Public Health Care for the poor? A gendered analysis of the implementation of the Integrated Health Insurance (SIS) and its effects on the access of the poor to health services in Peru

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ABSTRACT

This study indentifies the factors in the implementation of the Integrated Health Insurance (Seguro Integral de Salud - SIS) that are impeding the fully access of the poorest to the entitlement to a health scheme and the use of health services in Peru. The analysis emphasizes the differences in the effects of this process on female and male groups. The information collected is based on interviews with health personnel working under the SIS scheme and female and male inhabitants of six poor districts where SIS is being implemented. The results demonstrate that failures at the level of the patterns guiding the practice of health personnel in the implementation, the way of addressing people's health needs and the management of SIS in the provision of resources to health centers are the reasons why SIS has not reduced, and in some cases has enhanced, the social and gender inequality among poor population, and in particular between women and men.

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List of Abbreviations

EMA - External Medical Assistance

ENAHO – National Household Survey (Encuesta Nacional de Hogares)

ENDES - National Health Survey (Encuesta Demográfica y de Salud Familiar)

FCP – Free Cost Plan

FESE - Socio-economical evaluation form

HP - Health Personnel

MCP - Minimal Cost Plan

PAHO - Pan-American Health Organization

Q - Quintile of poverty

SEG – Free School Health Insurance (Seguro Escolar Gratuito)

SIS - Integrated Health Insurance (Seguro Integral de Salud)

SMI – Mother and Child Insurance (Seguro Materno-Infantil)

UNRISD - United Nations Research Institute for Social Development

INTRODUCTION

In the 1980s the situation in Peru was one of widespread poverty, ethnic inequalities, poor state provision and a weak entitlement to health and pension systems for those excluded of formal labor market. Organizational and managerial deficiencies contributed to overlapping welfare institutions and lack of coordination between different social and economical sectors (Molyneux, 2006). The poor performance of the state as a manager and regulator of policy and public administration forced the adoption of new reforms.

The privatization of the welfare system was one of the options to solve the crisis. It created new forms of social entitlements to incorporate people in the major social insurance scheme: the health sector. However, access to private health systems required that people could afford the cost of this service which was difficult taking into account that 39.3% of the population lived under the poverty line, including people in extreme poverty among indigenous people in rural areas and women who are not usually part of the paid-labor segment (INEI - ENAHO, 2007). Thus, the privatization of health system brought a greater social and economic exclusion. In these circumstances, the implementation of new kinds of health care schemes which target the poorest arose as an urgent task.

The reforms included the creation of a new social health scheme which is called Integrated Health Insurance (Seguro Integral de Salud – SIS). SIS targets the poor population who cannot afford any of the other health schemes created with the privatization of the welfare system. It is managed directly by the Ministry of Health, and together with the private health scheme and the Social Security System (Seguro Social de Salud del Perú- ESSALUD), which target workers in the formal sector, makes up the fragmented and segmented Peruvian health system (PAHO, 2007).

SIS is a social mechanism to guarantee the access to health for the poorest. The basic component of SIS is the coverage of health services for those entitled through two plans: the Free Cost Plan (FCP) and the Minimal Cost Plan (MCP). The system introduces targeting and means-testing methods to classify people in one of the plans. Up to now, SIS has already functioned for 8 years, but although it has increased the number of formal entitled among the poorest, especially women and children, the use of health services for the poorest in rural areas is still low. For instance, according to Parodi (2005) who focuses on maternal services, 75% of women entitled to SIS who live in rural areas have given birth at home in 2005. The situation is aggravated in these areas because of the lack of skilled health personnel and adequate health services that have not been improved regardless the implementation of SIS.

Reports released on the topic attribute the economic variable as the main reason why the poorest do not access to health services. To use health services in rural areas demands additional extra costs not covered by SIS, such as transportation (Vera, 2003; Parodi, 2005). Other research about SIS, which focuses on the use of maternal services, emphasize that poor women are the most excluded since they have no access to money to cover extra health care costs and they deal with cultural constraints that conflict with the medical practice applied in health centers in rural areas (Parodi, 2005; PAHO, 2007). The latter means that the implementation of SIS far from addressing the obstacles, it is supposed to tackle seems on the contrary to be reinforcing the exclusion of the poorest, especially women, as introduces fee-payment mechanisms and omits cultural variables such as different styles of birthing position into the practice of the health services covered. However, research on the topic has largely overlooked how concrete actions in the

implementation of SIS in the field, for example at the level of means-tested evaluation, entitlement procedures, among others, influence in the lack of access to health services for the poorest. Likewise, the access of men and the use of other health services different than children and maternal services have not been analyzed.

In the light of the above, this thesis will identify and analyze the factors in the implementation of SIS that affect the access of poor women and men to claim entitlement to SIS and to use health services covered by it. It will be shown that this situation is caused not only by economic factors; but also by failures at the level of the conception, management and application of the SIS system in the field. This study collects information through interviews with health personnel, who are working with SIS, and with female and male inhabitants, who are users and not users of health services, in six districts considered poor in Peru. The sample was chosen to have a better understanding of the effects of the implementation of SIS in the real users of the system.

The first part of the thesis offers theoretical explanations about the introduction of social health schemes in developing countries and the factor of universal access as mechanism to guarantee the protection of the most excluded. The second chapter describes the methodology used to collect the data of this study. The third chapter describes the characteristics of the Integrated Health Insurance (SIS), as well as revising findings of research devoted to this topic. The fourth chapter analyses the results of the study, emphasizing those elements in the implementation of SIS in the field that are reinforcing the exclusion of the poorest. The last chapter presents the conclusions of this study.

CHAPTER 1: HEALTH CARE SCHEMES AS WELFARE SYSTEM FOR VULNERABLE GROUPS

The chapter will review the concepts related to health care schemes as part of the welfare systems of developing countries. The analysis will assess the effects of their implementation on living conditions of the vulnerable people, particularly among female populations.

The implementation of Social Health Schemes in Latin America was framed for the first time into the privatization policies running during the 1990s. The Welfare systems in the region, specifically in the health care, adopted a market-based model with the inclusion of private sector as managers of different social systems. The unstable and weak institutional, financial and social conditions of the Latin American countries at that time did not ensure a successful implementation of privatization policies; consequently, the adoption of social policies, such as social health schemes were crucial to thwart the effects generated by privatization policies on the employment and health on the most vulnerable populations (Hassim & Razavi, 2006). The role of the State, in that context, was to regulate and provide social services as instruments to guarantee social protection for the poor with at least some degree of redistribution among poor people. The state intervention focused on market distortions that could put at risk social interests of the poorest (Sainsbury, 1996; UNRISD, 2005; Hassim & Razavi, 2006).

In the case of Health policy reforms, Koivusalo (1996 cited by Stein, 2006, p 70) claims that health schemes are seen both as solutions and as problems. In developed countries they are considered solutions since they are conceived as a procedure based on the payment affordability; consequently, the provision of health care is funded and does not generate changes in benefits to be received by the

people. However, in developing countries, where economic and social conditions among populations are extremely different, health schemes are considered as problems because as long as they rely on privatization and market behavior it will be difficult to address the different existing health needs of the population, especially of the poorest. As a result, health schemes will not ensure the implementation of high quality standards and universal access to health care provision (Petchesky, 2003).

The new structures of welfare services that have been applied in the region are supported by base-payment and mean-testing strategies, which in a way, reinforces inequalities between those who could pay and those who could not pay. Those with low income or no income ended up being excluded from the health care benefits scheme since either they were not eligible to be entitled or were not able to keep their entitlement for long. Consequently, base payment health schemes worsen health and social conditions of the poorest, legitimizing exclusion and inequality (Mackintosh, 2001).

Empirical data in some countries in Africa and Latin America show that public health schemes have increased the access to health services but they have not necessarily increased the access and benefits of the poorest groups (World Bank; 2006). Among the pauperized population, those who are less poor are taking a better advantage of health services because they have access to more information, have higher level of education and live in larger proportions in areas where health services are available geographically (Mackintosh et.al., 2001; Eweg, 2006). Therefore, public health schemes contribute to the reduction of some economic barriers, but with little or no impact on non economic ones.

The current debate in the literature focuses on *universality* as a key element of the health schemes to service vulnerable groups. The Pan-American Health

Organization (PAHO, 2007, p.1) in its latest study about health schemes in Latin America, defines “social protection health schemes” as “public intervention aimed at allowing groups and/or individuals to meet their health needs and demands through access to health care and/or other goods, services or opportunities in adequate conditions of quality, opportunity, and dignity, regardless of their ability to pay”. Thus, health care access for all is not only a matter of financial capacity but also a matter of addressing other possible social variables, such as place of residence, culture, gender that could be constraining the access to high quality health services.

Based on the above, it may be argued that health care reforms should include the legitimate right of the poor to demand access to health care independently of economic, labor, and other restrictive conditions. This will happen when public institutions will ensure an adequate and universal redistribution of health care provision (Mackintosh, 2006). According to some authors (Makintosh, 2006; Londoño et al., 1997), the legitimization of universal of health care schemes will encourage people to demand more efficient and qualitative health care services since they will perceive this demand as a lawful right for them as citizens. Likewise, universality will encourage public institutions to be more committed and to keep on track mechanisms that will facilitate the access of population to these services (WHO, 2002; Redden, 2002). In this sense, Londoño et al. (1997, p. 186) assert that health reforms should be taken as instruments to strengthen the link between population and institutions, the latter meaning encouraging citizens to mobilize and participate in the decision-making process on this matter. Thus, the authors claim that health reforms should be conceived as a social commitment between institutions and people based on citizenship principles. In this line of thought, Redden (2002, p. 98) asserts that the concept of citizenship in health reforms should be based on the

provision of health services to all citizens, and not contingent on need, wealth, or income. Engaging communities in health care decision-making is also empowering and edifying for citizens since it makes them actively engaged in the protection of their rights. Participation enables people to be involved in the designing and implementation of health care policies and thus makes health care services more suitable for their needs. It is also advantageous in the sense that it balances the power of health personnel that usually tend to impose their own culture and techniques in medical practice. Furthermore, in order to build more equal health schemes based on citizenship; it is necessary to recognize the differences among various ethnic, gender, cultural and socioeconomic populations, that could be achieved by understanding how population's demands and needs are expressed and how could be created suitable strategies to reasonably satisfy them (Baxter, 2001; Redden, 2002; Henke, et. al., 2004; Stein, 2006).

Regarding the gender dimension of health care policy, and focusing on the poor female population in particular, the United Nations Research Institute for Social Development (UNRISD, 2005) argues that market-based model works as a sort of "commodification" of public services which exacerbates traditional gender inequalities since women are likely to be poorer than men; consequently, women tend to have a more limited access to public services such as health care. In this sense, health policies should be designed in such a way as to take into consideration all social conditions and rules that frame the role of woman in the society as a fundamental user and participant of the health sector. For instance, the double role of breadwinner/caregiver that women are expected to assume determines social identities and types of work (unpaid) in the contexts where they are immersed (Sainsbury, 1996; Seinfield, 2005; Molyneux, 2006). Sainsbury (1996) argues that

entitlement based on citizenship has a stronger “defamilializing” potential because it can neutralize the influence of marriage on social rights. Therefore, benefits and services cannot be either differentiated between husband and wife; or differentiated as relating to paid and unpaid work.

Moreover, welfare systems should involve not only benefits such as material consumption, qualitative health services, etc., but also variables that contribute to the psychological and social welfare of women. Some authors (Redden, 2002; Francke, 2006; Vera, 2003) add to this respect that health initiatives should also integrate other areas where women activate such as employment, education, economy, etc., in order to address real women needs more effectively and guarantee their free and universal access to health services.

Summing up, the implementation of comprehensive health schemes is feasible as long as it takes into account different effects that health scheme implementation produces on each single group of people. In contexts where social and economic conditions of people are different, efficient health schemes should be contingent to a base-citizenship and universal conception that recognizes the universal right of participation and access to its benefits.

CHAPTER 2: RESEARCH DESIGN AND METHODOLOGY

The Integrated Health Insurance (Seguro Integral de Salud – SIS) is a social health scheme which was implemented in Peru in 2002 to attend populations who were excluded from other public and private health schemes after the privatization of the welfare system. Low income-earning or unemployed citizens and people living under the poverty line in all 24 regions of the country are eligible to claim benefits offered by this scheme.

SIS is composed of two plans: The Free Cost Plan (FCP) - no fee payment -, and the Minimal Cost Plan (MCP) – which is a monthly payment that may range from US$4 to US$15. Both plans cover the same types of health services. In order to be classified in one of the two plans, people are evaluated based on a socio-economical evaluation form (FESE) which is a means-testing procedure (Ministry of Health of Peru, 2008; SIS, 2008). SIS has already been functioning for 8 years and even though the number of people entitled to its benefits has increased, the access to health services sustained by SIS is apparently not fully offered to the poor who, at the same time, are precisely the target population of SIS.

In this sense, the present study aims to indentify the factors in implementation of the Integrated Health Insurance (SIS) that are impeding the poorest full access to health care services. The study also analyses the impact of SIS implementation from a gender perspective and whether this scheme is reinforcing economic, social and gender inequalities.

Peru is known for its geographical, social, economical and ethnical diversity; thus, the election of three different regions to collect data for this study responds to the necessity to compare the effects of SIS on different contexts. Puno, Lima and

San Martin are three of the 24 regions which reflect the country's regional mixture. For the purpose of this study, interviews were conducted in two selected districts from each region (for details of the selection process see 2.3). The interviewees, health personnel (HP) and female and male inhabitants were asked about the quality of health services provided under the SIS scheme in their districts.

Lima, the capital city of the country, which lies on the coast of Pacific Ocean, is the place which historically has hosted most of the political, social and economic institutions of the country. In the last 30 years due to fast development in the region, thousands of people from the Andean and Amazon zone migrated to Lima and settled down at the periphery of the city. This "settlement ring" created a new dynamic of life with different social, economic and health needs. Despite the proximity of these places to Lima, the population living there is entangled in extreme poverty. In health care terms, Lima concentrates the most sophisticated and technically equipped health care services in the country such as hospitals, research medical centers, universities and the most qualified and well paid health professionals. Lima displays the best health indicators compared to the country average; for instance, most of women who seek health care assistance are attended by doctors (53%), moreover, 81.2% of the women who give births are normally assisted in health centers (ENDES; 2007). The districts of Pachacamac (slum) and Santa Rosa de Quives (rural) in this region were chosen as a sample for this study.

Puno is one of the poorest regions in the country located in the Andean region. It is a rural area with a high number of Quechua and Aymara indigenous people. The customs and values are still preserved as patterns of behavior among this population, especially among the women. Agriculture and commerce are the main labor sectors of the region. Regarding health issues, health indicators show that

59.5% of women in 2006 had given births at home (ENDES, 2007). Zepita and Chucuito, both rural areas, are the two districts chosen to be part of this sample.

San Martin is located in the Amazon, in the forest part of the country. This zone suffered attacks of terrorist groups and military forces for years. Currently, drug trafficking is being fought by military forces in the region. The population living in rural areas is considered to be living under poverty line and several indigenous groups survive thanks to agriculture being the only way of subsisting. Regarding health matters, reports show that in 2007 29.1% of women gave births at home; whereas 61% did not take postnatal check up (ENDES, 2007). The districts of Sauce and Chazuta, were chosen to represent this region.

Health services are operated relatively well in the bigger cities; however health centers in rural areas lack sufficient equipment, appropriate infrastructure and qualified health personnel. In the case of the slum areas in Lima, health centers operate in better conditions.

2.1 Research Questions and Hypothesis

My research was guided by three general research questions:

- What are the effects of the implementation of SIS on the entitlement and access to health services of the poorest women and men?
- What are the factors in the implementation of SIS that affect the entitlement and access to health services of the poorest women and men?
- How can SIS be reformed in a way that would make the system more responsive to the poorest' women needs especially in view of improving the access to health services?

Based on the theory and research on the performance of social health schemes in developing countries, as revisited in chapter 1, three hypotheses are expected to be proved:

1. The implementation of SIS has increased the number of poorest people formally entitled to a health scheme; however, it has reinforced the social and gender gap since less poor people and men find access to health services sustained by SIS easier than the poorest population and particularly women belonging to this group.
2. The real use of health services is not fully exploited by the poorest and women because of socio - cultural, geographic and economic hindrances.
3. The indigenous people continue to be discriminated against in terms of access to health services since the medical practices provided in the frame of SIS do not take into account a number of aspects of their particular life styles.

2.2 Methods:

Primary and secondary sources are used to prove or reject the hypothesis presented above:

Interviews with health personnel (HP) in the health centers in six districts:: The information collected aimed to explore health personnel's ideas and perceptions on the functioning of SIS, the method of entitlement and classification, women's and men' demand of health services as well as advantages and disadvantages of the services provided.

Interviews with female and male inhabitants of six districts: The information collected explored women and men inhabitants' ideas and perceptions on the functioning of SIS, the method of classification of people in one the plans, the quality of services they receive, obstacles to access health services; as well as suggestions to improve the provision of health services and proper functioning of SIS.

The questionnaires for health personnel and inhabitants were designed by the author of this study and sent to colleagues in Peru who conducted the interviews in the six districts during the months of May and June 2008. In the particular case of health personnel in Pachacamac and Sauce, some of them were interviewed via email.

Evaluation of routine data of 2007 from Ministry of Health and SIS: The data selected are compared with the information obtained from the interviews. The data selected from the routine data is the following: number of individuals entitled to SIS, the gap between those who are entitled and those who should be entitled but they are not, sex/age of entitled people. Number of health services provided by SIS to women and men of all ages in five quintiles of poverty during the year of 2007. Likewise, studies developed on this topic in Peru were revisited.

2.3 Sample

As the research has mainly a qualitative approach, the interview/based information was collected in six districts known as areas where the poorest population is concentrated. This selection permitted a more in depth analysis.

Two districts per region were selected to be part of the sample. The selection of the districts in each region was based on the categories established by SIS's expansion strategy which has classified Peruvian regions and their districts according to 5 Poverty Group Quintiles (Q):

- Q1 exempted to be means-tested by Socio-economic evaluation form (FESE) and automatically classified in FCP.
- Q2, Q3, Q4 and Q5 means-tested by FESE before being classified into any of the two plans.

Most of the districts in Lima are classified as belonging to Q3, Q4 and Q5; consequently most of the population has to be mean-tested by FESE in order to be entitled. In San Martin, most of the regions are considered within Q1, Q2 and Q3; therefore, the proportion of population that is entitled to FCP and MCP is similar. However, in the case of Puno, most of the districts are considered extremely poor belonging to Q1; consequently, the population is automatically entitled to the FCP.

The following table describes the composition of the sample:

Table 1: Characteristics of the sample

Region	District	Poverty Group Quintile (Q)	Condition of entitlement	Interviewees: Health Personnel (HP) / Inhabitants
Lima	Pachacamac (slum)	Q2	Means – testing	**HP**: HP1 & HP2 **Inhabitants**: W1 & W2 (women) M1 & M2 (men)
	Santa Rosa de Quives (rural)	Q2	Means – testing	**HP**: HP1 & HP2 **Inhabitants**: W1 & W2 (women) M1 & M2 (men)
Puno	Zepita (rural)	Q1	Automatic entitlement to FCP	**HP**: HP1 & HP2 **Inhabitants**: W1 & W2 (women) M1 & M2 (men)
	Chucuito (rural)	Q2	Means – testing	**HP**: HP1 & HP2 **Inhabitants**: W1 & W2 (women) M1 & M2 (men)
San Martin	Chazuta (rural)	Q1	Automatic entitlement to FCP	**HP**: HP1 & HP2 **Inhabitants**: W1 & W2 (women) M1 & M2 (men)
	Sauce (rural)	Q2	Means – testing	**HP**: HP1 & HP2 **Inhabitants**: W1 & W2 (women) M1 & M2 (men)
			Total	**Health Personnel:** 12 **Inhabitants:** 12 women,12 men

Unlike previous researches about SIS performance, this study points out inhabitants and health personnel's points of view regarding possible reasons of the SIS implementation's failure in the access improvement for the poorest.

CHAPTER 3: THE INTEGRATED HEALTH INSURANCE

This section will assess the Integrated Health Insurance (Seguro Integral de Salud - SIS) as the new social health scheme implemented in Peru. The first part of the chapter describes the formal elements of SIS and the way of its implementation. The second part comments some studies' findings regarding the effects of SIS implementation on certain health areas such as maternal services. The latter provides an initial guideline for further qualitative explanations provided by this study.

3.1 Formal characteristics of the SIS

The SIS is the main social health scheme implemented by the Peruvian state to increase the access to health care services for the poor population. According to Parodi (2005), SIS is conceived as a mechanism to thwart the effects of the privatization of the Peruvian welfare system by subsidizing the cost of health facilities. In addition, the implementation of SIS seeks a better distribution of financial and human resources in the health sector since it introduces means/testing and payment fee strategies to target beneficiaries; consequently, it will broad the range of potential people entitled to health schemes (Petrera, 2007; PAHO et. al., 2007; SIS, 2008).

SIS was created in 2002, enacted by the supreme decree No. 009-2002-SA and law No. 27657 which regulate the organization and operation of SIS. SIS comes from the merger of two preceding health schemes: the Mother and Child Insurance (Seguro Materno-Infantil, SMI) for pregnant women, and the Free School Health Insurance (Seguro Escolar Gratuito, SEG) for students of public schools from 7 to 17 years old (Vera, 2003; Parodi, 2005; Ewig, 2006; PAHO et. al., 2007).

The SMI and SEG had been launched in 1997 to grant free access to health care, specifically to children registered in public schools and to pregnant women

excluded from any other public and private health scheme. Both health schemes worked based on subsidies and reimbursements; this is, the State paid to designated health centres per attention provided to this particular target population. Nevertheless, the criteria for entitlement were not inclusive enough. The entitlement for SEG was based on school status since only children who were registered in formal public schools were entitled; this criterion did not consider the fact that the poorest children most of the time are not sent to schools (Vera, 2003; Parodi, 2005). The entitlement for SMI was restricted to pregnant women and children in the areas with high rates of maternal mortality[1]; thus, it let aside all women who were not pregnant and other poor women living in other districts. As a result, both failed targeting not only many individuals in need but also the poorest (Parodi, 2005). For instance, the ENDES (2002) reports that only 25% of entitled to SMI belonged to the lowest quintile of poverty, while entitlement in the highest quintile of poverty was 37%, this means, the better off strata had more access to these schemes.

To compensate the failures of SMI and SEG, SIS expanded the coverage to all Peruvians citizens who are under the poverty line, unemployed and with no entitlement to any other health scheme in the entire territory (Holst, 2005; SIS supreme decree 004-2007). Nevertheless, the entitlement strategy continues to employ means-testing and fee payments methods as the previous method to classify potential entitled in one of the SIS' two plans. People that are entitled to SIS can be classified in two plans, the Free Cost Plan (FCP) and the Minimal Cost Plan (MCP), both cover exactly the same kind of health services, but at different cost (Ministry of Health of Peru, 2008; SIS, 2008). The FCP is free of charge for people living under the poverty line. People are either automatic entitled to FCP or previously evaluated

[1] Andean and Altiplano regions

as unable to afford any cost for health facilities. The MCP is semi-subsidized for those with limited ability to pay, people who earn more than US$250 monthly. It requires a monthly payment which is between US$4 to US$15. The amount varies depending on the number of relatives the entitled person wants to include in the coverage.

The SIS' means-testing method evaluates candidates to be entitled to SIS in one of the two plans through the Socio-economical evaluation form (FESE). This evaluation considers financial and geographical indicators of people's situation to come up with a final classification. In this way, SIS means-testing method takes into account the classification of poverty groups or quintiles of poverty made by the Peruvian Statistic National Institute (Instituto Nacional de Estadistica del Peru – INEI, 2005) to determine the districts where FESE should be used or not. Thus, SIS has classified districts according to their degree of poverty in five poverty group quintiles (Q). The range goes from districts classified in Q1 - at least 65% of their population under the poverty line – with population considered as the poorest in the country – to Q5 with population considered the less poor among the total poor population. Thus, in districts classified in Q1 people are exempted to be means-tested by FESE being automatically classified to FCP. Whereas in districts classified in Q2, Q3, Q4 or Q5 the population should be means-tested by FESE before being classified in any of the two plans. It is important to mention that the Socio-economic evaluation form (FESE) is filled normally by health personnel in health centres in rural areas and filled by SIS agents or through internet by the same candidate in urban and slum areas (SIS, 2008). FESE evaluates the amount of household income, number of family members who depends on this income, kind of belongings in the house, services (electricity, sanitary services), house material, among others physical belonging.

In addition, SIS has five different Health Plans. These plans consider health priorities in the country and specific needs of vulnerable population. Thus, all health plans cover a set of preventive, curative and rehabilitation health care interventions such as diagnosis and treatment of common illnesses, health care, immediate emergency care, emergency transportation services and funeral expenses (SIS Law, 2002; SIS List of Prioritized Sanitary Interventions, 2007; PAHO et. al., 2007). The list of health plans is the following:

- Plan A covers children of 0-4 years of age in some of the following health services: well-child & low-weight check ups, immediate care of newborn, care of children born, hospitalization for newborns with pathologies, drugs, surgery, etc.
- Plan B covers children and teenagers from 5-17 years of age in some of the following health services: check ups, X Rays & other imaging services, dental services, transfer, burial expenses, etc.
- Plan C covers pregnant women in some of the following health services: prenatal care, institutional delivery, postpartum care, drugs, emergency care, laboratory, etc.
- Plan D aimed at providing coverage of emergency services for adults: drugs, X Ray and imaging services, laboratory, transfer, surgery, etc.
- Plan E aimed at sectors of the adult population in the following health services: medical check ups, drugs, emergency care, laboratory, surgery, transfer, burial expenses, etc.

In addition, because of political decisions four other population groups were incorporated as automatically beneficiaries (Vera, 2003):

Popular dining facilities (“comedores populares”) leaders; Mothers of children who are beneficiaries of the Supplementary Food Program (“El vaso de leche”); Mothers who work at public day care facilities (“Wawa Wasi”); Women who are members of

Local Health Management Committees (Comités de gestión); Shoe shiners (PAHO et. al., 2007, p.119). All of them receive the same health services explained for the other health plans. Therefore, SIS is specially focused on children and women as considered the most vulnerable population in the country (Parodi, 2005; SIS, 2008).

Regarding the administrative management of SIS, it operates based on demand subsidy by reimbursing health centres which provide health services included in the list of prioritized sanitary interventions (Vera, 2003). The reimbursement to the health centres is based on the number of consultations already supplied to those entitled to SIS; thus, health centres should afford the costs of the services before SIS reimburses them. The tariff costs per each service are fixed by SIS, which are usually accepted by health centres without any negotiation. Besides, health centres which are part of SIS network are public providers which belong to the Ministry of Health; thus, SIS services use existing human resources and infrastructure funded already by the Peruvian state (Vera, 2003; Parodi, 2005; Petrera et. al., 2007; PAHO et. al., 2007). The financing mechanism of SIS relies mostly on national treasury which represents 94% of its budget. International cooperation provides 5.5% of the total SIS budget and only 0.03% of the budget is generated by money collected from the system itself (fee payment of entitled in MCP) (Vera, 2003; Holster, 2005, Parodi, 2005).

3.2 Preliminary findings regarding SIS implementation

According to some studies about SIS initial results, SIS has improved the access to health schemes for the lower income quintiles, especially in rural areas (Vera, 2003; World Bank PID 2006; Cotlear, 2006; ENAHO, 2007). Thus, from the total Peruvian population, 46.9% of women and 44.6% of men are entitled to some

public or private health schemes. Most of them, either women or men are entitled to SIS, which represents 17% of the entire Peruvian population while in rural areas this represents 47.5% of women and 41.7% of men (Petrera, 2007; ENAHO, 2007). However, although the number of entitlements increased thanks to SIS, there is still more than 50% of the Peruvian population without being insured by any other health scheme (Petrera, et al., 2007). In the same line, other studies reveal that by 2003, only 64% of SIS entitled belonged to the two poorest quintiles; but almost 50% of SIS resources and provision of health services benefited non-poor population (Vera, 2003; World Bank, 2005 cited in PAHO et al., 2007). According to USAID (2005), in a study focuses on the use of maternal services, SIS increased the demand for these services since it facilitates the access of those entitled to free prenatal and delivery care services. For instance, the percentage of pregnant women with four or more prenatal checkups increased from 32% in 2000 to more than 57% in 2006 (World Bank, 2007). Nevertheless, the increasing demand for these services does not come from, apparently, the lowest quintiles of poverty but from the highest ones. As a result, SIS did not have accomplished so far to reach efficiently the poorest which confirms the big disparity and exclusion of the poor population regarding access to basic health care service.

Furthermore, Vera (2003) and Parodi (2005) state that an additional obstacle for SIS to broaden the range of beneficiaries to poor population, unable to afford other health schemes, its due to National Treasury deficient functioning. The authors agreed on the fact that this is risky since the funds allocated do not increase in the same magnitude as the demand generated for health facilities. Therefore, health centers might be unable to afford the costs of services demanded in the near future which will have negative effects not only on the frequency and quality of the service;

but also on patients' income who will have to pay by themselves some of the services which are supposed to be covered by SIS. Likewise, the evaluation and monitoring of progress of SIS is limited to aggregate number of entitlements and health services supply letting aside specific qualitative variables such as gender, quintile of poverty, place of residence (rural, urban, slum) among others (Parodi, 2005). Inaccurate monitoring contributes to the derailment of the progress to be achieved for particular vulnerable groups that need special and differentiate attention; as well as, a correct monitoring of quality of the services provided.

Summing up, even though SIS has proved to broaden the range of individuals with access to a social health scheme, especially to the population belonging to poverty group quintiles; it has not increased the access of the poorest to the health system itself. Failures in its implementation in terms of targeting and addressing real needs of users, which are diverse, would be some of the obstacles to its success.

The following chapter of this study focuses on identifying the variables that explain why the implementation of SIS has not achieved to close the gap to the access of health care of the poorest population. Moreover, it explores how SIS' implementation is affecting the role of women and men with regard to health care issues. Interviews conducted with health personnel and inhabitants will provide relevant information on this topic since they are those who experience the process directly.

CHAPTER 4: ANALYSIS

This chapter analyzes the effects of the implementation of SIS and the factors that influence on its lack of success in reaching all the target population eligible to SIS and in the fully availability of its health services for the poorest. The information was collected through interviews with health personnel (HP) and women and men inhabitants of six districts located in Lima, Puno and San Martin. This information is complemented with statistical data provided by the Ministry of Health and SIS office on coverage and supply of health services in people of quintiles of poverty in slum and rural areas in the three regions where the districts of the sample of this study are located. The analysis of the results is presented in two parts: 1) Factors in the implementation of SIS that affect the entitlement of the poorest to SIS; 2) Factors in the implementation of SIS that affect the access of heath services of the poorest.

It is important to mention that female informants of this study showed more knowledge about SIS and the provision of health services than male informants. Thus, 90% of male informants of this study reported little knowledge about SIS, arguing that their partners (women) or daughters are those in charge of health care issues. However, they were able to make some recommendations to improve health centers and their health service offer.

4.1 Factors in the implementation of SIS that affect the Entitlement of poor population to SIS

As mentioned in chapter 3, research about SIS performance reveals that the number of poor people entitled to a health scheme has increased thanks to SIS, especially in rural areas. Nevertheless, there is more than 50% of the population who is not covered by any health scheme (Vera, 2003; World Bank PID 2006; Cotlear, 2006; ENDES, 2007). HP and inhabitants informants of this study have identified four

factors within the implementation of SIS that may impede to reach SIS target population to be registered to SIS. The factors are the following: Lack of information about requirements to entitle to SIS by HP and inhabitants; excessive bureaucratic procedures to be entitled to SIS; failures in the use of FESE as means-testing procedure for the classification of people in one of the SIS plans (FCP or MCP); and the strategy of entitlement to SIS which reinforces traditional gender roles.

4.1.1 Lack of information on requirements for the entitlement to SIS

HP informants, as well as female and male informants showed misunderstandings about the requirements and procedures to be entitled to SIS. The majority of women and men informants in the six districts of the sample mentioned that HP in their districts are not usually willing to provide information about how the system of entitlement works which generates confusion in the population. For instance, in Pachacamac (Lima, slum) HP informants maintain that despite the proximity of its village to the capital city (45 minutes by car) they have been informed about the changes on the entitlement requirements, which include poor children and adult population regardless the sex and age as able to be part of SIS, only some months ago. Even worse, personnel in Santa Rosa de Quives (Lima, rural) said they have never been informed about these changes, either by the Regional Health Office or by the Ministry of Health; although SIS has been operating since 2002. Therefore, in both districts, HP fail to reach the new SIS' target population of poor people because they keep applying the entitlement requirements of former health schemes (SMI and SEG) limiting the access to SIS exclusively to children registered at school and pregnant women. This is confirmed by 50% of female informants in these districts, who are not pregnant, when they and their husbands were told by HP they were not entitled to SIS, but allowed their children were.

"I was told that I am older than 18 and I am not pregnant; so only my children were entitled to SIS" (Santa Rosa de Quives, W1, May 28th, 2008)

In Sauce and Chazuta (San Martin) all women informants reported that HP rarely go to their zones in the districts to explain the process of entitlement and its benefits. HP informants in Sauce, although they know how to apply the new entitlement system, argue that the lack of financial and human resources to reach people in remote rural areas is the cause for SIS entitlement goals have not been achieved yet in those districts. They believe that people should look for information to be entitled to SIS, if they really need to be subsidized. They suggest that no strategy for promoting entitlement to SIS should be developed from HP side because people should decide by themselves to be entitled or not.

"We do not have any strategy to entitle to SIS because people in our village are not poor. If they were really poor they would come to (health center)…to be registered when they need" (Sauce,HP2,women ,June 22nd,2008)

The findings explained above demonstrate that the lack of clarity on the entitlement requirements is also a disincentive for people to look for entitlement to SIS. As a result, people's perception on SIS is distorted. Most of the female and male informants in the six districts continue to see SIS as an expensive and exclusive children/pregnant women health scheme which is available only to those who can send children to school and afford monthly payments. In this sense, it is possible to affirm that the obstacles to provide access to SIS to poor people can be attributed to failures in the strategy to disseminate new regulations and procedures to entitle to SIS from public institutions in charge of it to the implementers in health centers. The latter is creating arbitrary and inconsistent ways to implement SIS by individual health centers, which in the end, leads to confusion and uncertainty for users, who expect to be protected by a health scheme which fits with their needs (PAHO et al., 2007). This can reinforce the exclusion of a large part of adult population who look entitlement to

SIS but because of misinterpretation of the rules and process their possibilities to do it decrease.

4.1.2 Bureaucratic entitlement process to SIS

The administrative process of entitlement to SIS is perceived as difficult, expensive and bureaucratic by a significant number of interviewees, especially women, in all the districts. According to SIS regulations, in order for people to be entitled, they should present documents of personal identification and fill out a set of forms. In the case of districts belonging Q2, where FESE is applied, people should also present documentation to prove their economic living conditions. Hence, 90% of female informants in the rural districts report difficulties to comply with all these requirements. The lack of personal identification document (ID) is very common in those areas since women are not able to afford the costs of transportation to visit public institution to obtain it; even though, the ID is provided for free to poor people.

The majority of female informants in Chucuito, Zepita and Chazuta also refer to experience embarrassed situation when they are asked to fill out SIS forms that are not easy for them to understand. This situation is exacerbated with those who are illiterate. In Chucuito and Zepita, the situation is more complicated since HP sometimes either do not speak the local language, Aymara, or use technical language that is difficult for informants to understand. Furthermore, informants in these districts claim to feel themselves insecure to deal with this situation opting for not to register to SIS.

Other obstacles in the procedure are the possible places and times to entitle to SIS. SIS regulations allow people to be entitled and receive assistance in only one place. However, HP informants in all the districts state that people are registered to SIS twice or three times in different communities because of the proximity of health

centers to their houses or for moving reasons. Once HP detect this mistake they refuse to provide the service until the registration mistake is corrected. HP informants emphasize that complying with formal documentation and procedures is strictly demanded by SIS office since reimbursement per attention depends on it. SIS office does not acknowledge any payment to health center if the patient is not appropriately registered. It includes correct spelling of names, specification of the service provided, update monthly user's payments, etc. Consequently, it appears that the correct administrative procedures to ensure the financial inputs for the health center are more important than the necessity of population to receive prompt health care.

Moreover, in the particular case of Pachacamac, the majority of female and male informants state that the schedule of attendance is not appropriate for them since it is opened for a short period of time between 8.00 am to 14.00 pm; time they usually spend working either at home, in the case of women, or out of home, in the case of men. This again reduces the possibilities of both sexes to approach to health center to be entitled to SIS.

4.1.3 Failures in the use of FESE as means-testing procedure

The use of the Socio-economical form (FESE) as means-test mechanism to classify people in one of the plans of SIS could be a disincentive for women to entitle to SIS. The majority of female informants belonging to Q2 in rural districts state that HP make judgments on their living conditions subjectively and with prejudice. They claim that once they are evaluated through FESE, HP go to houses to verify the veracity of the information provided. They argue that is in these circumstances when personnel arbitrarily decide if a person is saying the truth or not. Based on HP subjective conclusion, a person is "classified" or "re-classified" in a new plan.

> *"First they ask everything. Then, they come to our place to see how we live. But, when the Miss (HP) went to mine; she said I should not be in the FCP, only those who live in the "cerro"[2] (hill) belong to it. You should belong to MCP. So, she changed my plan" (Sta. Rosa de Quives, W2, May 28th, 2008)*

Conversely, HP informants in Zepita and Sauce maintain that collecting reliable information in the process of means-testing is crucial to ensure the access of the poorest to SIS. According to them, people hide crucial data on financial conditions in order to be classified in FCP in detriment of people who really deserve be classified in FCP. Likewise, in areas where FESE is applied, personnel report the use of software which registers and analyzes the data provided by a person to suggest a final classification in any of the plans; however, they argue that this procedure makes mistakes in the classification since it omits relevant information of the real financial conditions of the candidates. For instance, they mentioned motorcycles or mobiles as objects that are not considered by FESE as signs of a minimal good financial condition. In this sense, the majority of HP informants in Zepita and Sauce consider that the mobilization of HP to applicants' houses to verify the information provided is crucial. HP informants in Chazuta and Sauce sustain that a complete subsidy such as FCP is detrimental to the quality of health care services since reduces funds that can be used to improve the infrastructure, equipment and capacity of human resources of health centers. They consider that people in their districts can afford at least US$ 4 monthly for health care since it is not expensive. Therefore, from these results strong bias can be seen which guides HP's conception on provision of adequate health services. The provision of health care is seen as service which should be financially supported by people instead of seeing it as a right for them as citizens. The latter coincides with this idea expressed by HP in Sauce

[2] Pejorative word used to refer the place where extreme poor people live.

and Chazuta on put on people shoulders the responsibility to look for entitlement to SIS and not as a duty of the State.

4.1.4 Strategy of entitlement to SIS which reinforces traditional gender roles

The strategy to reach the target population of SIS applied by HP of the sample is focused on women population. This focus could be reinforcing traditional roles about gender division of labor. According to the majority of HP informants, focusing on women to reach SIS target population responds to the fact that women in their districts are usually responsible for family health care, whereas men are responsible for "working" to generate financial input for the family. In this regard, HP in all the districts mentioned that women normally initiate the action to entitle the members of their family and themselves to SIS especially when they are pregnant or have ill children. The latter is confirmed by all the informants in the six districts who sustain that women normally contact health services to look for information about SIS and health services covered, as well as to make use of health facilities for children, elderly and themselves because they have time to do that. Besides, 90% of men informants showed little knowledge about SIS procedures and requirements to be entitled; moreover, they do not even consider themselves as eligible for SIS. They recognize that the decisions regarding the use of health facilities are made by women of the family since they are informed about it.

> *"I do not know about it (SIS), my daughter knows everything. I just follow her when she tells me that I need to go to see a doctor. I think she does not pay for the service I receive…I am not sure" (Pachacamac, M1, June 27th, 2008)*

As a result, HP informants in all the districts points out that the way of motivate men to be entitled to SIS is through the information provided to women about the benefits of SIS which will be used by women to convince men of the family to be entitled to SIS: "W*omen are those responsible to convince them about the*

importance to attend health centers and be part of SIS" (Zepita,HP2,women,June 19th, 2008)

In the light of the presented results, it is possible to conclude that the failures at the level of targeting and managing the entitlement process of SIS in the field reinforce on the one side, the exclusion of people to SIS to those with low level of education and remote areas of location; and on the other side, the traditional gender division of labor which ascribes to women the role of responsible of health care and to men the role of economic provider. The latter casts into question the claim made by other studies that men have more access to health schemes than women.

4.2 Factors in the implementation of SIS that affect that demand of poor population for health services

Having analyzed the process of entitlement to SIS, this section moves to the analysis of the use of health services by people entitle to SIS in the location area of this study. First, statistical data provided by SIS and Ministry of Health about the demand of different health services covered by SIS in Lima, Puno and San Martin will be presented. This will provide a general picture of the pattern of use of health facilities of women and men belong to the different quintiles of poverty. Second, information collected through interviews with HP and inhabitants in the six districts of the sample will offer possible explanations of this behavior from a more qualitative and in depth analysis.

4.2.1 Statistical data on the demand for health services covered by SIS

Among the health services covered by SIS, Children health services are the most demanded services by population entitled to SIS by 2007 (SIS, 2008). However, the degree of access varies depending on the quintile of poverty and place of residence (slum or rural) in the three regions. The next table will show the ratio of

children services provided per quintiles of poverty and place of residence in the three regions where the six districts of the sample are located.

Table 2: Ratio of the provision of Children Health Services in rural and slum areas according to quintiles of poverty in Lima, Puno and San Martin by 2007

Region & Quintile of Poverty	Ratio of Children health services provided	
Lima	Districts in Rural areas	Districts in Slum areas
Q3	**0.1**	0.1
Q4	**3.9**	0.3
Puno		
Q1	**0.2**	**0.7**
Q2	**0.5**	**0.3**
San Martin		
Q1	**0.3**	1.1
Q2/Q3/Q4	**0.5**	0.5

+ My elaboration based on SIS data (2007)

The figures show that in rural areas, the ratio of provision of Children Health services is higher for children belonging to higher quintiles than to lowest quintiles in the three regions. In Lima, children in Q4 received more medical appointments than children in Q3 where there were children who did not receive any consultation (ratios lower than 1). In Puno, the child population has been classified mostly in Q1 (14755-slum areas and 108661-rural areas) and Q2 (14073-slum areas and 3396-rural areas). Nevertheless, the differences in the demand of these services show that, in slum areas, the ratio of attendance of children in Q1 is higher than in children in Q2 despite the similar number of entitled to SIS; the economic variable may have an effect on this pattern. In rural areas despite that almost the totality of children entitled to SIS belong to Q1 and FCP; Q1 has a lower ratio of demand of health services than children in Q2. Therefore, in rural Puno, children of the lowest quintile do not have the same access to health centers than children in the same quintile in slum areas. Thus, place of residence can be a potential variable to determine the access to health facilities. In San Martin, the ratio of attendance to children services is similar to Puno; children in the lowest quintiles had less access than children in higher

quintiles. In general, potential reasons for this situation could be the lack of necessity of people in lower quintiles of poverty to require children health services, which is questionable, given that, usually they live in more precarious conditions than people in higher quintiles of poverty. Other reasons could be the difficulty to access to health centers for rural families in the lowest quintiles because of geographical or economic reasons.

Maternal services are the second kind of health services demanded by the population entitled to SIS among the rest of other health services covered by SIS. Nevertheless, higher quintiles usually have more access to these services than the lowest quintiles, especially in rural areas. The following table describes the ratio of attendance to prenatal care based on place of residence and quintile of poverty in the three regions.

Table 3: Ratio of the provision of prenatal care in rural and slum areas according to quintiles of poverty in Lima, Puno and San Martin in the first semester of 2007

Region & Quintile of Poverty	Ratio of Prenatal Care provided (first semester 2007)	
Lima	Districts in Rural areas	Districts in Slum areas
Q2	**0.5**	**0.2**
Q4	**2.5**	**0.7**
Puno		
Q1	**0.46**	1.2
Q2	**1.3**	0.9
San Martin		
Q1	**0.48**	1.3
Q2/Q3	**1.1**	1.0

+ My elaboration based on SIS data (2007)

The figures show that the ratio of attendance to prenatal care is higher in the highest quintiles than in the lowest ones in the three regions in rural areas. This pattern is similar in slum areas in Lima. The data demonstrate that in the lowest quintiles women did not have fully access to prenatal care (ratios lower than 1), but in rural areas this situation is worsening. In Puno, almost the total women entitled to

SIS belong to FCP; thus, it seems that other kind of barriers different than economic ones influence in the lack of attendance of pregnant women for prenatal check up. Furthermore, in the case of give birth, rural Lima shows that, although there were more pregnant women in Q3 than in Q4 entitled to SIS by 2007, less pregnant women in Q3 gave birth in health centers (266) than women in Q4 did (2667). It is possible to assume that in this case, economic barriers indeed could be determining the access to institutional deliveries since there is likely that women in Q3 and Q4 belong to MCP. Moreover, unlike the Andean and Amazon region, pregnancy tests and scan services are more demanded and done in Lima in rural areas but only for women belonging to Q4 and Q5. Data shows that HIV test have been provided only to women in urban and slum areas. There are no significant figures about HIV tests for women in the lowest quintile in San Martin and Puno. The latter can be attributed to the scarcity of modern equipment in health centers in rural areas to provide such sophistical services. Nonetheless, even though rural health centers in Lima do not have capacity to provide this service, their proximity to the main city helps women to access more to this service. These results confirm what researchers suggested regarding the fact that women belonging to highest quintile have more access to health facilities than women belonging to the lowest ones (Vera, 2003; Parodi, 2005).

"External Medical Assistance" (EMA) is a service used by both sexes of all ages. It is defined as temporary consultation for specific illnesses. Data shows that the demand varies also depending on the quintile of poverty, place of location and age along the three regions. The table below describes the most significant differences found in the access of this service among the three regions:

Table 4: Number of people entitled to SIS in rural areas in Lima, Puno and San Martin compared to the number of EMA provided in 2007

Region & Quintile of Poverty	Number of Entitled			Number of EMA provided in Rural Areas		
Lima	Women	Men		Children*	Women	Men
Q2	1059	906		4817	**851**	199
Q3	**18874**	**16169**		14533	**3184**	658
Q4	**9340**	**7798**		23307	**5598**	947
Puno						
Q1	109427	95338		**56480**	**7244**	**2169**
Q2	3378	2981		**3464**	**521**	**52 13**
San Martin						
Q2	37464	14669		**51083**	9028	2244
Q3	34753	13378		**21797**	3987	1221

+ My elaboration based on SIS data (2008)

* The number of assistances provided includes women and men since the decision to take the service is made by parents.

From table 4, it can be seen that in Lima, even though the highest number of those entitled to SIS belong to Q3; most of the consultations were provided to people belonging to Q4 in all the groups. Furthermore, in San Martin, although the number of people entitled to SIS belonging to Q2 and Q3 is similar; there is a big difference between the number of consultations provided to people in Q2 and those in Q3. At this point, it is important to mention that living conditions in terms of existing facilities, for example, transportation, roads, equipment and resources in health centers are in so much better condition in Lima than in any other region in the country. Consequently, it is likely that people in the highest quintiles in Lima can take more advantage of these facilities than people in the lowest quintiles. In contrast, in San Martin, the probability to be classified in FCP is higher for people in Q2 than for people in Q3 which makes more difficult for people in Q3 to afford the extra costs required to attend health centers because of the lack of facilities mentioned previously. Moreover, the three regions show that this service has been provided more to children than adult women and men for all the quintiles. This can be an indicator that either children are more vulnerable to get ill or children health care is

prioritized over others. Regarding the assistance provided to women and men, in all the cases the use of this service is extremely higher in women than in men. Again, it is likely that women have more need to receive health care than men, or perhaps, traditional roles assumed by both sexes make women to dedicate more time for their health care than men, who usually spend their time working out of home.

Data about the provision of “Dental Services” show that in the three regions, the demand of this service in rural areas is very low in all the quintiles. For instance, in Puno there were provided only 356 consultations to female in Q1; although the number of female entitled to SIS in Q1 is 109427. In San Martin, there were provided only 457 services for women in Q3 when the total female entitled to SIS in Q3 is 37464. In Lima, the service again has been provided more to people in Q4 (1871), especially to women, than people in Q3 (781). In this case, it seems that first, economic variables could reduce or increase the access to this service given the high costs required to receive it. Second, dental care could be considered less important than other kinds of treatment. Third, the lack of necessary equipment in health centers in rural areas could impede its provision. Men usually do not like with other services.

The service of “visit to houses by HP” is not frequently done in Lima for any quintile or area of residence. Data reports that HP did 35 visits to women and men in rural areas by 2007. Probably the easier access to main districts makes it suitable for people to attend to health centers in the region. The assistance is basically provided to children. In Puno, visits are frequently undertaken in rural areas to assist children in Q1 (3036). In adult groups the number is much lower, although women have received more assistance (480) than men (23). In San Martin**,** reports show that HP only visited houses in rural areas for attending only children (3472) and women (823)

in Q2 and much less in Q3. People in Q1 have not received any visit by 2007 (SIS, 2008). It is likely that because the poorest live far away from health centers, HP finds more difficult to reach them. Moreover, no significant figures are shown in the provision of “transfer of patients for emergencies to other health centers” although is a service covered by SIS. Transfer for emergencies is expensive which makes difficult for health centers and users to afford it.

In sum, figures reported by SIS for 2007 show three general important findings. First, the access to children health services and maternal health services is higher in people belonging to higher quintiles than those in the lowest ones in each of the three regions, especially in rural areas. Second, children health care is prioritized over women and men’s; however, women have more access to health facilities than men. Third, the weakness of some health centers in rural areas could be the reason why there is a small number of sophisticated health services provided to people in rural areas; e.g. dental services, HIV tests, scan and transfers. The following section will analyze the results obtained in interviews with HP and female and male inhabitants about the reasons behind this situation in the six districts part of the sample which are located in the regions analyzed previously.

4.2.2 Factors identified that affect the demand for health services

Interviewees offer substantial information on the reasons why the implementation of SIS is limiting the access of the poorest to health facilities, and increases the differences in the access to health centers among children, adult women and adult men. In general there are four reasons to explain this situation: first, SIS would be reinforcing traditional roles assumed by women and men regarding health care and division of labor; second, SIS would not be taking into

account the strong influence of cultural and geographical barriers as obstacles to access health services. Third, the bad quality of health services provided under SIS scheme is disincentive to attend health centers; and fourth, the weak management relationship between SIS and health centers which provide the services. These four reasons will be analyzed next.

4.2.2.1 Traditional gender roles reinforced by SIS implementation

All HP informants confirmed the fact that children receive more health care than women, and women receive more than men in their districts. Most informants claim that the high availability of children' and maternal services in health centers in rural and slum areas, which is considered a priority, together with the widespread role of women for family health care and domestic work encourage women to make use of health facilities more than men do. Besides this, they point out that the low demand of men for health services corresponds to a low awareness of their health needs and low valuing of spending time in health centers than in working. *"They only attend health services when the symptoms are difficult to bear" (Chucuito, HP1, women, June 20th, 2008)*. The latter, according to personnel in Zepita and Chucuito, is an obstacle to providing prompt attention when required. Furthermore, they add that the big difference in the demand for health services between women and men is also associated with the pattern of involvement of men and women in decision-making process about health care issues. Thus, all HP informants, all men informants and 85% of women informants agree that men only involve themselves in family health care issues when the situation is considered serious and implies mobilization of financial and physical resources such as transfer of a patient to a main city, side effects after a medical procedure, establishing location for carrying deliveries, etc. Women, make autonomous decisions on health care when they are

minor; for instance, deciding to take children and parents (elderly) to health centers, following SIS administrative procedures, buying cheap medicines or receiving pregnancy check ups. Data reported by ENDES (2007) show that in the poorest regions in the Andean zone, where Zepita and Chucuito are located, women are more likely to be depended on husband/partners' permission to access to health care. However, our results tell that this situation will vary depending on the gravity of the decision to be made. Therefore, this dynamic shows woman in a more proactive role in health care decision making since they autonomously decide on some topics. In this sense, this pattern of behavior seems to be taken as basis to design and undertake the strategy of promotion of health care in the districts of the sample. HP reach the target women and address their needs and preferences as means of reach men of all ages within the families. For instance, HP informants in Zepita, Chucuito, Santa Rosa de Quives and Pachacamac said to implement campaigns for promoting SIS in places where women usually attend such as community organizations, schools, health centers and local radio. Also, HP in Zepita and Santa Rosa de Quives claim to offer food as an exchange for the use of children and maternal services. Nevertheless, all HP in Chazuta and Sauce argue that the gratuity of the health services in FCP is the main motivation for women to attend to health centre. This is neglecting any other reason such as more awareness on health care, rights to be fulfilled, and so on.

4.2.2.2 Cultural and geographical barriers

HP and female and male informants emphasize the importance of cultural and geographical variables as limitations to access to health services especially in rural areas. On the one hand, HP in Chazuta, Chucuito and Zepita - in the last two places the population belong to indigenous aymara group - claim the strong influence of

cultural beliefs and patterns on the decision to seek for medical health care in users. For instance, the strong reliance on herbal medicine as medication is the main reason of postponing or rejecting to attend to health centers. This produces further negative effects for providing prompt assistance since women and men decide finally to attend health center when symptoms are aggravated; thus, personnel have to transfer the case to the nearest hospital in a main city because of the impossibility to provide the necessary health care at that moment.

> *"Women come after the folk healer could not solve the problem…so it means when the case is already very serious" (Zepita, HP1, women, June 19th, 2008)*

All HP in the same districts add that the development of local markets and traditional holidays in the main communities (where usually health centers are located) in certain days is used by women to attend to health services. Therefore, the demand of health services increases in particular days making difficult for HP to respond to such demand. In Puno, for instance, people use to attend health center on Tuesday and Thursday which are the days when population sells their products in local markets. Therefore, personnel ask people to wait long periods of time to be attended and in some cases they are asked to leave because of the impossibility to be checked up that day. On the other hand, 57% of women informants in Chucuito, Zepita, Sauce and Chazuta claim that the assistance provided by HP is discriminatory and different to their health care practices; that's why, they prefer to avoid health centers. For example, women informants mention that the communication between them and personnel is very difficult since personnel refuse to talk in the local language and make use of technical language. In addition, personnel are reluctant to accept women' preferences on the way of examination of their bodies and impose occidental practices into the consultation. This situation is especially reproduced in maternal health delivery practices when HP fail to take local

culture into consideration; consequently they neglect particular women users' needs (Reprosalud, 2005; Barrig, 2008). Related to the latter, more than 50% of women informants mentioned the absence of female HP in health centers; which discourages them to seek health care since they feel uncomfortable and unsafe when they are examined by men personnel. The latter is confirmed by ENDES (2007) which report that 41.7% of women in San Martin; 52,4% in Lima; and 77,6% in Puno had problems to access to health services because of the lack of female health care provider. Furthermore, most of the female informants in Chucuito and Zepita report that HP are unkind and aggressive when they see them wearing typical Andean skirt. For instance, they are asked to "*come back the following day after have been awaited for hours"* (Chucuito, W1, June 20th, 2008). As a result, women prefer changing the way of dressing before approaching to health centers. All these circumstances depict how cultural patterns which are not addressed by health care interventions covered by SIS become in a serious barrier to make health services suitable to women needs, especially when they belong to different ethnical groups. In this regard, Lopez (1997, p 442) affirms that citizenship in this context is constructed through forced homogenization; this is, forcing people to transform their customs, dress, language, and not by recognizing cultural differences. In this regard, Barrig (2008, p.110) says Andean women are especially affected by this factor since they are the less literate, have fewer opportunities to learn Spanish and used to preserve traditional pattern of behavior. As a result, indigenous women will be only able to exercise their rights if they adopt western customs.

Geographical constraints were also mentioned by the interviewees. 75% of women informants in Zepita, Chucuito, Chazuta and Sauce reported long distances to health center as an obstacle to receive health care. Usually, health centers that

are part of SIS network in rural areas are located in main communities usually far away of the zones where the poorest population is settled down. This means that a person should spend time, effort and additional money to get there. This issue is confirmed by ENDES (2007) which report that in general 62.5% of women in rural areas in Peru mentioned “distance” as a problem to access to health center, whereas in urban areas only 26.9% of women did it. By quintiles of poverty, in 2006, 72.4% of women who mentioned this reason belong to Q1; whereas only 20.6% belong to Q5. Moreover, 60% of women informants of this study state that the lack of capacities of HP to deal with emergencies obliges them to transfer patients to the nearest hospital in a main city which implies again an additional spending and greater mobilization from their districts. It is important to mention that since transport from the house to a health facility are not covered by SIS (SIS, 2007), users should afford this extra cost when required. Therefore, the lists of services covered by SIS would not be considering the social, geographical and economic real conditions of the Peruvian population and of the country itself. Peru is characterized by its diverse and difficult geography which actually makes difficult the provision and access of health services.

4.2.2.3 Quality of health services provided

A significant number of women and men informants in the six districts qualified health services available as deficient. In principle, women informants state that HP do not have sufficient technical capacities to develop the medical practice; they complain about the presence of only nurses or obstetrics in the health centers. Likewise, they refer again the excessive documentation to be presented just before being attended by HP which delays a prompt attention when is really needed. For instance, delays in monthly payments to those classified in MCP make to postpone the assistance till the debt is paid off. Furthermore, 65% of women informants

belonging to FCP in all the rural districts argue that the fact that the service is free could be a reason for HP to be so resistant in providing health care accordingly, based on the idea that "*women should receive what they provide no matter what because they do not pay for that, it means, no right to complain"* (Sauce, HP1, women, June 22nd, 2008). Moreover, poor infrastructure of health center, lack of equipment and the very limited time offered to the users for health services were mentioned by 100% of men and 85% of women of the sample as characteristics of the bad quality of the service provided in their districts. As a result, women informants maintain the idea of attending health centers only when it is absolutely necessary.

> *"I would not like to be asked to fill formats many times for not to pay for medicines… sometimes they (HP) are not there (health center) or we have to wait a lot to be attended to finally hear that they have to leave, so we do not receive any attention in the end" (Santa Rosa de Quives, W1, May 28th, 2008)*

Another factor mentioned by informants, 85% of women of sample, is the shortage of medicines supposed to be covered by SIS in health centers which forces them to afford the costs with their own money. Regarding this issue, studies show that when out-of-pocket expenses are high, the ability to pay becomes the most important determining factor in whether or not an individual will seek health care (WHO, 2000; World Bank, 1993 cited in PAHO et al. 2007). According to United Nations (2005) and ECLAC (2005) gender play a role in out-pocket expenditure since it has found that women's out-of-pocket expenses in health care are systematically higher than men's in Peru. This issue would be forcing low-income rural woman to choose between paying out-of-pocket for a health service or to try other healing methods like self-medication or folk healings.

> *"Health centers are not able to transfer patient in case of emergency on weekends because the administrative area is always closed. We have to travel*

to the closest city to receive health care and afford the costs by our own without any promise to reimbursement" (Pachacamac, W1, June 27th, 2008)

Some advantages of SIS recognized by 100% of the informants who belong to FCP is the possibility to save money for receiving health care services and to receive HP at home to attend elderly people. However, extra costs, as explained before, would reduce the benefits achieved from the gratuity of one of the plans.

4.2.2.4 Relationship between health centers and SIS management

According to HP in the 6 districts, the relationship established between SIS and health centers is still highly dependant despite the type of contract they have. HP have to report the number of attentions done monthly in order to receive the payment per attention provided, which in many cases, is always delayed. Actually, the number of people to be hired in SIS and health centers depends on the Ministry of Health which manages SIS scheme at the same time; thus, the overlapping of responsibilities for providing health care for the entire population and managing SIS scheme creates difficulties in both scopes to be efficient. Besides, the money received per costs of the health services supplied is not enough to cover the maintenance of medical equipment and hiring new health professionals. Therefore, in order to improve the quality of health service; HP in Sauce, suggest increasing the tariff of MCP for users and also the tariff that SIS pays per consultation provided. This coincides with Vera (2003) and USAID (2005) findings on SIS' budget to afford the program. They state SIS' budget is far behind the real costs of the program. In this regard, PAHO et al (2007) and USAID (2005) affirm that a barrier in the implementation of SIS has been to increase the demand for health services without expanding provision, resources, and infrastructure accordingly. As a result, the availability of HP at health centers does not correspond to the volume of users for

which each health center is responsible to reach. This is aggravated because of the lack of ties with other civil institutions such as NGOs or social organizations with experience in health issues whom could facilitate the referral process and the prompt attention of population in remote areas (UNRISD, 2005; Ewig, 2006; Mackintosh, 2006).

To summarize the analysis made in this chapter, the results show, on the one hand that the focus of the provision of health care within the SIS framework in the areas of the sample seems to be tinge on the one side by a traditional perspective regarding gender division of labor and on the other side by an occidental medical point of view. In the first case, the strategy to target and reach potential entitled to SIS addresses mainly women based on the idea that they are responsible of family health care, so that, they will involve family members in health care. The strategy of SIS implementation could be, thus, reinforcing this traditional role letting men, once again, aside of being responsible of health care. In the second case, the medical practice is not taking into account the diversity of social conditions and pattern of beliefs and behavior in Andean (Chucuito & Zepita) and Amazonian (Chazuta & Sauce) population groups. This would be, then, a disincentive for indigenous women to make use of health facilities since force them to adapt their ways of living to a foreign and sophisticated scheme of work.

On the other hand, the obstacles to access to SIS are intensified as long as their mechanisms of means-testing, entitlement process and provision of health services are still weak. As target people are those with precarious social and economical conditions, the incapacity to comprehend the process and afford the costs of health care - not covered by SIS either for regulations or for shortages – reduces the probability that the poorest fully get benefits from this social health

scheme. As PAHO et al. (2008, p. 143) concludes the experience of the implementation of SIS demonstrates that in socially and ethnically diverse countries and/or countries with geographically dispersed human settlements, removing economic barriers alone does not guarantee access to health care.

CONCLUSIONS

The implementation of SIS has not reduced the social gap among the poor population as people in the highest quintiles of poverty have easier access to health care than those in the lowest quintiles. In this line, SIS has not reduced the low access of indigenous people to health care who continue to be discriminated by the system. Finally, SIS has reinforced gender inequalities but in a way that this study did not expect; thus, poor women access easier to health care than poor men.

Three factors contribute to explaining the continued, or in some cases enhanced, gender and social gaps in accessing health care: the patterns guiding the practice of health personnel in implementing SIS, the way of addressing people's health needs and the complexity and inefficiency of the management of the system.

The first factor is the patterns guiding the practice of HP in the implementation of SIS. HP reinforce traditional gender roles when they focus on women as a way to target the poorest population. The assumption that women are responsible for family health care leads to the involvement of women in a more active role in this issue, and at the same time, to reinforcing the historically passive role of men in health care. This vision also influences the way that Ministry of Health and health centers in rural areas prioritize the health services to be provided. It focuses on maternal and children services and this, in turn, limits the access of women to other dimensions of health care, i.e. the access to health care for women who are not pregnant and men who require different health services. In this sense, this study can not confirm what is commonly stated in the literature that women have less access to any health care than men largely for economic reasons (see chapter 1); on the contrary, men have less access to SIS-sustained health care than women because SIS focus on maternal and children services and its sustained health care is directed at women in

a particularly gendered way. Therefore, part of the assumption presented in the first hypothesis in chapter 2 regarding the access of men to health services is unfounded.

The second factor is the way of addressing health care needs in the population which does not consider the different cultural, educational and geographical barriers that characterize the diversity of the Peruvian population in rural areas. In this sense, the lack of adaptation of the medical practice to local patterns of behavior, the difficult administrative procedures that exceed the level of education of the users and the lack of coverage of transportation, home-doctor visits, etc., increase the social gap among the poor population in the access to health care. As result, ethnic minorities suffer of greater exclusion than other groups of population since concrete practices developed by health personnel (way of examination, healing methods, language, etc.) conflict with indigenous' cultural beliefs and pattern of behavior on health care. This is exacerbated in female population as they are who preserve more these traditions than men.

The third factor is the complexity and inefficient management of the system. First, the process of entitlement and the evaluation of financial conditions of the candidates to be classified in one of the plans are experienced by the population as complex and totally subjective. This is a disincentive for people to look for this health coverage. However, it is beyond of the scope of this study to explore whether or not means-testing procedures classify people to the right plan. A second weakness of the management is the shortage of medicines supposed to be covered by SIS, which is attributed to the lack of quality in the provision of the service. The third aspect is the lack of equipment and HP in health centers which reduces the capacity of health centers to provide quality health care. The poor provision of resources by the Ministry of Health to equip health centers has effects on people's confidence to use health

services, and on the vision of HP about to what extent people have the right to demand health care if it is not supported financially by any source.

Based on the findings presented above, this study suggests the following recommendations in order to make SIS more responsive to the poorest' health needs: First, the notion of citizenship should be adopted as point of reference for stipulating the right for all to have access to health care regardless any condition and based on recognizing difference. Such an approach can provide a better perspective for covering the variety of health needs and problems that characterize the diversity of social and cultural groups in the country. It requires on the one hand, reassessment of the social construction of the different communities to which target women and men belong (Barrig, 2008); and on the other hand, building capacities in health personnel and management staff to be more responsive in their vision and practice of health care to ethnic minorities' social and cultural patterns. Second, the Ministry of Health should guarantee the provision of a broader range of health services on a regular basis. This is crucial in order to encourage adult women who are not pregnant, men and elderly to make use of health care. Such broadening of the range of service should include the coverage of transportation and the inclusion of visits of HP to remote areas periodically in order to reduce geographical and economic barriers to accessing SIS. This should also be complemented with the inclusion of community associations and non-governmental organizations with proved experience in health care as partners of health centers. They can collaborate in raising specific health needs in each population since they are closer to them, improve the referral of ill people to health centers and reach people in very remote areas. Third, a more accurate monitoring of the quality of the services provided, the changes in people's health needs, as well as, the correct classification of people in

the two health plans would guarantee the sustainability of SIS. This would contribute to a more adequate distribution of the budget too.

The political will of the State is crucial in order to introduce these and other necessary reforms to make SIS a more efficient and responsive health scheme to the real necessities of the most excluded. The present research is based on information collected in six districts of the country; thus, the results described cannot be generalized to the entire population. However, this study gives additional resources to widen the analysis of this process. It also encourages decision makers to consider cross cutting variables such gender, social, culture and education into the design and implementation of SIS or any other health reform to ensure the right of the Peruvian citizens to receive quality and equal health care.

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