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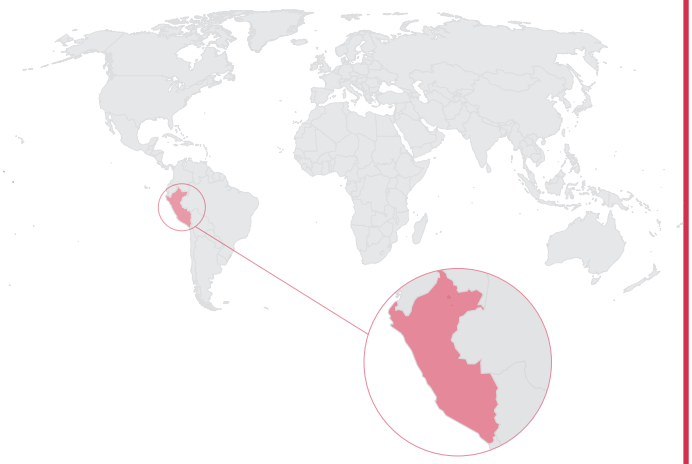
Peru



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The Health Care System in Peru

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Content

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1. Country overview (latest data available)

Source: https://ontheworldmap.com/peru/ (Accessed May 15, 2025)

- Sub-Region: South America
- Capital: Lima
- Official Language: Spanish and Indigenous languages
- Population size: 33,845,617 (in 2023)
- Share of rural population: 7,133,979 (in 2023)
- GDP: 267.6 billion (in 2023)
- Income group: Upper-middle (in 2023)
- Gini Index: 40.3 (in 2022)
- Colonial period: Former Spanish Colony, from 1533 until 1821 (288 years)

Source: World Bank 2024.

2. Selected health indicators

Indicator	Country	Global Average
Life expectancy (years)	73	72
Male life expectancy (years)	71.3	69.6
Female life expectancy (years)	75.5	75.5
Under-5 mortality rate (per 100,000 live births)	15	37.1
Maternal mortality rate (per 100,000 live births)	69 (2020)	223 (2020)
HIV prevalence (% ages 15-49)	0.4	0.7%
Incidence of tuberculosis (per 100,000 people)	153	134

Source: World Bank 2023, all data from 2022

3. Legal beginning of the system

Name and type of legal act	Law Decree Nº. 8124 created the Public Health, Labor and Social Welfare Ministry .
Date the law was passed	September 12th, 1935
Date of *de jure* implementation	October 05th, 1935
Brief summary of content	Through Law Decree Nº. 8124, the Public Health, Labor, and Social Welfare Ministry was created under the legal framework of the Public Salubrity Direction and the Sections of Labor and Indigenous Affairs. This ministry represented an attempt of the state to restructure and enhance efficiency within public administration. The main objective was to centralize, coordinate, and manage the country's public health and social welfare. Moreover, one of the leading purposes was implementing regulation, prevention, and health promotion as a priority. The ministry's mandate established the central objective of enhancing hygiene and occupational health conditions in industrial environments, particularly targeting high-risk sectors such as mining, manufacturing, and construction. The ministry´s foundation was strongly related to labor Law and social protection for workers, which is why syndicates and blue-collar movements exerted huge pressure to bring it to fruition. Improving sanitary conditions within Indigenous communities was also one of the priorities (Congreso Constituyente de Perú 1935). In 1942, through law Nº. 9679, the Labor and Indigenous Affairs areas were separated from the Health Ministry and transferred to both the Labor Ministry and the Justice Ministry (Congreso de la Republica Peruana 1942).
Socio-political context of introduction	Between 1935 and 1958, Peru was marked by intermittent economic growth, persistent social inequality, and a changing political environment. In the decade of 1930, Peru faced a deep economic crisis due to the Great Depression. However, in the next decade, the economy started to recover, driven by the demand for raw materials during World War II. Despite this economic growth, the inequality remained because this economic surge benefited only the elite, whilst most of the population that was based in rural areas lived under extreme poverty conditions. Social tensions increased due to the existent inequality, and the migratory process started from the departments (provinces) to Lima, the capital, looking for better employment opportunities. Authoritarian governors characterized this period. By the end of the 50s, a vast social mobilization, driven by working and student groups, demanded both improvement of life quality and the establishment of democratic policies. The political repression and social crises led to making health and social welfare the center of public debates, pushing the governments into considering reforms for sanitary public attention (Lazo-Gonzales, Alcalde-Rabanal, and Espinosa-Henao 2016).

Name and type of legal act	Law Nº. 8433 Creation of Mandatory Social Security
Date the law was passed	1935
Date of *de jure* implementation	August 12th, 1936

Brief summary of content	The Mandatory Social Security Law established the basis for social security in Peru. The law´s objective was to guarantee medical attention to formal employees. The main targeted social group was urban workers and employees of big companies, vastly disregarding rural areas and informal sectors. One of the main goals was to cover risks related to sickness, maternity, disability, old age, and death for the working class and their dependents, which is why it was known as Worker Insurance of Peru. Trade workers needed to be affiliated and make payments alongside their employees and the state. The National Treasury for Social Security was created to manage the funds and financial aspects of the Worker Insurance operations. This entity offered economic and medical aid in case of the aforementioned conditions. The list of services included medical attention, subsidies for sickness and maternity, disability and old-age pensions, and expenses for funeral procedures.
Socio-political context of introduction	The growth of the working-class movement and the labor conflicts in the first half of the XX century, mainly in the 1930s, held many protests, strikes, and demands for better working conditions. These events triggered several law proclamations, including the Law Nº. 8433 (Seguro Social Obligatorio, 1936). The demographic explosion in cities such as Lima, Callao, and Arequipa intensified problems in living conditions, health, and employment. Several precarious labor conditions were acknowledged, such as 12-hour working days, low wages, lack of social security, and nonexistent social benefits. The influence of socialist and anarchist ideas made syndicates adopt Marxist and anarchist ideologies, promoting the organization of the working class.

a. Organizational structure

The initial structure of the Public Health, Work and Social Provision Ministry was headed by the Ministerial Main Office (Despacho Ministerial), which was represented by the Minister, who oversaw the coordination and management of the whole sector. Five dependencies were created:

1) Public Health General Directory: oversaw actions derived from hygiene, prophylaxis, and sanitary surveillance. They also undertook environmental health, epidemic control, vaccination, and general salubrity activities.
2) Social Assistance General Directory: oversaw hospital supervision, health posts, orphanages, elderly homes, and other health facilities for the attention of the general population.
3) Social Provision and Work General Directory: oversaw social security attention, insurance sector, mutual funds, retirement funds, and labor relations
4) Hygiene Institute: oversaw health research, clinical trials, epidemiology, and the training of technical personnel.
5) Technical Committees or Consultation Groups: oversaw consulting services for the Minister in medical, sanitary, and social matters.

Table 1. Attention Coverage according to type of insurance

Percentage of population covered by government schemes	There is no statistical information of Attention coverage from that period
Percentage of population covered by social insurance schemes	
Percentage of population covered by private schemes	
Percentage of population uncovered	

b. Coverage

Despite the aforementioned efforts, in the decade of 1950, a big portion of the Peruvian population, especially those in rural areas and indigenous communities, lacked proper access to health services. The geographical barriers, the lack of infrastructure, and limited resources contributed to the disparities (Academia Peruana de Salud 2001).

c. Provision

Regrettably, no exact data is available about the total number of doctors and nurses in Peru during the 1930s. However, it is known that Lima had almost 70% of doctors and a big fraction of all available nurses. Rural areas had almost no access at all: a vast number of communities were treated by local medicine, community midwives, or missionaries (Carvallo 1939). Between 1935 and 1936, the number of doctors was estimated to be between 2,000 and 2,500. Moreover, the number of nurses ranged between 500 and 1,000 in the whole country, which meant a small number compared to the current population at the time of approximately 7 million. Universidad Nacional Mayor de San Marcos formed both doctors and nurses. These figures resulted in a ratio of 3.5 doctors and 1.42 nurses per 10,000 people ("Vista de Historia de La Enfermería En El Perú: Determinantes Sociales de Su Construcción En El Siglo XX | Aquichan," n.d.).

The attention was basically on symptom healing, which was offered in medical posts, hospitals located in Lima, and some departmental capitals. The hospitals at the time were Hospital Dos de Mayo, Hospital Arzobispo Loayza, Hospital Militar Central, and regional hospitals in Arequipa, Trujillo, and Cusco. The attention focused on treating and controlling tuberculosis, malaria, syphilis, leprosy, and other transmissible diseases. Also, vaccination services and hygiene campaigns were offered to prevent malaria and tuberculosis infections. The Hygiene Institute offered microbiological studies. There was no correlation between the offer and the demand for health services.

d. Financing

In 1935, it was reported that Peru spent 3,768 soles de oro, about 0.5 % of the GDP. Subsequently, in 1937, the GDP expenditure was 4,487 soles de oro, about 1% of the GDP in the health sector. The state made investments in infrastructure and public health programs, but an important dependence on private funds still remained, as well as the contributions of workers and employees to social insurance. Although public funds collection improved, the health system faced financial limitations that affected the quality and effective coverage of health services. A lack of resources for health attention was noticeable, especially in rural areas.

e. Regulation

Health regulation remained fragmented. During these years, efforts to establish norms to regulate public health services were oriented to ensure disease prevention, labor hygiene, food control, and urban Salubrity; however, the execution was inadequate. A uniform regulatory framework was missing, causing variations in health attention throughout the country. In 1961, the Law of Health Modernization was passed, intended to generate integration and coordination for the health system.

4. Subsequent historical development of public policy on health care

a. Major reform I

Name and type of legal act	Decentralization Basis Law Nº. 27783
Date the law was passed	January 2001
Date of *de jure* implementation	July 20th, 2002
Brief summary of content	Decentralization in Peru meant changes in all sectors of the country. In the case of the Health Ministry, it was recognized as the governing body of the whole national health system, granting normative supervision and regulatory functions. It proposed the progressive decentralization in the provision of health services under the management of regional and local governments. At the regional level, the Regional Health Directory (DIRESAs) was created to assume roles in planning, organizing, and managing public health services. Primary health facilities, regional hospitals, and public health programs are all under each DIRESA´s responsibility,

Brief summary of content (continued)	which all received independent budgets from the Economy and Finance Ministry. Each region had the power to prioritize the treatment of prevalent diseases, implement intercultural policies, and organize service networks according to the needs of each territory. Local governments (Municipalities) are given functions to manage community health, basic sanitation, promotion, and prevention of health. It was intended to implement committees of city surveillance for social control, but its kick-off was very deficient. Nevertheless, despite the efforts to develop decentralization in service delivery, inequalities increased. A major weakness was that decentralization was only implemented for those health services provided for the population without social security. The entities under the social security scheme proceeded with a different approach (Presidente La República, n.d.).
Population coverage	Approximately 20% of the Peruvian population is covered by Social Security Insurance (EsSalud), which includes formal workers and their dependents. The private health providers covered 2%; whereas the MINSA covered 60% of the population. It was estimated that 10-20% of the population did not receive any attention, especially the poorest (Alcalde Rabanal et al. 2019). Amidst this context, Integral Health Insurance (SIS) was created to widen the attention coverage to the most vulnerable sectors of the population, such as children under 5 years, pregnant women, and people living in extreme poverty conditions. In 2004, the population coverage in rural areas and hard-to-access zones to provide health services reached 20-25%.
Available benefits	The service portfolio offered varied benefits according to the type of insurance to which the population was affiliated. EsSalud offered total procedure coverage to its affiliated members, such as ambulatory attention, hospitalization, maternity care, chronic diseases, rehabilitation, therapies, and insurance against work-related accidents. Private Insurance offered general and specialist consultations, as well as hospitalization, without long waiting lists, varying in the acquired service package. SIS offered a basic service package to treat the most prevalent diseases and urgent care. It did not offer coverage for complicated illnesses such as advanced cancer, esthetic surgery, or long-term treatments of complex diseases. Its service portfolio offered general and specialist consultations at hospitals and facilities that belong to MINSA, emergency care, and hospitalization. Essential medicines were offered for disease treatment, childcare, infectious diseases, and chronic illnesses. For those non-affiliated, MINSA offered primary and emergency care, disease prevention and health promotion, mother and child care, mental health, and environment sanitation for rural areas; these were all offered at MINSA´s primary health facilities.
Socio-political context of introduction	Between 2001 and 2006, Peru was submerged in democratic reconstruction after the Fujimori's authoritarian administration regime weakened all state institutions due to rampant corruption within public entities. The constant social protests were always present. There were strikes and various syndicates marched (teachers, country people, and indigenous communities) against the neoliberal police of this period that widened social inclusion. For the first time, regional governors and their regional counseling committees were elected as a part of the kick-off of the country's decentralization initiatives. After the crisis of the 90s, between 2002 and 2004, the Peruvian economy started to improve with a GDP increase of 5%, which was linked to the mining of precious metals, that in the end, caused serious socio-environmental conflicts between the private companies and the local and indigenous communities. The Central Reserve Bank kept yearly inflation under 2.5%. Despite this economic growth, poverty affected over 50% of the population. Unemployment, and underemployment were very high, and the informal working regimes reached 60%. Poverty affected mainly rural areas where high levels of malnutrition, illiteracy, and lack of access to basic services such as drinkable water, sanitation, and health services were always present (Informática 2008).

b. Major reform II

Name and type of legal act	Universal Health Insurance Law (Ley de Aseguramiento Universal en Salud – LAUS) – Law Nº29344
Date the law was passed	Proyecto de Ley N.º 786/2006-CR. Presentando al Congreso 3 de noviembre de 2006
Date of *de jure* implementation	April 08th, 2009

Brief summary of content	This law aims to ensure that everyone can access health insurance and preventive, promotional, rehabilitative, and recovery health services. The LAUS is based on the following principles: universality, solidarity, unity, integrality, equity, irreversibility, and participation. The LAUS establishes the regulatory framework for universal health insurance, and regulates health services' access, financing, provision, and supervision (Congreso de la Republica 2009).
Population coverage	Health coverage increased in a very significant way, with approximately 65% of the whole Peruvian population having some type of health insurance (Mezones-Holguín et al. 2019). SIS covered around 34% of the population, which was also people unable to pay for this coverage. EsSalud covered 22.8% of workers with formal employment and their dependents, and the 8.2% missing corresponded to private insurance, armed forces and national police (Superintendencia Nacional de Aseguramiento En Salud, n.d.) and 35% of the population did not have any access to health service attention.
Available benefits	The SIS established an essential plan for health insurance called PEAS that contains an updated list of insurable conditions, procedures, and financial benefits. The list included coverage for 140 health conditions that made up an estimated 65% of the disease load of the country, which included transmissible, non-transmissible, and mental health diseases (Gobierno de Perú 2021). Attention was offered to all three attention levels and included a medicines coverage that was considered in the Petitorio Nacional Unico de Medicamentos Esenciales (Essential Medicines Single National Petition). Additionally, the Solidarity Health Intangible Fund was created to finance high-cost diseases that the PEAS did not cover (Velásquez, Suarez, and Nepo-Linares, n.d.). However, this package was suspended by Chief Resolution N.° 105-2023-SIS/J in May 2023 until the end of the sanitary emergency. The PEAS contemplates care for: prevention, ambulatory treatment, hospital-related events (medical consultations, hospitalization, surgery, and emergencies), transmissible and non-transmissible diseases, mother-child health, mental health (depression and anxiety), medicines, laboratory tests, and diagnostics. It also covers transportation up to 1,000 Peruvian Soles in reimbursement associated with death events (Gobierno del Perú 2024).
Introduction to Socio-Political context	There was a steep economic growth that reached between 8.5 and 9 % of the yearly GDP because of the international high demand for minerals, cautious fiscal policies, and a solid macroeconomic setting, which led Peru to resist the global 2008 crisis (Instituto Nacional de Estadística, n.d.). Despite this economic growth, poverty and social exclusion intensified in Andean rural areas. Between 30 and 36% of the population lived in poverty. Moreover, socio-environmental conflicts involving both the mining and hydrocarbon sectors, as well as tensions between private companies and communities persisted. The liberal policies and extraction economic activities intensified, and executive and legislative decrees were enacted to facilitate foreign investment, often bypassing the need for consultation indigenous communities, which generated more protests, causing dozens of deaths in the fights between the police and the indigenous population (Meléndez and León 2010). Even though the country had macroeconomic stability, structural problems in public sectors persisted. High presence of corruption and very limited state presence in rural areas were always major obstacles. Peru signed a Free Trade Agreement with the USA and was an active party in the regional forums of UNASUR and the Andean Community.

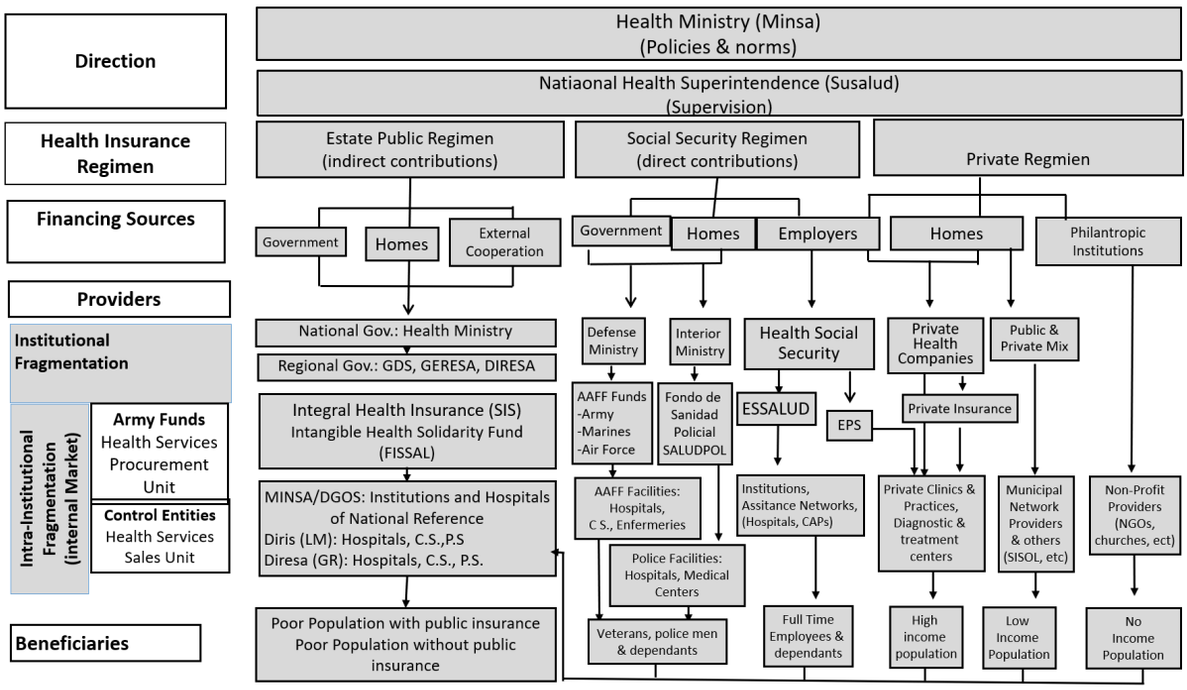
5. Description of current health care system

a. Organizational structure

The healthcare system in Peru is the result of a complex and multifaceted evolution where various structures have coexisted. The Ministry of Health (MINSA) conducts, regulates, and promotes the intervention of the National Health System (Ministerio de Salud 2002). Meanwhile, the private sector operates on a market logic, often aiming to cover segments of the population that can afford specialized and/or quicker services (Elizabeth Alcalde-Rabanal, Lazo-González, and Nigenda 2011). Health insurance has three modalities to provide health services:

- The Indirect Contributory Regime (subsidized) is funded by fiscal resources, household contributions, and occasional donations from intergovernmental cooperation.
- The Direct Contributory Regime is financed through direct and mandatory employer contributions. It includes the Social Health Security System (the Social Health Insurance (EsSalud) and the Defense Ministry (MINDEF) and private social insurance.

Figure 1. Structure of the Health System in Peru



Source: Adapted from Lazo-Gonzales, Alcalde-Rabanal, y Espinosa-Henao (2016)

» The Private Regime is financed by families (out-of-pocket expenses) through direct payment of professional fees or by purchasing private insurance plans (insurance companies, self-insurance, and prepaid plans) (Alcalde-Rabanal et al. 2019).

People without social security received attention in the network of regional facilities and national hospitals that belong to MINSA. Social security beneficiaries received services within EsSalud's network of attention centers. Each of the three military branches and the national police have their own healthcare service networks. A network of private health services exists in the private sector, highly concentrated in the country's main regions.

Currently, there are 25 Health Regional Directorates ("Ley Del Sistema Nacional Coordinado y Descentralizado de Salud," n.d.) who are responsible for managing health services in their respective areas, although under the policies and regulations set by MINSA. Each regional government organized a Regional Health Directorate (DIRESA) for management purposes. Metropolitan Lima was an exception, and for this region, the Institute for Health Service Management (IGSS) was created as a decentralized agency of MINSA.

It is worth mentioning that, although it is not a part of the organization of the health system, there is an entity called "Defensoria del Pueblo" (Ombudsman Office), which has the role of supervising and protecting people's health right, ensuring that the population receives opportune, accessible, and quality attention. This state entity has proposed improvements in the distribution of medicines, reduced waiting time, and priority attention to severe illnesses. Its main tasks are:

1) Supervision of the Health System: it evaluates hospitals, ESSALUD and MINSA to detect deficiencies.
2) Complaint Attention: It receives and manages the complaints about lack of medicines, delays in attention, and bad procedures.
3) Protection of Vulnerable Communities: It defends health access for children, elderly people, and indigenous communities.
4) Public Policies Overseeing: It watches the execution of health programs and proposes improvements.
5) Evaluation of the response against sanitary emergencies: It evaluates the country's preparation against pandemics and natural disasters.

To improve attention coverage, the Redes Integradas de Salud (RIS) (Integrated Health Networks) were implemented, constituting an organizational model of the health system to improve accessibility, quality, and efficiency for providing health services, especially in the first level of attention. In 2018, Law N°30885 was passed, which established the formation and operation of the RIS (Cosavalente-Vidarte et al. 2019). In 2020, by Supreme Decree N°019-2020-SA, the set of rules of the Law N°30885 was accepted. In 2021, MINSA approved the "National Plan of Formation of Integrated Health Networks" by Ministry Resolution N° 969-2021-MINSA. For its implementation, the Integrated Health Networks Creation Program (PCRIS) was established to reorganize the entities that provided health services to the networks, improving their resolution capabilities, and strengthening the support of medical services (Llanos Zavalaga et al. 2020).

b. Coverage (principal health insurance)

Percentage of population covered by government schemes	60.7% (SIS)
Percentage of population covered by social insurance schemes	25.3% (EsSalud)
Percentage of population covered by private 9schemes	3.8%
Percentage of population uncovered	10.1%

Source: World Bank 2022

By 2022, approximately 86% of the population was enrolled in a health insurance scheme, regardless of the type of coverage. The population affiliated at the SIS was 60.7% (54.5% urban, 85.3% rural). EsSalud, covered 25.3% of the population (25.5% urban, 5.9% rural), and private schemes covered 3.8%. The Universal Health Coverage Index went from 40% to 78% between 2000 and 2019, and in 2021 it decreased to 71%. (World Health Organization 2023)

c. Provision

The offering of health services is carried out within the health units of each institution. Ambulatory attention is given mainly in primary health facilities (health centers and health posts). More complex attention is provided at the hospital level and National Institutes. The second and third attention-level hospitals (Category II and III) are concentrated in metropolitan Lima (Ministerio de Salud - 2023). In 2022, 24,729 active units providing services were counted, of which 61,2% belong to the private sector, 32.9% to MINSA, 1.8% to regional governments, and 1.6% to EsSalud. Of the total units, 76.1% are primary health facilities, 2.1% are second attention level, and 0.2% are third attention level. Of the total units, 2.6% are hospitals and national institutes (20 National Institutes), 10.6% are health centers, 35.9% are health posts, and the remaining percentage are private medical practices. In 2020, 98.8% of MINSA´s establishments of the first attention level and 97.5% of their hospitals had inadequate

Table 2. Beds and Medical Devices Availability 2022

Infrastructure (by 10,000 inhabitants)	No	%
Hospital Beds	53,380	16.0
Hospital Beds (private sector)	37,000	11.1
Intensive Care Units	3,300	0.99
Medical Devices (by million /inhabitants)		
Mammogram	60	1.79
Computarized Tomograph	80	2.38
MRI Machines	35	1.05
Radio therapy equipment	40	1.20

Source: Data from the *Reunión de Dirección General de Monitoreo y Evaluación de la Gestión.* Source: Ministerio de Salud del Perú n.d.

installed capacities, according to the technical norms (precarious infrastructure, obsolete/inoperative/insufficient equipment). A gap of 1,791 primary health facilities and 156 hospitals have been estimated to achieve optimal coverage.

The density of the health workforce (including doctors, nurses, and obstetricians) is 41.7 per 10,000 inhabitants at the national level. However, in 28% of provinces, this density drops to 25 per 10,000. Disaggregated by profession, there are 15.83 doctors, 19.94 nurses, and 6.0 obstetricians per 10,000 inhabitants.

Although the number of hospital beds has increased in recent years—from 41,824 in 2003 to 51,781 in 2019—the national ratio remains at 15.9 beds per 10,000, which is below the WHO recommendation of 24 to 40 per 10,000. Significant disparities persist at the regional level, with only 10.3 beds per 10,000 inhabitants in regions such as Huancavelica and Loreto, compared to 24.3 in Moquegua.

SIS offers health attention within the service network of the Health Ministry and cares for Peruvian citizens, residents with valid migratory status, people in poverty, pregnant women, children under 5, firefighters, people in abandonment situations, employees of small/micro companies and their relatives, and independent workers under specific tributary schemes (Gobierno de Perú 2024). SIS offers coverage for more than 1400 medical diagnostics (including various types of cancer), medicines, medical procedures, surgeries, medical supplies, emergency transportation, and funeral arrangements. However, it is often characterized by incomplete coverage, insufficient funding, shortage of medicines, corruption, and bad management (Alcalde Rabanal et al. 2019).

EsSalud offers health attention services within its own service network and cares for full-time employees of all economic activities and their dependents, including citizens and formal residents, pensioners, and independent workers under specific tributary schemes (EsSalud 2012). EsSalud offers total coverage in attention services but faces deficient infrastructure and equipment, long waiting lists, shortage of medicines, insufficient funding, bad management, and inadequate interoperability among its units (Pereyra Colchado 2022).

EPS (Entidad Prestadora de Salud – Health Care Entity) cares for full-time employees of all economic activities and their dependents, including citizens and formal residents, whereas private insurance companies offer the provision of health services and are carried out by private institutions. Although these EPS sometimes sub-contract SIS or EsSalud for highly skilled procedures or highly complicated treatments.

The defense ministry cares for army, marine, and air force personnel, their families, and dependents in its own service network. It delivers a universal range of health services

d. Financing

In 2023, public health expenditure in Peru was 30.6 billion soles, representing around 60% of the country's total health spending. Private health expenditure reached 21.3 billion soles, bringing total health expenditure up to 51.9 billion soles. Overall, health spending represented 6% of the national GDP, a proportion similar to that of 2021.

Indicators	2021
Total current health expenditure (in million US$)**	13898
Total health expenditure (% of GDP)*	6.1
Public health expenditure (% of total health expenditure)*	64.8
Private health expenditure (% of total health expenditure)*	34.9
Total health expenditure per capita (US$)*	855.8
Public health expenditure per capita (US$)*	555
Private health expenditure per capita (US$)*	298.7
Out-of-pocket expenditure (% of total health expenditure)*	27.2
Households falling into deeper poverty due to out-of-pocket expenses (%)*	7.5
Households with catastrophic health expenditure (%)*	13

Source: *World Bank Open Data, 2024; **World Health Organization (WHO) Global Health Expenditure Database, 2024

e. Regulation

By law, the health ministry works as the governing authority of the national health system; therefore, it is the one in charge of designing and implementing all health sector policies within the country. However, this role is weak and lacks legitimacy within EsSalud and the Defense Ministry. Its norms are only implemented in its own MINSA units.

EsSalud operates under the rules of the Labor and Employment Promotion Ministry – MTPE (Ministerio de Trabajo y Promoción del Empleo). Theoretically, it follows the guidelines set by MINSA, but it operates under its own discretion.

The National Health Superintendency (SUSALUD) is responsible for protecting health rights, overseeing the quality of services, and guaranteeing that public and private institutions comply with already established norms. The General Health Directorate (DIGESA), which operates under MINSA by regulating compliance with food and drug policies, as well as issuing and monitoring sanitary norms.

Peruvian Colleges (Medical, Nurse, Dentist, among others.) operate as licensing institutions that grant working permits and regulate and control their correspondent health professionals.

6. Role of global actors

Global institutions from the international cooperation focused their efforts on the improvement of hospital infrastructure, provision of medicines, technical assistance and training, emergency response, and programs against infectious diseases in programs for public health (Ministerio de Salud 2024). The resource funneling is done via loans or donations. In the case of the World Bank, the loans are conditioned to be used before the implementation of suggested policies that are negotiated by this entity

The global actors with more presence in Peru are the World Bank, USAID, Global Fund, OPS/OMS, JICA, BID, PNUD, The Church, and other international donors that have focused their attention on Social Security for the most vulnerable portions of the population.

7. List of additional relevant legal acts

1) The Law N. º 27056 (January 30, 1999), created Health Social Insurance (EsSalud).
2) The General Heath Low N. º 26842 (1997).
3) The Free School Insurance (1997). Supreme Decree N. º 004-97-SA.
4) The Maternal and Child Health Insurance (1997). Ministerial Resolution N. º 573-97-SA.
5) The Comprehensive Health Insurance (Seguro Integral de Salud, 2002). Supreme Decree N. º 009-2002-SA.
6) The National Plan for Strengthening Primary Health Care 2011-2021.

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