Board of Executive Directors
For consideration
On or after 18 November 2015

PR-4339
3 November 2015
Original: Spanish
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Simultaneous Disclosure

To: The Executive Directors

From: The Secretary

Subject: Peru. Proposal for a loan for the "Management Modernization for Universal Health Coverage Program I"

Basic Information:

Loan type .... Programmatic Policy-Based Loan (PBP)
Borrower .... Republic of Peru

Amount .... up to US$300,000,000
Source ....Ordinary Capital

Inquiries to: Frederico Guanais (telephone Country Office in Peru 511-2151870) or Ignacio Astorga (extension 3708)

Remarks: This operation is the first loan in a programmatic series of two consecutive single-tranche operations, technically related to one another but independently financed as programmatic policy based loans, in accordance with document CS-3633-1, "Policy-based Loans: Guidelines for Preparation and Implementation. New version".

As established in document GN-1838-1, "Criteria and norms for Board and Management relations", dated 1 July 1994, policy-lending operations are considered by the Board of Executive Directors by Standard Procedure.

Reference: GN-1838-1(7/94), DR-398-17(1/15), CS-3633-1(6/14), GN-2200-13(4/05), CS-4099(11/15), PR-2428(9/99), DE-92/99, PR-3358(11/08), DE-194/08, PR-3469(11/09), DE-169/09, PR-3558(6/10), DE-66/10, PR-3582(8/10), DE-97/10, PR-3618(10/10), DE-162/10, PR-3912(9/12), DE-127/12, PR-4208(10/14), DE-146/14, DE-147/14

PUBLIC
SIMULTANEOUS DISCLOSURE

DOCUMENT OF THE INTER-AMERICAN DEVELOPMENT BANK

PERU

MANAGEMENT MODERNIZATION FOR UNIVERSAL HEALTH COVERAGE PROGRAM I

(PE-L1169)

LOAN PROPOSAL

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CONTENTS

PROJECT SUMMARY

I. DESCRIPTION AND RESULTS MONITORING 2

- A. Background, problem to be addressed, and rationale 2
- B. Objectives, components, and cost 14
- C. Key results indicators 16

II. FINANCING STRUCTURE AND MAIN RISKS 17

- A. Financing instruments 17
- B. Environmental and social safeguard risks 18
- C. Other project risks 18

III. IMPLEMENTATION AND MANAGEMENT PLAN 18

- A. Summary of implementation arrangements 18
- B. Summary of arrangements for monitoring results 19

IV. POLICY LETTER 19

ANNEXES	
Annex I	Development Effectiveness Matrix (DEM) – Summary
Annex II	Policy Matrix

ELECTRONIC LINKS
REQUIRED
1. Policy letter
2. Means of verification
3. Results matrix
OPTIONAL
1. Project economic analysis
2. Health sector reform guidelines and measures
3. Health and Nutrition Sector Framework Document
4. Monitoring and evaluation plan
5. Bibliography

ABBREVIATIONS

CRED	Controles de crecimiento y desarrollo [Growth and development checkups]
DALY	Disability adjusted life years
DDO	Deferred drawdown option
DGETP	Dirección General de Endeudamiento y Tesoro Público [General Directorate of Public Borrowing and Treasury]
EsSalud	Seguro Social de Salud [Social Health Insurance]
FISSAL	Fondo Intangible Solidario de Salud [Health Solidarity Intangible Fund]
IAFAS	Instituciones Administradoras de Fondos de Aseguramiento en Salud [Health Insurance Fund Administrator Institutions]
ICER	Incremental cost-effectiveness ratio
INEI	Instituto Nacional de Estadística e Informática [National Institute of Statistics and Information Technology]
IPRESS	Instituciones Prestadoras de Servicios de Salud [Health Service Provider Institutions]
LAC	Latin America and the Caribbean
LB	Live births
MEF	Ministry of Economy and Finance
MINSA	Ministry of Health
OC	Ordinary Capital
OECD	Organisation for Economic Co-operation and Development
PARSalud	Programa de Apoyo a la Reforma del Sector Salud [Program to Support Health Sector Reform]
PBP	Programmatic policy-based loan
PPP	Public-private partnership
PRONIS	Programa Nacional de Inversiones en Salud [National Health Investment Program]
RIAPS	Redes Integradas de Atención Primaria de Salud [Integrated Primary Health Care Networks]
SIS	Seguro Integral de Salud [Comprehensive Health Insurance]
SISFOH	Sistema de Focalización de Hogares [Household Targeting System]
SUNAT	Superintendencia Nacional de Aduanas y de Administración Tributaria [National Superintendency of Customs and Tax Administration]
WAL	Weighted average life

PROJECT SUMMARY

PERU

MANAGEMENT MODERNIZATION FOR UNIVERSAL HEALTH COVERAGE PROGRAM I

(PE-L1169)

Financial Terms and Conditions				
Borrower: Republic of Peru **Executing agency:** Ministry of Economy and Finance (MEF), acting through the General Directorate of Public Borrowing and Treasury (DGETP)			**Flexible Financing Facility**[(a)]	
			Amortization period:	Bullet on 15 April 2028
			Original WAL:	Max. 12.33 years[(b)]
			Drawdown period:[(b)]	3 years
			Grace period:	[(d)]
			Font-end fee:	50 basis points
Source	**Amount (US$)**	**%**	Standby fee:	25 basis points[(e)]
			Renewal fee:	50 basis points[(e)]
IDB (Ordinary Capital)	300 million	100%	Inspection and supervision fee:	[(e)]
			Interest rate:	LIBOR-based
Total	300 million	100%	Currency of approval:	United States dollars from the Ordinary Capital

Project at a Glance
Project objective/description: The objective of the programmatic series is to support management modernization of the health sector in order to achieve universal coverage of health care services. The operation's specific objectives are: (i) to improve the management of health investment; (ii) to support implementation of the integrated health service delivery networks model of organization; and (iii) to consolidate the financing of health care services through the Seguro Integral de Salud [Comprehensive Health Insurance] (SIS) as a public health insurance policy.
Special contractual conditions precedent to disbursement of the loan proceeds: Completion of the policy reform measures, as described in the program's components (section B, paragraphs 1.39 to 1.45, and Annex II), and satisfaction of the other conditions established in the loan contract (see paragraph 2.2).
Exceptions to Bank policy: None.
Project qualifies as:[(f)] SV ☐ PE ☑ CC ☐ CI ☐

(a) Under the terms of the Flexible Financing Facility (document FN-655-1), the borrower has the option of requesting changes to the amortization schedule, as well as currency and interest rate conversions. The Bank will take operational and risk management considerations into account when reviewing such requests.

(b) The weighted average life (WAL) was calculated on the basis of an expected signature date of 15 December 2015. Consequently, the WAL may be shorter, if the signature date is later than 15 December.

(c) This loan operation has been structured as a policy-based loan with deferred drawdown option (document GN-2667-2, section VI.C establishes an original drawdown period of up to three years, running from the date of entry into force of the loan contract, with an option for a one-time renewal of another three years).

(d) The grace period will run from the disbursement date to the selected final repayment date, 15 April 2028.

(e) The standby fee, renewal fee, and inspection and supervision fee may be revised by the Board of Executive Directors as part of its regular review of the Bank's lending charges. The grace period and these fees run from the date of entry into force of the loan contract.

(f) SV (small and vulnerable countries), PE (poverty reduction and equity enhancement), CC (climate change, sustainable energy, and environmental sustainability), CI (regional cooperation and integration).

I. DESCRIPTION AND RESULTS MONITORING

A. Background, problem to be addressed, and rationale

1.1 This operation is the first of a series of two operations under the programmatic modality, to support management modernization of the health sector in order to achieve universal coverage of health care services in Peru. This first operation will help to improve the management of health investment, support implementation of the integrated health service delivery networks model of organization, and consolidate the financing of health care services through the Seguro Integral de Salud [Comprehensive Health Insurance] (SIS) as a public health insurance policy. The second operation will help build capacity for the supervision of infrastructure investments of the Ministry of Health (MINSA) and projects of public-private partnerships (PPPs) in health care, the coordination of investment cycles with regional governments, the integration of health care provider networks and the management of primary health care networks, the development of actuarial planning capacities at the SIS, and the definition of a pricing policy for public hospitals that provides incentives to voluntary insurance.

1. Macroeconomic and poverty conditions

1.2 **Strong macroeconomic performance, but with challenges going forward given the current economic slowdown.** The macroeconomic performance of the Peruvian economy has been strong in recent years with average annual growth of 6.2% for the period 2005-2014.[1] Although prudent macroeconomic policy management and measures to promote macroeconomic stability were key factors, favorable external conditions—particularly the high prices of the commodities exported by Peru and access to low-cost external finance—also played a decisive role.

1.3 **Peru faces the challenge of growing at slower rates.** In the context of lower commodity prices and the imminent rise in international funding costs, Peru now faces the challenge of growing more slowly, even below its potential growth rate which is estimated at 5%.[2] The average current account deficit for 2015-2018 is estimated at 2.7% of GDP, fully financed by foreign direct investment (FDI) flows averaging 2.9% in that period. The nonfinancial public sector (NFPS) is projected to run a deficit, in line with the countercyclical fiscal policy implemented to support economic recovery (−2.6% of GDP, 2015-2018 average). Given a decline in structural tax revenue in conjunction with a greater expenditure stimulus, this spending will be financed by greater public borrowing, which is projected to represent 25.1% of GDP for 2015-2018. Financing requirements are estimated at US$7.427 billion in 2015-2018, equivalent to 3.7% of GDP, with projected debt repayments on the order of 1.1% of GDP in that period (US$2.608 billion). The amount of this first operation of the programmatic series (US$300 million) would be equivalent to approximately 4% of the total financing requirements for 2015 (US$7.75 million).

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[1] Peru's growth has outpaced the LAC-4 group, comprising Brazil, Colombia, Chile and Mexico. In 2005-2014, the LAC-4 group grew at a weighted average rate of 3.1% per year, whereas Peru grew at twice that rate during the same period.

[2] Marco macroeconómico multianual 2016-2018 [Multiyear macroeconomic framework 2016-2018] (April, 2015), Ministry of Economy and Finance (MEF).

1.4 **Persistent development challenges.** Economic performance stands in contrast to the progress made in crucial aspects of development. On the one hand, Peru is an upper-middle-income country,[3] open to external trade, with free capital mobility. It has an investment-grade rating and may join the Organisation for Economic Co-operation and Development (OECD). In contrast, its productivity levels relative to those of the United States have deteriorated in the last several decades (from 71% in the 1970s to just 49% today). The country has a highly polarized income distribution (Gini coefficient of 0.45), with the rural population accounting for 48.8% of all of the country's poor.[4]

1.5 **Factors exacerbating the business cycle.** Certain structural aspects of the Peruvian economy continue to exacerbate business cycles rather than mitigate them. One example is the economy's heavy dependence on the export sector, which is concentrated in commodities. Moreover, high levels of informality in the labor market—74.3% in 2014[5]—result in low productivity levels and a small segment of workers covered by social security.[6]

1.6 **Challenges of the economic slowdown.** In line with other economies of the region, Peru is suffering from the impact of the commodity price decline and its consequences on investment, exports, and employment. Potential climate shocks, such as the possibility of a strong El Niño phenomenon, could undermine economic performance in the productive sectors and adversely impact the rural population and health. Slower economic growth could risk a reversal of the gains made in social sectors, particularly poverty reduction, and in efforts to raise the population's living standards in various domains, including the health sector.

2. The health sector in Peru

1.7 **Peru's health sector is highly segmented, with subsystems operating with different rules, pricing, and beneficiaries.** The sector has public and private components, and the national and regional government levels are involved as service providers. The public sector includes MINSA, the Social Health Insurance of Peru (EsSalud), and the health services of the armed forces and police. The private sector includes private insurance systems, clinics, nongovernmental organizations, and others. MINSA is the apex agency of the health sector with responsibility for the promotion, protection, recovery, and rehabilitation of the health of the Peruvian people.

1.8 At the public level, the main insurers and service providers are MINSA and EsSalud: (i) MINSA is responsible for providing health care services to the poor or vulnerable population through subsidized and semicontributory regimes[7] administered by the SIS. It also finances the operation of health care facilities out of ordinary resources. Health care services are financed by the SIS and delivered through the network of health care facilities operated by MINSA and the regional

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[3] With a GDP per capita of around US$6,500.

[4] National Institute of Statistics and Information Technology (INEI), 2015, Evolución de la pobreza monetaria 2009-2014 [Trend of monetary poverty 2009-2014].

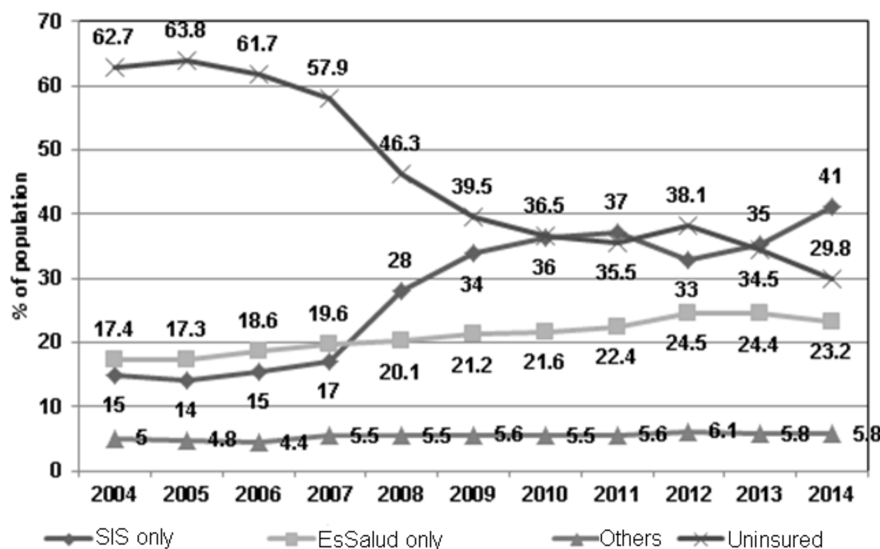
[5] INEI 2015. Informality defined as the percentage of workers not enrolled in social security.

[6] In Peru, just 17.2% of workers were contributing to the pension system in 2010. See Bosch et al. (2013).

[7] The subsidized regime is the public insurance modality targeted to people and families in conditions of extreme and nonextreme poverty, fully financed with public funds; the semicontributory regime is the modality targeted to the nonpoor population, with some ability to pay but within the zone of vulnerability. (see paragraphs 1.18 to 1.21).

government; and (ii) EsSalud, reporting to the Ministry of Labor and Employment Promotion, provides services to the population enrolled in the contributory regime. EsSalud provides services through its own network of facilities. As shown in Figure 1, the growth of health insurance over the last decade has been driven mainly by the expansion of the SIS.

Figure 1.1
Health Insurance in Peru, 2004-2014



Source: INEI-ENAHO, cutoff Q4 2014.

1.9 **In the last two decades, the Peruvian government has focused on improving mother and child health and expanding insurance among the poorest of the poor.** In the 1990s, the government launched a process to reform the health sector, through the Health Sector Development Program (PARSalud) (loan PE-0146, 1208/OC-PE), seeking to improve the integration of health care and institutional actions to reduce maternal and child morbidity and mortality through sector reform and modernization measures.[8] Those efforts led to the creation of the SIS in 2002, with the aim of helping to expand health care coverage and financial protection for the poorest population groups, initially targeting mother and child health. The Framework Legislation for Universal Health Insurance (Law 29344) was enacted in 2009, establishing mechanisms to increase coverage of the insured population and creating the Essential Health Insurance Plan (PEAS)[9], which has been extended to all SIS insured. The Second Phase of the Program to Support Health Sector Reform (PARSalud II) (loan PE-L1005, 2783/OC-PE) was launched that same year, with the objectives of promoting comprehensive health care and fostering adequate growth among children up to age 3, contributing to the sector's decentralization process, strengthening MINSA capacity as the apex agency for service delivery,

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[8] The Peruvian government initiative was supported by a multiphase program partially financed by an IDB investment loan (PE-0146) and by the World Bank.

[9] PEAS is the benefits package that defined insurable conditions throughout the life cycle, but does not cover high-cost therapies, such as cancer treatment or major surgeries.

strengthening the SIS as a public insurance instrument, and improving public health financing.[10]

1.10 The sector reform initiatives implemented in the different stages of PARSalud have contributed to important outcomes, such as improvements in mother and child health indicators. Between 1992 and 2013, the infant mortality rate fell from 55 to 16 deaths per 1,000 live births, and the maternal mortality rate fell from 265 per 1,000 live births in 1996 to 93 per 1,000 live births in 2013.[11] Progress has also been made on decentralization and the regulatory framework for the financing and delivery of services. In 2007 the SIS became the leading health insurer, overtaking EsSalud and making a substantial contribution to expanding health insurance among the poorest segments of the population. Despite these achievements, however, a number of challenges remain in the sector.

3. Health sector challenges and the recent government response

1.11 **Despite the progress in mother and child health, that agenda remains unfinished, and the rapid growth of chronic diseases is an emerging issue.** In 2014, the infant mortality rate in Peru (16.0 per 1,000 live births) was still above the equivalent figures for Chile (7.4), Costa Rica (8.7), or Uruguay (8.8). Moreover, in areas outside the capital in Peru, disparities persist between persons with no schooling (34.0), those with a primary school education (24.0), those with a secondary school education (15.0), and those with higher education (17.0).[12] Currently, the main epidemiological challenge is the growing burden of chronic noncommunicable diseases. Of the 10 leading causes of death in 2010, eight were associated with chronic diseases, one with infectious diseases, and one with external causes.[13] In 2014, 32.9% of the urban population and 25.3% of the rural population reported suffering from some chronic health problem.[14] Despite the recent increase in public funding, 29.8% of the population remains without insurance, and levels of out-of-pocket payments are high, representing 35% of total health spending.[15] The three major sector challenges that need to be addressed to achieve universal health coverage in Peru are as follows: (i) for the expansion of insurance to translate into actual expansion of health care coverage, the network must offer quality, accessible services; (ii) the system's segmentation poses challenges for coordination and efficiency in health care networks; and (iii) including the nonpoor vulnerable population in the semicontributory regime and increasing preventive care actions are challenges for the sustainability of universal health coverage.

1.12 **For the expansion of insurance to translate into an effective increase in health coverage, the network must offer quality, accessible services.** The expansion of the SIS has increased the demand on a health care network that is neither structurally nor functionally ready to ensure adequate service coverage.

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[10] PARSalud II is supported by a program partly financed by an IDB investment loan (PE-L1005) and by the World Bank, both in the final phase of execution.

[11] INEI, Encuesta Demográfica y de Salud Familiar 2013 [Demographic and Family Health Survey 2013]. Data estimated for the 10 years prior to the survey.

[12] INEI, Demographic and Family Health Survey 2013 and PAHO 2014.

[13] IHME 2013.

[14] INEI 2015. Condiciones de vida en el Perú. Primer trimestre 2015 [Living conditions in Peru. First-quarter 2015].

[15] World Health Organization. System of National Health Accounts.

At the structural level, MINSA has identified an investment gap of around US$5 billion, to build new health care establishments, particularly primary care facilities, and to replace, expand, or modernize other existing facilities particularly at the hospital level. In addition, a health facilities network needs to be designed to ensure population coverage and the complementarity of higher-complexity hospitals.[16] As these do not have population groups or territories assigned to them, it is impossible to ensure continuity of care from level to level.

1.13 In 2012, Peru had an average of 1.5 hospital beds for every 1,000 inhabitants, and the figure for users of MINSA facilities was even lower (less than one per 1,000). Those levels are below the average for Latin America and the Caribbean (2 per 1,000) or the OECD member countries (3.8 per 1,000).[17] The hospital network suffers from a high degree of deterioration, owing to its age or constructional defects. On average, MINSA hospitals in the Lima region are more than 65 years old. In addition, hospitals built in the 1970s failings structural failings due to old technical specifications that make them vulnerable to seismic events.[18] This situation is repeated at the regional level and results in a mixed demand for investment, both to expand capacity and to modernize existing facilities.

1.14 Investment management in the public sector suffers from three main weaknesses: (i) the discretionary nature investment decisions; (ii) duplications owing to a lack of joint planning between the different segments of the system (see paragraph 1.8); and (iii) limited institutional capacities for timely execution of the investment cycle.[19] In the health sector, this means the over- or undersizing of networks and health care facilities, and a mismatch between service portfolios and demand. The causes of this situation are the segmentation of the entities responsible for managing the investment cycle (both within MINSA and between it and the regional governments) and the lack of network and facility planning tools.

1.15 **The system's segmentation poses challenges for coordination and efficiency in health care networks.** Given the many different insurers and service providers,[20] and the lack of a coordination model, service delivery is inefficient. Coordination problems can be seen on at least two broad levels: (i) coordination between MINSA and EsSalud; and (ii) within the MINSA network. In 2013, 20.4% of persons insured by EsSalud sought health care from facilities run by MINSA, regional governments, or the private network, where they had to make out-of-pocket payments to receive care.[21] In addition, MINSA referred patients needing highly complex treatments to EsSalud. Nonetheless, the

[16] Low-complexity includes primary care to prevent onset of the disease and its ongoing management; medium-complexity includes specialized medical care and hospitals responsible for halting the progress of the disease; and high-complexity includes hospitals responsible for the rehabilitation of patients with advanced disease.

[17] World Development Indicators. The number of hospital beds reflects health infrastructure only partially, because it does not consider other levels of care. Nonetheless, this indicator is a proxy for total infrastructure. See OECD 2014.

[18] Studies of seismic vulnerability at 14 hospitals under MINSA administration. See CISMID 2014.

[19] See optional electronic link 2.

[20] The insurers are known as Health Insurance Fund Administrator Institutions (IAFAS), and the health service providers are known as Health Service Provider Institutions (IPRESS).

[21] INEI. Encuesta Nacional de Hogares [National Household Survey] (ENAHO).

exchanges between the two systems are not governed by explicit rules that make it possible to strengthen the advantages of each system in its specific domain.

1.16 At the MINSA level, there are low levels of access, treatment capabilities, and coordination of primary care, with limited preventive care and overburdened hospitals. In 2014, 43.8% of the insured population reported that they did not seek treatment when they had a health problem, and 17.8% reported that they did not do so because of how far away the health care facilities were located, lack of confidence, or how long it took to get treatment.[22] Just 48.7% of public hospital users from the first income quintile reported that their health problem had been resolved by their most recent treatment, compared to 34.3% among users from the fifth income quintile.[23] For persons accessing primary care facilities, their referral to specialized care levels is neither guaranteed nor regulated.

1.17 In the hospitals, problems of coordination and inefficiency in the service delivery networks worsened in the 1980s and 1990s, owing to a hospital autonomy policy that forced them to charge for services provided to users and to compete, while fiscal support was cut back.[24] Given the level of out-of-pocket expenses, public hospitals had incentives to shape their services portfolio according to the users' ability to pay rather than in response to the epidemiological profile, leading to duplications and inefficiency. In 1999, 25.2% of the revenues of the 10 largest MINSA hospitals in the Lima metropolitan region came from out-of-pocket payments by users, while the rest came from ordinary resources of the public budget. Following the creation of the SIS in 2002, there was a progressive increase in public funding for hospitals. In 2013, the share of out-of-pocket payments in the budget of those same 10 hospitals fell to 11.1%, while the financing of services from the SIS rose to 18.6%; the remainder was financed by ordinary resources.[25] However, the proportion of out-of-pocket payments varies from public hospital to hospital. For example, 15.3% of the budget of the National Institute of Neoplastic Diseases, the leading public hospital specializing in cancer treatment in Peru, comes from out-of-pocket payments by uninsured users; whereas at the Dos de Mayo General Hospital, which provides less complex care, this figure is 7.3%.

1.18 **Including the vulnerable population and making use of preventive health care are major challenges for the sustainability of universal insurance.** In 2014, 29.8% of the Peruvian population reported having no health insurance of any kind. The most neglected group consists mainly of the nonpoor who are in the zone of vulnerability, a population group that has been referred to as the "vulnerable population" or "emerging middle class."[26] In 2013, insurance coverage rates among the extreme poor, nonextreme poor, and nonpoor groups were 78.7%, 69.8%, and 63.4%, respectively. The Peruvian government's strategy in the last decade has been to increase coverage and expand benefit plans among the poor, targeted according to their socioeconomic features through the Household Targeting System (SISFOH), operated by the Ministry of Development and Social Inclusion (MIDIS). That group has been eligible for a

[22] INEI, ENAHO 2014.

[23] Nino 2014.

[24] Arroyo Laguna 1999.

[25] Informal consultation, MEF.

[26] Jaramillo and Zambrano 2013.

comprehensive package of services that includes a set of high-cost diseases, since the creation of the Health Solidarity Intangible Fund (FISSAL) in 2012.[27]

1.19 Among the vulnerable population, the challenges of increasing insurance are tied to the high rate of labor informality in Peru (see paragraph 1.5). As shown in Figure 1, the coverage of EsSalud was around 20% throughout the last decade, with just a slight increase, whereas 29.8% of the population remains uninsured. Including the vulnerable population in health insurance, whether the SIS or EsSalud, is important not only to protect those families from the risk of falling into poverty due to an illness, but also to make it possible to diversify risk among a broader group of users. Depending on their ability to prepay, new users would contribute to the long-run financial sustainability of the system through their contributions in the form of the insurance premium. Incorporating the vulnerable population is a major challenge for the sustainability of the health system, and is highly complex owing to the potential adverse impact on labor formalization.

1.20 Another factor in the sustainability of universal insurance is the low rate of use of preventive care. Between now and 2030, diabetes prevalence in Peru is expected to grow by 31%, which will increase the incidence of high-cost diseases, such as chronic kidney disease.[28] In 2015, 37.0% of individuals claiming to suffer from a chronic disease in urban areas, and 35.5% in rural areas, did not seek treatment[29] for their problem. The coverage of preventive care services among those insured by the SIS is low for both men and women, but the situation is worse for men. In 2015, just 10.9% of women and 8.8% of men enrolled in the SIS had been screened in the preventive package for chronic diseases.[30] In the medium and long term, this low coverage of preventive care services could endanger the financial sustainability of the health system, owing to the increased prevalence of diseases requiring high-cost treatments.

1.21 **New stage in health sector reform.** As a response to these problems, in 2013 the Peruvian government launched a new reform process in the sector, which is still underway and aims to bring the entire population under insurance.[31] The reform approved legislative measures,[32] specifying guidelines to be adhered to, among other objectives: (i) modernization of health investment, including better management of public investment and greater participation by private investment, with public cofinancing in the provision of infrastructure; (ii) strengthening of the integration of services and financing in public health service networks; and (iii) continued expansion of insurance among the poor and

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27 According to Ministerial Resolution 325-2012/MINSA, the following pathologies are covered: cervical cancer, breast cancer, colon cancer, stomach cancer, prostate cancer, leukemias, and chronic renal insufficiency.

28 Whiting et al. 2011; Francis et al. 2015.

29 INEI. Informe de condiciones de vida [Report on living conditions].

30 Screening tests are examinations applied in an apparently healthy population, to identify individuals who are most at risk of having a specific disease (e.g. hypertension, diabetes). The premise of the screening is that early detection of many diseases improves their prognosis (Rothman 2002; Trucco 1998).

31 General Health Law 26842. The definition of insured party is variable.

32 See Decree-Law 1157 (Modernization of the management of public health investment); DL 1159 (Benefit exchange); and Decree-Law 1166 (Integrated primary health care networks).

vulnerable population, matched by increases in the public health budget.[33] To date, the successes of the main reform measures implemented have been an increase in budgetary appropriations for investment in infrastructure, expansion of the coverage of the SIS among the poorest sectors, and the creation of semicontributory modalities in the SIS to attract the vulnerable population, thereby allowing for SIS affiliation by small-scale entrepreneurs who are registered in the simplified taxation regime, operated by the National Superintendency of Customs and Tax Administration (SUNAT).[34] Nonetheless, needs persist in terms of improving the management of investment to execute the budget assigned for the construction of new infrastructure; increasing the efficiency and integration of the networks; increasing affiliation among the vulnerable nonpoor population; and improving incentives for making use of preventive care services. If those issues are not addressed, it will be difficult for Peru to achieve sustainable universal health coverage.

4. Program intervention strategy and technical evidence of support

1.22 To support the current challenges facing the country and the objective of achieving universal health service coverage, the government has asked for Bank support through a series of two operations, under the programmatic policy-based loan (PBP) modality. This first operation will be for US$300 million, and will be structured as a policy-based loan with a deferred drawdown option (DDO), under the programmatic modality. It will support policy measures aimed at: (i) modernizing the management of health investment; (ii) supporting implementation of the model of services organized in integrated health care networks; and (iii) supporting consolidation of the financing of health services through the SIS as a public insurance policy. The DDO is consistent with the guidelines and directives specified in Section VI.C of document GN-2667-2, Proposal to Establish a Set of Contingent Lending Instruments of the IDB, and with the country's macroeconomic context. The following paragraphs set out the program's intervention strategy according to the three key challenges identified in the previous section.

1.23 **Modernizing the management of health investments.** Based on the expansion of public insurance and the benefits plan in the public insurance policy, MINSA has prioritized the process of sector investment targeting a group of projects aimed at expanding access to community-based services, known as "strategic establishments", which include 170 hospitals and 578 outpatient centers.[35] For this process to be successful, it has been considered necessary to strengthen the governance of the investments, along with the technical instruments used for their planning and execution. The evidence[36] shows that a scheme of governance for the investment process that makes it possible to identify, prioritize, and

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[33] At constant prices, the MINSA budget (including the SIS, but excluding EsSalud) rose by 20% between 2010 and 2013. This means that the MINSA budget grew from 7.7% to 10.3% of the total public budget between 2010 and 2014, and from 1.6% to 2.1% of GDP between 2010 and 2013.

[34] The New Simplified Single Regime (NRUS).

[35] MINSA investment portfolio.

[36] The region's experiences in the management of health sector investment include the case of Chile, where the governance process is highly regulated, which makes it possible to avoid over- and underinvestment in health care facilities. See the discussion of the cases of Chile, Peru, South Africa, and Turkey in Aslan and Duarte (2014).

execute investment initiatives with homogeneous instruments and criteria, helps to make the investment process more socially and economically efficient.

1.24 The essential tools for adequately managing investment include those that make it possible to comprehensively evaluate the networks and services used, so as to adequately size the facilities in question. To ensure the timeliness, quality, and efficiency of public provision systems, it is essential to have planning processes that make it possible to understand how the network is responding to health care demand, and to project its improvement by considering long-term demographic and epidemiological variables.[37]

1.25 Since 2008, one of the methods used by the government to execute investments has been public-private partnership (PPP); and most of the projects executed are in the transportation and energy sectors.[38] In the health sector, EsSalud has three active PPPs, two for hospitals providing clinical services in Lima and Callao, and one for logistical management of drugs and supplies in the Lima metropolitan area. MINSA has a PPP providing nonclinical services for the San Borja Children's Hospital. The success in executing complex projects has encouraged greater use of PPPs within the health sector, and the Peruvian government has decided to supplement the conventional model with them. According to MINSA investment plans, at least half of the investments at the hospital level, particularly in the highest-complexity hospitals, should be executed through the PPP modality. In Latin America, PPPs in the health sector have been gaining ground as a response to the demand for investments that strengthen public supply, since there is evidence that they generate benefits such as better adherence to deadlines and contracted prices.[39] Nonetheless, for those benefits to materialize, the best execution modality (conventional or PPP) must be identified in each investment project, by applying quantitative and qualitative criteria for selecting the execution instrument. The analysis of the PPP experience in the region identified a number of factors that are crucial for its success, such as an emphasis on communication to make the objectives transparent, and on the control and development of projects.[40] For that purpose, it is important to design and implement communication strategies at the outset of PPP projects.

1.26 **Support for implementing the networks model and the integration of health services.** The evidence shows that a primary health care focus, integrated into a network of health centers, clinics, and outpatient and hospital services, improves the quality of care provision and curb the growth of costs. This results in less premature mortality and a better health status.[41] In this connection, Peru has

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[37] See technical note containing the analysis of the project in Latin America: Astorga and Cambiasso (2015).

[38] The regulatory framework for PPPs in Peru is mainly based on Legislative Decree 1012 of 2008, and its subsequent amendments. See Aslan and Duarte (2014).

[39] See, for example, the Bank's Technical Note series on PPPs in health and the international experience, including the case of Peru: Alonso et al. (2015); Alonso et al. (2014). See also the international and regional evidence on PPPs in the health sector: Fernández 2014; Engel and Fischer 2014; Oliveira Cruz and Cunha Marques 2013; Carrera 2012.

[40] See Alonso et al. 2015.

[41] See the international evidence and that applied to the Peruvian case on the effectiveness of the primary care approach in: Cesur et al. (2015); Macinko (2015); Solari (2013); Tejada de Rivero (2013); Kringos et al. (2013), Schoen et al. (2010), WHO (2008), Starfield et al. (2005). See also the discussion contained in the Bank's Health and Nutrition Sector Framework Document at optional electronic link 3.

prioritized development of the integrated primary health care networks (RIAPS) model, to integrate services between the different care levels.

1.27 An integrated services network also makes it easier to apply management and planning tools to improve efficiency.[42] This allows the best use to be made of each resource, and it avoids duplications. The integration of networks is one of the pillars of health policy; and in particular, the complementation of the networks attached to MINSA and EsSalud has been identified as an opportunity, because the diversity of existing networks renders parallel development between the two infeasible. Nonetheless, for this development to be consistent, it is essential to have technical, administrative, and financial tools to make it viable. For that reason, the RIAPS tool should include coordination not only between care levels, but also between MINSA and EsSalud.

1.28 **The path to universal health insurance.** Over the last decade, Peru has focused its efforts on incorporating the poorest groups into the SIS subsidized regimes, offering them a wide-ranging package of health care services without the need for contribution. At the opposite end of the socioeconomic spectrum, formal workers are covered by EsSalud through contributions deducted from the payroll. The major challenge is to extend insurance to the vulnerable population, in other words the nonpoor, who are not covered by social security (see paragraph 1.18), an aspect promoted by Peru through the 2013 reform, with the creation of the SIS semicontributory regime. Nonetheless, only about 285,000 people have thus far enrolled in that modality, out of a target population of 3.2 million.[43]

1.29 International experience shows that expanding health insurance to the population not enrolled in contributory social security is a major challenge, not only in Latin America and the Caribbean, but also in middle-income countries in Asia.[44] The global and regional evidence[45] identifies a number of critical factors for successfully expanding affiliation to the uninsured nonpoor: (i) institutional capacity to apply eligibility criteria for a semicontributory regime and to distinguish between those that have the ability to pay and those who do not; (ii) the capacity to enforce affiliation rules (e.g. obtain payment from nonenrollees for the cost of a health care action at the point of delivery); (iii) the offer of a new benefits plan that is attractive for persons eligible for the semicontributory regime; and (iv) the definition of a premium that ensures financial sustainability for the semicontributory regime and is adapted to the eligible population’s ability to pay.

1.30 With regard to the application of eligibility criteria for the subsidized and semicontributory regimes, Peru has been working to implement tools to discriminate between the poor and nonpoor: (i) to gain access to the subsidized SIS, an individual must live in a household classified as poor in the SISFOH registry;[46] and to be able to access the semicontributory SIS, the person must

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[42] See optional electronic link 3.

[43] SIS and National Committee for the Universalization of Social Security in Health.

[44] The literature refers to that group as the “missing middle”. See Bredenkamp et al. (2015).

[45] See the studies of strategies for including the nonpoor within the vulnerability threshold, both internationally and in Peru, described in: Bredenkamp et al. (2015); Seinfeld and Besich (2014); Bitran (2014); Kwon (2011); Cheng Li (2011); Hughes et al. (2010).

[46] SISOH strengthening received Bank support in the programmatic series consisting of loans PE-L1072 (2234/OC-PE), PE-L1078 (2446/OC-PE), and PE-L1105 (2783/OC-PE); and as well as loan operation PE-L1100 (2374/OC-PE). See paragraph 1.33.

contribute to the SUNAT simplified tax regime, which collects the insurance premium and transfers the funds to the SIS; (ii) persons not enrolled in the SIS have to pay for services in public hospitals out of their own pocket, otherwise treatment is refused. Nonetheless, as the prices charged are subsidized and do not reflect costs,[47] there is a disincentive to insurance. Accordingly, the pricing policy of the public hospitals needs to be revised to encourage voluntary insurance; (iii) as regards the characteristics of the services covered, the benefits plan offered initially through the semicontributory scheme did not include high-cost services which account for a sizeable share of the current demand profile, such as cancer treatment. Accordingly, the benefits plan needs to be revised, to align it to that of the subsidized plan; and (iv) the composition of the benefits plan and the size of the insurance premium must be calculated through actuarial studies, to ensure the sustainability of the system and prevent the level of the premium becoming a disincentive to insurance.

1.31 Lastly, the SIS expansion effort needs to be linked to the incentive for applying preventive measures, particularly those targeting chronic diseases; otherwise the increase in insurance will be fiscally unsustainable. There is strong evidence both internationally and in Peru, that the six high-cost pathologies covered in the FISSAL (cervical cancer, breast cancer, colon cancer, stomach cancer, prostate cancer, leukemia, and chronic renal insufficiency), could be reduced in the population through primary and secondary preventive care measures.[48] Lastly, bearing in mind the expansion of coverage and service packages, consolidating the SIS as a public insurance will require actuarial projection tools that make it possible to calculate and adjust contribution premiums so that they are sustainable, which will function as the basis for the budgetary management process.

5. Relationship to other Bank operations and lessons learned

1.32 Over the last decade, Peru has received Bank support through two loan operations that partly financed PARSalud I and II.[49] The financing of PARSalud II benefited over 7.2 million people who received health services. The previous programmatic series in support of social program reform[50] included the health sector with measures aimed at financing the SIS and strengthening SISFOH. A portfolio of technical cooperation programs supported studies and technical dialogue on issues of financing sustainability, PPP models in the health sector, and the supervision and quality of services.[51]

1.33 Important lessons have been learned from the execution of the loans, which have been incorporated in the design of this operation. Thus, the execution of PARSalud I and II made clear the need to actively involve regional governments in infrastructure and strategic projects, to guarantee their implementation and

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47 See the studies on the structure of financing of public hospitals in Peru in: Jaramillo and Sparrow (2013); Vargas-Gonzales (2008); Seinfeld and La Serna (2007); and de Habich (2005).

48 See evidence of the effects of screening both internationally and in Peru in: Segura et al. (2014); López-Gómez et al. (2013; Franceschi and Wild (2013).

49 PE-0146 (1208/OC-PE) and PE-L1005 (2783/OC-PE). See paragraph 1.9.

50 PE-L1072 (2234/OC-PE), PE-L1078 (2446/OC-PE), and PE-L1105 (2783/OC-PE).

51 PE-L1100 (2374/OC-PE), PE-T1173 (ATN/FT-12373-PE), and PE-T1281 (ATN/FG-13984-PE). PE-L1100 was a reimbursable technical cooperation (TCR), whose objective was to approve the fulfillment of the conditions of the programmatic series.

long-term sustainability, and above all to improve access and coverage to health services in the country's poorest regions. Similarly, while progress has been made in terms of mother and child health, this approach neglected key aspects such as family health and the integration of services. Moreover, difficulties in processes involved in contracting and constructing the works proposed in the project, make clear the importance of planning the investment cycle, with an analysis of demand and infrastructure, together with a review of MINSA capacities as the key actor in the investment cycle.

1.34 In terms of technical cooperation associated with the recent loan portfolio, issues which will be continued in the present operation, include the following: (i) the support provided for performing an actuarial study whose results are expected to assist the SIS in sustaining its budgetary needs; [52] (ii) strengthening of targeting on poor and vulnerable households through SISFOH; and (iii) the first MINSA designs to sustain the launch of PPP initiatives in health. A new technical cooperation already approved in 2015,[53] will continue support for fulfillment of the conditions of the programmatic series and associated technical issues, such as implications for compatibility between the SIS and SISFOH databases, design of methodologies for planning care networks and PPP initiatives.

1.35 At the regional level, the Bank has a growing stock of experience in the planning of networks and investments, the lessons of which are also reflected in this operation. The evaluation of the hospital projects portfolio executed in 2003-2013, made it possible for this operation to support planning processes to avoid over- and under investment (see paragraphs 1.23 and 1.24). In terms of recent projects, the investment management modernization proposed in this operation benefits from lessons that were learned during the exercise to project the demand for investment in health infrastructure in El Salvador and Nicaragua.[54] The analysis of the PPP experience in the region identified, for example, the importance of a communication campaign associated with the launch of the projects (see paragraph 1.25).

6. Strategic alignment

1.36 **Strategic alignment of the program.** The program will contribute to the lending program priority target of the Ninth General Increase in the Resources of the Inter-American Development Bank (GCI-9) (document AB-2764) for poverty reduction and equity enhancement, through actions to provide greater financial protection for households against impoverishing expenses, and the strengthening of public health care offerings that predominantly target households in the bottom income distribution quintiles. It will also contribute to the regional goals for reducing infant mortality and the output for individuals receiving health services. The activities proposed in the series are aligned with the Bank's country strategy with Peru 2012-2016 (document GN-2668), as they contribute to the goal to increase the coverage and enhance the quality of health services in the country's

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[52] The SIS actuarial study was financed by loan PE-L1100. See SIS 2015.

[53] Support for the implementation of PPPs and health service networks (technical cooperation operation PE-T1327, ATN/OC-14986-PE).

[54] ES-L1027 (2347/OC-ES) and NI-L1082 (3306/BL-NI), especially the development of the methodology for determining hospital size in relation to a network of health facilities, and for competitive bidding models that include design, construction, and initial maintenance, so as to reduce the risks of time extensions, overpricing, and infrastructure maintenance in the first few years after delivery.

poorest districts, and to the outcome to increase the number of families receiving an integrated set of health services.

1.37 The objectives of this operation also contribute to the strategy on Social Policy for Equity and Productivity (document GN-2588-4) and to the lines of action of the Bank's Health and Nutrition Sector Framework Document (document GN-2735-3), specifically by supporting efficient redistributive instruments that promote human capital accumulation, and quality health services for the vulnerable population. Although the operation is not included in the 2015 Country Programming Document (CPD), the Government of Peru has requested its approval of the program in 2015, so it was included in a programming aide mémoire between the Bank and the government.

B. Objectives, components, and cost

1.38 The objective of the programmatic series is to support management modernization of the health sector in order to achieve universal coverage of health care services. The operation's specific objectives are: (i) to improve the management of health investment; (ii) to support implementation of the integrated health service delivery networks model of organization; and (iii) to consolidate the financing of health care services through the Seguro Integral de Salud [Comprehensive Health Insurance] (SIS) as a public health insurance policy. The second operation will help build capacity for the supervision of infrastructure investments of the Ministry of Health (MINSA) and projects of public-private partnerships (PPPs), the coordination of investment cycles with regional governments, the integration of health care provider networks and the management of primary health care networks, the development of actuarial planning capacities at the SIS, and the definition of a pricing policy for public hospitals that provides incentives to voluntary insurance. The conditions and documentation for their fulfillment are described in the Policy Matrix.

1.39 **Component 1. Macroeconomic framework.** The objective of this component is to ensure a macroeconomic context consistent with the program objectives, as established in the Policy Matrix (Annex II).

1.40 **Component 2. Support for modernizing the management of health investment.** The specific objectives of this component are to support the role of planning, execution, and monitoring to optimize public investment in health services and help to consolidate the model for public-private interventions in health care. It will also support strengthening of the MINSA organizational structure for the management of infrastructure investment and the design of PPP projects. In this first operation, the component will support the following policy measures: (i) consolidation of MINSA's role in directing sector investment policy, in the functions of planning, coordination, evaluation, and monitoring in the investment cycle; (ii) consolidation of the National Health Investments Program (PRONIS), in its role of formulation, execution, and supervision of health investment projects at the national level, in coordination with different levels of government; (iii) multiyear planning of medium- and high-complexity investments in the health services network of the Lima metropolitan area and Callao, to organize investment decisions considering the public system offerings; (iv) preparation of technical standards and specifications to design, build, and equip high-complexity health care facilities (third-tier), to improve the quality of investment projects; (v) definition of MINSA criteria for making decisions on the

execution modality for health investment projects (modalities: (a) conventional, (b) PPP, and (c) "works for taxes"),[55] to make the investment process more transparent and effective; and (vi) preparation of the main points of the communication strategy for PPP implementation, to raise stakeholder awareness.

1.41 In the second operation, the component will continue to consolidate the reform process by supporting: (i) progress in implementing the role of planning and coordinating sector policy with the regional governments by approving 12 multiyear regional plans for health investment, of low- and medium-complexity and district and provincial scope, coordinated with the strategic establishments; (ii) improvement of the investment management capabilities of the Investment Projects Office (OPI), PRONIS, and the MINSA General Directorate of Infrastructure, Equipment, and Maintenance (DGIEM); (iii) standardization of MINSA processes and their relationship with the regional governments associated with management of the health services investment cycle by approving the Manual of Processes and Procedures; (iv) development of the multiyear planning methodology for medium- and high-complexity health services of regional and macroregional scope, based on the experience in the Lima metropolitan area and Callao, for the organization of investment decision-making, considering the public system offerings; (v) strengthening of the skills of technical staff to apply the sector technical standard for high-complexity health care (third-tier) for projects to be declared viable; (vi) definition of contract supervision mechanisms for health care investment projects awarded through PPPs; and (vii) strengthening of MINSA capacity to implement PPP contracts.

1.42 **Component 3. Support for implementation of the integrated health service delivery networks model of organization**. The specific objectives of this component are to make the organization of health care services more efficient and consolidate sector coordination processes in order to improve access to networks of insurers and health service providers, and their implementation. In this first operation, the component will support the following policy measures: (i) optimization of the installed capacity of health services, and improved access for the insured through regulation of health service exchanges; and (ii) laying the foundation for getting integrated primary health care networks (RIAPS) up and running, to better coordinate and improve access to low- and medium-complexity services.

1.43 In the second operation, the component will continue to consolidate the reform process by supporting: (i) standardization of clinical procedures through a common catalogue that includes a description of benefits and medical/surgical procedures and other clinical services to be exchanged; (ii) definition of interoperability standards (data and transactions), between the information technology systems of the public Health Service Provider Institutions (IPRESS) and Health Insurance Fund Administrator Institutions (IAFAS), to optimize the

[55] The conventional modality is executed with public funding for the design, construction, and operation of the public health infrastructure; PPPs are modalities of private investment participation which incorporate the experience, knowledge, equipment and technology, and they distribute risks and resources for the design, construction or operation of public health infrastructure; in the case of works for taxes, instead of a monetary payment, the tax is "paid" by implementing a health infrastructure project in a municipal or regional locality, without the regional or local government or public university having to raise public funds up front.

exchange of services; and (iii) planning of the national implementation of RIAPSs, based on analysis of all low- and medium-complexity health service offerings.

1.44 **Component 4. Support for consolidating the financing of health care service delivery through the Comprehensive Health Insurance (SIS) as a public insurance policy.** The specific objective of this component is to consolidate the financing of health care service delivery through the SIS as a public insurance policy. In this first operation, the component will support the following policy measures: (i) reorganization of the SIS databases to meet the requirements of actuarial studies to update the premium calculation for the subsidized and semicontributory regimes; (ii) introduction of incentives for expanding the SIS semicontributory regime by aligning its benefits plan with the subsidized regime's plan; (iii) guaranteeing the sustainability of the new semicontributory regime by updating the premium; and (iv) evaluation of intermediate outcomes of incorporating health indicators into the SIS agreements with regional governments to expand the coverage of preventive care services.

1.45 In the second operation, the component will continue consolidating the reform process by supporting: (i) development of the actuarial projection skills of SIS staff; (ii) establishment of a pricing policy for public hospitals aimed at creating incentives for expanding the semicontributory regime and ensuring system sustainability; (iii) consolidation of the premium adjustment mechanism of the semicontributory regime; and (iv) adjustments to health indicators in the SIS management agreements, incorporating the conclusions of the evaluation.

C. Key results indicators

1.46 The Results Matrix of the programmatic series specifies the outputs and outcomes to be obtained from the policy measures adopted. The results expected from these outputs are the percentage of strategic hospitals that have viable preinvestment studies, those that already have a final investment study, and the number of PPP projects formulated. In addition, the amount financed through service exchange and the number of RIAPS established is expected to increase. Lastly, it is expected that the number of beneficiaries of the SIS semicontributory regime will increase, and the percentage of regional governments meeting at least 35% of the service delivery targets will also increase; the percentage of the population aged 18 years or older, enrolled in the SIS, will have been screened with a preventive package, and the gap between men and women will have been reduced; and the percentage of children under one year of age enrolled in the SIS who have received 11 growth and development checkups (CREDs) will have increased. Taken as a whole, the combined outcomes of more widespread insurance among the population and timely, integrated, and high-quality health care for the population (in relation to chronic diseases for adults and CREDs for children under one year of age) will lead to a reduction in disability adjusted life years (DALYs) (see paragraph 1.48 and Project economic analysis).

1.47 **Economic analysis.** The economic analysis of a PBP poses specific difficulties, because the loan proceeds are untied and unlinked to the cost of implementing the reforms. Nonetheless, an extensive economic analysis was performed on the impacts associated with the policy reforms supported by the programmatic series (see Project economic analysis). The analysis was based mainly on the benefits

that could be obtained from meeting the targets set for Component 4. Components 2 and 3 are regarded as enabling factors for meeting these targets.

1.48 Accordingly, an estimate was made of the effect on the cohort of SIS enrollees of completion of the policy measures and, consequently, the expected outcomes, as specified in the Results Matrix: (i) the increase in the SIS population enrolled in the semicontributory regime and the consequent effect on reducing DALYs,[56] as a result of improved access to hospitalization services; (ii) the effect, in terms of DALYs, of increasing the number of children under one year old who have received all of their CREDs, achieved through the prevention of anemia and the beneficial effects of breastfeeding; and (iii) the reduction in DALYs caused by a reduction in the number of patients with undiagnosed and untreated diabetes, high cholesterol, and high blood pressure through an increase the percentages of the population age 18 and over screened for these pathologies. The estimates performed[57] show that the operation would make it possible to avoid 45,456 DALYs, corresponding to an incremental cost-effectiveness ratio (ICER) of US$1,234 per DALY avoided. Taking as a benchmark a willingness-to-pay threshold per DALY avoided equal to Peru's per capita GDP (US$5,962), the proposed intervention can be regarded as highly cost-effective.[58] In sensitivity analyses involving a longer time horizon or lower discount rates, the ICER falls, making the operation even more cost-effective. As an additional step in the economic analysis, the benefits to be obtained as a result of implementing the policy measures were estimated at US$743 million under conservative scenarios.

II. FINANCING STRUCTURE AND MAIN RISKS

A. Financing instruments

2.1 This operation is structured as a programmatic policy-based loan (PBP) with deferred drawdown option (DDO). The structure of the operation is consistent with the guidelines and directives established in document CS-3633-1, "Policy-based loans: Guidelines for preparation and implementation;" and in section VI.C on the deferred drawdown option in document GN-2667-2, "Proposal to establish a set of contingent lending instruments of the IDB." The amount of this operation is US$300 million from the Bank's Ordinary Capital resources. The loan proceeds will be disbursed in an original drawdown period of up to three years, running from the date of entry into force of the loan contract. This period may be extended for an additional three years, provided the Bank has indicated its consent to the borrower in writing. The use of the DDO modality is justified by its precautionary nature in view of potential changes in the country's financing requirements. The amount of the subsequent operation will be determined on the basis of the country's financing requirements and the programming exercise with the Bank.

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[56] According to the World Health Organization (WHO) a DALY can be understood as one lost year of healthy life. DALYs are calculated as the sum of the years of life lost owing to premature mortality, and the years of life lost due to disability.

[57] The time horizon is five years, and the costs and outcomes were discounted at a 12% effective annual rate. Details of the analysis can be found in the Project economic analysis.

[58] See the cost-effectiveness thresholds defined by the WHO at http://www.who.int/choice/costs/CER_thresholds/en/.

2.2 **As special contractual conditions precedent to the disbursement of the loan proceeds, the policy reform measures will be completed, as described in the program's components (section B, paragraphs 1.39 to 1.45 and Annex II), and satisfaction of the other conditions established in the loan contract.**

B. Environmental and social safeguard risks

2.3 This operation does not envisage activities with negative implications for natural resources. For that reason, pursuant to Directive B.13 of the Bank's Environment and Safeguards Compliance Policy (document GN-2208-20, Operational Policy OP-703), and as a sector policy loan, this operation does not require classification. A positive social impact is expected from the program's policy measures (document GN-2531-10).

C. Other project risks

2.4 The majority of the operation's risks are medium and associated with public management and governance, and mitigation actions have been identified. The two main risks identified are: (i) potential opposition to the PPP projects for the execution of hospital investment. To mitigate this risk, the Bank has been working with MINSA, supported by nonreimbursable technical cooperation funding, on a stakeholder map to support the design of the MINSA communication strategy explaining projects under the PPP modality. This is a policy condition for this operation (see paragraph 1.40). Steps will also be taken to promote ongoing dissemination of the outcomes achieved and benefits obtained; and (ii) discontinuity in the progress of reforms owing to changeover of the administration. Although the reform has sound theoretical foundations which generate strong arguments in favor of its implementation, a high-level technical dialogue is proposed, to present the key reasons for continued implementation of the reform and the results already achieved.

2.5 The technical and financial support that the Bank is providing to MINSA also contributes to the sustainability of the reforms in the health sector by generating the inputs necessary to overcome the technical challenges faced by the health authorities in implementing the measures. Moreover, the contribution of solid evidence of the results associated with the implementation of the policy measures, as an output of the program monitoring and evaluation activities, is a tool for building societal consensus as to the importance and usefulness of the measures, so as to ensure their sustainability.

III. IMPLEMENTATION AND MANAGEMENT PLAN

A. Summary of implementation arrangements

3.1 The borrower is the Republic of Peru, and the program executing agency will be the Ministry of Economy and Finance (MEF), acting through the General Directorate of Public Borrowing and Treasury (DGETP), which will be responsible for coordinating with the entities involved in implementing the planned reforms; promoting actions to achieve the objectives of the policies defined, and delivering reports and evidence of fulfillment of the program's policy conditions. In particular, the Unit-Directorate of Sector Loan Coordination (D-UCPS), as part of the DGETP, is responsible for intersector and intergovernmental coordination for

programmatic loans, and will work in coordination with MINSA and its constituent institutions to monitor the policy measures.

B. Summary of arrangements for monitoring results

3.2 Monitoring of the program will involve verification of the policy measures agreed upon as disbursement conditions, as indicated in the Means of Verification Matrix. The results of these policy changes will be monitored through the operational process indicators of the programs in the programmatic series. In terms of evaluation, the results associated with the national expansion of the SIS will be evaluated using the administrative databases that explore the extent to which the expansion of public insurance has contributed to broader use of preventive measures and, hence, lower disease burdens. As the SIS will not be expanded simultaneously in all parts of the country, a "differences-in-differences" model will be used for longitudinal analysis of Peru's 1,842 districts in 2013-2017. The analysis will make it possible to evaluate the extent to which SIS expansion was associated with an increase in preventive checkups among adults and children and the reduction of child mortality, including variables of infrastructure and human and financial resources at the district level. See Monitoring and evaluation plan. This evaluation will be performed at the end of the programmatic series, when the project completion report (PCR) will also be produced, presenting conclusions on the outcomes, impacts, and lessons learned in program execution.

IV. POLICY LETTER

4.1 The Bank has reached agreement with the Government of Peru on the macroeconomic and sector policies included in the Policy Letter to be presented by the Ministry of Economy and Finance (MEF), describing the main components of the government's strategy for this program, and reaffirming its commitment to implement the agreed activities.

Development Effectiveness Matrix			
Summary			
I. Strategic Alignment			
1. IDB Strategic Development Objectives	**Aligned**		
Lending Program	**-Lending for poverty reduction and equity enhancement**		
Regional Development Goals	**-Infant mortality ratio**		
Bank Output Contribution (as defined in Results Framework of IDB-9)	**-Individuals receiving a basic package of health services**		
2. Country Strategy Development Objectives	**Aligned**		
Country Strategy Results Matrix	**GN-2668**	**Increase the coverage of comprehensive child development services in the country's 600 poorest districts.**	
Country Program Results Matrix		**The intervention is not included in the 2015 Operational Program.**	
Relevance of this project to country development challenges (If not aligned to country strategy or country program)			
II. Development Outcomes - Evaluability	Highly Evaluable	Weight	Maximum Score
	9.7		10
3. Evidence-based Assessment & Solution	10.0	33.33%	10
3.1 Program Diagnosis	3.0		
3.2 Proposed Interventions or Solutions	4.0		
3.3 Results Matrix Quality	3.0		
4. Ex ante Economic Analysis	10.0	33.33%	10
4.1 The program has an ERR/NPV, a Cost-Effectiveness Analysis or a General Economic Analysis	2.5		
4.2 Identified and Quantified Benefits	2.0		
4.3 Identified and Quantified Costs	2.0		
4.4 Reasonable Assumptions	2.0		
4.5 Sensitivity Analysis	1.5		
5. Monitoring and Evaluation	9.0	33.33%	10
5.1 Monitoring Mechanisms	1.5		
5.2 Evaluation Plan	7.5		
III. Risks & Mitigation Monitoring Matrix			
Overall risks rate = magnitude of risks*likelihood	**Medium**		
Identified risks have been rated for magnitude and likelihood	Yes		
Mitigation measures have been identified for major risks	Yes		
Mitigation measures have indicators for tracking their implementation	Yes		
Environmental & social risk classification	**B.13**		
IV. IDB´s Role - Additionality			
The project relies on the use of country systems			
Fiduciary (VPC/FMP Criteria)	**Yes**	**Financial Management: External control.**	
Non-Fiduciary	**Yes**	**Strategic Planning National System, Monitoring and Evaluation National System.**	
The IDB's involvement promotes additional improvements of the intended beneficiaries and/or public sector entity in the following dimensions:			
Gender Equality	**Yes**	**Supporting actions to close the gap in use of preventive services for men and women.**	
Labor			
Environment			
Additional (to project preparation) technical assistance was provided to the public sector entity prior to approval to increase the likelihood of success of the project	**Yes**	**Technical cooperation PE-T1327: Support for the implementation of PPPs and Health Services Networks.**	
The ex-post impact evaluation of the project will produce evidence to close knowledge gaps in the sector that were identified in the project document and/or in the evaluation plan	**Yes**	**The impact evaluation contributes to knowledge on the impacts of expanding health insurance on the population's health.**	

The objective of this Programmatic Loan for Policy Reform (PBP) is to support the modernization of policy management in the health sector to reach universal coverage of public health services in Peru. Specifically, it aims to i) modernize investment management in the health sector, ii) support the implementation of an organizational model that offers health services within an integrated network-based approach, and iii) contribute to the consolidation of a financing system for the sustainability of health services offered through the Sistema Integral de Salud (SIS) as a public insurance system.

To achieve these goals, this operation seeks to implement specific components based on a series of policy measures synthesized in: (a) capacity building, (b) implementation of coordination mechanisms through network design and (c) redesigning financial systems. The document presents an informed diagnosis of the current situation with historical trends and a clear identification of challenges related to the proposed direction of the project´s support. The results matrix includes outputs and outcomes. Impacts are not included in the results matrix, but are identified in the document as part of the logical framework, and are consistent with the economic analysis. Proposed indicators to measure outcomes and outputs meet SMART criteria.

The document includes a plan for the program's monitoring and evaluation. The monitoring and evaluation activities have been planned and budgeted. The proposed impact evaluation follows a difference in differences methodology (fixed effects) that looks to identify effects of SIS coverage on specific indicators (child mortality rates, number of health and growth monitoring check-ups for children).

Potential risks have been identified with the sustainability of the operation considering changes in the national administration and resistance to PPP implementation. These risks are matched with mitigation measures.

POLICY MATRIX

Components	Programmatic policies I (2015)	Programmatic policies II (2017)
1. Macroeconomic framework	(1.1) Macroeconomic framework consistent with the program objectives and with the general contents of the sector policy letter.	(1.1) Macroeconomic framework consistent with the program objectives and with the general contents of the sector policy letter.
2. Support for modernizing the management of health investment (i) Support the role of planning, execution, and monitoring to optimize public investment in health services. (ii) Help to consolidate the model for public-private interventions in health care.	(2.1 a) Consolidation of the role of the Ministry of Health (MINSA) in directing sector investment policy, in the functions of planning, coordination, evaluation, and monitoring in the investment cycle. (2.1 b) Consolidation of the National Health Investments Program (PRONIS), in its role of formulation, execution, and supervision of health investment projects at the national level, in coordination with different levels of government.	(2.1 a) Progress in implementing the role of planning and coordinating sector policy with the regional governments by approving 12 multiyear regional plans for health investment, of low- and medium-complexity and district and provincial scope, coordinated with the strategic establishments. (2.1 b) Improvement of the investment management capabilities of the Investment Projects Office (OPI), PRONIS, and the MINSA General Directorate of Infrastructure, Equipment, and Maintenance (DGIEM). (2.1 c) Standardization of MINSA processes and their relationship with the regional governments associated with management of the health services investment cycle by approving the Manual of Processes and Procedures.
	(2.2) Multiyear planning of medium- and high-complexity investments in the health services network of the Lima metropolitan area and Callao, to organize investment decisions considering the public system offerings.	(2.2) Development of the multiyear planning methodology for medium- and high-complexity health services of regional and macroregional scope, based on the experience in the Lima metropolitan area and Callao, for the organization of investment decision-making, considering the public system offerings.
	(2.3) Preparation of technical standards and specifications to design, build, and equip high-complexity health care facilities (third-tier), to improve the quality of investment projects.	(2.3) Strengthening of the skills of technical staff to apply the sector technical standard for high-complexity health care (third-tier) for projects to be declared viable.
	(2.4 a) Definition of MINSA criteria for making decisions on the execution modality for health investment projects (modalities: (a) conventional, (b) PPP, and (c) “works for taxes”), to make the investment process more transparent and effective.	(2.4 a) Definition of contract supervision mechanisms for health care investment projects awarded through PPPs.

Components	Programmatic policies I (2015)	Programmatic policies II (2017)
	(2.4 b) Preparation of the main points of the communication strategy for PPP implementation, to raise stakeholder awareness.	(2.4 b) Strengthening of MINSA capacity to implement PPP contracts.
3. Support for implementation of the integrated health service delivery networks model of organization (i) Make the organization of health care services more efficient. (ii) Consolidate sector coordination processes in order to improve access to networks and their implementation.	(3.1) Optimization of the installed capacity of health services, and improved access for the insured through regulation of health service exchanges.	(3.1 a) Standardization of clinical procedures through a common catalogue that includes a description of benefits and medical/surgical procedures and other clinical services to be exchanged. (3.1 b) Definition of interoperability standards (data and transactions), between the information technology systems of the public Health Service Provider Institutions (IPRESS) and Health Insurance Fund Administrator Institutions (IAFAS), to optimize the exchange of services.
	(3.2) Laying the foundation for getting integrated primary health care networks (RIAPS) up and running, to better coordinate and improve access to low- and medium-complexity services.	(3.2) Planning of the national implementation of RIAPSs, based on analysis of all low- and medium-complexity health service offerings.
4. Support for consolidating the financing of health care service delivery through the Comprehensive Health Insurance (SIS) as a public insurance policy. (i) Consolidate financing of health care service delivery through the SIS as a public insurance policy.	(4.1) Reorganization of the SIS databases to meet the requirements of actuarial studies to update the premium calculation for the subsidized and semicontributory regimes.	(4.1) Development of the actuarial projection skills of SIS staff.
	(4.2 a) Introduction of incentives for expanding the SIS semicontributory regime by aligning its benefits plan with the subsidized regime's plan. (4.2 b) Guaranteeing the sustainability of the new semicontributory regime by updating the premium.	(4.2a) Establishment of a pricing policy for public hospitals aimed at creating incentives for expanding the semicontributory regime and ensuring system sustainability. (4.2b) Consolidation of the premium adjustment mechanism of the semicontributory regime.
	(4.3) Evaluation of intermediate outcomes of incorporating health indicators into the SIS agreements with regional governments to expand the coverage of preventive care services.	(4.3) Adjustments to health indicators in the SIS management agreements, incorporating the conclusions of the evaluation.

DOCUMENT OF THE INTER-AMERICAN DEVELOPMENT BANK

PROPOSED RESOLUTION DE-__/15

Peru. Loan ____/OC-PE to the Republic of Peru
Program for the Modernization of Universal Health Care Coverage Management I

The Board of Executive Directors

RESOLVES:

That the President of the Bank, or such representative as he shall designate, is authorized, in the name and on behalf of the Bank, to enter into such contract or contracts as may be necessary with the Republic of Peru, as Borrower, for the purpose of granting it a financing to cooperate in the execution of a program for the modernization of universal health care coverage management I. Such financing will be for the amount of up to US$300,000,000 from the resources of the Bank's Ordinary Capital, and will be subject to the Financial Terms and Conditions and the Special Contractual Conditions of the Project Summary of the Loan Proposal.

(Adopted on ______________)

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