VIEWPOINT

Good Health Indicators are Not Enough: Lessons from COVID-19 in Peru

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Peru received international acclaim for being one of the first countries to implement a comprehensive package of measures to control the spread of the COVID-19 pandemic. The government imposed a general lockdown, combined with social protection measures—mainly cash transfers and the distribution of food parcels. This was an attempt to mitigate the impact of the lockdown, in a country where 70% of the population works in the informal sector.[1] Yet despite this, the transmission rate remained high, and as of early June Peru's COVID-19 mortality rates were amongst the highest worldwide.[2] The pandemic has shed a stark light on Peru's failure to guarantee the right to health and the limits of the tools used to assess the health system's performance.

Over the past two decades Peru has been praised for introducing a series of reforms aimed at achieving Universal Health Coverage (UHC), primarily through the expansion of health insurance across low-income groups. Nevertheless, reforms have failed to overcome the historical fragmentation of the system, where access to services is determined by income, gender, and geographical location. Peru has focused on key health indicators, such as neonatal mortality, reduction of under-5 mortality and the prevalence of stunting, and the adoption of management systems such as contracts that prioritise health indicators included in national poverty reduction policies.[3] However, the excessive focus on numerical targets rather than putting human rights at the centre of healthcare, has led to a system that overlooks significant vulnerabilities that have now been exposed, and even intensified, by COVID-19. Human rights-based imperatives, such as equality, acceptability, availability, accessibility, adaptability, and quality (known as the 'AAAAQ' criteria) are critical to the analysis of these vulnerabilities.

First, there are clear limitations regarding accessibility and adaptability that undermine state capacity to adequately respond to COVID-19. Despite steps towards UHC, the public system remains characterised by unequal distribution of resources and coverage between different sub-sectors of the system. The public health insurance plan (*Seguro Integral de Salud - SIS*) is targeted towards low-income users and it provides the lowest level of service coverage and has the least financial resourcing within the entire system.[4] The deeply embedded fragmentation of the system has severely constrained the government's response and quality of healthcare. The Ministry of Health (MoH) lacks a central information point so there is

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no real time information available about the level and status of equipment across the country, nor data on available beds or ventilators. Furthermore, the national prioritisation of certain health conditions and diseases, linked to global goals and national targets, has contributed to a health system that prioritises basic health packages that deliver on numerical targets. These packages provide essential care at primary health facilities, including preventive measures, such as antenatal checks, and cervical cancer and tuberculosis screening. However, a holistic approach to healthcare is missing, as is timely access to treatment, which results in poor health outcomes.[5] This focus has come at the expense of capacity to test and treat for any other health conditions, including novel ones such as COVID-19.

Second, Peruvian hospitals are constrained by limited health workers and unusable essential equipment. In 2017 the Office of the Comptroller General of the Republic, the central regulator, reviewed 251 secondary and tertiary level hospitals across the country. This revealed a precarious system in which 43% of the facilities lacked sufficient health workers to function effectively. Basic pathology, such as immunological, haematological, biochemical and other tests were not being performed by 42% of hospital laboratories, and the same percentage lacked the minimum equipment necessary for sample processing, delaying patient diagnoses. These failings had not been corrected prior to the pandemic. In April 2020, 36 mechanical ventilators and oxygen plants (25% of the public sector EsSalud's stock) were found in disrepair, contributing to the loss of many lives.[6] Urgent questions must be asked as to why and how these and other essential equipment were not functioning.

Third, the COVID-19 pandemic has brought attention to deep inequalities within the system, including gender and ethnic inequalities. Despite increased health coverage, out of pocket expenditure remains high and was increasing even before the pandemic.[7] Given the limited supplies of oxygen within public hospitals, relatives of COVID-19 patients have been forced to buy oxygen on the open market, paying high prices, and exacerbating the economic impact of the pandemic.

The inequalities exposed by COVID-19 draw attention to the Amazonian indigenous communities where basic sanitation conditions are limited and 60.8% lack access to a water pipeline or well.[8] At the time the first COVID-19 case was reported in Lima, Amazonian regions of Loreto and Ucayali were facing a dengue outbreak that had put health services under great stress. Yet the Ministry of Health did not issue specific regional guidelines. Nor did it assess the capacity of the health system to respond to the double burden of two outbreaks, and it did not reinforce information systems, including epidemiology surveillance, making it impossible to perform a rigorous analysis of the health needs of people in these regions. Indigenous organisations produced some information showing the speed of the infection at the community level. For example, by May 22 there were 40 confirmed COVID-19 cases among indigenous communities in Ucayali. The number increased to 773 by June 16.[9] Loreto and Ucayali, have the highest rates of COVID-19 (32.49% and 33.95% respectively) in the country (national average is 16.95 per cent).[10]

In conclusion, the early measures adopted by the Peruvian government to respond to COVID-19 must be analysed in the context of the structural shortcomings of the health system, which have been exacerbated by the pandemic. The global health agenda which prioritises progress on selected indicators, linked to global development goals, has come at the cost of a holistic, rights-based approach to healthcare in Peru. This analysis must contribute to an urgent review of the ideology that drives health indicators and is a renewed call to introduce human rights principles when designing and assessing health systems.[11]

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