to be filled in order to provide PEAS with the characteristics defined in its benefit plan. Although investment plans are consistently identified as a need in order to increase the clinical capacity of public facilities, there have been no efforts to align these needs to the specific requirements of PEAS. Usually the investment

planning process has been oriented to fulfill the infrastructure and equipment requirements associated with categories of public health facilities. Less attention has been provided to the examination of how many facilities should be available for the satisfactory provision of a specific health benefit package. In other words, the investment planning process has not been involving a systematic assessment on the health production needs, posing a potential for an inefficient allocation of resources.

Following the requested made by the General Planning and Budgeting Office (OGPP) of the MOH, HS 20/20 developed a proposal for the alignment of a multiannual investment plan formulation with the projection of the health production of medical services, based on PEAS and its tool ASEGURA, previously mentioned. This proposal describes on a step-by-step basis the process to be followed in order to prepare the investment plan. The general approach of the methodology is shown in figure 5. The proposal will be used by OGPP to serve as the reference document from which a series of user-friendly guidelines will be developed.

FIGURE 5: OVERVIEW OF THE PEAS-BASED MULTIYEAR INVESTMENT PLAN



4.3 ADDITIONAL ACTIVITIES

4.3.1 BURDEN OF DISEASE STUDY

After the elaboration of the Burden of Disease study under USAID/Promoting Alliances and Strategies, a dissemination publication was prepared. Its presentation was made in June to MOH officials as well as to the representatives of political parties. During August and September, the publication was distributed among the MOH, Regional Health Directorates, and academic institutions.

4.3.2 GALENHOS

HS 20/20 provided assistance to Ayacucho's Regional Hospital for GalenHos' implementation process. Specifically, the project financed the execution of a general maintenance of this hospital information system. The maintenance included the design and development of two prototype modules to be added to GalenHos' standard version: an imaging module and a laboratory module. Although the development of these modules have been finished, and field tests have been successful, it is necessary to proceed to a technological auditing in order to guarantee that the overall design of this IT application maintains its safety and database integration characteristics.

The project also organized a GalenHos Board meeting in Ayacucho with representatives of Huancavelica and Apurimac (from Andahuaylas and Abancay hospitals). Executive directors from both hospitals attended to the meeting and showed interest in the implementation of GalenHos in their corresponding hospitals. Following this meeting HS 20/20 performed a general IT infrastructure diagnosis on these hospitals. After this meeting, San Martin and Cajamarca Regional Health Directorates asked the project the technical assistance for the implementation of GalenHos. Tarapoto and Cajamarca hospitals were also added to the list of hospitals subject to the IT infrastructure diagnosis. The results of the study showed the following generalized weaknesses that need to be solved before any information system is to be implemented:

- Lack of institutional policies for accessing shared files, allowing the non controlled modification of sensitive information
- Lack of institutional policies for IT auditing
- Absence of corporate antivirus software licensing, increasing the vulnerability of all hospital information and databases
- Lack of licensing for common office IT applications
- Absence of institutional policies for the access and use of internet
- Lack of files backup policies
- Inadequate configuration of workstations allowing the unsafe use of their databases and other sensitive information
- Inadequate physical conditions for the stable functioning of the computing helpdesk

In addition to this diagnosis, HS 20/20 coordinated with Ayacucho Regional Hospital the delivery of the IT investment plan that this hospital presented and executed, so as to have a reference document to be used as a standard for this type of projects.

Regarding GalenHos development, HS 20/20 performed an audit on the design and development of the pharmacy module developed by Ayacucho Regional Hospital. This audit served to identify design and software development flaws that needed to be corrected in order to preserve the overall efficiency of the system. Currently GalenHos v 2.0 includes the pharmacy module replicating every institutional requirement posed by SISMED, but without the severe security vulnerabilities that SISMED has. This is the new standard version that shall be distributed to any public hospital that fulfills the basic requirements for IT infrastructure and safe data management.

4.3.3 REGIONAL HEALTH ACCOUNTS

HS 20/20 updated the Regional Health Accounts (RHA) for Lambayeque and San Martin. In the first case, RHA included the analysis of information from 2004 to 2006. In the second case, RHA included the time span that goes from 2007 to 2008.

Concerning San Martin, over the past five years health expenditure has been increased, both in constant terms and as a percentage of the global expenditure. However, it is remarkable that in contrast to the national health accounts, out of pocket financing is the most relevant source for health funding, with an upward trend. Main health providers are local pharmacies and the most important destination of funds is for medical drugs. Public expenditure has increased from a regional perspective, but not at the same pace as out of pocket expenses.

In Lambayeque, for the three year period of analysis, there was a positive trend towards more health expenditure both in absolute and per capita terms. The main financial source corresponds to households, followed by employers. Main health providers are hospitals, followed by local pharmacies. The most important destination of funds is hospital care followed by medical drugs. In short, in Lambayeque, although there is higher health expenditure, its increase is not proportionately related to the gross regional product. Per capita expenditure remains lower than the national level.

4.3.4 ACRES

The software application for the estimation of Regional Health Accounts was designed and developed in 2006, and was subject to an expert-led revision prior to the updating of San Martin and Lambayeque Regional Health Accounts. Modifications introduced to the revised version of ACRES involve the following components:

- Data entry module
- Reporting module
- Maintenance module
- User manuals

General maintenance of the application has been performed and the observations have been solved.

5. RECOMMENDATIONS

5.1 ADVOCACY OF HEALTH REFORM

- Political dialogue needs to be sustained at the national level, both to inform about the formulation of health policies by the MOH (such as the health decentralization road map and the health insurance implementation strategies), as to deliberate about pending reforms in the health sector (particularly sensitive is the topic of civil service reform which will be a main issue in the following years). At the regional level, there is a general lack of information and capacity of the political representatives, which needs to be tackled in the coming pre-election period and sustained over the next years. It is also recommended to reinitiate the courses for young members of the political parties of the national and the regional levels to broaden the scope of knowledge regarding the health sector of the health professionals and economists that belong to the different political organizations.

5.2 HEALTH SECTOR DECENTRALIZATION

- The health decentralization road map 2010-14 should be formally approved by the Decentralization Secretariat as the Multi Annual Health Decentralization Plan. The Intergovernmental Health Committee should initiate activities during 2010, specifying and allocating the responsibilities of the MOH and the Regional Health Directorates regarding the 8 broad policies of the road map. Additionally, the road map should be taken as reference for further technical assistance from cooperation agencies.
- Regarding the reorganization of the MOH it is necessary to design a new organizational structure that reflects the separation of functions:
 - Regarding the stewardship/regulatory functions, a clear identification of regulatory roles of the MOH, the SUNASA and the Regional Health Authorities is of the outmost importance. On the one hand, strengthening the regulatory capacity of the MOH regarding health markets - such as human resources, pharmaceuticals and technology, etc. - will pose significant challenges in the coming years; while on the other hand, the delegated regulation of insurance and provision markets to the SUNASA will require substantial modernization of the current SEPS.
 - In regards to the health service provision function it is necessary to proceed with the transference to the Metropolitan Lima Region of the current Health Directorates (DISAs); and delegate the management of the national hospitals and institutes to a specialized agency, dependent of the MOH but with some degree of administrative autonomy.
 - The strengthening of the financing function will require the redesign of the SIS to transform it into a “knowledgeable purchaser” of health services for the population affiliated to the subsidized insurance regime. In the long run a merger of the SIS with the EsSalud Financing Division should be promoted to have a single public financing agency.
- At the regional level, continued assistance is needed to carry out the reorganization of the Regional Health Directorates, while simultaneously deconcentrating health service provision functions to health networks. This requires the introduction of a new management model of health networks and

capacity building of health network managers. Additionally, local health decentralization needs to be reinvigorated; the Local Governments can play a substantial role in the governance of primary health care, thus increasing the responsiveness of these services to local population needs and preferences.

- Anti corruption Health Plans need to be developed on a wider scale in the country, on the basis of lessons learned in the initial experiences in Lambayeque, La Libertad and San Martin. The implementation of these plans needs to balance external interventions oriented to civil society surveillance mechanisms with internal measures to change the behavior of the health personnel. The progress of these initiatives should be monitored by the MOH and the PCM in the framework of the National Anti corruption Plan.

5.3 HEALTH FINANCING AND INSURANCE

- There is need to design and execute a strategy to engage the MOF in the process of implementation of the health insurance reform, particularly in its financial component. On one hand, to gradually bridge the existing financial gap a more stable rule of financing is to be defined and implemented for the expansion of health insurance. On the other hand, implementation of new payment mechanisms – such as global and prospective budgeting- will require significant changes in the way that budgets are defined and executed. All these changes need the active participation of the MOF,
- The implementation of health insurance presupposes the exercise of a new function in the MOH, and as such the core competencies are lacking at the present moment. To overcome this limitation, a new organic Health Insurance Unit within the MOH is needed with a multidisciplinary and stable expert group in charge of the design, coordination and the M&E of the implementation of the health insurance reform. This Unit should also set up the procedures for the periodical update of the PEAS as established by law, identifying the different studies that are needed, including cost- effectiveness studies to justify the inclusion of new conditions and treatments.
- In most cases, the Regional Health Directorates of selected pilot regions and their CTIRs have revealed strong interest and good capacity to define action plans for health insurance implementation. In the short run, the MOH and the Regional Governments need to establish a permanent coordination mechanism to harmonize their technical agendas for the implementation of the health insurance reform. This process should contain the monitoring of ongoing efforts as well as the pending agenda. For example, a standardized methodology for the assessment of the health service provision gap in each pilot zone regarding the PEAS is needed to define the scope of the cross purchasing policy as well as of the investment plans.
- Clinical guidelines need to be developed for universal health insurance implementation. Currently there is insufficient specification on the type of procedures to be carried out and the health service process that has to be executed in the facility in order to provide a quality care. This deficiency is present on the majority of PEAS conditions, even in some maternal and child health conditions. The clinical guidelines developed in other countries could be adapted, particularly the ones that have been defined in Colombia with the assistance of the Harvard School of Public Health.

ANNEX A: HEALTH DECENTRALIZATION ROAD MAP 2010-14

1. Fortalecimiento de la rectoría de la Autoridad Sanitaria Nacional y la articulación intergubernamental en salud		
1.1	Definición de rol y funciones del nuevo Ministerio de Salud.	Formulación de nuevas matrices de funciones del MINSA en "concertación" con los gobiernos regionales/locales.
		Elaboración y aprobación del proyecto nueva Ley de Organización y Funciones del MINSA.
1.2	Reorganización institucional del MINSA.	Rediseño institucional del MINSA para el mejor ejercicio de sus funciones en el marco del proceso de descentralización y adecuación de sus principales procesos de gestión.
1.3	Articulación intergubernamental en salud.	Establecimiento e institucionalización de mecanismos formales de articulación intergubernamental entre los tres niveles de gobierno.
		Redefinición del convenio de gestión como instrumento de acuerdo intergubernamental que compromete a ambas partes.
1.4	Articulación de la política nacional y las políticas regionales en salud.	Definición, implementación, articulación y seguimiento de la política, del plan nacional y de los planes regionales de salud.
1.5	Articulación sectorial nacional.	Convenio de intercambio de prestaciones de servicio, bajo el principio de complementariedad y diferenciación de servicios.
1.6	Adecuaciones normativas para el ejercicio de funciones en los tres niveles de gobierno.	Identificación y actualización de normas vigentes (Ley General de Salud, Ley Orgánica de Gobiernos Regionales, Ley del Sistema Nacional Coordinado y Descentralizado de Salud, otros).
		Formulación y aprobación de nuevas normas (Ej. Transplantes, etc.).
1.7	Conducción y articulación de los sistemas de información.	Inventario de los sistemas de información disponible a nivel nacional y regional.
		Estandarización de los sistemas de información en salud (Flujos, Criterios, otros).
		Diseño de Sistema de información integrados en salud (Gestión/Sanitaria).
2. Fortalecimiento de la Autoridad Sanitaria Regional y la articulación interregional en salud		
2.1	Transferencia de funciones al Régimen Especial de Lima Metropolitana	Culminar transferencia de funciones a Lima Metropolitana: a) reorganización de las DISAs b) redelimitación de redes y microrredes
2.2	Reorganización institucional de los gobiernos regionales en salud.	Rediseño institucional de las DIRESA, adecuando su estructura organizacional para el ejercicio de las funciones transferidas.
		Adecuación de sus principales procesos de gestión.
2.2	Articulación interregional e intra regional en salud	Institucionalización de mecanismos de articulación interregional: Macro regiones, intra regional (CRS) e intergubernamental.

3. Descentralización local de la salud		
3.1	Implementar los pilotos de descentralización diseñados.	Implementación de disposiciones específicas para la transferencia de funciones sectoriales (elaborar directiva de efectivización) DS. 047-2009-PCM y en el marco del AUS. Suscripción de convenios de delegación entre el gobierno regional y los gobiernos locales.
3.2	Promoción y expansión de la descentralización local, así como la conformación de mancomunidades en una perspectiva territorial	Implementar la expansión de proyectos piloto en nuevos gobiernos regionales y expandir otros pilotos en aquellos ámbitos regionales en los que ya se inició; considerando condiciones favorables.
3.3	Fortalecimiento del ejercicio de las funciones en salud de las municipalidades y mancomunidades.	Brindar asistencia técnica, financiamiento, recursos humanos, infraestructura y equipamiento; para el ejercicio de las funciones de salud de los gobiernos locales conforme a sus competencias.
3.4	Definición concertada de un sistema de acreditación para la transferencia de funciones al gobierno local.	Definir en forma concertada entre los tres niveles de gobierno los requisitos específicos de acreditación de los gobiernos locales.
3.5	Evaluación de experiencias de pilotos de descentralización local	Sistematizar la experiencia de la descentralización al nivel local actualmente en ejecución desde los gobiernos regionales, para construir concertadamente modelos de descentralización local
4. Monitoreo de la descentralización y fortalecimiento de capacidades nacionales, regionales y locales		
4.1	Monitoreo y evaluación de la descentralización.	Diseño de un instrumento de medición de desempeño (MED) para el Ministerio de Salud, para tener una línea de base sobre el grado de ejercicio de las nuevas funciones nacionales de salud. Aplicación del instrumento de medición de desempeño (MED) para obtener la línea de base regional del grado de ejercicio de las funciones transferidas. Diseño y aplicación del módulo de resultados e impacto de la descentralización para contar con una línea de base nacional (en vinculación con la implementación del aseguramiento universal de salud). Diseño de un instrumento de medición del desempeño para el nivel local, que permita reconocer la situación de los gobiernos locales. Aplicación del instrumento de medición del desempeño para el nivel local, a través de dos etapas: a) En los pilotos de descentralización b) En los gobiernos locales interesados en firmar convenios de delegación c) En otros gobiernos locales que acuerdan hacer una medición del ejercicio de sus funciones inherentes (LOM).
4.2	Desarrollo de capacidades institucionales (1)	Fortalecimiento de capacidades institucionales del MINSA para la rectoría nacional, el desarrollo y la gestión de políticas nacionales concertadas. Fortalecimiento de capacidades de los gobiernos regionales para el ejercicio de las funciones descentralizadas. a) Fortalecer las capacidades priorizadas por el GR en función a la aplicación del MED b) Fortalecer las capacidades institucionales en el mediano y largo plazo

		Fortalecimiento de las capacidades de los gobiernos locales para el ejercicio de las funciones descentralizadas. a) Fortalecer las capacidades priorizadas por el GR en función a la aplicación del MED b) Fortalecer las capacidades institucionales en el mediano y largo plazo
5. Recursos humanos		
5.1	Desarrollo de la política nacional de recursos humanos	<p>Diseño y establecimiento de la carrera pública en salud, en el marco de la descentralización (Incluye destaques).</p> <p>Revisión del marco jurídico legal de la gestión del trabajo, incluyendo la normatividad de la doble remuneración y la elaboración de las propuestas correspondientes, incluyendo la normativa de desplazamiento de personal, y brindar asistencia legal.</p> <p>Apoyo en la gestión de generación de nuevas plazas para cerrar brechas de recursos humanos.</p> <p>Agenda de corto plazo: – Revisar las políticas remunerativas: nivelación de sueldos, pago de la cuota patronal de los contratos de administración de servicios, flexibilidad de contratación por los gobiernos regionales y locales, desplazamiento de personal, destaques, SERUMS, pagos de AETA.</p> <p>Agenda de corto plazo: – Pago diferenciado con estímulos para trabajadores en zonas excluidas y dispersas.</p> <p>Agenda de corto plazo: – Nivelación de pagos de AETA a nivel nacional.</p>
5.2	Planeamiento estratégico de la gestión de recursos humanos.	<p>Planeamiento estratégico de la gestión de recursos humanos a nivel nacional, regional y local (brechas, proyección financiera, especialización, asignación equitativa) Incluir el tema de formación (1)</p> <p>Reactivar con Decreto Supremo la Ley 29242, restableciendo las prestaciones complementarias y horas extras.</p> <p>Incluir la articulación docente-asistencial para optimizar la formación de los recursos humanos y su adecuación a los requerimientos operativos del sector salud.</p> <p>Reformular la normativa del Residentado Médico, priorizando que la totalidad de plazas de ingreso sea por la modalidad de destaques y asegurando el financiamiento para las plazas en los establecimientos de origen. (2)</p> <p>Plantear modalidades de Residentado Médico flexibles, que permitan combinar el trabajo asistencial efectivo con periodos de entrenamiento y capacitación académica.</p>
6. Financiamiento del sector público de salud		
6.1	Financiamiento de las funciones de salud	Identificar y concluir con la transferencia de fondos por encargo hacia los gobiernos regionales en el corto plazo, restringiéndose a futuro a situaciones excepcionales.

		Realizar el costeo de las actividades comprendidas en las funciones transferidas en salud y su respectivo financiamiento. Incluye los tres niveles. El MEF brindará asistencia técnica en el marco del DS 047-2009
		Reformular la RM 240-2009/MINSA (disminución de la tarifa de atención médica) y simplificar el proceso de reembolso del SIS. Las regiones deben participar en la elaboración del Tarifario. Establecer otros mecanismos de financiamiento en cumplimiento de los acuerdos suscritos entre GR-SIS.
		Financiamiento del SIS/AUS. De inmediato, constituir un espacio multilateral (MEF, SIS, OGPP, gobiernos regionales) permanente para definir cómo, quién negocia presupuesto para salud.
		Gestionar el financiamiento para el fortalecimiento de las capacidades institucionales en los niveles nacional, regional y local, en el marco del proceso de descentralización.
		Transferencia fluida y oportuna de los presupuestos de los Gobiernos Regionales, precisando las Unidades Ejecutoras de Salud del ámbito regional para garantizar el ejercicio de las funciones en salud. Establecer los mecanismos necesarios para optimizar los flujos financieros desde el nivel nacional al regional y del nivel regional al local.
6.2	Movilización y gestión del financiamiento	Fortalecimiento de la gestión del financiamiento y uso de recursos en los hospitales, redes y micro redes.
		Formulación del Plan Multianual de inversiones del sector salud (nacional, regional y local).
		Fortalecimiento de la gestión de las inversiones.
7. Participación ciudadana		
7.1	Fortalecimiento de la participación ciudadana en la gestión pública de la salud.	Proponer el rediseño de la estructura y rol de los consejos de salud otorgándole carácter vinculante.
		Diseño de estrategias para el desarrollo de capacidades y una propuesta para fortalecer los actuales mecanismos de participación ciudadana que impulsen la concertación Estado-Sociedad civil
		Propuesta para fortalecer la vigilancia social de los servicios de salud a nivel nacional, regional y local. Incorporar nuevos mecanismos de vigilancia social.
8. Aseguramiento Universal en Salud		
8.1	Asegurar el financiamiento para la prestación del Plan Esencial de Aseguramiento en Salud (PEAS).	Sostenibilidad presupuestal para atender las brechas financieras del PEAS. El SIS debe transformarse en un Fondo de Aseguramiento con un presupuesto intangible.(elaborar propuesta Ley)
8.2	Intercambio y complementariedad de servicios entre prestadores.	Articular la oferta de servicios de salud entre el MINSA, EsSalud y otros prestadores: Referencias y contrarreferencias, tarifarios y contratos de profesionales. Implementar el artículo 22° de la Ley 29344.
8.3	Asegurar las garantías del PEAS y puntos críticos del AUS.	Aprobar el Reglamento de la Ley 29344-AUS y aprobar el PEAS. Debe darse una reunión MINSA-GR para abordar la implementación del AUS

		-Asegurar el financiamiento para medicamentos, equipos e infraestructura.
		Cubrir la brecha de recursos humanos, equipamiento e infraestructura como inversión inicial para la implementación del PEAS, en los pilotos de AUS.
		Mecanismos para identificar la población asegurada (Utilizar SISFOH para identificar beneficiarios del régimen subsidiado).
		Establecer la estructura de costos del financiamiento del aseguramiento universal (costos fijos y variables) y mecanismos de pago apropiados (se sugiere la modalidad pago percapita)

