HEALTH FINANCING CASE STUDY No 17
BUDGETING IN HEALTH

BUDGETING FOR RESULTS IN HEALTH:

KEY FEATURES, ACHIEVEMENTS AND CHALLENGES IN PERU

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ABBREVIATIONS

AC	*Acciones centrales* (Central Actions)
APNOP	*Asignaciones presupuestales que no resultan en productos* (Budget assignments that do not result in products)
CCP	*Certificación del crédito presupuestario* (Expenditure Appropriation Certificate)
CDC	*Centro de Control de Enfermedades* (Center for Disease Control)
Cenares	*Centro Nacional de Abastecimiento de Recursos Estratégicos en Salud* (National Center for the Supply of Strategic Resources in Health)
Ceplan	*Centro Nacional de Planeamiento Estratégico* (National Center for Strategic Planning)
COFOG	Classification of the Functions of Government
CRED	*Control de crecimiento y desarrollo* (Growth and development monitoring)
DGIESP	*Dirección General de Intervenciones Estratégicas en Salud Pública* (General Directorate of Strategic Interventions in Public Health)
DGPP	*Dirección General de Presupuesto Público* (General Directorate of Public Budget)
Diresa	*Dirección Regional de Salud* (Regional Health Directorate)
Disa	*Dirección de Salud* (Subregional Health Directorate)
Dsare	*Dirección de Salud Sexual y Reproductiva* (Sexual and Reproductive Health Directorate)
D&T	*Donaciones y transferencias* (Donations and Transfers)
EDEP	*Evaluaciones de Diseño y Ejecución Presupuestal* (Budget Design and Execution Evaluations)
Enapres	*Encuesta Nacional de Programas Estratégicos* (National Survey of Strategic Programmes)
Enesa	*Encuesta Nacional a Establecimientos de Salud* (Health Facilities National Survey)
Endes	*Encuesta Demográfica y de Salud Familiar* (Demographic and Family Health Survey)
ENV	Esquema Nacional de Vacunación (National Vaccination Scheme)
EsSalud	*Seguro Social de Salud* (Social Health Insurance)
Geresa	*Gerencia Regional de Salud* (Regional Health Management)
GORE	*Gobierno Regional* (Regional Government)
INEI	*Instituto Nacional de Estadística e Informática* (National Statistical System)
INPE	*Instituto Nacional Penitenciario* (National Penitentiary Institute)
IP	*Intercambio prestacional* (Provisional exchange)
MEF	*Ministerio de Economía y Finanzas* (Ministry of Economics and Finance)
MINSA	*Ministerio de Salud* (Ministry of Health)
OGPP	*Oficina General de Planeamiento, Presupuesto y Modernización* (General Office of Planning, Budget and Modernization)
PAN	*Programa Articulado Nutricional* (Nutritional Program)
PDI	*Plan de Desarrollo Institucional* (Institutional Development Plan)
PDLC	*Plan de Desarrollo Local Concertado* (Local Concerted Development Plan)
PDRC	*Plan de Desarrollo Regional Concertado* (Regional Concerted Development Plan)

PEAS	*Plan Esencial de Aseguramiento en Salud* (Essential Health Insurance Plan)
PEDN	*Plan Estratégico de Desarrollo Nacional* (Strategic National Development Plan)
PEI	*Plan Estratégico Institucional* (Institutional Strategic Plan)
PEM	*Plan Estratégico Multisectorial* (Multisectoral Strategic Plan)
PESEM	*Plan Estratégico Sectorial Multianual* (Multiannual Sectorial Strategic Plan)
PIA	*Presupuesto Inicial de Apertura* (Institutional Initial Budget)
PIM	*Presupuesto Institucional Modificado* (Institutional Modified Budget)
PIP	*Proyectos de Inversión Pública* (Public Investment Projects)
Pliego	Major spending unit
POI	*Plan Operativo Institucional* (Institutional Operational Plan)
PP	*Programa Presupuestal* (Budget Program)
PpR	*Presupuesto por Resultados* (Budgeting for Results)
RDR	*Recursos directamente recaudados* (Resources Directly Raised)
RO	*Recursos ordinarios* (Ordinary Resources)
SDGs	Sustainable Development Goals
SIAF	*Sistema Integrado de Administración Financiera del Sector Público* (Integrated Financial Management System of the Public Sector)
SIGA	*Sistema Integrado de Gestión Administrativa* (Integrated system of Administrative Management)
Sinaplan	*Sistema Nacional de Planeamiento Estratégico* (National System of Strategic Planning)
SIS	*Seguro Integral de Salud* (Public Health Insurance)
SMN	*Salud Materno Neonatal* (Maternal and Neonatal Health Program)
STI	Science, Technology and Technological Innovation
SuSalud	*Superintendencia Nacional de Salud* (National Health Superintendence)
UE	*Unidad ejecutora* (Implementation Unit)

EXECUTIVE SUMMARY

There is no universal health coverage (UHC) without public financing, making public budgeting a central piece of UHC reforms. Peru has made significant progress in shifting the focus of budgetary processes to reflect priorities based on results. This shift has already produced results: over the last decade Peru has made significant progress on reducing malnutrition, maternal and child mortality. While such impressive results were achieved through a multi-pronged strategy, programme budgeting (or Presupuesto por Resultados as it is known in Peru) played a key role. However, key challenges remain and should be addressed for the progress to continue. The paper provides some recommendations to support Peru, and particularly its health sector, in realizing its full potential when it comes to programme budgeting.

The most important issue facing the reform is the need to shift away from a focus on specific population groups and diseases to enlarge the scope of budgetary programmes, moving towards a system-wide approach by combining activities for specific diseases into broader goal-oriented programmes. This would address the contradiction of the current programme structure with essential health services package (PEAS). The Health programme structure should focus on providing the incentives for comprehensive primary health care actions complemented with strong prevention and promotion interventions.

Secondly there is a need to enhance spending flexibility within budgetary programmes. Programme budgeting as a form of performance budgeting means shifting the focus from compliance budgeting to management accountability for results. This is yet to happen in Peru. The current very fragmented financial flows limit the ability of managers to be accountable for results. Therefore, post appropriation detailed ex ante controls currently imposed on programme managers should be removed. While shifts between risky line items such as salaries and capital expenditures are understandable and are likely to remain at programme level, control over input lines at product level result in unnecessary rigidities.

Peru can advance further in its health financing reforms but the orientation on results in budgeting should also translate into output-oriented provider payment methods. Currently, public providers have little autonomy or incentives for improving efficiency and quality of care. Input-based payments which are dominant in the public sector need to gradually change to ensure that the orientation on results permeates the entire system, from top to bottom.

Finally, there is a need to strengthen the stewardship function of the Ministry of Health (MINSA). Stronger central governance is needed to reduce fragmentation in the health system. However, with decentralization, MINSA's capacity in health financing policy has been limited. Programme budgeting, by many accounts, has limited the decision-making space for MINSA further. As the sector lead accountable for the results of the programmes, it should also have the corresponding powers.

1. INTRODUCTION

In 2018, the World Health Organization's (WHO) Department of Health Systems Governance and Financing began a work programme on issues related to health budget structure to generate evidence and to offer more support to countries as they undertake budget reforms. This work programme is divided into three principal areas: 1) A global review of health budget structures; 2) Case studies on the transition to programme budgets in the health sector; and 3) Training and support for health budget reform.

Peru was among the initial set of countries selected for case studies because it had a well-developed and highly institutionalized programme-based budgeting [1] and made significant progress towards increasing service coverage while improving financial protection. At the same time, there were clearly issues related to how well the budget structure supported health policy priorities, such as Public Health Insurance (Seguro Integral de Salud) [2] which has played a key role in progress towards the universal health coverage in Peru.

The main reform in health financing was the establishment of Public Health Insurance in 2001 with the aim of eliminating user fees in public health facilities and protecting the poor and the vulnerable. The next big milestone came in 2009 with the approval of the Universal Health Insurance Law (AUS), establishing a minimum package for all insurance plans [2]. In parallel, decentralization transformed health service delivery and transferred responsibility to the regional level for public providers. The Ministry of Health (Ministerio de Salud) remained responsible for part of the service delivery (Lima and national hospitals) as well as for providing an overall stewardship role for the sector.

Since 2006, a large broader public financial management (PFM) reform was initiated to enhance performance in public resource management and overall accountability. It included the introduction of "programmes" across sectors, under the "Budgeting for Results" initiative (Presupuesto por Resultados). It aimed to promote prioritization in public spending through budgetary programmes, which had well defined objectives and were based on clear results-chain and performance measures, to move away from an input-based logic. This reform echoes those introduced in other countries to promote better flexibility and accountability in public resource management [3].

In health, the first two priority programmes that were introduced were on nutrition and maternal and neonatal health; several others have been added gradually. Currently, there are nine programmes in place: Ministry of Health (MINSA) is a manager for these budgetary programmes, although given decentralization, funds are allocated and flow directly to regional and local governments, including for health. Emerging evidence seems to suggest that the reforms effectively enhanced accountability towards results for the specific targeted areas (e.g. nutrition) [1]. However, because of financial fragmentation, the reform did not fully reach its objective.

Budgetary programmes account for less than half of public spending on health, and several other allocation mechanisms have remained to fund services and activities across the different levels of the health system, creating extreme financial fragmentation and complexities in resource management.

The main objective of this study is to analyse the health programme structure in Peru with the view to provide recommendations for further reform adjustments. The study analyses the entire health budget structure and unpacks the interconnections between various budget classifications and funding mechanisms to provide a common understanding of the complex structure in Peru and its current functioning in health.

The report begins with description of the key aspects of the health financing system in Peru. In Section 3 it examines the main aspects of the current budget structure. In Section 4, the paper takes a closer look at the programme classification, focusing on two programmes – nutrition (PAN) and maternal and neonatal health (SMN). PAN and SMN were selected for a more in-depth look because they are the oldest and largest programmes in health initiated 11 years ago as part of the first wave of reforms, introducing budgeting for results in Peru. The performance measurement framework is discussed in Section 5. The report analyses achievements and challenges in Section 6. It highlights challenges related to the current budget structure and health system priorities, specifically implementation of the package of essential health services (PEAS). Finally, the paper concludes by providing key policy recommendations on changes to the current budget structure to support Peru's progress towards universal health coverage.

2. HEALTH FINANCING SYSTEM: KEY FEATURES

Peru has made remarkable progress in increasing coverage over the past fifteen years. In 2004, the majority of Peru's population (63%) had to rely on user fees when accessing the public system and were not affiliated with any of the insurance schemes As of this year nearly 90% of the population is covered by one of the schemes [4, 5]. This is reflected in improved utilization, equity in service coverage, and health outcomes [2, 4]. However, significant challenges remain, and Peru continues to struggle with a highly fragmented health system with multiple institutions responsible for health financing and service delivery (Table 2.1).

Seguro Integral de Salud (SIS), created in 2001, played a major role improving financial protection and access to basic health services for most of the population. When SIS was created, it covered only poor pregnant women, all children under five years of age and children over five years attending public schools. In 2007, coverage through the programme was extended to all low-income population. This gave six million Peruvian adults – 21% of the population – entitlement to basic healthcare at public facilities without having to pay user charges [6]. Prior to this reform, these individuals were required to pay user fees ranging from $2 for an outpatient consultation to $53 for a hospitalization with major surgery, not including payments for medicines and medical supplies [6]. At the same time, services covered by SIS were made more comprehensive.

A key milestone in health financing reforms was the passing of the Universal Health Insurance Law (AUS) in 2009. The AUS included the following key elements: (a) establishment of a minimum level of coverage for all insurance plans (including those from the private sector and the social security system), (b) creation of a public supervisory body to monitor the quality of insurers and providers (SUNASA), and (c) the possibility for the SIS or another public insurance scheme to purchase services from private providers. MINSA then approved the Essential Health Assurance Plan (Plan Esencial de Aseguramiento en Salud, PEAS), thus establishing a minimum set of entitlements. This public basic package is quite comprehensive: it includes 140 conditions with approximately 1,100 diagnoses coded in the International Classification of Diseases (ICD-10) and includes explicit guarantees of timeliness and quality. It was designed to meet 65% of the causes of morbidity. Implementation of AUS, however, has been slow and PEAS has not received sufficient funding [7]. According to a World Bank study focusing on AUS implementation, in 2013, SIS received just 10% of the sector budget to finance pharmaceutical products and medical devices, which was approximately the same percentage that the country's only cancer hospital received [2].

Formal sector workers and their families are covered mainly through EsSalud, although there are separate schemes for the national police and armed forces (Table 1.1). EsSalud is funded through payroll contributions, while the police and armed forces are financed by a mixed scheme of contributions and general budget

allocations. They all have their own network of providers, although service exchange agreements are being slowly put in place to allow different population groups to access different providers [8, 9], e.g. SIS affiliates to access EsSalud facilities or vice versa. All these schemes are required to provide PEAS at minimum but can and do provide more.

The governance of the health system is shared between the central level and the regions. MINSA is the governing body of the Peruvian health system, responsible for the sector policy design and its implementation. However, the capacity of MINSA to effectively regulate and oversee health services is limited by the fact that highly autonomous regional governments (Gobiernos Regionales – GOREs) are owners of public providers in their respective regions [10]. The National Health Superintendency (Superintendencia Nacional de Salud, SUSALUD) is responsible for supervision of health providers and insurers, as well as enforcement of the legislation for the whole sector.

The law on regional governments [11] granted significant independence to regional and local governments, which has diminished MINSA's effectiveness as the main body responsible for health policies in the country. GOREs can formulate, approve, execute, evaluate, direct, control and administer health policies of the region. While MINSA is still responsible for setting national policies, and regional governments must develop their policies in accordance with national policies and sectoral plans, their policies are not always properly aligned with those set at the central level. MINSA's leadership of the sector has also been affected due to shared responsibilities with another three ministries linked to the health subsystems: Ministry of Work and Labour Promotion (EsSalud), Ministry of Defence (Sanidad de las Fuerzas Armadas) and Ministry of Home Affairs (Sanidad de la Policía Nacional del Perú). The financing function is carried out by the Ministry of Economics and Finance (MEF) according to the General Budget Law. MEF also has direct control over the SIS budget, as is explained further in this section.

The fragmentation in health financing is mirrored in service delivery[1]:

- The public sector provides services through public facilities,
- EsSalud provides services through its own separate network of providers,
- National Armed Forces / Police operate their own providers, and
- There are private providers associated with private insurers.

In the Lima Metropolitan Area, public providers are organized in four Integrated Health Network Directorates (Dirección de Redes Integradas de Salud – DIRIS). These are operated by MINSA. In the rest of the country, in accordance with the country's decentralized administrative structure, service delivery is organized in 25 Regional Health Directorates (Dirección Regional de Salud – DIRESA or Gerencia Regional de Salud – GERESA) that fall under each regional government (GORE). GOREs are owners of public providers in their regions.

1 All health providers are Instituciones Prestadoras de Servicios de Salud (IPRESS).

Table 2.1: Summary of major health coverage schemes in Peru

	Public system		Social security system	
Target population	All citizens	Poor and vulnerable populations (defined by approved regulations prioritizing certain population groups, such as pregnant women and children under 5 years old)	Personnel of the armed forces / national police and their families	Formal sector workers and their families
Enrolment basis	Automatic	– Mandatory but individuals that want to become affiliated to SIS must actively enrol (apply at health facility) – Level of subsidization is determined through the National Household Targeting System (SISFOH)	Automatic for the personnel	Mandatory
Revenue sources	– General revenue allocations – User charges	General taxation through the budget and, in theory, premiums from members with capacity to pay	Compulsory contribution through payroll tax and public budget allocations	Payroll contributions to EsSalud
Pooling	Regional	National	National	National
Main purchaser	GOREs and MINSA (Lima)	SIS	National Armed Forces / Police Health Funds	EsSalud
Purchasing / payment	Historic input-based line-item payments[2]	Capitation for PHC and fee-for-service for hospital[3]	Historic input-based line-item payments	Historic input-based line-item payments
Benefits and patient cost-sharing	– Public health services – Other services are available but require user fees, which are subsidized (does not include medicines)	Services defined under: Essential Health Coverage Plan [Plan Esencial de Aseguramiento en Salud, PEAS] Complementary Plan Extraordinary coverage No patient co-payment until financial taps are reached	Comprehensive, including inpatient and outpatient services No patient co-payment	Comprehensive, including inpatient and outpatient services at any EsSalud facility or public facilities (if service exchange agreement is in place) No patient co-payment
Main providers	Public facilities operated by GOREs and MINSA (Lima)	Public facilities operated by GOREs and MINSA (Lima)	For armed forces (and police force) the main providers are their own health facilities. In addition, the Police fund provides access to private services though purchasing arrangements.	Own network operated by EsSalud

Source: Compiled by the authors based on [2, 4].

2 All funds in the public system flow to UEs, which are implementation or execution units. These were specifically set up to manage funds. These can be individual hospitals but also independent units managing funds for provider networks. Importantly, they are responsible only for financial management, including procurement of input to providers.

3 Similar to the general public system, funds flow to UEs not providers directly, although in some cases these can be individual hospitals.

DIRESA and GERESA have functions similar to MINSA's, although they vary across regions. Each region (or department) can specify the functions of the DIRESA/GERESA based on Article 49 of the Organic Law of Regional Governments [11].[4] Functions include preparing regional health policies and plans, coordination and management of health service provision within the region in coordination with Local Governments. The DIRESA/GERESA do not provide health services, they are part of the administration of the GORE.

The SIS is the national health insurer and it works as an autonomous entity with a budget allocated directly from the MEF without requiring previous MINSA approval and can manage its budget independently. The SIS budget is approved by Parliament as part of the main budget and follows the same budget classification as MINSA, as explained in the following sections. It should be noted that the SIS is budgeted to finance only its variable costs, which is about 10% of total spending on health.[5]

For primary care, SIS establishes agreements with GOREs, using capitation, which has two parts: a variable (depending on performance and based on defined indicators in the agreements with GOREs) and a fixed component. The latter is adjusted for a number of factors including: a road dispersion index, poverty, rurality, prioritized areas, and for the populations of underage and elderly citizens and adolescent girls [12]. However, SIS transfers these funds directly to implementation units (UEs), which are responsible for managing funds on behalf of service delivery units. Eighty percent of these funds are disbursed at the beginning of the year, and the remaining twenty percent is granted mid-year based on compliance with pre-defined performance indicators. UEs can be part of individual hospitals but they can also manage provider networks. UEs in turn provide inputs to providers. Some providers charge subsidized user fees (for the uninsured, for example), which are retained as income for the provider. It should also be noted that the general expenses (e.g. electricity, water, etc) are paid directly by the GORE to which the establishment belongs. For the secondary care level, SIS allocations are based on a combination of a fixed component (fee-for-service), historically determined, and a variable component for inputs consumed. They receive a percentage as an advance at the beginning of the year and this is then compared to the actual services provided, using a list of tariffs and inputs consumed. Some hospitals also receive direct funding from SIS, but this depends on their status as an UE.

4 Article 49 of Law N° 27867 states that the GOREs formulate, propose, execute, evaluate, direct, control and manage the health policies of the region in accordance with national policies and sector plans. More specifically, they are responsible for formulation and execution of the regional health development plans; coordinating comprehensive health actions at the regional level; implementation of health promotion and prevention activities; planning, financing and execution of health infrastructure projects and equipment.

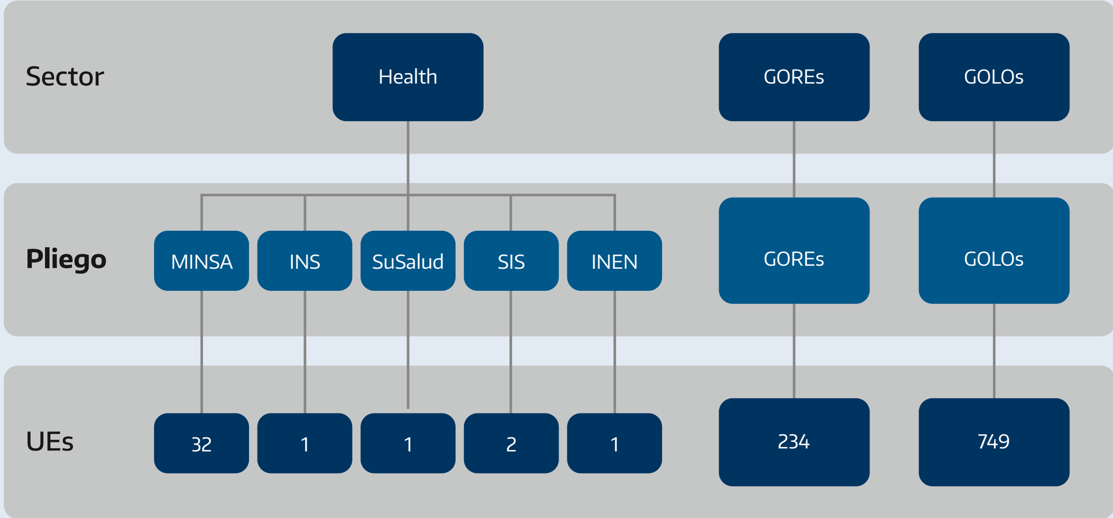
5 This refers to health function.

3. KEY ASPECTS OF THE CURRENT BUDGET STRUCTURE

From a budgetary perspective, the health function includes all the activities and interventions related to health at any of the three government levels (National, Regional or Local). The health function is reflected in five sectors at the national level: justice, defence, health, interior and agriculture. Each sector, has their own "pliegos" i.e. spending entities. In the case of the health sector, there are five pliegos: National Health Institute (INS), Ministry of Health (Ministerio de Salud, MINSA), the National Health Superintendence (Superintendencia Nacional de Salud, SuSalud), the public insurer known as Integral Health Insurance (Seguro Integral de Salud, SIS), and the National Institute for Neoplasms (INEN). At the regional level, there are 25 "sectors" which are part of the regional governments (GOREs) (Figure 3.1). Each regional government is in turn a pliego. Local governments (Gobiernos Locales, GOLOs) also play a role, particularly in case of the Lima Metropolitan area. GOLOs receive funding for the provision of services related to health promotion, sanitary surveillance and zoonoses.

Below the level of pliego, there are implementation units (unidades ejecutoras, UEs), which manage resources but do not appear separately in the annual budget law. As noted in the previous section, UEs can be DIRESAs (Direcciones Regionales de Salud), hospitals or health networks (a

Figure 3.1: Institutional structure of the health sector budget in 2018



Source: Compiled by the authors based on Ministry of Economics and Finance (2018) [13].
Note: This figure does not include Justice, Defence, Interior and Agriculture sectors which have health related expenditures, which are part of the health function in Peru's budget.

group of primary care level facilities). Not all providers appear as UEs and there are no formal clear criteria for establishing UEs [1].[6]

The current analysis is limited to the health sector budget at national level and the health spending under regional governments. It does not include health spending under other sectors, including justice and agriculture, although some of the programmes in Peru are multi-sectoral. Therefore, it focuses on five national level health sector pliegos mentioned above and the health spending under GOREs and GOLOs.

The annual budget in Peru is approved according to several classifications. As the Annual budget law states, budgetary allocations are detailed in the annexes that are part of the law and hence, are considered to be the basis for appropriations [14]. Annexes 5 and 6 appropriate at the most detailed or lowest level of classification, so effectively the budget is appropriated at activity level (see Figure 3.2).[7] There are eight annexes in total:

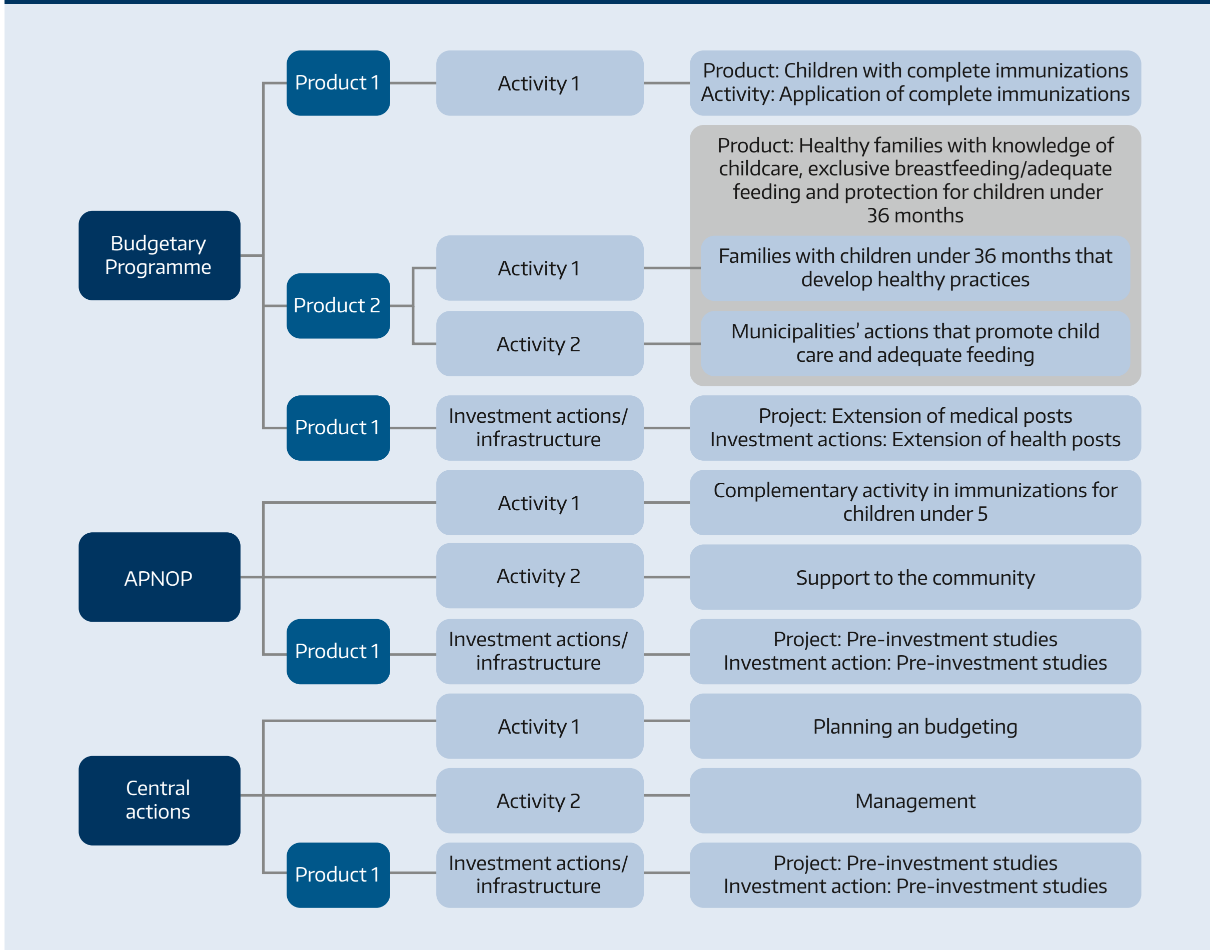
- Annex 1 – High level economic classification (i.e. at the level of article / 1 character), such as salaries and social payments, pensions, goods and services, and capital expenditures
- Annex 2 – High level economic classification and level of government (national, regional and local)
- Annex 3 – Functional classification and level of government, although functional classification in Peru does not explicitly follow the IMF's GFSM 2014 Classifications of the Functions of Government classification [16]
- Annex 4 – High level administrative classification, i.e. at the level of ministry or independent agency, although in Peru regional and local governments are also considered as administrative units at this level
- Annex 5 – High level administrative classification for national entities and three budget categories: (i) budgetary programmes (PPs); (ii) budget assignments that do not result in products to a specific population (APNOP), and (iii) central actions (AC), which cover budgets for management activities
- Annex 6 – Regional (GOREs) and local government (GOLOs) units and three budget categories of PP, APNOP and AC – all further divided into activities
- Annex 7 – High level economic classification by local government units (GOLOs)
- Annex 8 – Programme and high level administrative classification.

Each pliego's budget is approved based on three categories: (i) budgetary programmes (PPs); (ii) budget assignments that do not result in products to a specific population (APNOP), and (iii) central actions (AC), which cover budgets for management activities [14]. APNOP and AC are based on historical budgets that, in theory, are not associated with any specific results or outputs. For health sector pliegos at national level, only one third of the budget is allocated

6 The UEs organizational model has a hospital as the network head; the other health facilities are subordinated. Therefore, budgets of providers within a network depend significantly on the health manager's ability to negotiate with the UE's head.

7 PPs are further classified into products and projects. Products are linked to activities. Projects are investments and they are not linked to activities. APNOP and AC can have either projects or activities. The pliego's budget is also presented by economic classifications. Annex 6 does the same as annex 5 but for the regional and local governments.

Figure 3.2: Budget structure



Source: Compiled by the authors based on Ministry of Economics and Finance (2018).
Note: A product is the intermediate result of activities; an activity includes actions needed for the operability and maintenance of the existing public or administrative services (continuous and permanent); and, investment actions/infrastructure is an investment project (for a specific period).

based on PPs (Table 3.1). All three categories (PP, APNOP, AC) contain activities at the lowest level of expenditure in the budget law.

There is no clear distinction between APNOP and PPs when one examines the activities under each of these categories. For example, both PP and APNOP contain an activity on vaccination of children. The essential package of services provided by SIS is also funded through APNOP and several PPs. The way it works become clearer if one examines a budget of a pliego (Table 3.2). As it is shown in the figure, the budget for the GORE 440 for the region of Amazonas, has the following categories: (i) budgetary programmes, which are further broken down by products/ projects, and activities (PP), (ii) central actions, which are further broken down by activities, and (iii) budget assignments that do not result in products, which are also broken down by activities. In addition, the budget for the entire pliego is shown by general input categories (salaries and social payments, pensions, goods and services, other and capital). Funding provided

Table 3.1: Approved budget by health sector pliego at national level, 2019			
		Budget (SOLES)	%
11	Ministry of Health (MINSA)	7,092,483,491	
	PP	2,253,689,185	31.8
	AC	2,393,841,412	33.8
	APNOP	2,444,952,894	34.5
131	National Institute of Health (INS)	139,051,556	
	PP	52,099,643	37.5
	AC	27,904,880	20.1
	APNOP	59,047,033	42.5
134	National Health Superintendence (SuSalud)	46,329,231	
	PP	-	-
	AC	15,287,467	33
	APNOP	31,041,764	67
135	Public Health Insurance (SIS)	1,765,088,874	
	PP	673,678,544	38.2
	AC	101,138,055	5.7
	APNOP	990,272,275	56.1
136	National Institute for Neoplasms (INEN)	333,445,759	
	PP	159,608,356	47.9
	AC	14,737,603	4.4
	APNOP	159,099,800	47.7
	TOTAL	9,376,398,911	
	PP	3,139,075,728	33.5
	AC	2,552,909,417	27.2
	APNOP	3,684,413,766	39.3

Source: Annual budget law 2019, Annex 5.

through SIS APNOP appears at activity level in regional and local budgets (Figure 3.2).

Following the approval of the budget, MEF develops quarterly allocation plans by pliego, source of financing, programmes, activities and input lines. Within each source expenditures are classified into one of the three categories (APNOP, AC or PP). Even in the case of PPs, the budget under each product is further broken down by input lines, referred to as “genéricas”. For example, under the SMN (SALUD MATERNO NEONATAL) programme the budget for the product on normal deliveries (budget code 3033295) is further divided into input lines for salaries and social contributions, pensions and other social benefits, good and services etc (Table 3.3). Pliegos transfer resources to their UEs using a line-item budget following economic classification.

Table 3.2: Structure of the regional budget in the annual budget law

Regional government (GOBIERNO REGIONAL)				
Pliego	440	GOBIERNO REGIONAL DEL DEPARTAMENTO DE [REGION]		
Budget category (CATEGORIAS PRESUPUESTARIAS)	Products/ projects (PRODUCTOS /PROYECTOS)	Activities (ACTIVIDADES)		**Total**
Budgetary programmes (PROGRAMAS PRESUPUESTALES)				**XXX**
Products				
	3033251	FAMILIAS SALUDABLES CON CONOCIMIENTOS PARA EL CUIDADO INFANTIL, LACTANCIA MATERNA EXCLUSIVA Y LA ADECUADA ALIMENTACION Y PROTECCION DEL MENOR DE 36 MESES		**XXX**
		5000014	*FAMILIAS CON NIÑO/AS MENORES DE 36 MESES DESARROLLAN PRACTICAS SALUDABLES*	**XXX**
		5005982	*CAPACITACION A ACTORES SOCIALES QUE PROMUEVEN EL CUIDADO INFANTIL, LACTANCIA MATERNA EXCLUSIVA Y LA ADECUADA ALIMENTACION Y PROTECCION DEL MENOR DE 36 MESES*	**XXX**
	3033254	NIÑOS CON VACUNA COMPLETA		**XXX**
		5000017	*APLICACION DE VACUNAS COMPLETAS*	**XXX**
Central actions (ACCIONES CENTRALES)				
		5000001	*PLANEAMIENTO Y PRESUPUESTO*	**XXX**
		5000006	*ACCIONES DE CONTROL Y AUDITORIA*	**XXX**
Budget assignments that do not result in products (ASIGNACIONES PRESUPUESTALES QUE NO RESULTAN EN PRODUCTOS)				
		5000276	*GESTION DEL PROGRAMA*	**XXX**
		5000377	*MEJORAMIENTO DE LA OFERTA DE LOS SERVICIOS DE SALUD*	**XXX**
		5000395	*ACTIVIDAD REGULAR DE INMUNIZACIONES DE PERSONAS MAYORES DE 5 AÑOS*	**XXX**
		5000500	*ATENCION BASICA DE SALUD*	**XXX**
		5000514	*ATENCION INTEGRAL DE SALUD*	**XXX**
		5001075	*PROMOCION DE LA SALUD*	**XXX**
		5001171	SEGURO INTEGRAL DE SALUD	**XXX**
Total pliego				**XXX**
Current expenditures				
	1	PERSONAL Y OBLIGACIONES SOCIALES		**XXX**
	2	PENSIONES Y OTRAS PRESTACIONES SOCIALES		**XXX**
	3	BIENES Y SERVICIOS		**XXX**
	5	OTROS GASTOS		**XXX**
Capital expenditures				
	6	ADQUISICION DE ACTIVOS NO FINANCIEROS		**XXX**
Total pliego				**XXX**

Source: Annual budget law 2019, Annex 6. [14]

Table 3.3: Post-appropriation allocation plan for Product 3033295, 2019					
Product: Normal deliveries (n=620,389)	**RO**	**RDR**	**DT**	**RD**	**Total**
Personnel and social contributions	154,658,778				154,658,778
Pensions and other social benefits	0				0
Goods and services	30,139,853	338,216	0	0	30,662,800
Donations and transfers	18,643,666				19,306,539
Other expenditures	1,082,263		0		1,082,168
Purchase of non-financial assets	0		0	170,220	170,220
Total	**176,880,297**	**338,216**	**0**	**170,220**	**205,880,505**

Compilation: Authors.
Source: MEF [17].

According to the budget law, MINSA or GOREs can request MEF to make reallocations between budgetary programmes as long as it does not imply the increase in the overall budget and within ceilings specified in the law. However, pliegos, including MINSA, cannot reallocate between salaries and other lines. Salaries are strictly regulated and in case of public servants, including those in the health sector, follow the national remuneration scale. Reallocations of pensions and capital expenditures are also largely prohibited. These are standard virement controls in most countries; however, reallocation across programmes is not a common practice.

Peru has a single nationwide integrated financial management system (IFMIS)[8], referred to as Sistema Integrado de Administración Financiera (SIAF), that incorporates the results-based budgeting approach. The IFMIS in Peru was designed to integrate all stages of public expenditure for the national, regional, and local levels of government by utilizing a single budget classifier and chart of accounts as a basic prerequisite for effectiveness [17]. A key feature in Peru's IFMIS is that its budgetary planning module incorporates the results-based budget approach that includes a logical framework with output and outcome indicators for programmes. In 2000, Integrated Administrative Management System (Sistema Integrado de Gestión Administrativa, SIGA) was developed to support the budget formulation and planning process. Later, a specific module on budgetary programmes was developed: SIGA-PpR guides the UEs in estimating their funding requirements to provide products and services as described in the budgetary programme documents. SIGA-PpR module feeds into the SIAF [18].

8 IFMIS are computerized systems that automate the financial procedures to register information on the collection of public revenue and commit them to public sector objectives (Farías and Pimenta, 2012). The main objective of IFMIS is to provide the public sector with the necessary information to plan, execute, and monitor public finance. This includes the execution of the budget, consistent and systematic accounting recording, and assisting the Treasury to meet its commitments and manage its payments and debts, while simultaneously ensuring the quality of reporting including financial statements.

4. STRUCTURE AND CONTENT OF BUDGETARY PROGRAMMES

The budget law (Annex 8) shows allocations by programme, product / project and activity. In addition, it shows the programme allocation by pliego, which in health include MINSA, SIS and regional and local governments (Figure 4.1). For example, under the programme for nutrition, MINSA, SIS and National Institute for Health each have their separate allocation. In the case of MINSA, these budget programs are subject to PpR.

Since the start, the process of designing budgetary programmes in Peru was based on rigorous technical analysis of evidence, resulting in clearly formulated problem statements and objectives. The design began with the identification of a specific problem based on quantitative and qualitative data. The problem and the population it affects must be quantifiable: for example, for a programme on nutrition, one must identify prevalence of malnutrition among children under five and estimate the number of affected children based on national statistics. The analysis of the problem and solutions must be presented using a problem tree ("Árbol de Problemas")

Figure 4.1: Example of a programme budget presentation in the annual budget law

LEY Nº 30879 DEL PRESUPUESTO DEL SECTOR PUBLICO PARA EL AÑO FISCAL 2019
DISTRIBUCION DEL GASTO DEL PRESUPUESTO DEL SECTOR PUBLICO
POR PROGRAMAS PRESUPUESTALES Y PLIEGOS
(EN SOLES)

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ANEXO : 8

PROGRAMAS PRESUPUESTALES / PRODUCTOS / PROYECTOS	ACTIVIDADES	TOTAL
PROGRAMA ARTICULADO NUTRICIONAL		**2 271 993 014**
PRODUCTOS		**1 987 487 849**
3033317	**GESTANTE CON SUPLEMENTO DE HIERRO Y ACIDO FOLICO**	**53 171 295**
	5000032 ADMINISTRAR SUPLEMENTO DE HIERRO Y ACIDO FOLICO A GESTANTES	53 171 295
3033414	**ATENCION DE NIÑOS Y NIÑAS CON PARASITOSIS INTESTINAL**	**34 716 410**
	5000035 ATENDER A NIÑOS Y NIÑAS CON DIAGNOSTICO DE PARASITOSIS INTESTINAL	34 716 410
PROYECTOS		**284 505 165**
2001621	ESTUDIOS DE PRE-INVERSION	12 023 280
2003227	AMPLIACION DE POSTAS MEDICAS	180 000
2003232	AMPLIACION DE PUESTOS DE SALUD	5 634 870
2005660	CONSTRUCCION Y EQUIPAMIENTO DE PUESTOS DE SALUD	53 611 772
2006226	CONSTRUCCION DE PUESTOS DE SALUD	8 932 497
2007228	CONSTRUCCION DE POSTAS MEDICAS	1 554 731
2008367	CONSTRUCCION Y EQUIPAMIENTO DE POSTAS MEDICAS	7 577 632
2011406	MEJORAMIENTO DE POSTAS MEDICAS	8 393 765
2013361	REHABILITACION DE PUESTOS DE SALUD	655 350
2014570	EQUIPAMIENTO DE POSTAS MEDICAS	135 000
2014571	EQUIPAMIENTO DE PUESTOS DE SALUD	2 994 280
2063966	MEJORAMIENTO Y CONVERSION DE LA CAPACIDAD RESOLUTIVA DE LOS SERVICIOS DE SALUD DEL CENTRO DE SALUD PEDRO RUIZ GALLO EN HOSPITAL REFERENCIAL, RED DE SALUD CHACHAPOYAS - AMAZONAS	10 764 543
2094709	FORTALECIMIENTO DE LA CAPACIDAD RESOLUTIVA DE LOS SERVICIOS DE SALUD DEL HOSPITAL SANTIAGO APOSTOL DE UTCUBAMBA - DIRESA AMAZONAS	5 585 969
2100531	CONSTRUCCION Y EQUIPAMIENTO DE LA INFRAESTRUCTURA DEL PUESTO DE SALUD DE PARIACC, DISTRITO DE HUARIBAMBA - TAYACAJA - HUANCAVELICA	64 063
2106266	MEJORAMIENTO DE LA CAPACIDAD RESOLUTIVA DE LOS SERVICIOS DE SALUD DE PRIMER NIVEL DE ATENCION DE LOS PUESTOS DE SALUD DE LLAMACANCHA, SAN JUAN DE PALTARUMI, DOS DE MAYO Y RUNDOVILCA, DE LA MICRORED PAMPAS, RED TAYACAJA-HUANCAVELICA	69 610
2109716	MEJORAMIENTO DE LA OFERTA DE SERVICIOS EN EL CENTRO DE SALUD SAN MARTIN DE PORRES - MICRORED TRUJILLO- RED TRUJILLO- LA LIBERTAD	1 187 399
2117268	MEJORAMIENTO DE LA ATENCION INTEGRAL DE LA SALUD EN EL PRIMER NIVEL DE ATENCION A LA POBLACION DEL P.S. ECHARATE CONCEPCION, DISTRITO DE ECHARATE - LA CONVENCION - CUSCO	148 507
2122337	CONSTRUCCION DEL CENTRO MATERNO INFANTIL ARICAPAMPA, DISTRITO DE COCHORCO - SANCHEZ CARRION - LA LIBERTAD	884 575
2140940	MEJORAMIENTO DE LA CAPACIDAD OPERATIVA Y RESOLUTIVA DE LOS SERVICIOS DEL CENTRO DE SALUD DE PAZOS, DISTRITO DE PAZOS - TAYACAJA - HUANCAVELICA	4 988 235
2150281	MEJORAMIENTO Y CONVERSION DE LA CAPACIDAD RESOLUTIVA DE LOS SERVICIOS DEL PUESTO DE SALUD CHETO, DISTRITO DE CHETO - CHACHAPOYAS - AMAZONAS	10 000
2150545	MEJORAMIENTO DE LA GESTION SOCIAL DE LOS GOBIERNOS LOCALES Y COMUNIDADES PARA DESMINUIR LA DESNUTRICION INFANTIL EN LA REGION AYACUCHO	673 140
2151978	MEJORAMIENTO DE LOS SERVICIOS DE SALUD DEL CENTRO DE SALUD SAN ISIDRO DE ACOBAMBA, EN LA LOCALIDAD DE SAN ISIDRO DE ACOBAMBA, DISTRITO DE SAN MARCOS DE ROCCHAC, PROVINCIA DE TAYACAJA - DEPARTAMENTO DE HUANCAVELICA	9 852
2152567	MEJORAMIENTO DE LOS SERVICIOS DE SALUD DEL P.S. PAMPACHACRA CATEGORA I 1 DEL PRIMER NIVEL DE COMPLEJIDAD, EN LA LOCALIDAD DE PAMPACHACRA, DISTRITO DE HUANCAVELICA, PROVINCIA DE HUANCAVELICA DEPARTAMENTO HUANCAVELICA	19 249
2154443	MEJORAMIENTO DEL ESTADO NUTRICIONAL DEL NIÑO MENOR DE TRES AÑOS Y LA MADRE GESTANTE EN LAS PROVINCIAS DE AZANGARO, LAMPA Y SAN ROMAN DE LA REGION PUNO	2 240 720
2155472	MEJORAMIENTO DEL SERVICIO DE SALUD EN EL CENTRO DE SALUD DE SAN CRISTOBAL EN EL DISTRITO, PROVINCIA Y DEPARTAMENTO DE HUANCAVELICA	31 728

Source: Annual budget law 2019, Annex 8. [14]

and supported by scientific evidence on identified causes. Alternative solutions must be also presented and analysed. Based on this analysis, products and activities as well as performance indicators were developed. Finally, the budget was developed by products and activities. The document on nutrition programme contains 268 pages and contains an extremely detailed systematic analysis of the literature on malnutrition [19].

Despite their clear formulation, the nine programmes that currently exist in the health sector appear to be very focused on specific conditions or types of diseases (Table 4.1). Programme design in Peru reflects the history and context within which they were developed. They were developed in response to specific health priorities, such as widespread malnutrition among women and children, which were meant to result in tangible

Box 4.1: Key steps in program budget introduction in Peru

The first major political decision to change the public system fell in a broad law of modernisation of the State's Management-Law N° 27658 (*Ley Marco de Modernización de la Gestión del Estado*) - approved in 2002. This law included as one of its key actions to "increase efficiency in the use of State resources".

In this context, the Ministry of Economy and Finance (*Ministerio de Economía y Finanzas*, MEF), through the General Directorate of Public Budget (*Dirección General de Presupuesto Público*, DGPP), led initiatives aimed at incorporating result-based public management in the public budget. In 2002, management agreements by results (*Convenios de Administración por Resultados*, CAR) were implemented, and in 2004 the Monitoring and Evaluation of Public Expenditure System began. However, no significant changes in the budgetary system were made at this stage and the budget continued to be appropriated using administrative and economic classifications [20].

In 2007, results-based budgeting (*Presupuesto por Resultados*, PpR) was introduced (Budget Law N° 28927), changing the public budget and its formulation process from an input-based model to the one based on outputs. The PpR is a tool to prepare the budgetary programmes (*Programas Presupuestales*, PPs). The Law mentioned its gradual implementation nationwide, in all entities of the public administration and at all levels of government.

The main reform objective was to improve the quality of expenditure by substituting the traditional public budget based on historical line-item budgets, with a management oriented towards outcomes and products. The PpR was supposed to link the resource allocation to products and measurable results in favour of the population [21].

In 2008, the first PPs were implemented, two of which were in the health sector. In 2010, MEF put in place a module in the Integrated System of Administrative Management (*Sistema Integrado de Gestión Administrativa*, SIGA) to support planning of PPs. In 2011, five new PPs were included in the health sector.

In 2012, the approach to designing budgetary programmes changed and the multisectoral approach was abandoned. The current approach is "more operationally driven" –the logical framework– and is more aligned with organizational structure [1]. Therefore, programmes created post 2012 are typically limited to one ministry. This is in line with the general recommendation that each program would be the direct responsibility of one, and only one manager, to ensure clear performance accountability [22].

improvements in health outcomes. Therefore, budgetary programmes in Peru, unlike in many other countries, including Armenia, Burkina Faso, Chile, Estonia, Kyrgyzstan, and South Africa, are based on targeting specific disease or vertical health interventions and there is no programme for overall administration and management.[9] The budget for these types of

Table 4.1: Summary of PPs in the health sector and their main goals, 2019

	Programme and programme code	Target population	Objective	Technical manager
1	0001: PAN (Nutrition Programme)	Children under 5	Decrease chronic malnutrition (stunting) in children under five	General Director of Strategic Interventions in Public Health (Dirección General de Intervenciones Estratégicas en Salud Pública, DGIESP)
2	0002: SMN (Maternal and neonatal health)	Women of childbearing age, pregnant women and new-borns	Reduce maternal-neonatal morbidity and mortality	
3	0016: TBC-HIV/AIDS (TB and HIV/AIDS)	Respiratory symptoms identified, contacts of people affected by pulmonary tuberculosis, and the population in general	Reduction of the rate of incidence of sensitive and resistant tuberculosis in the community, and low morbidity and mortality due to STI / HIV	
4	0017: Zoonotic and vector-borne diseases	Population susceptible to acquire a zoonotic and vector-borne diseases. These people are residents of endemic areas of these diseases, as well as migrants who move to these areas. All ages and sexes are susceptible to getting sick.	Decrease in morbidity and mortality due to zoonotic and vector-borne diseases through health interventions, according to the risk scenario	
5	0018: Non-Communicable Diseases	Populations at risk of NCDs related to eye health, oral health, chronic diseases, heavy metals	Reduction of morbidity, mortality and disability due to NCDs	
6	0024: Cancer Prevention and Control	Entire population for promotional preventive actions, treatment and population with the disease for palliative care	Decrease cancer mortality and morbidity by improving access to oncology health services	
7	0129: Prevention and Handling of Secondary Health Conditions in Persons with Disabilities	Poor people with permanent disability, (excludes EsSalud and private insurance beneficiaries)	Decrease secondary health conditions and the degree of disability of people with disabilities	
8	0131: Control and Prevention in Mental Health	Entire population for promotional preventive actions and screening according to age and gender, the population for diagnosis, treatment and rehabilitation care is one that presents a mental health disorder	Reduce prevalence of mental health disorders in the Peruvian population	
9	0104: Reduction of Mortality for Emergencies and Medical Emergencies	All persons who report an emergency or medical emergency, whether identified by the same or by third parties	Reduce mortality due to emergencies and medical emergencies	General Director of Telehealth, Referrals and Emergencies (Director/a General de Telesalud, Referencias y Urgencias)

Source: Authors based on [23, 24].

9 Peru is not completely unique, however. Partial coverage also exists in Vietnam and UK.

activities as well many other health system support functions which could not be assigned clearly to one of these vertical programmes sits outside of the programme structure, as it was described in Section 3.

Importantly, even though ensuring access to the essential package of health services (PEAS) under SIS is one of the key policy priorities in the progress towards universal health coverage in Peru, expenditures for PEAS are not easily identifiable under the current programme structure. PEAS is not a separate budgetary programme: instead, it is funded through a combination of several different programmes, APNOP and AC. One of the key reasons for introducing programme budgeting is to facilitate budget prioritization, and therefore it seems important to ensure that key priorities such as PEAS are reflected in the budget.

The program structure has three levels: programme, products and activities, but the scope and size of activities varies widely. On average, there are thirteen products per programme. The programme with the largest number of products is TB-HIV/AIDS programme, which has twenty-two products. The program with the least number of products is the Control and Prevention of Mental Health programme, which has three products. As the example of the nutrition programme below shows (Table 4.2), activities vary widely in their scope and resources: in PAN, two activities – immunization and growth monitoring – make up 42.5% of the programme budget, while most others are allocated 3% or less.

The way programmes are structured in Peru exacerbates financial fragmentation. One provider can be assigned to several programmes, which requires splitting specific resources – for example, health staff of a facility or cars – between these programmes. While there is nothing conceptually difficult or unusual about the maintenance of such records or the use of shared input, their maintenance – and monitoring to ensure their accuracy – is time-consuming and is associated with significant administrative costs. It is generally recommended that programs should not be defined in a way that requires specific resources to be split in this way [22].

In addition, a set of consistent activities or interventions (e.g. immunization) can be spread across different programmes, which complexifies resource management and monitoring. For instance, the purchase of different vaccines is included in several different programmes (Table 4.3). By 2018, immunization activities are included in seven different budgetary programmes: i) PAN, ii) SMN, iii) zoonotic and vector-borne diseases, iv) cancer prevention and control, v) the improvement of military capacities for defence and national development, (vi) non-communicable diseases and (vii) TB-HIV/AIDS. The yellow fever vaccine, in particular, shows fragmentation – three programmes are delivering the same vaccine. Immunization activities in PAN seek to avoid the recurrence and intercurrence of infectious diseases interfering with child growth; vaccination at SMN are targeting pregnant women, mothers and neonates and seek to reduce their morbidity and mortality; vaccination activities of domestic animals and inhabitants of endemic areas of zoonotic and vector-borne diseases aim to prevent and cut the cycle of disease spread. While this division makes sense from a scientific intervention point of view, it may be difficult from the programme manager's perspective to manage budgets for these activities under these separate programmes.

Table 4.2: Programme on nutrition (PAN) budget, 2019

Budget code		Budget (SOLES)	Budget (%)
	Programme on nutrition (PROGRAMA ARTICULADO NUTRICIONAL)	**2,271,993,014**	
3000001	**Common actions**	**179,412,350**	**7.9**
5004424	Surveillance, research and technology in nutrition	21,439,330	0.9
5004425	Development of nutrition standards and technical guides	9,681,305	0.4
5004426	Monitoring, supervision, evaluation and control of the nutritional articulated program	148291715	6.5
3000608	**Day care services access nutritional quality control of food**	**18,787,911**	**0.8**
5004427	Nutritional quality control of food	18,787,911	0.8
3000609	**Community access to safe water**	**72,114,978**	**3.2**
5004428	Monitoring of water quality for human consumption	56,945,591	2.5
5004429	Disinfection and / or treatment of water for human consumption	15,169,387	0.7
3000733	**Informed population on child care and healthy practices for the prevention of childhood anaemia and chronic malnutrition**	**15,964,274**	**0.7**
5005326	Communication interventions for child care and prevention of childhood anaemia and chronic malnutrition	15,964,274	0.7
3033251	**Healthy families with knowledge for child care, exclusive breastfeeding and adequate nutrition and protection for children under 36 months**	**89,870,753**	**4.0**
5000014	Families with children under 36 months develop healthy practices	62,568,368	2.8
5005982	Training for social actors promoting child care, exclusive breastfeeding and adequate nutrition and protection for children under 36 months	16,791,321	0.7
5005983	Actions of the municipalities promoting child care and adequate nutrition	1,051,106	0.0
3033254	**Fully vaccinated children**	**623,451,782**	**27.4**
5000017	Application of complete vaccines	623,451,782	27.4
3033255	**Children with complete and timely monitoring of growth and development**	**342,520,593**	**15.1**
5000018	Monitoring of growth and development among children	342,520,593	15.1
3033256	**Children with iron and vitamin A supplement**	**121,412,576**	**5.3**
5000019	Administer iron and vitamin supplement	121,412,576	5.3
3033311	**Acute respiratory infection care**	**164,954,238**	**7.3**
5000027	Care for children with acute respiratory infections	164,954,238	7.3
3033312	**Acute diarrheal disease care**	**82,336,531**	**3.6**
5000028	Care for children with acute diarrheal diseases	82,336,531	3.6
3033313	**Care for acute respiratory infections with complications**	**81,386,111**	**3.6**
5000029	Care for children diagnosed with acute respiratory infections with complications	81,386,111	3.6
3033314	**Care for acute diarrheal diseases with complications**	**57,530,973**	**2.5**
5000030	Care for children diagnosed with complicated acute diarrheal disease	57,530,973	2.5
3033315	**Care for other prevalent diseases**	**49,857,074**	**2.2**
5000031	Provide attention to other prevalent diseases	49,857,074	2.2
3033317	**Pregnant women receiving iron and folic acid supplement**	**53,171,295**	**2.3**
5000032	Administer supplementation of iron and folic acid to pregnant women	53,171,295	2.3
3033414	**Care for children with intestinal parasites**	**34,716,410**	**1.5**
5000035	Provide care to children diagnosed with intestinal parasites	34,716,410	1.5
	Projects	**284,505,165**	**12.5**

Source: Annual budget law 2019, Annex 8 [14].

Table 4.3: Fragmentation in inclusion of immunization activities in Peru's PPs

ENV vaccines	PP
BCG vaccine, Hepatitis B vaccine (HvB), Pentavalent vaccine, Paediatric diphtheritic toxoid vaccine (DT), Vaccine against Haemophilus influenzae type B (Hib), Polio vaccines (IPV – APO), Vaccine against rotavirus, Vaccine against pneumococcus, Vaccine against measles, mumps and rubella (SPR), Vaccine against measles and rubella (SR), Yellow fever vaccine (AMA), Vaccine against diphtheria, pertussis and tetanus (DPT), Influenza vaccine	PAN
Adult diphtheria vaccine (dT), Yellow fever vaccine (AMA), Influenza vaccine	SMN
Vaccine against the human papilloma virus (VPH)	Cancer prevention and control
Other vaccines	**PP**
Human anti-rabies vaccine, Animal anti-rabies vaccine, Yellow fever vaccine for adults (AMA)	Zoonotic and vector-borne diseases
PP specific information is not available for the public (classified).	Improvement of military capacities for defence and national development.

Source: NTS N° 080-MINSA/DGIESP V.04 (2018).

5. PERFORMANCE MEASUREMENT FRAMEWORK AND INDICATORS

There is a high number of indicators at the programme level, which is against the general recommendation of having fewer top level indicators [25, 26]. On average there are six indicators at programme level, although it ranges from two to fourteen. In total, there are 51 programme level indicators for the health sector alone (Table 5.1). Moreover, each of these indicators is reported by region as well as at the national level. Several indicators are not measured on a regular basis because of delays in data publication coming from various surveys. Therefore, the utility of these indicators in the budgeting process is unclear. This observation was also supported during the interviews for this study, where officials indicated that performance monitoring is somewhat of a

Table 5.1: Summary of indicators by programme, 2019

Programme	Territorially articulated	Products*	Final result indicators	Intermediate result indicators	Specific result indicators
0001: PAN (Nutrition Programme)	Yes	14	1	13	
0002: SMN (Maternal and neonatal health)	Yes	17	2	9	
0016: TBC-HIV/AIDS (TB and HIV/AIDS)	Yes	22	3	5	
0017: Zoonotic and vector-borne diseases	Yes	6	5		
0018: Non-communicable diseases	Yes	17			4
0024: Cancer prevention and control	Yes	18			2
0104: Reduction of mortality for emergencies and medical emergencies	Yes	7	1		1
0129: Prevention and handling of secondary health conditions in persons with disabilities	Yes	3			2
0131: Control and prevention in mental health	Yes	9	2		1
Total		**113**	**14**	**27**	**10**

Source: Compilation by authors from Ficha resumen de Programa presupuestales PpR - 2019 (Summary reports of budgetary programmes)
Note: *Products here do not include a product on management and coordination of the programme ("acciones comunes") which is considered to be a product on its own but is not part of the logical framework.

perfunctory exercise and there is little real analysis that happens once these indicators are collected and reported.

Performance measures are defined at three levels: programme, product, and activity. Programme indicators are defined at three levels: (i) the final results or outcomes, (ii) intermediate results, and (iii) specific or immediate results (Table 5.2). In addition, there are indicators at product and activity level, although not all products have individual indicators. These are typically described in the main programme document [23] and are reported on an annual basis; therefore, making performance information an integral part of the budgeting process.

Programme performance indicators are regularly collected, reported and published

Table 5.2: Performance indicators for Nutrition programme (PAN), 2019

Description	Indicators
Outcome	
Reduce chronic malnutrition in children under 5 years	Prevalence of chronic malnutrition in children under 5 years (using WHO standards, %)
Intermediate results	
Improve the feeding and nutrition of children under 36 months.	Prevalence of anemia in children under 36 months (%)
	Proportion of children under 6 months receiving exclusive breastfeeding
Reduce morbidity of Acute Respiratory Infections (ARI) and Acute Diarrheal Disease (ADD) and other prevalent diseases.	Incidence of Acute Diarrheal Disease (ADD) in under 36 months
	Incidence of Acute Respiratory Infection (ARI) in under 36 months
Reduce the incidence of low birth weight in new-borns	Incidence of low birth weight (<2.5 Kg)
Improve the nutritional status of pregnant women	Proportion of pregnant women who received ferrous sulfate plus folic acid.
Households that adopt healthy practices for child care and adequate feeding for children under 36 months	Proportion of children under 36 months who have received all the recommended vaccines for their age
	Proportion of children with complete vaccines according to their age.
	Proportion of children aged 6 to less than 36 months who received iron supplementation.
Immediate results	
Improve the nutritional status of pregnant women	Proportion of pregnant women who received ferrous sulfate plus folic acid
• Households • Mothers that adopt healthy practices for child care and adequate feeding for children under 36 months	
Increase access and use of safe water	Proportion of households with treated water
	Percentage of households with access to safe water supply

Source: Ficha resumen de Programa presupuestales PpR: Programa articulado nutricional (Summary report for Programme on Nutrition 2019)

in RESULTA, a MEF web application open to the public.[10] The information on products and activities is collected through administrative records reported by the implementation units (UEs) and consolidated by the technical manager, for example the DGIESP in MINSA, while outcome indicators are estimated using survey data, collected by the National Statistical System (INEI). MEF, specifically the DGPP (General Directorate of Public Budget), consolidates the performance information at the programme level (i.e. outcome indicators) and budget execution data from all the sectors every six months and presents it to the Budget and General Account Commission of the Congress, as well as to the General Controllership. There is no action taken if targets are not met: at this stage, Peru could be described as having more of a performance-informed rather than performance-based budgeting, although some incentive schemes do exist as it is explained further below.

However, the extent to which the performance information collected is used for decision making is questionable. According to interviews with policy-makers, there is a lack of technical capacities to make rigorous use of performance information. Information is frequently outdated and cannot be used by the Pliegos because many performance indicators use national surveys; but this information come out with significant delay. Moreover, the planning system (SIGA) and the SIAF are not well linked. The Pliegos cannot connect the progress of the physical targets to the financial ones. At the national level, there are also problems. Diminished MINSA stewardship has decrease its monitoring capacity: MINSA cannot access the regional and local Pliegos monitoring system —SIGA. Its capacity to follow up is limited to the budget execution figures at the SIAF aggregate level. The Pliegos have few incentives to focus on the evaluation phase and monitor performance indicators since MEF mostly focusses on budget execution and not outputs or outcomes. The Pliegos end up focusing on spending resources to improve their budget execution indicators. Thus, performance monitoring reports are a formality. Performance information does not feed back into the budget process and is not used as a management instrument to improve the public expenditure quality.

There are two incentive mechanisms tied to the PPs: Budgetary Support Agreement (Convenio de Apoyo Presupuestario, CAP) and Performance and Social Outcomes Stimulus Fund (Fondo de Estímulo de Desempeño y Logro de Resultados Sociales, FED). CAP is an agreement between pliegos (MINSA and GOREs) and MEF's DGPP as a performance-based incentive to improve management of Health PPs. CAP is financed externally (EUROPAN) to promote specific programmes, such as PAN and SMN. Independent assessments have shown that CAPs had a positive effect on management and increased coverage of priority services. Furthermore, CAPs have enabled the various players and management processes to align with the achievement of predefined health targets (e.g. PAN) [27]. The FED is managed by the Midis (Ministry of Development and Social Inclusion), with the participation of the MEF, using regular budget funds. The FED follows the same logic as the CAP, and it is gradually implemented in selected regions (GOREs).

10 See Ministry of Economy and Finance website for more information and to access the indicators https://www.mef.gob.pe/es/aplicaciones-informaticas/400-presupuesto-publico/5053-resulta-indicadores-de-desempeno-de-los-programas-presupuestales

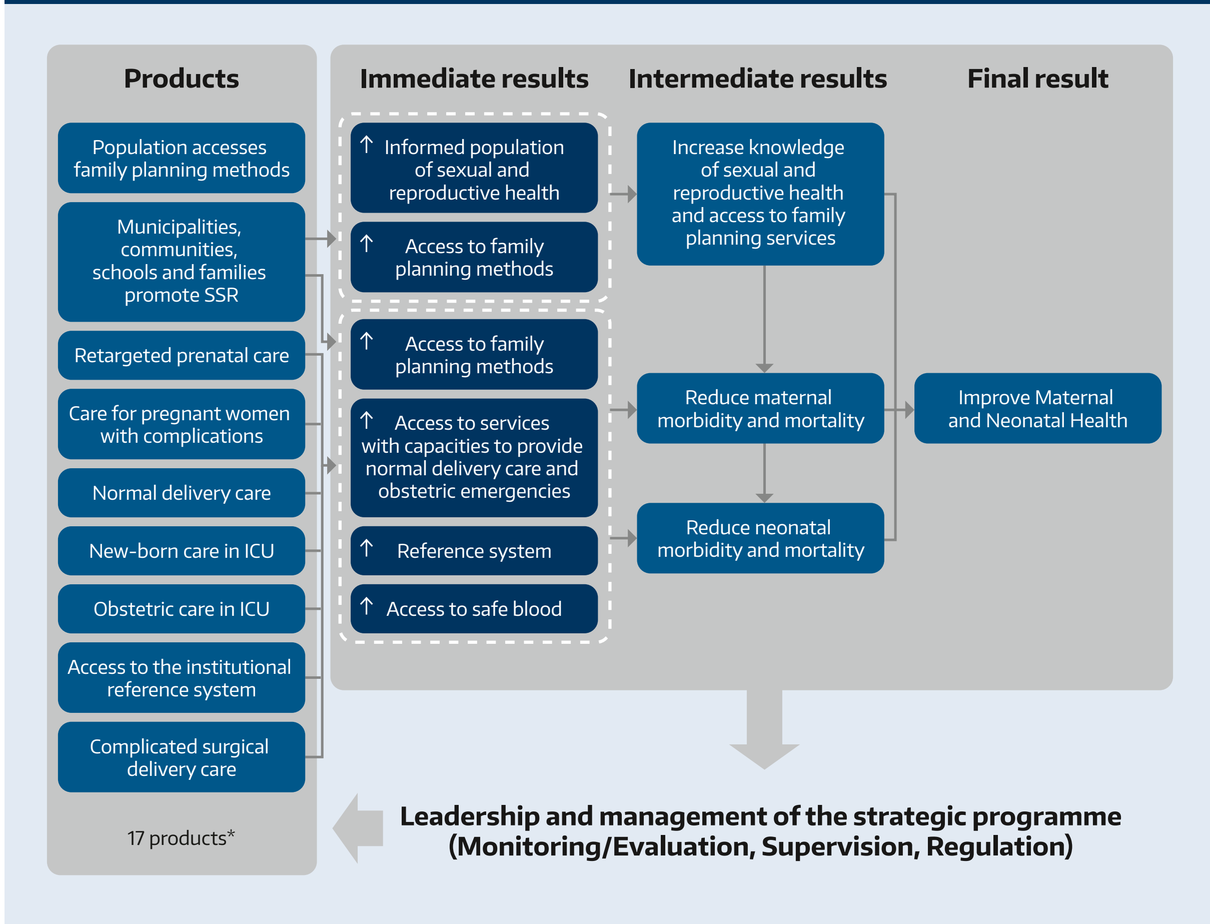
6. BUDGETING FOR RESULTS IN PERU: ACHIEVEMENTS AND CHALLENGES IN HEALTH

One of the key successes of Peru's approach to programme budgeting is real changes in health outcomes for conditions targeted by its budgetary programmes, particularly malnutrition and maternal and neonatal health. According to a recent study, PpR allowed a focus on results, value for money and prioritization of spending [28]. Introducing PAN as a budgetary programme in 2008 was key in ensuring a rigorous approach to allocating spending to achieve results in children's health, growth and development. Only the most cost-effective and globally proven ways of reducing stunting were included as activities and allocated money. Performance indicators linked to the budget from activity to programme level played a critical role in evaluating priorities and progress. Regional health authorities were rewarded with an increase in their budgets if they achieved development targets, including on chronic malnutrition, sanitation and water [28]. Also, PpR promoted the use of a budget planning tool (SIGA) and linking of results to spending. In 2010, a SIGA analysis justified budget increments to PAN, which increased the per capita (child) budget for growth monitoring and vaccination by 331 percent and 150 percent respectively, to fund growth monitoring and nutrition services in remote locations (Sierra and Selva regions) and improve awareness campaigns and vaccinations against respiratory and diarrheic diseases. Positive results in control of HIV/AIDs are also partly attributed to Peru's programme budgeting [29].

The process of developing budgetary programmes in Peru aims to ensure a rigorous evidence-based approach. The programme description documents (Anexo 2) provide systematic literature reviews of the causes of a particular health problem and interventions. They also describe alternative approaches to address the problem and provide justification for the chosen interventions. In this respect, Peru has made a real attempt to take a scientific approach in its programme design (Figure 6.1). As such, budgetary programmes in health have clearly formulated programme objectives with a set of products to focus activities in the areas of highest need.

Peru has a robust IFMIS (SIAF) and this is critical element for supporting performance-budgeting. The IFMIS in Peru operates as one single system for all three levels of the government (i.e. central, regional and local) with a special module to monitor financial and non-financial performance under the programme-based budgeting [17]. Therefore, unlike in many other LMICs, when embarking on programme budgeting, it had a good foundation because a robust financial management information system (FMIS) plays a key role in supporting management of public sector budgetary, accounting, treasury, and public debt management processes as well as generate corresponding reporting documents [30].

Figure 6.1: Logical model for the SMN Programme, 2019



Note: *Number of products can vary from year to year. For SMN Programme in 2019 budget there are 17 products plus acciones comunes (product on management and coordination of a particular programme).
Source: Anexo 2. Contenidos mínimos del Programa Presupuestal. PROGRAMA PRESUPUESTAL 0002 SALUD MATERNO NEONATAL.

However, even though MEF has been implementing results-based budgeting for more than a decade, it still covers less than half of the public spending on health and seems to be more of an activity-based budget rather than a programme budget. The strength of Peru's approach lies in how it tries to establish comprehensive links between outcomes, outputs, activities and inputs based on a rigorous evidence-based approach, but this also appears to be its weakness. It seems unable to incorporate a large portion of government activities because they are categorized as "budgetary allocations, which do not result in products" (Asignaciones Presupuestarias que no resultan en Productos (APNOP)). The public budget should reflect clearly identified activities, avoiding undefined pockets. A unified classification of programs which encompasses all health spending should help. This also requires a redevelopment of the budget classification in general. If large expenditures remain unidentified, the existence of a basis for deciding spending priorities would be questionable [31]. In addition, as noted earlier, the distinction between these categories in Peru's budget is not clear and at times, confusing.

The current programme structure does not support a system-wide approach and integrated care. The fragmentation in budget structure affects service provision. Providers are dealing with nine PPs that each have activities, products and results, covering 50% of health spending. In addition there are other health actions not included in PP which impose an additional administrative burden on providers [32]. This breaks the logic of integrated care provision established in the primary health care strategy and the model of care. Under its current design the programme structure does not promote people-centred care and is rather focused on specific health problems and populations, perpetuating fragmentation in the delivery of health services. In terms of the objectives, it induces planning to be done based on specific fragmented population groups and with no clear direction. Under the principles of universal health, the health system should guarantee equitable access to effective, comprehensive quality health care to the entire population focusing on strengthening the response capacity of the first level of care integrated within health service delivery networks, to attend the differentiated needs of the population.

The current budget structure does not support budget prioritization towards PEAS, which is a key step on the path to UHC in Peru [33]. In fact, the focus on (targeted) vertical programmes in the current programme classification makes it impossible to easily identify spending on PEAS. The vertical programmes such as nutrition, maternal and neonatal health, TB and HIV/AIDS, and cancer receive significantly higher priority in the current budget than PEAS. Approximately 40%[11] of the services covered by PEAS are not part of the PPs.

One of the key reasons for introducing programme budgeting is to allow managers to manage. According to the experts, PPs do not give greater autonomy for budget spending to the Pliegos and UEs. On the contrary, PpR scheme has been created to decrease discretionary spending and to give the MEF more control over budget execution. There are strict ex ante controls imposed by MEF: as described in Section II MEF approves very detailed quarterly allocation plans where each programme is broken down by product, which in turn is further divided by input lines (following economic classifications, e.g., personnel and social benefits, pensions and other social benefits, goods and services, etc.). Any shifts between these lines require a prior approval from MEF [14, 34, 35].

11 Information from preliminary results of the ongoing analysis by SIS.

7. POLICY RECOMMENDATIONS

Peru has made significant progress in shifting the focus of budgetary processes to reflect priorities based on results, but key challenges remain and should be addressed for the progress to continue. The paper provides some recommendations to support Peru, and particularly its health sector, in realizing its full potential when it comes to programme budgeting reforms.

Firstly, there is a need to shift away from a focus on specific population groups and diseases and enlarge the scope of PPs, moving towards a system-wide approach by combining activities for specific diseases into broader goal-oriented programmes. This would address the contradiction of the current PP structure with PEAS. The health budgetary programme structure should move to one that provides the incentives of comprehensive PHC actions with a strong component in prevention and promotion interventions. For example, programmes could address local health priorities organized into actions of promotion, prevention, recovery and rehabilitation in three types of target groups: individuals, families and communities. The continuity of care would be a logical consequence of this new scheme and would strengthen the conformation of health service networks and hospitals. It would also address the issue of fragmented flows and increased administrative burden to providers. It is not typically recommended to have programmes such that individual providers, particularly smaller ones, need to allocate their budgets across several programmes, which is currently required for health providers in Peru. Related to above, the programme classification should be revised to ensure similar activities are not allocated to different programmes (e.g. immunization activities).

Secondly, it is recommended to enhance spending flexibility within PPs. Programme budgeting as a form of performance budgeting means shifting the focus from compliance budgeting to results accountability. This is yet to happen in Peru. The current fragmented financial flow limits the accountability for the results. Post appropriation detailed ex ante controls currently imposed by MEF on programme managers should be lifted. While shifts between risky line items such as salaries and capital expenditures are understandable and are likely to remain at programme level, control over input lines at product level result in unnecessary rigidities.

Thirdly, Peru can advance further in its health financing reforms but the orientation on results in budgeting should also translate into output-oriented provider payment methods. Currently, public providers have little autonomy or incentives for improving efficiency and quality of care. Input-based payments dominant, and the public sector needs to gradually change to ensure that orientation on results permeates the entire system: from top to bottom.

Fourthly, the budget structure needs to be revisited and expenditures under AC and APNOP merged with PPs. Expenditures under the AC can be combined into an overall policy and management programme as it is typically recommended [22]. At least in the health sector, there is no clear difference between expenditures classified under APNOP and PP, and it appears that if budgetary programmes are less focused on specific diseases or populations, many of the expenditures under APNOP can be absorbed into programmes.

Fifthly, to enhance accountability for sector results programme managers should be appointed below the level of the DGIESP. DGIESP is currently responsible for eight out of nine budgetary programmes under MINSA. While DGIESP can continue providing strategic oversight of these programmes, technical managers at lower levels who are assigned to specific programmes can provide a more meaningful day-to-day engagement, including reviewing performance framework, analysing performance data, and managing budgets.

Finally, there is a need to strengthen the role of MINSA as a body setting national health policy and spending. As discussed before, because budgets are approved by pliego and each GORE is a separate pliego, MINSA's role in financing is limited: it does not have an overview of the entire health sector budget during the budget formulation and approval stages. Moreover, it does not have access to disaggregated data from SIGA, it can only access SIAF budget execution figures at the aggregate level, limiting its capacity to monitor results. Furthermore, programme budgeting seems to have limited its role in managing health sector budget as there are strict rules on reallocations across activities and inputs. While the technical manager for many of the health-related budgetary programmes is MINSA, it does not seem to have corresponding powers and capacity.

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ANNEX

LIST OF INTERVIEWS

Name	Position	Public Entity
Augusto Portocarrero	Former head of the General Office of Planning and Budget of the Ministry of Health	Ministry of Health - MINSA
Oscar Ugarte	Former Minister of Health	Ministry of Health - MINSA
Pedro Grillo	Former Chief of SIS and Former Deputy Minister of Health	Ministry of Health - MINSA and SIS
Leslie Zevallos	Former General Director of Health Interventions and Strategies	Ministry of Health -MINSA
Alfonso Gutiérrez	Current budget specialist of the Ministry of Economics and Finance	Ministry of Economy and Finances
Carlos Acosta	National Superintendent of Health	Susalud
José del Carmen	Former Chief of the Intangible Solidarity Fund in Health (Fondo Intangible Solidario en Salud – Fissal) Former Minister of Health	Fissal Ministry of Health - MINSA
Aldo Lama	Regional Health Manager of Callao	Regional government of Callao
Félix Palomo	Regional Health Manager of Lima*	Regional government of Lima*
Saraí Valdivia	Former specialist of PPR	Ministry of Health -MINSA
María Helena Saravia	Head of the General Office of Planning and Budget of the Ministry of Health	Ministry of Health -MINSA

Note: *The Metropolitan area of Lima is not included.

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