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Access to health care among marginal groups in Lima, Perú

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ABSTRACT

In the World 400 million people do not have access to essential health services.

The rapid growth rate of the population and increasing urbanization calls for an analysis of the perceived access to health care services and the types of services offered to the low-income strata of the population in heavily urbanized area of developing countries.

As an example of this, the work described in this thesis focuses on the marginal-urban area in Lima, in Perú. This is a qualitative interview-based study of 25 individuals selected as for performing informal sporadic jobs, poor and extremely poor, and living in marginalized urban areas of Lima.

The aim of this study is to understand the specific right that these individuals perceive in terms of accessing the heath care service and the challenges and barriers encountered.

The main findings of this thesis are:

a) Despite the socio-economic status of the strata of the population analysed, they have access to public health care services.
b) The quality and type of health care services they have access to is however, poor and unequal in the sense that it requires engagements and unforeseen out-of-pocket payments for certain services.
c) The improvements foreseen by the reforms to the health care service in Perú has not brought a perceivable effect on the effective access to health care for the poorest.

In conclusion, this work highlights the challenges of the population to effectively access the health care services offered in Perú, and pinpoints new polices the government should undertake in order to solve these challenges.

LIST OF ABBREVIATIONS

CBHI: Community-Based Health Schemes

CENSI: Executive Direction of Complementary and Alternative Medicine

CHE: Catastrophic health expenditure

DIRIS: Dirección de Redes Integradas de Salud (Directorate of Integrated Health Networks)

DNI: National Document of Identity

ENAHO: National Household Survey

EsSalud: Seguro Social de Salud (Social health insurance)

FFAA/FFPP: police, army, air force or navy

INEI: National Household Survey

INS: National Institute of Health

MDL: Ministry of Internal Affairs.

MDT: Ministry of Labor

MINSA: Ministry of Health

MINJUS: Ministry of Justice

NRUS: New Simplified Single Regime

NSD: Norwegian Center Data.

OOPs: Out-of-pocket payments

OECD: Organization for Economic Cooperation and Development.

PEAS: prioritized list of insurable conditions and interventions

PGH: General Household Register

SERUMS: Rural Internship Programs)

SISFOH: Household Targeting System

SUNAT: National Superintendence of Tax Administration

SuSalud: Superintendecia Nacional de Salud (National Super Intendence of Health)

UDR: Decentralized Regional Units

UHC: Universal Health Coverage

ULE: Local Registration Unit.

UNFV: National University Federico Villarreal

WHO: World Health Organization

SIS: Seguro Integral de Salud (Comprehensive health insurance)

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Chapter 1: INTRODUCTION

There is a vast majority of the population in the globe that lack proper access to health care services. According to the report by WHO in 2017, worldwide access to essential health services is increasing. However, “400 million people do not have access to essential health services” (WHO 2015).

Lack of proper health care is both a rural and an urban problem. This thesis will focus on the situation on the urban sector. Urbanization has increased rapidly and exponentially in the last decades; most of the world’s population now live in cities (Cotlear 2006). In 2018, “55% of the world’s population live in urban areas, a proportion that is expected to increase to 68% by 2050” (UNITED NATIONS 2018).

Urbanization growth has been particularly fast among middle and low-income countries. Such expansion threatens to overburden the administrative capacities of the State.

Perú, like many other countries in Latin America, has “experienced an increase in population growth and a tendency toward urbanization” (Cotlear 2006, 116).

The importance of securing sufficient level of quality in the health services of urban marginal areas is of the outmost importance. Although, access to health care is a problem that is more dire in remote areas of Perú, particularly among the indigenous population groups, the situation among marginal groups in the rapidly growing cities is worthy of attention; the urban poor may (relatively speaking) have better access than people in remote rural areas, but there are many more of them, and the pollution effects of eventual diseases on the health situation of others may be more widespread.

Fast population and urbanization growth pose a threat for the vulnerable groups, especially the poor. It is increasingly important to consider them because this groups are also a rapidly growing segment of the population.

Thus, in the search for equality, their larger size in proportion compared to the rest of the population implies that their needs will also increase. More importantly, diseases have historically spread more easily in urban areas, simply because people tend to live closer together. To make matters worse, citizens with marginal resources often live in areas that despite being part of the city, have insufficient infrastructure and where sanitation is inadequate.

The largest and fastest growing urban area in Perú is Lima, hence the choice of city. This important growth can be attributed mainly to internal migration; people from rural areas move to urban areas, and particularly to the capital city of Lima. At the same time, Lima has seen an important increase of its poverty rate and it is the region with most disparity of access to care services. (Cotlear 2006).

The Peruvian government has taken measures intended to reduce inequality. The most important expansions in the health sector, take place mostly in rural, peri-urban and remote areas (Cotlear 2006). According to the National Household Survey (ENAHO) from 2015, coverage in rural areas is higher than it is in urban areas. This data matches with the report from the Organization for Economic Cooperation and Development (OECD) 2017, which shows that 30 percentage of the urban population lacks insurance coverage, while in the rural area this number is just above 20 percentage (OECD 2017b, 40). This may be thanks to SIS' efforts to cover the most vulnerable population, which are considered to typically live in rural areas. Moreover, affiliations to health insurance schemes are higher in quantity among the extremely poor and poor, than they are among the non-poor (ENAHO 2015), that do not live in rural areas necessarily.

Moreover, according to the ENAHO in 2015, 70 percent of the population in Lima are insured to some type of health insurance scheme whilst in Apurimac this percentage is 90,6. Of those insured in Lima, 25,6 percent belong to Seguro Integral de Salud (SIS; comprehensive health insurance) scheme in Lima, while in Apurimac this percentage is as high as 76,8 percent. This speaks for the ability of different cities to be able to implement these services.

The aim of this study is to identify the barriers and/or challenges faced by population from marginal urban areas when they access effective health care services. Based on the ever-increasing importance of urban poverty in middle-income in Lima the focus has been put on this city.

Therefore, the main research question in the thesis are:

-How can access to health care for marginalized urban groups be conceptualized and investigated?

-What are the perceived problems by these groups to access health care services?

Marginal-urban districts are characteristically composed by migrants, mostly internal migrants, informal workers, poor and extremely poor population. The cost of life in these districts tends to lower and therefore, more affordable for the poor than in other districts. Lima, just like other capitals in the world, is an expensive city and this is the main reason why these groups tend to cluster in districts considered marginals and they can be studied together with the population that has neither any sort of health insurance nor they belong to SIS scheme.

The district of Carabayllo is very representative of such case. It has been labelled as a marginalized-urban district and has also experienced a rapid increase in its population rate and this pattern is expected to continue. The district is also one of the poorest of Lima (Rodriguez 2017), 23,15% of the population in Carabayllo is poor (DIRIS 2018, 36) and unemployment and underemployment rates are relatively high (Rodriguez 2017). Therefore, this is the reason for choosing the sample groups in this district.

A case study of "access" to health care among marginal groups in Lima is potentially relevant also for a broader audience that is concerned with research on access to health care in other countries that also experience rapid urbanization.

My motivation

My motivation for this case study based on Perú, is my concern with equality in regard to access to health services. Every citizen should have the same opportunity and should be able to receive proper care in my opinion. I am very invested in the environmental and social landscape of Perú, because it is a setting I know well, and I deeply care about. The negative effects on the quality of life of millions are at bay. It is the norm that the most economically vulnerable suffer the most.

Moreover, Perú is a fast-growing economy that has recently acquired the status of middle-income country. Economic growth usually attracts urbanization, and in that respect, Perú is no different to other middle-income countries in the world.

I believe it is more than relevant to observe and study all the possible obstacles that may prevent people from proper access to health care services, only then can governments be able to tackle these problems and ensure equality in a world where economic reasons are usually the gap that separates healthy individuals and those who cannot afford to access the bare basic health care. Most importantly, patients who need and seek medical attention should feel that health institutions are providing a service for them, and not some favor. It will be discussed later that many patients feel shame, are shunt by personnel and may also feel frustrated when they try to fulfill their need of health care. This should not be the case, patients should be treated with respect and dignity in health centers as opposed to feeling discriminated, mistreated, etc. Access to health care is a right and adequate access to health care services is an act of justice, which should not be reserved for the wealthy.

Chapter 2: LITERATURE REVIEW.

Definitions of access are introduced, first in general context and then applied as access in health care services. In order to improve the definitions, a literature review was necessary, I performed this with the help of Oria and Google Scholar. First, I will describe how health care has been defined by different authors; and the theoretical approach of access that I have chosen to answer on the research question. Later, I will explain the relationship between access in health care and heal insurance coverage and the benefits offered by the different health insurance schemes. Risk protection meaning and how risk can be measured. Later, the relationship between health care access and the quality of health care services and how quality can be quantified. In short, this chapter will explain how access is related to health systems, health insurance and health services.

2.1. Access as an aspect of a broader health care "system"

The world health organization defines a health system as "all actors, institutions and resources that undertake health actions" (WHO, Skolnik 2012, 88). These actions are addressed to improve people's health.

Health systems have many different goals, functions and tasks. The provision of health services, ruled by horizontal equity, is its primary goal (Glorioso 2014). Horizontal equity "is considered as a key indicator of the performance of any health care system" (Allin, Hernandez-Quevedo and Masseria 2009) (Glorioso 2014, 951).

Other goals are to provide "good health, responsiveness sufficient to the expectations of the population, and fairness of financial contribution" (Skolnik 2012, 89). Among the functions of health systems are the "provision of health services, raise money for health, and finance health services" (Skolnik 2012, 88).

Health systems play a role in the proper delivery of health services, proper training of health care human resources, effectiveness assurance of health information systems, quality and affordability of health care materials, such as drugs and equipment. They must also provide enough financial resources to protect individuals from economic harm (Skolnik 2012, 89).

When health systems fulfil their role, improvement of equality, outcome, financial protection, among others, are more likely to be achieved. When these goals are achieved, a health system can be labelled as effective.

In contrast, a health system is considered inefficient, when its population lacks access to health services. It can be stablished that the quality of health care systems is measured by lack of access and the waiting period to receive health care (Pereira 2014). Health systems are also formed by "interdependent parts", which can be public, private, for-profit, or private, not-for-profit (Skolnik 2012, 88).

According to the definition of the World Health Organization, Universal Health Coverage (UHC) is the assurance of access to health services in its different levels, whether in the level of promotion, prevention, curing or rehabilitation (WHO 2013b). An important aspect of UHC is that access to these services should have sufficient quality, and not cause financial hardship. The goal

of UHC is “to ensure that everyone can use the health services they need without risk of financial ruin or impoverishment” (WHO 2013b, 5).

To achieve this goal, “is necessary to eliminate the gap between the poorest and the richest” (WHO 2013b, 7), and offer health services that are “available, affordable, efficient and have good quality” (WHO 2013b, 7). In recent years, governments worldwide have been developing their health systems around this goal. A possible reason might be that different studies have shown that a healthy population is a productive population (Bloom and Canning 2008). A more productive population contributes to the economic growth of a country. Proper identification of which health services are needed, and how to make sure they are universally available, affordable, efficient and of good quality is also a task that belongs to governments.

“The concept of UHC is represented in three dimensions: the health services that are needed, the number of people that need them, and the costs to whoever must pay – users and third-party funders”. (WHO 2013b, 6)

It is important to point out that universal health coverage is a way to express “concern for equity and for honoring everyone’s right to health” (WHO 2013b, 5), which is recognized as a human and basic right.

Achievement of UHC is so relevant that it is included as one of the 17 sustainable development goals, 3.8. It is also the “key to achieving the World Bank Group’s twin goals of ending extreme poverty and increasing equity and shared prosperity (World Bank 2019).

Due to its importance, different global organizations are combining efforts to achieve UHC. In the first chapter of the World Health Report 2010, regarding the importance of research for UHC, they focus on identifying which questions are necessary to answer in order to accelerate the achievement of universal health coverage. Among other questions, they highlight the relevance of improving financial risk protection and the “measurement of the indicators for financial risk protection and its monitoring” (WHO 2010, 21).

2.2 Theoretical definitions of access to health care

Access has an etymological definition, however, that definition in the health setting varies among different authors. The variation of its definition can be because authors have not agreed on which

dimensions should be included in the concept of access, and whether the description of providers features should receive more emphasis than the actual process. (Levesque, Harris and Russell 2013, 1).

As a result of lack of a strict theoretical definition of access in a health care context, the measurement of access represents a challenge. “The current frameworks look at access as person-based and do not capture the complexity of the health care system and the complex structures involved in managed care organizations” (Gold 1998, 625).

Some previous studies have tackled “issues surrounding access and need” (Shengelia 2005, 98). In the study of access, utilization, quality, and effective coverage: authors have focused on a framework that tackles two themes: access and need, although in another studies access is explained independently.

A central idea has been to analyze factors from the supplier’s point of view while removing deviations in utilization attributed exclusively to individual choices other than those linked to income or socioeconomic status. One definition sees access as an “attribute of health services”. Thus, when people require care these services should be accessible. (Levesque, Harris and Russell 2013, 1). Others stress that the “characteristics of users, and providers”, and health care need is the focus. Yet other focuses on these two characteristics plus the characteristics of health care resources.

Others make a differentiation between “realized access and potential access” (Golden 1998, 633). *Realized access* is about use and level of satisfaction by the user, while *potential access* refers to predisposition and “availability and organization of health care services” (Gold 1998, 633). These approaches have as concern the “outcomes of utilization” (Gold 1998, 633), and the effectiveness and efficiency of access. This is because both approaches have an impact in the user, both by improving the “health or satisfaction” (Gold 1998, 633) of the users through effective access, and by producing “gains in outcomes for each unit of use” by efficient access. For both of these approaches, indicators to measure access are strongly related to the outcome.

Several authors have different definitions about access. Levesque 2013 sums up previous research by defining access as the “opportunity to reach and obtain appropriate care in situations of perceived need for care” satisfying all the levels to meet the service (Levesque, Harris and Russell 2013, 4). This definition of access includes not just the idea of obtaining health care

services but, and likely more important, also the satisfaction of the client in each step before reach of access. The lack of satisfaction in any of the steps can reveal where various barriers to access health care are located.

The utilization of services will be influenced by the characteristics of the provider, in the sense that providers offer services that are simple to access, but also by the characteristics of the individual. For instance, a person with a low level of education might experience more barriers to access care, in comparison with a person with a higher level of education. Although health services may formally be easy to access, it does not guarantee that a population will know of their existence or would search for them.

Apart from considering a client's satisfaction, Levesque sees access in different domains, such as Narrow, Intermediate and Broader:

> "A ***narrow domain*** sees access as pertaining to a restricted part of the health care seeking process often starting from the search for care and continuing to the initiation of care. An ***intermediate domain*** adds the continuing care aspects in the evaluation (access does not pertain to the first contact only but is relevant each time a person tries to access a source of care). In addition, access to some services may be contingent on use of other services (e.g. use of primary care providers or case managers in order to access specialist or allied health professional care). A ***broader domain*** includes the delay between the desire for care and the actual search for care (including aspects such as trust in and expectation towards the health care system, health literacy, knowledge about services and their usefulness)" (Levesque, Harris and Russell 2013, 4-5)

Levesque et.al. end by conceptualizing five dimensions of accessibility: Approachability, availability and accommodation, affordability and appropriateness (Levesque, Harris and Russell 2013, 5). Levesque sums up the various dimensions of access in Fig 1. This is paralleled by five dimensions of health seeking on the demanding side: Ability to perceive, to seek, to reach, to pay, and to engage with health care providers.

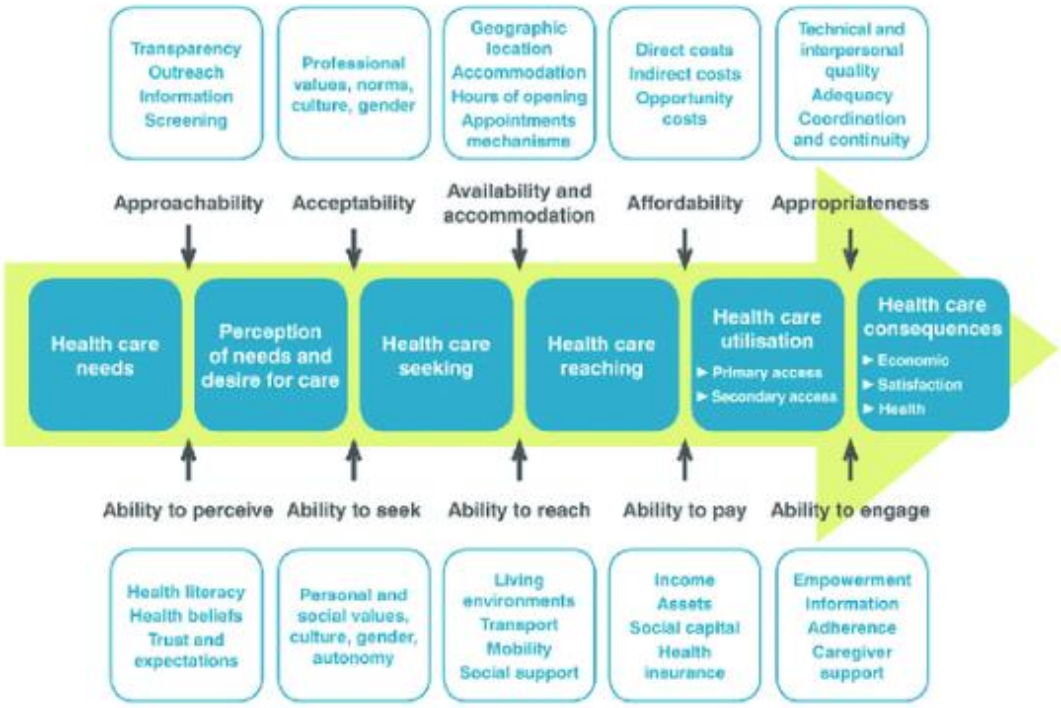


Figure 1 Access to health care. From Levesque et.al. (2013)

This theoretical framework defines access to health care services as the opportunity to fulfill the health care needs of an individual from the moment the user identifies their need for health care to the moment the user satisfies this need. The theoretical framework includes five dimensions. These dimensions represent the steps the users go through in order to reach access to health care services.

This way to conceptualize access has its origin in the "behavioral model" (Gold 1998, 633). This "model suggested that peoples used of health care is a function of their predisposition and their need for care" (Gold 1998, 633).

I will use this theoretical framework as a starting point to answer the research question stated in the Introduction: ***How can access to health care for marginalized urban groups can be conceptualized and investigated, and what are perceived problems to access among such groups?***

In addition to this framework, I consider it pertinent to further expand on what Goddard states about which features services should offer. health care services must have a certain "level of quality, of personal convenience and cost, and of information" (Goddard and Smith 2001, 1152).

I will take this framework as a starting point in the empirical part of the thesis. First, however, it is necessary to sort out the relationship between health insurance coverage and access to actual health services (health care).

2.3. The relationship between health care access and health insurance coverage

The definition of access is certainly linked to economic aspects. Therefore, first, it is necessary to sort out the relationship between health insurance coverage and access to actual health services.

health insurance coverage means to be "protected against the financial uncertainty associated with the need to use health services and pay for them" (Saksena 2014, 3). "health insurance is considered and promoted as the major financing mechanism to improve access to health services and provide financial risk protection" (Wang et al. 2010, 33), and the form to achieve UHC, the lack of such coverage can lead in adverse consequences.

health insurance has different financing and management systems. They can be public, private and or a combination of both. Their purpose is similar however, to let households whose higher risk and most vulnerability would not normally afford health care.

In Levesque et.al.'s model (Figure 1), health insurance coverage is related to dimension 4 (Ability to pay) on the demand side, and the corresponding dimension 4 (Affordability) on the supply side.

Financial hardship can be exacerbated by numerous factors, such as the number of family members, and/or its composition, the level of education of the members of the household, ethnicity, the location of the household, who is the breadwinner for the home, and whether a family member suffers from chronic illness.

Households should not be put in the situation where they have to choose between access to health care services or they should cover other financial burdens; households should be guaranteed they would not end up in poverty because of health expenditure.

Globally, out of pocket (OOP) health care financing can mean bankruptcy for households that have not enough funds to pay for health care services. However, OOP is still the most common way of "finance health" in the world (Saksena, Millett and Smith 2014, 1), and it is responsible for "adverse financial consequences" (Saksena, Millett and Smith 2014, 1) in many households. health insurance coverage is also one element in the package of measures that provides overall social protection" (WHO 2010, 5).

Being more specific, health insurance "is a formal arrangement" (Wang et al 2010,13). It should be "the main form" (Lieberthal 2016, 1) to finance health expenditure when an affiliated household needs access to health care services.

The objectives of health insurance are:

- "Increase the use of primary health care servicess
- The promotion of health
- Increase access also to secondary level health care
- Provision of financial risk protection.
- Improvement of health outcomes and quality of life" (Wang et al. 2010).

2.3.1. health insurance benefits.

There are two main types of health insurance benefits:

1. Improvement of the population's health outcomes, and
2. catastrophic health expenditure's protection. (Wang et. al 2010).

To achieve the improvement of the population's health outcomes, data regarding interventions that were effective with low-cost, should be considered by policy makers, such as features of the population, rates in mortality and morbidity, "burden of disease, demographics" and trends in epidemiology and "historical data on service use" (Wang et al. 2010, 33)

To protect households from catastrophic health expenditures, "household surveys and health facility data can be used to analyze the target population's current pattern of out-of-pocket health expenditures" (Wang et al. 2010, 33). It is also necessary to recognize which of the

expenditures may represent catastrophic financial burden for households, and make sure that they at least among the health care services that are covered by the health insurance system.

2.3.2. health insurance schemes

In order to ensure that the poor population has proper access to health care, governments around the world have developed different schemes for "health insurance". Below, I discuss three categories that explain broadly the different health insurance schemes:

Tax-based national health systems (Kolbe 2014, 82). This model of health insurance is financed by "national and local taxes" (Normand and Weber, 2009b, ILO, 2008b, Ceri an Anna, 2013, Kolbe 2014, 85). This health insurance model usually covers every person that lives in the country and it focuses on providing "primary and community health care" (Belcon et al. 2009, 42).

Partly or wholly contribution-based social health insurance systems. health care services in this scheme are usually partly funded by at least employee contributions. This means that employees must pay a "percentage of their salaries to a health insurance" (Kolbe 2014, 82). The services covered by the insurance are often delivered by "private providers and paid through non-profit agencies" (Belcon eat al. 2009, 43). health insurance coverage provides services that are universal for those insured, and contributions are affordable to members.

Private health insurance systems. This model has as target groups the wealthy, or the population that can afford to pay the required premiums. These groups are often considered as being a low-risk population. Private systems exclude the most vulnerable groups, like for example the elderly, women, and low-income families, since they cannot afford for to pay for it.

Community-Based Health Schemes (CBHI). This scheme is most common in countries where large populations belong to the informal sector and most live in the rural areas that are difficult to reach by the government because of its isolation or insufficient capacity.

This model offers different "financing arrangements" (Kolbe 2014, 83). The arrangements are to "facilitate explicit or implicit involvement of community members in the design and implementation process that limits abuse and fraud and contributes to trust and confidence in the scheme" (Kolbe 2014, 83).

Insurance systems based on home-grown health financing mechanisms. This insurance provides basic health's protection to the poor (Kolbe 2014) by using "Multiple financing mechanisms" (Kolbe 2014, 86). Here "contributors and non-contributors" (Kolbe 2014, 86) are in the same pool.

In general, whatever is the model the country chooses to follow, "developing countries would still face a huge challenge extending health insurance coverage to the poor" (Kolbe 2014, 86).

2.4. Measuring (lack of) financial risk protection.

To measure the lack of financial risk protection, two concepts are often used. The two concepts are "catastrophic health expenditure" and "impoverishment" (Saksena, Hsu and Evans 2014, 2).

2.4.1. Catastrophic health expenditure (CHE)

CHE can be defined as the expenditures in health services that may exceed the "available resources" (Saksena Hsu and Evans 2014, 3) of a household. A health expenditure that ranks between 10 and 40% of the available household resources can be considered catastrophic (Saksena, Hsu and Evans 2014, 3). "It is estimated that 150 million people globally suffer from CHE" (Khan 2017, 1103). Populations that suffer from CHE belong, in its majority, to low-income countries. Features that worsen OOP payments are "socioeconomic status, presence of chronic and childhood and adult illness" (Khan 2017, 1103). Different studies show, that populations that are more likely to suffer CHE are those in rural areas, with low socioeconomic status (Khan 2017, 1108).

Tools have been developed that help identify whether an expenditure in health can become catastrophic or not, measurement is done with the help of different considerations and denominators. For example, some studies consider that even a health spending of 40% (Saksena, Hsu and Evans 2014, 3) is not catastrophic if the household is not facing other burdens. Other studies however, either use a "lower threshold" (Saksena, Hsu and Evans 2014, 3) or change the function of the threshold. Denominators like "non-food expenditure or household's total

expenditure (Saksena, Hsu and Evans 3) are those used to determine available household resources.

Some measurement indicators for CHE are:

"Incidence of catastrophic health expenditure" (Saksena, Hsu and Evans 2014, 3). This indicator measures "the proportion of households in a population facing catastrophic health expenditure" (Saksena, Hsu and Evans 2014, 3), this indicator is useful because includes all the population. The main features of this indicator are its "pre-established framework and its specialized concept to health" (Saksena, Hsu and Evans 2014, 3).

"Mean positive catastrophic overshoot". This indicator measures the percentage points on which the actual health expenditures of a household in a period that exceeds the stipulated maximum health expenditure derived from the "defined threshold" (Saksena, Hsu and Evans 2014, 3).

2.4.2. Impoverishment (due to Out-of-Pocket health payments).

This indicator refers to situations where a household is pushed under the poverty line because of health expenditures. (The household was not under the poverty line until its situation changed when faced with the burden of health expenditure.) Out of pocket health care payments can further exacerbate the problem, working individuals who cannot afford health services will be absent from work more often, which in turn will take them further away from fulfilling their health care needs.

In order to measure this concept, it is necessary to decide between *absolute poverty line* or *relative poverty line*. This choice is very relevant, because it will greatly affect "the number of people who are thought to be in poverty" (Saksena, Hsu and Evans 2014, 4). Measurement indicators for impoverishment include:

Incidence of impoverishment. Percentage of households in a population who fell into poverty due to health spending.

Increase in the depth of poverty. Amount by which a household fell further into poverty due to OOP health spending.

In addition to these measurements, one may further include indirect measurements of financial deprivation that is not covered by health insurance:

Out-of-pocket payments (OOP) as a share of total health expenditure. This indicator is linked with the direct indicator of "incidence of financial catastrophe" (WHO 2013, 13).

Government health expenditure as a share of GDP. This indicator states that "general-government revenues" (WHO 2013, 13) are addressed to provide financial risk protection to the poor.

It is suggested that in order to improve these conventional measures and to "obtain a broader picture of financial protection levels" (Moreno, Millett and Smith 2011, 3), other factors and indicators should be included like for example "cultural issues, workforce shortages, health system planning" (Moreno, Millett and Smith 2011, 4). Additionally, the "information provided by facto coverage indicators" (Moreno, Millett and Smith 2011, 3). Although these indicators have limitations as well, such as its variety across countries and its "limited information on other potential dimensions of forgone care" (Moreno, Millet and Smith 2011, 4). We now turn our attention to these "other potential dimensions".

2.5. The relationship between health care access and the quality of health care services

Access to health care services is not the merely idea of individuals using health care services for free or with only moderate user fees. Access also implies that the services must offer a certain level of quality to their clients. What does **quality** mean? Quality is a concept that may vary according to perspective. For example, users define quality as "accessibility, affordability of health care, promptness of delivery, early diagnosis and treatment, thereby ensuring early return to productivity and to be treated with empathy, respect and concern" (Kapoor 2011, 206).

On the other hand, health care providers define quality as "providing care as per established practices, availability of resources, self-satisfaction with outcomes and acquisition of knowledge, skills, and competence" (Kapoor 2011, 206).

According to Donabedian (1980), there are three quality levels: structure, process, and outcome. Lack of, or poor quality in any of these levels will result in overall quality issues and undesirable outcomes. Quality should be measured in a way that is translated as "a road of

improvement with the end goal being a valid and reliable method to assess" (Shengelia et al. 2005, 105). Thus, when population perceive that health care services are offering low quality, the consequence is its low utilization (Shengelia et al 2005)

Levesque's model above captures the various aspects of service quality in the four remaining upper boxes in Figure 1: *Approachability, acceptability, availability and accommodation and appropriateness*. In addition to *affordability* (which is related to Health Insurance coverage), these four dimensions/boxes illustrate that "access" is related quality of the health services as such, not only whether users can afford to access them.

2.5.1. Measuring quality of health care services

The Health Care Quality Indicators project, started in 2001 by the OECD, has split the quality concept into three main dimensions: effectiveness, patient safety, and responsiveness (World Bank 2017)

Effectiveness "Effective service coverage is defined as service coverage that results in the desired health gains" (World Bank 2017, 5). Effectiveness can be measured by monitoring tracer coverage indicators, and by assessing the medical practice of the providers using medical 'vignettes' (hypothetical cases) or standardized patients (actors trained to present the same condition to several providers) (World Bank 2017).

Patient safety "is concerned with avoiding injuries to the people who receive care" (World Bank 2017, 5).

Responsiveness/people-centeredness it refers to "patient's experiences" (patient's preferences, necessities, and values) (World Bank 2017, 5), and integrity (integrated, continued and holistic attention). This indicator is usually measured through interviews or surveys. However, the information provided by patients is not always reliable. "what a patient perceives as good health care might not correspond to effective health care" or it can "be biased by language and cultural barriers" (World Bank 2017,5).

After this general presentation of the relationship between health systems, health insurance and health services and how they all relate to "access", it is now relevant to continue with a

description of the Peruvian health care system, including the many health insurance schemes within it.

Chapter 3: THE PERUVIAN HEALTH CARE SYSTEM

In order to study access to health care among marginalized groups in Lima-Perú, it is first necessary to understand the rather complex Peruvian health care system. In this chapter we give a general overview, and in the next chapter I will describe in more detail the public health insurance system aimed to provide financial risk protection for poor citizens in rural as well as urban areas: Comprehensive health insurance (SIS).

Perú was the first country in South America that "created and organized a modern system of national health" (Sanchez-Moreno 2014, 748). The present Peruvian health system is mixed and composed of private and public elements.

- The ***private elements*** are composed of "private providers and insurance companies, non-profit entities, private medical doctors and other health professionals providing health services" (Vermeersch, Medici and Narvaez 2014, 2-3).

- The ***public elements*** are primarily a subsidiary regime of indirect tax contributions and direct contributions to the health insurance and health services. It is composed by EsSalud, schemes for the police and armed forces, and SIS.

Among the public elements there are:

-*EsSalud* is the social security health insurance it belongs to the Ministry of Labor (MDT), and it is meant for the population whose breadwinners are employed and their family. EsSalud is funded by active employers and covered pensioners. EsSalud receives 4% of its funds from assured pensioners. However, funds from active employers can vary because the cost is different if they want access to EsSalud health centers exclusively (9%), or whether they want both EsSalud and

Health Care Providers (EPS) centers (6.75% EsSalud and 2.25% EPS). The rest of the funding comes in the form of out of pocket payments (Alcalde-Rabanal et al 2011).

- FFAA/FFPP. Beneficiaries that belong to the "police, army, air force or navy" (Vermeersch, Medici and Narvaez 2014, 2) have a right to coverage from their respective Police and Armed Force systems, which belongs to the Ministry of Internal Affairs (MDL). Both schemes are currently financed by the Ministry of Labor. Finally, the Ministry of Health through the SIS provide health care for population considered poor and extremely poor (Cotlear 2006).

- Finally, the Ministry of Health through the SIS provide health care for population considered poor and extremely poor (Cotlear 2006).

The Ministry of Health (MINSA) has the task to "regulate the Peruvian health care system" (Vermeersch, Medici and Narvaez 2014, 148). The Ministry of Health also performs "financial and operating functions" (Cotlear 2006, 148).

The health care centers (*Posta*) of the Ministry of Health and regional governments, hospitals and specialized institutions (Alcalde-Rabanal 2011) are the health care service providers for SIS beneficiaries In case of emergency, beneficiaries can obtain care in any health care center which can either be public or private (SIS 2011a) This is explained with other benefits later. SIS is relevant to the health scheme for this study; thus, its financing will be explained further in chapter number 4.

Figure 2 gives an overview of the number of people subscribing the above-mentioned services.

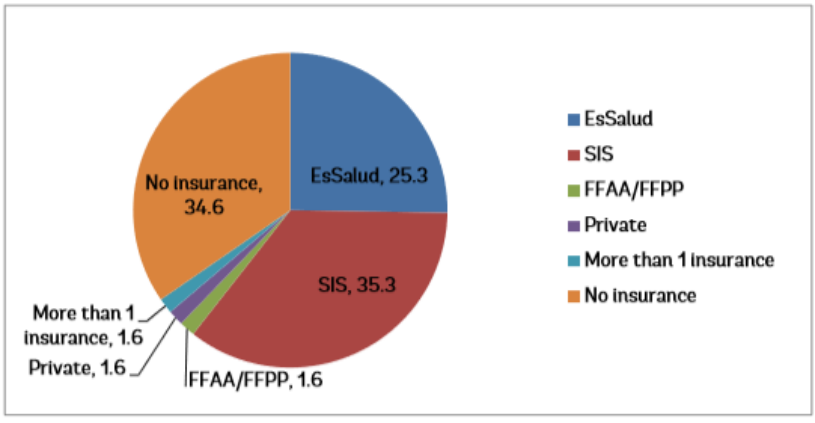
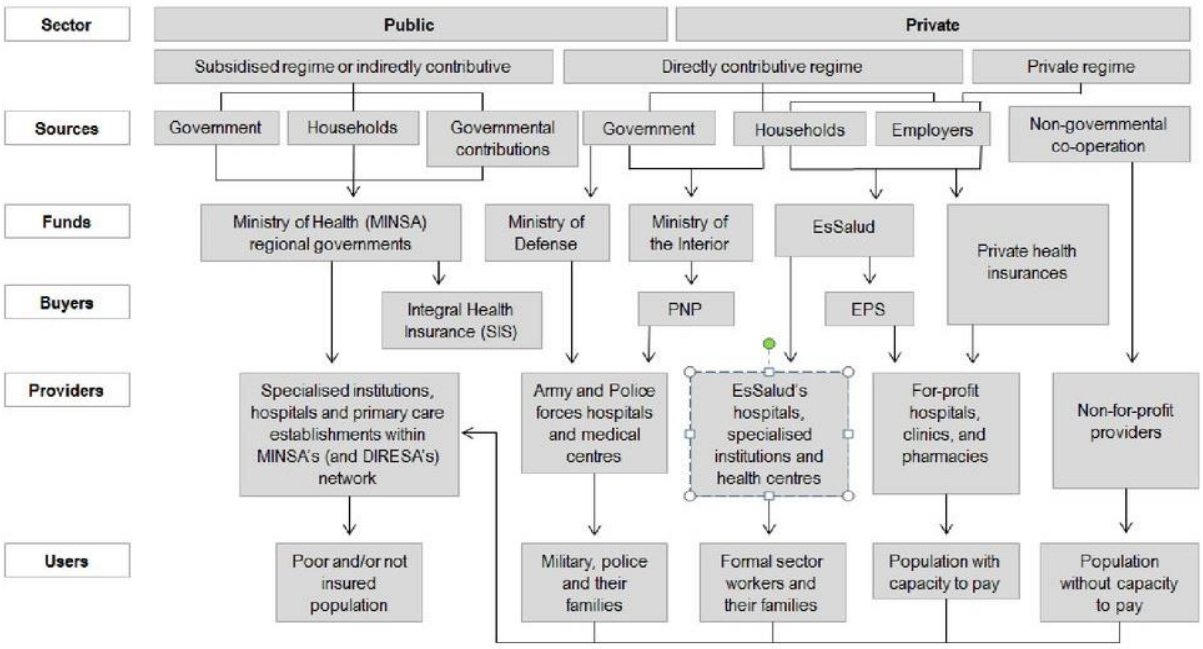


Figure 2. An overview of "percentage of population affiliated in each program in 2013

Vermeersch, Medici and Narvaez 2014, 3.



Source: Alcalde-Rabanal (2011), Sistema de salud de Perú, Salud Pública de México, Vol. 53:2.

OECD REVIEWS OF HEALTH SYSTEMS: MONITORING HEALTH SYSTEM PERFORMANCE IN PERU: DATA AND STATISTICS © OECD 2017

Figure 3. Structure of the Peruvian health system

3.1. Health Reforms in Perú.

Perú is characterized by a high level of out-of-pocket payment (Velasquez 2016, 546), a fragmented system, "low finance, deficient access to health services, inequity in the delivery of human resources, low payments," (Velasquez 2016, 546) and a relatively high rate of uninsured population.

To improve its HS, a reform in the health sector started, the reform started in 2013 and still ongoing, to solve some of these problems. This reform was based on "23 legislative decrees" (Velasquez 2016, 546). The decrees were premised on the right of universal health access with quality and equity (Velasquez 2016, 547). The main objectives of the ongoing health reform are:

"Strengthening of rectory and governance" (Velasquez 2016, 547) through decentralization and the "delimitation of specific, shared and exclusive functions" (Velasquez 2016, 548) of MINSA. To achieve this objective, different commissions and institutes were created, such as the Intergovernmental Commission of Health, the Institute Management of Health Services, the National Center of Epidemiology, Prevention and Control of Diseases, and the sectorial commission of multi-year budget. The creation of these commissions, institutes and norms have the goal of strengthening the "regulatory capacity of MINSA" (Velasquez 2016, 548) and to improve individual and collective health.

"Protection of individual health, collective health and health rights". Individual health, "health insurance and strengthening of the health service offer" (Velasquez 2016, 548). This objective is to provide coverage to independent workers, and poor children in public schools. Also, to "reduce the gap between the offer and effective demand of health services and improve access to medicine" (Velasquez 2016, 551).

Improvement on the benefits packages, which have resulted in increased number of health institutes (Velasquez 2016, 552), health resources. Also, interchangeable exchanges were achieved with the development of the health reform.

To "defend the rights population have of access health services and supervise the provision of such services" (Velasquez 2016, 554), the National Super Intendence of Health (SuSalud) has also been created. The institute has different functions and capacities, like supervision, management and information (Velasquez 2016, 554). The last one means that SuSalud has the task to "inform and promote that citizens know their rights and how to respect them" (Velasquez 2016, 554). SuSalud is meant to have the capacity of "sanction provider institutes of health services and institutions that administer health insurance funds" (Velasquez 2016, 554).

The outcome has been an increase in the rate of the population covered by health insurance, especially among the extremely poor and poor population. According to the Magazine of Public Health of Perú, the increase of the coverage rate in poor population went from 62% to 74%, and in extremely poor from 75% to 81% in the period from 2012 to 2015 (Velasquez 2016, 549). It remains to be seen if the above reforms will be enough to cover all the Peruvian population, especially the poor.

Chapter 4: A CLOSER LOOK AT THE COMPREHENSIVE HEALTH INSURANCE

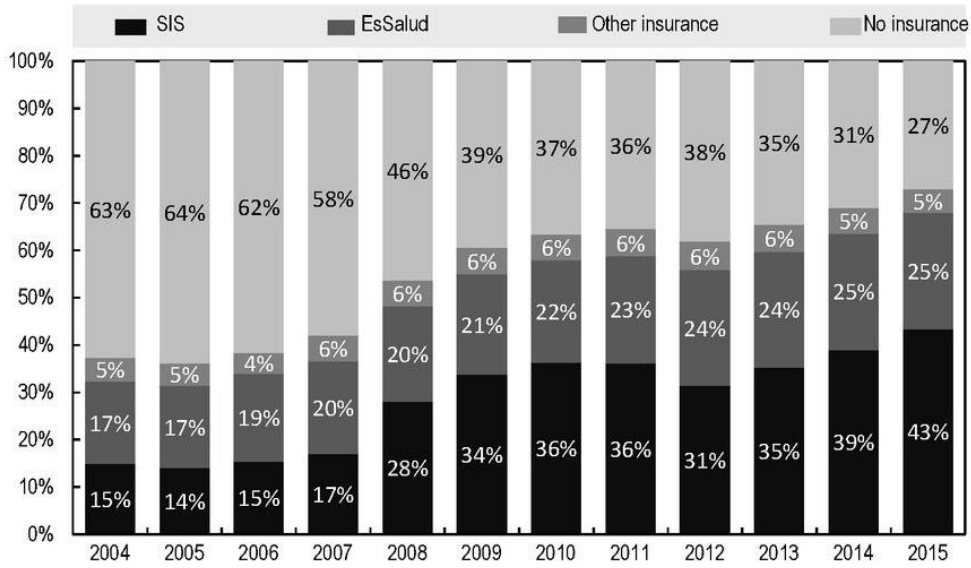
A more complete outlook into the SIS scheme: its creation, mission, founding, target groups, its achievements since its conception and the different types of coverage[1] that are made so SIS can reach its target population and preserve its principle to offer coverage to those who have no other means of obtaining health insurance and consequently access to health care services. This chapter also enumerates the benefits that SIS offers to those who are affiliated to its scheme, the exceptions of the benefits and the exclusions. Last but not least, how members of the SIS can be aware about their affiliation to the scheme.

This thesis is concerned with the health care access of marginalized urban groups. For this group, SIS public insurance scheme is the most significant. Therefore, we will present in some detail how this scheme is set up, how one becomes a member, what kind of health services SIS membership gives access to, and how one gets reimbursed for the costs of health services in the case of being a SIS member.

SIS was created in 2002, as the result of the merger of Mother-Child Insurance and Schoolchildren insurance. SIS is a decentralized public bureau "with economy and administrative autonomy that is functionally part of the Ministry of Health" (Arrospodi, Rozas and Valderrama 2009, 20) in this manner SIS covers the most vulnerable population, which is the poorest. This is the population that cannot otherwise access health care due to financial barriers. "SIS has the mission of providing funds destined to the financing of individual health benefits according with the policy of the sector" (MINSA n.d).

[1] *Regímenes* are the different types of coverage offered by SIS

In the OECD review of the Peruvian health system in 2017 is revealed that health insurance coverage has increased from 37% in 2004 to 73% in 2015, SIS being the most important reason for the increase (OECD 2017a, 58). In 2004, 15% of the people that had any sort of insurance belonged to SIS scheme, while in 2015 this rate increased to 43%. (OECD 2017a, 58).



Source: INEI (2016), *Condiciones de Vida en el Perú*, Retrieved from Lima: https://www.inei.gob.pe/media/MenuRecursivo/boletines/informe-tecnico-n02_condiciones-vida_octnovdic15.pdf.

Figure 4. health insurance coverage in Perú, 2004-15

4.1. SIS objectives

"Finance the health benefits of the population that are not cover by other type of insurance, with focus on the poorest and most vulnerable" (Arrospide, Rozas and Valderrama 2009, 21).

4.2. SIS budget - how SIS is financed

94% of SIS financing comes from General Health Budget, 6% comes from donations and non-reimbursable contributions from regional governments, international cooperation agencies, contributions made by individuals, public and private institutions, and transfers from the intangible

solidarity fund of health and resources directly collected in its operation" (Alcalde-Rabanal 2011, s248).

4.3. How to register at SIS

There are four different ways to register at SIS, and thus to get access to SIS insurance coverage.

There is one group which affiliation to the SIS scheme is automatic (SIS 2015). Among this group, are the most vulnerable such as population that live in focused population centers, homeless, children under 5 years old, children living in residential attention center, student from Qali Warma[2], and women in puerperium period (SIS 2015). Also, those that were victims of violence in the period of 1980 and 2000, fireman, and all the cases the Ministry of Health consider necessary. Entrepreneurs are also automatically affiliated, see further bellow.

Affiliated people get automatically assigned to the nearest Posta to their homes (SIS 2011a). It is clearly stated on the SIS website that affiliated people should attend health care facilities that are nearest to the district they belong for consultations with general practitioners, the only exceptions being cases of emergency or special care. (SIS 2011a).

4.3.1 For the fully subsidized regime

4.3.1.1. SIS *Gratuito* (Costless)

Only the poor and the poorest can be covered by the fully tax subsidized scheme. It is necessary to present the national document of identity (DNI) or residence card, electricity, or water receipt to a SIS office (for those which have these services). In the case of family members, DNI must be brought to SIS office as well. Once at SIS office, two requisites must be verifiable: First, the candidate must be registered in the databases of the General Household Register (PGH; Padron General de Hogares); PGH is the channel developed by the Household Targeting System (SISFOH;) to evaluate those who are classified as poor or extremely poor. It is necessary to for applicants to apply for registration on PGH. Second, it is required that the candidate must not have another health insurance. For those who fulfil the requirements, their registration and access to

[2] School Nourishing Program

health attention will be immediate (SIS 2011a). In the case of individuals that are not registered in the PGH because they are not aware of the requirement, they can apply to be registered. If individuals appear as non-poor in the PGH system, but they consider they belong to one of these groups, they can apply for a new evaluation. In both cases, individuals must first contact the Local Registration Unit.

ULE is the "unique instance in charge of the process of requesting socio-economic classification of households" (El Perúano 2018). Each municipality has its own ULE. Individuals must go to the municipality where they belong and apply for their socio-economic classification. The municipality will then identify individuals belonging to it according to the address they have in the National document of identity (SIS 2011a). In the case of individuals that are not classified as poor or extremely poor groups, but they wish to have SIS insurance, they must follow a similar process.

4.3.2. For the semi-subsidized regime

The semi-subsidized part of SIS is for other individuals that are not poor or extremely poor, meaning those who are not on the PGH registry. They must pay a contribution, and the rest will be covered by SIS, which means that their coverage is also partly tax financed.

4.3.2.1. SIS *Independiente* (Independent)

Independent SIS is meant for groups that do not qualify to EsSalud: those who either have private insurance or other form of SIS scheme. They are mostly "independent workers, university students, dependent younger and elderly people" (SIS 2011b). To affiliate, the candidate must visit a SIS health center or office. He/she must bring her/his document of identity (DNI) for a SIS worker to verify that the applicant is not registered in another health insurance. Then, the person will be registered in SIS. In contrast to the poor and extremely poor population, this group must pay a monthly fee. If the monthly fee is not paid, it will result in lack of right to access to SIS covered health care services.

The monthly fee amount is different for every person and depends among other factors on the age of the affiliated: In the group under 60 years it is S/39 nuevos soles (13 USD). For those

who are over 60 years the fee depends on whether the person has been registered before or is a newly affiliated. For the existing affiliated the fee is S/44 nuevos soles (15 USD), and for new affiliated S/58 nuevos soles (19 USD) (SIS 2011b). The monthly fee also varies according to how many relatives the affiliated wants to register, in case of one relative the monthly fee is S/78 nuevos soles (25 USD), two relatives S/94 nuevos soles (33 USD), three or more 115 nuevos soles (39 USD) (SIS 2011b).

Once the applicant is affiliated, he/she will receive a *digital affiliation sheet*, this format is necessary to perform the payment which must be done at the Peruvian National Bank. Once the new affiliated person pays, he/she will receive a contract, which contains information regarding duties and rights on SIS scheme. The contract must be picked up in SIS office, where the affiliated started the process.

Unlike the *Costless* SIS, those affiliated to this scheme must wait thirty days for consultations, and in the case of "emergencies and promotional preventive benefits related to conditions of healthy population" (SIS 2011b) the attention can begin from the affiliation day.

4.3.2.2. SIS *Emprendedor* (Entrepreneur)

The following list of requirements must be met to qualify for this scheme:

1. National identity document.
2. Do not be registered in other insurance.
3. Must be a taxpayer at the New Simplified Single Regime (NRUS).
4. Do not have employee(s).
5. Have paid taxes at the National Superintendence of Tax Administration (SUNAT) in the previous three months before affiliation. Tax fee is 20 nuevos soles (7 USD) or 50 nuevos soles (17 USD).
6. For children over 18 years old with sick leave, they must provide a document that explains their condition. (SIS 2011c)

The affiliation process is the following: SIS gets a list of all the NRUS' taxpayers, this list is provided by the SUNAT. Taxpayers that are early and punctual in their payments are affiliated

automatically to SIS. For those with foreign ID, the affiliation is individual (the applicant must do it his/herself) at any SIS center with internet. (SIS 2011c). If the applicant wishes to affiliate relatives, they must contact the "digital center" with the ID of the other person interested and must provide proof of the family relation.

4.3.2.3. For Micro-empresario (Micro-enterprises)

Micro-enterprises must follow a different process to be affiliated, they also have different time deadlines related to SIS insurance scheme. This scheme is meant for the group of people that work in a micro-enterprise and their relatives. In order to become an affiliate, the owner of the microenterprise must first register the enterprise and send all the information of his/her workers and their families in the Register of Micro and Small Enterprise (REMYPE). (SIS 2011d)

"The enterprise owner will then get a password" (SIS 2010, 61) and will then have to login to SIS website to find the monthly fee he/she must pay for each worker. After that, a fee must be paid in the National Bank of Perú. There is a waiting period from the moment of registration to the moment the person affiliated can get an appointment with a general practitioner. This period is 30 days for (UHC) case and for non UHC cases, the waiting time is between 30 and 180 days (SIS 2011d). In case of emergency, they receive immediate care.

Benefits are equal for all those who are SIS affiliated, regardless of which SIS sub-regime they belong to. The only exception to this rule, is the *Independent SIS*, where the affiliated must also pay part of the expenses of hospitalization, cease, magnetic resonances.[3](Ministry of Economy and Finance n.d, 14)

4.4. What type of Health Care Services does SIS cover?

Like other insurance schemes, SIS has a list of conditions that are covered as well as a complementary list that are covered if certain requirements are met, and finally list of exceptions that are not covered by SIS. The coverage list is the same for all the SIS regimes.

[3] Copayments are only mentioned on the scheme called Independent SIS (Ministry of Economy and Finance, n.d)

The Essential Plan for health insurance (PEAS) "is the prioritized list of insurable conditions and interventions that are at least financed for all those that are the insured by SIS" (MINSA 2012). Thus, all the conditions that are in the PEAS give right of access to medicine, surgeries, hospitalizations, complementary tests, health consultations, dental attention (such as extraction, fluorization, prophylaxis, scaling and odontogram) (SIS 2011) maternity and newborn care, burial expenses up to 1000 new soles (333 USD), and transportation to the health facility in case of emergency (SIS 2011). If a condition is on PEAS, it is covered by SIS scheme.

Cases where health centers are unable to meet the needs of the beneficiary (like in the case of medical specialists or small facilities with only general practitioners) and if the condition is listed on PEAS, the beneficiary has the right to be transferred to another health care center, whether private or public. The later includes emergency situations.

To determine which conditions, interventions and procedures are listed in PEAS, an evaluation has been done based on:

1. Epidemiological studies and the disease burden of the country
2. Analysis of previous effective procedures
3. Analysis of the supply capacity and budget of the Peruvian health system and budget. (MINSA 2010)

To sum it up, benefits included in the PEAS are those that deal with the health priorities of the country, that have shown its cost-effectiveness and that the Peruvian health system has the ability to handle. Some of the conditions covered are the most common cancers, newborn diseases, respiratory diseases, and pediatric conditions. For example, pneumonia, tuberculosis, uterine cancer and prostate cancer.

Complementary plan to PEAS. This complementary plan was created to improve the coverage benefits (MINSA 2012). The conditions that belong in the complementary plan are not in the PEAS and do not include the exclusion SIS list. Here are conditions that do not exceed the 2-tax unit in PEAS (MINSA 2012). 1 tax unit in 2018 was S /. 4150 nuevos soles (1400 USD) (SUNAT 2016).

In cases where expenses for the treatment of these conditions surpass the 2-tax unit, the health facility must apply for supplementary coverage. (MINSA 2012). The procedure begins at

the health facilities that must send an application to the Decentralized Regional Units (UDR) who are in charge of the approval or denial of applications. There is no cost involved in the application. For the health facility to be able to get the proper authorization of supplementary coverage, UDR must verify whether the patient fulfils a list of requirements.

***Specific exclusions*.** The list of SIS exclusions includes prophylactic, aesthetic or cosmetic surgery, any event that should be covered by other insurance scheme (like in case of traffic accidents), as well as events and/or conditions that take place outside Peruvian territory.

4.5. How to provide evidence of SIS membership when affiliates seek access to health care services

Population can get informed whether they are affiliated to SIS on their website (www.sis.gob.pe), where it is possible to check whether his/her status as affiliated to SIS is active or inactive. Under the option "consulta asegurado", the affiliated person must provide the number of his/her national document (DNI) or personal information. This website also provides the assigned health center. In cases where beneficiaries do not have access to the internet, she/he can also call INFOSALUD free of charge (SIS 2011).

Once the affiliated person has verified the previously mentioned information, and in the case where they need access to health services, they need only to visit their assigned health center and show their National Document of Identity (DNI) to receive the care they have right to. If the assigned health center does not have the capacity to treat the condition, as long the condition is included in the coverage plan, doctors will provide a "*Reference Paper"* (SIS 2011) for the patient to be transferred to another health center or a hospital has the capacity and resources necessary.

The *reference paper* states the reasons why the patient must be transferred to another health facility. Patients must then present themselves to the specialized health facility and provide their identity document (DNI) as well as the *reference paper* where they will then be able to receive proper treatment.

Chapter 5: HOW IS SIS TRYING TO ENHANCE ACCESS? (A SUPPLY SIDE PERSPECTIVE)

In this chapter I do a literature review of what previous research as well as government reports that have investigated regarding how widespread the coverage of SIS is, and what is known about access to health services by SIS members. In this chapter I concentrate on quantitative studies, while in my own study I use a qualitative approach (see chapter 6 to 9).

As stated earlier, access to health care can be defined as "the functional relationship between the population and medical facilities and resources, and which reflect the differential existence either of obstacles, impediments, and difficulties, or of factors that are facilitators of the beneficiaries of health care" (Levesque, Harris and Rusell 2013, 3).

Those seeking to deliver effective access to the beneficiaries, must ensure interaction between supply and demand (see Figure 1). We will focus first on the supply side, i.e. on the links between SIS and the health services SIS membership provides. Levesque labels these supply side factors as approachability, acceptability, availability and accommodation, affordability and appropriateness. Let us discuss them one by one in turn.

5.1. Approachability

Approachability is about the authorities getting information across the population and making sure they know about the existence of subsidized health care services for each person and their family when there is a need for health care.

According to different studies (OECD report of the Peruvian health system among others), rates of affiliated population to SIS scheme are increasing, this can be appreciated on Figure 4 in chapter 4. However, there still a group of people that remains unaware of their right of free access to public care services via SIS scheme (OECD 2017a). As it is showed in Figure 4 in 2015, 27% of the Peruvian population remains without an insurance (OECD 2017a). Numbers suggest that among those who are most vulnerable and hence eligible to be insured by SIS, a significant amount of people might not be aware about their rights. Alternatively, perhaps they choose to go without insurance because they do not regard their risk of getting sick as high, or they consider the quality of the health services they get through SIS too low.

To make sure that unaware people get information about their entitlement, SIS personnel have been developing strategical plans to "encourage, diffuse and promote the health insurance culture of the population" (MINSA 2017, 16). We shall briefly describe SIS efforts in this regard, using Lévesque's' sub-themes under "approachability" as a framework. These sub-themes are transparency, outreach, information, and screening (Figure 1).

5.1.1. Transparency and information

SIS is constantly developing strategies to improve its functions and to reach its target group, thus, in 2010 the strategy to improve transparency in the affiliation process was the "crossing of information provided by the Household Targeting System *(*SISFOH) of the Ministry of economy and finance with SIS database" (GOBIERNO DEL PERU 2010, 25).

Regarding information, a Defensoria's study in 2007 about SIS, mentioned the responsibility of the Peruvian government to "provide the information that people demand" (Defensoria 2007, 188) as long this information does not affect the rights of other people.

The Defensoria also highlighted that information is relevant to modify behaviors, improve sanitation conditions, for disease prevention, to seek for care opportunely but also to enrich people's knowledge about their "own rights and the obligations of SIS and health facilities" (Defensoria 2007, 189).

SIS 2009 highlights that the main problem is "the lack of information about SIS" (SIS 2009, 85). Information complemented with the study by the Defensoria 2007 indicates that the main problem people express is the "difficulty of accessing medical information and understanding the diagnosis that is provided" (Defensoria 2007, 189) like population unaware of their right to be affiliated to SIS and about their duties. Moreover, it is key to make sure the efforts are focused on spreading information widely and clearly. SIS is putting special efforts to make sure the information they broadcast is understood by its target population. Their goal is to reach the illiterate, the disabled, the low educated, and populations which are at a disadvantage.

In this section I will describe some of the strategies SIS has been implementing to improve its transparency and quality of information to its target group, in other words what SIS is doing to outreach and screen its target group.

To assure the target population of SIS is receiving information about their right of access to public health services, SIS started a massive campaign between 2014-2016 as part of the Strategic Plan of SIS. The primary aim is the proper diffusion of information concerning the requirements that are necessary to become a SIS member. The information is then broadcasted through different offices, centers and the internet (MINSA 2017, 30). Some of these are:

- Offices of the Insured.
- Insurance Service Centers.
- Citizen Attention Modules.
- Institutional website

5.1.2. Outreach

Independent workers and the poorest and most vulnerable are the target population of SIS, that is why they have designed a strategic plan where they have programs, massive campaigns, demonstrations and home visits among others.

For example, in 2015 SIS did “massive campaigns of affiliation and diffusion” (MINSA 2017, 16). SIS used “informative brochures” (MINSA 2017), presentation of the activities of SIS in different institutions and internet. In 2014 and 2015 and to be able to reach as large a population as possible and to spread information about their task, SIS made “demonstrations for the right of insured people” (MINSA 2017, 16). SIS is using internet and increasing the amount of “offices that provide attention to insured people” (MINSA 2017, 16). Also, not limiting the affiliation to MINSA entities but extending it to other public entities and private (MINSA 2017).

Strategies to reach native families and communities about the existence of SIS are:

- “Training of health personal, leaders and communal authorities” (UNFPA 2009, 85) not just in Spanish but also in the native language of the community.
- Involvement of communal authorities and media.
- “Collect the testimonies of the service quality to the insured of SIS and used them as promotional elements” (UNFPA 2009, 85).

Although this thesis focuses on health care access for the urban poor, it may be noticed in passing that SIS provides information about how is trying to reach disadvantaged groups. The

afore mentioned is an overview of all the strategies that SIS implements in order to reach the poorest and most vulnerable and so to increase the affiliation in this group.

5.1.3. Screening

SIS attempts to screen users according to their benefit plan. For it to reach poor children from 5 to 17 years, SIS merged with the "school nourishing program *Qali Warma"* (Velasquez 2016, 547).

To reach independent workers, in 2014 SIS launched a program called "SIS entrepreneur" (MINSA 2017, 16). This was launched in two strategic districts of Lima: Santa Anita and Puente Piedra. This program is meant specifically for independent workers who have paid a monthly fee of S/.20 nuevos soles (7 USD) to the tax office (SUNAT) in the last three months and do not have other type of insurance.

For the population that suffer from a chronic disease, which are often very likely not able to transport to health facilities, SIS has organized household visits. Thus, although this group is not able to reach health facilities by their own, they are still able to obtain care.

To reach and treat pregnant women, SIS has implemented a program that offers help in case they suffer complications either during pregnancy or labor. This plan aims to inform the family about which actions to take in the case of unforeseen complications.

All these efforts represent strategies SIS is implementing to ensure that health services are delivered according to the needs of each group.

5.2. Acceptability

Acceptability is "related to cultural and social factors" (Levesque, Harris and Rusell 2013, 5) of the entire population. According to the WHO 2019, acceptability is the respect to the privacy, integrity to individuals, regardless their culture, gender, ethnicity or socioeconomic group while improving the health status of the group.

When services are acceptable to the population, the possibility to seek care is higher, which is relevant if governments want to achieve UHC. Acceptability involves the engagement of the health service's human resources, provision of good communication from the health provider, non-

discrimination practices, and the “ability of the patient to exercise voice in medical care encounters” (Muller 2018, 8).

Negative experiences like use of stereotypes to discriminate patients, distrust from patients to health professionals as well as fear, insufficient information about health diagnosis (information must be tailored to every patient’s level of understanding). Can prevent people from seeking conventional health care.

Literature about acceptability is scarce, that alone is worrisome enough for us to put more focus on this area of access. When patients stop seeking health care, their situation may have harmful consequences in households. The situation is worst for the poor or extremely poor. According to Shabnam Asghari et al, 971 one of the main barriers to access to health care is acceptability, followed by availability and accessibility.

The Defensor’s Report, developed by the ombudsman's office, states that all cultures, religious and philosophical beliefs, values and confidentiality of the people, must be respected equally and should not interfere in the access to health care (MINSA 2017, 217) In order to fulfill the objectives mentioned above, the Peruvian government counts with citizen participation to ensure acceptability.

Discrimination at SIS facilities is not only limited to philosophical beliefs, values and cultures. Socioeconomic discrimination has also been identified. A study made by MINSA regarding cultural and ethical acceptability evaluated SIS facilities in the city of Huánuco, where users refer to have observed how those who make out of pocket payments get priority in waiting time. (MINSA 2007).

Perú is a country characterized by its cultural diversity, and its traditional medicine. The preservation, conservation and respect towards this kind of medicine a task that involves not just SIS but also other health institutions. The most relevant bureau whose job is to preserve ancient and alternative medicine in Perú is the Executive Direction of Complementary and Alternative Medicine (CENSI), which together with MINSA and the National Institute of Health (INS) are performing activities that tackle the multicultural aspect of health provision. Some of those activities are:

- Training of health personnel, and all the institutions that are involved with heath care about complementary and alternative medicine.
- “Develops actions that create awareness, training events and informative materials to deal with intercultural pertinence and that integrate the Amazonian and Andean indigenous peoples into strategies for the prevention and control of various damages” (INS 2019).
- In 1998 the Comprehensive Health care teams for excluded and scattered populations (AISPED) were created. The objective of AISPED is to approach groups that are extremely poor and who do not have access to care due to cultural and geographic barriers (UNFPA 2009), while “respecting the preservation of culture and customary practices” (UNFPA 2009, 33).

Acceptability is a matter that also regards gender. The Peruvian government recognizes the importance and need for women’s participation and their integration in different activities regarding national plans. The Peruvian government highlights that gender should not be a barrier to access to health care services or be a reason to get a different experience in the opportunities they obtain. According to a technical norm from the Ministry of Health of Perú in December 2012 to achieve the afore mentioned, the strategies that are taking place are:

- Encourage access to and use of services that address specific problems of women and men as different groups.
- Differently allocation of resources according to the health needs of each gender and in each socioeconomic context.
- Ensure equal participation of women and men in the design, implementation and evaluation of processes of health policies, programs and services (MINJUS 2012).

To fulfill these strategies, the government has stablished that these strategies should be spread in families and communities by multidisciplinary teams (MINJUS 2012). Health care centers are supposed to receive the necessary tools to train users. "The Health Directorates and regional health directorates are the bodies that will provide these tools but also the bodies in charge of adapting these tools according to the needs of the health care centers and the characteristics of the society and culture (MINJUS 2012, 5).

5.3. Availability and accommodation

This dimension of access refers not just to access to health care facilities, but also refers about how to access them at a specific period. Delivery is going to depend of both the "characteristics of the facilities (urban contexts, and of individuals), and of the providers (human resources, types of provision of services)" (Levesque, Harris and Rusell 2013, 6).

The following strategies are being implemented by SIS in order to improve availability health services:

- Agreements with external health facilities to the Ministry of Health, in both private and public sector. This agreement provides care for SIS beneficiaries in facilities other than MINSA, in case of emergency or in the case where the assigned Posta does not have the medical specialization that the SIS affiliated may require. This increases her/his access to care. As explained previously on Chapter 4. (MINSA 2017)
- To improve availability in critical communities, like those in rural areas in the poorest cities, a reform took the following two measures: an equal wage for health personnel in these areas and, the creation of a system that compensates those who perform with quality and do a specialized work in primary and secondary health (Velasquez 2016, 522). The outcomes of this reform lead to an increase of "doctors, nurses, and obstetricians" (Velasquez 2016, 522).
- Other measures to increase health resources in rural areas include the creation of the program *basic health care for all* (Cotlear 2006). The objective of this program is "to expand the availability of primary health care providers" (Cotlear 2006, 125) by increasing wages of care providers while providing only limited (temporary) contracts.

Geographic location. It is sometimes difficult to access health facilities due to their geographic location.

- To tackle the issue of limited access to health facilities due to geographical location, especially for the groups living in rural and poor areas "SIS will finance the transport of users and his/her companion to regional hospitals and Lima" (Velasquez 201, 550), in specific cases.

- The goal is to construct 468 new health facilities in the next eight years. This target should be achieved by 2026 (Velasquez 2016).
- Some of the patients that live in rural areas have more difficulty of access to health services because of geographical barriers. To increase the availability of human resources in these areas, the government has developed so-called SERUMS (Rural Internship Programs). This is a one-year internship "in a remote and rural setting, providing health care for the local population" (Vermeersch, Medici and Narvaez 2014, 26). Data from the World Bank confirms that the outcome of this strategy has been an increase of "presence of health professionals" (Vermeersch, Medici and Narvaez 2014, 27) in those areas who earlier had partial or total lack of them.

Although SERUM may be an appropriate solution to attend the poorest and those who have more disadvantages, concerns about the feasibility of this strategy have risen. First, some interns have no professional experience in many cases, and they usually quit working in the public sector as soon their internship concludes.

Opening hours. Health services that belong to the first level of attention (primary health care facilities) are meant offer service 12 hours a day. However, there is often shortage of doctors in the afternoons (Defensoria del Pueblo 2007).

Second Level of Attention (Secondary Health Care Facilities) are open 24 hours, but only for those who seek care that are special cases and emergencies. Regular consultations are attended only in the morning. The governmental strategy to increase the number of opening hours has been to offer regular consultations also in the afternoon. This measure has not yet been assessed.

5.4. Affordability

Affordability reflects the "economic ability of people to spend resources and time to use appropriate services" (Levesque, Harris and Rusell 2013, 6). This is where Levesque et.al.'s framework for studying health care access brings in coverage (or lack of coverage) of health insurance. As illustrated in Figure 1, costs can be split into direct costs and indirect costs, including opportunity costs.

5.4.1 Direct costs

Direct costs are OOPs for those who do not have health insurance, plus eventual user fees for those who have health insurance. In order to reduce the OOPs, there has been an "extension of the benefit package" (Velasquez 2016, 550) which allows users to access to more tests, medicines, specialists, procedures, treatments, that were not included previously; either because these did not exist in SIS benefit package previously, or because to access them, users had to pay directly and the fees were unaffordable for them.

Another way SIS has tackled direct costs, such as OOPs, is by "increasing public and private pre-paid funding" (OECD 2017, 44) because of this, more health services have become more affordable for the poor.

SIS has been "strengthening and innovating its payments mechanisms" (MINSA 2017, 19). Exchange agreements is a strategy to reduce direct payments (MINSA 2017, 19). The relevance of these agreements is that users are not limited to use health care facilities that belong to MINSA but can also use other health care facilities. This is particularly important in cases of emergency and when there is lack of specialists, equipment or tools are not readily available in the assigned health center. In cases of urgency, affiliated patients can get care in any facility that has an agreement with SIS and avoid direct payment.

Appointment fees are not the only direct costs that must be considered. Patients must also purchase medicines when they require them. Improvement in the access to drugs is also a strategy to reduce direct costs.

These are the measures that aim to reduce direct costs:

1. Allow SIS users to collect medicine prescribed by the doctor at "private, and free pharmacies" (Velasquez 2016, 552)
2. The creation of *generic pharmacies* that sell *generic drugs* to those who are not affiliated to SIS and that provide free medicine to those who are affiliated (Velasquez 2016, 553). *Generic medicine (or drugs)* refers to drugs that have the same components and effects of branded medicine that is patented. Generic drugs are not called by their brand, they are named after their composition (AESG 2019).

5.4.2. Indirect costs and opportunity costs

Indirect costs include transportation and accommodation costs. Opportunity costs are the extra use of the time that the health care seeker must spend to access health care. Opportunity costs are for example long waiting times, long distances, re-schedule of appointments. These circumstances lead to extra costs. Extension of appointment time also represents an indirect cost (opportunity cost).

There is not enough information on SIS literature that explains how the institution intends to reduce indirect and opportunity costs. It would be fair to assume, that it is not one of their priorities.

5.5. Appropriateness

Appropriateness is the relationship between "services and customer's needs" (Levesque, Harris and Rusell 2013); not just about which services the client can use, but also the quality and effectiveness of these services.

If patients get uneven access to health care and skilled health personnel, and some get inadequate quality, they have a "restriction of access to health care" (Levesque, Harris and Rusell 2013, 6). The efforts of the Ministry of Health to ensure SIS beneficiaries enjoy appropriate access to health care are:

- *Presupuestos por resultados.* PpR (budgets by results) is result-based, which means their budget request is based on cost estimations of each activity. This can be obtained by formulating output targets (OECD 2017b, 51).

  The PpR strategy seeks to improve efficiency by focusing on "what should be provided to meet population needs and at what cost, rather than focusing on what the available resources are" (OECD 2017b, 51).

- Evaluation of quality performance by using surveys. The main survey evaluates "the perception of satisfaction of the insured and performance of the provider" (OECD 2017b, 179): First one is ENDES (Demographic and Health National Survey) and second one is ENSUSALUD. To measure "Patient reported experience and outcome measurements" (OECD 2017b, 181): called PREMs and PROMs.

- The defensoria del Pueblo is often evaluating SIS performance, part of this evaluation is to perform interviews regarding “perception of quality from the users’ side” (Defensoria 2013, 185) which includes whether users feel they have a) Sufficient health facilities, and b) Whether health facilities have enough: services, human resources, equipment, instruments, medicine, and in cases where they perceive that the attention they receive is being limited due to lack of any of these (Defensoria del Pueblo 2007).
- Compensations, both monetary non-monetary to health workers for good performance (MINSA 2017).

To improve appropriateness of SIS affiliated health facilities located in remote and critical areas, strategies have been to increase vacancies that will lead to medical specializations and the improvement of incentives for health personnel to work in these areas, once the specialization training is finished.

According to Levesque, appropriateness also includes coordination and continuity of the treatment and/or to identify the need of medical attention among other members of the household. To fulfill these tasks, SIS practices integrated strategic visits to households.

There is little information on SIS’ efforts to coordinate and continue treatments, it seems InfoSalud is currently the best option for patients who need help and are in remote communities. InfoSalud was implemented by MINSA, and it is a free portal that provides “information and orientation related to health” as well as “institutional information about Minsa and SIS” through their Phone Service, Internet Chat and E-mail. “InfoSalud is available nationwide and has a team of professional doctors, psychologists, nurses, obstetricians, social workers and technicians that are available 24 hours a day, 365 days a year” (MINSA 2016).

Chapter 6: DOES THE TARGET POPULATION GET ACCESS TO SIS AND ACCOMPANYING SERVICES? (A DEMAND SIDE PERSPECTIVE)

This chapter will describe the perspective of the demand side about access to public health care services by using the SIS scheme, using Levesque's theoretical framework. This section is about the abilities of the demand side to perceive, seek, reach, pay and engage to health care services.

In chapter 5, we described how the Ministry of Health attempts to make SIS, and SIS-related health services, accessible for the Peruvian population. In this chapter, we will instead focus on the perspective to the demand side (cf. Figure 1). We will follow up on the demand side perspective in chapters 7 to 9.

Data from the National Household Survey 2014, (INEI) mentioned by an OECD's review 2017 about Perú, shows that health care consumption in the Peruvian population has increased (OECD 2017). However, the increase of health care consumption is mainly taking place in the private sector, followed by EsSalud and SIS as the last one. (OECD 2017b). Thus, what is the perspective of the demand side regarding SIS health services? To analyze this, we will use Levesque's framework of access.

Levesque et.al. (2013) differentiates "access" from a demand perspective to include ability to perceive, seek, reach, pay and engage with health problems and health personnel (cf- Figure 1 in chapter 2).

6.1. Ability to perceive

Levesque et.al. (op.cit.) differentiates this dimension into health literacy, health beliefs and trust and expectations that users may have vis-à-vis the health sector.

6.1.1. Health literacy

This refers to having certain knowledge about health information, in order to be able to "make judgments and take decisions concerning health care" (WHO 2013, 4). A population which has a good level of health literacy would "contribute more to community activities and enjoy better

health and well-being" (WHO 2013, 7). Lack or limitation of health literacy can lead in "less participation in health activities, reinforce inequalities and cause high health system costs" (WHO 2013, 7-8).

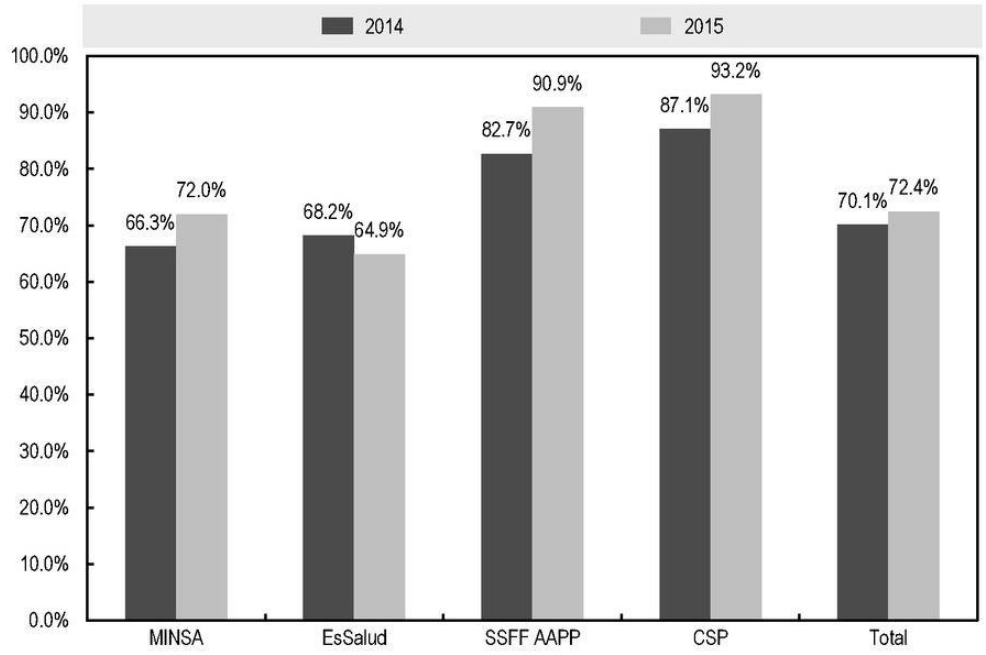
6.1.2 Heath beliefs and trust & expectations

According to a study of the OECD from 2017 to monitor the performance of the Peruvian health system, found that "low trust in service quality" (OECD 2017b) is typically found among the Peruvian population. This matches the findings of a *Defensoria del Pueblo*'s study from 2007, where SIS beneficiaries indicate to be unsatisfied with the attention they receive.

Although, the study for the OECD includes beneficiaries of EsSalud and SIS and the study for the *Defensoria del Pueblo* includes just SIS beneficiaries, both studies pointed out that low trust in the national care system is due to the low efficacy to solve their health problems, complicate information regarding diagnosis, treatment and long waiting time (OECD 2017).

To improve trust of the Peruvian population in the national health system and its quality, it is necessary to develop "quality indicators which can inform about differences in service quality" (OECD 2017b, 175).

Although, the concern for this study is SIS, the table below shows the satisfaction level of the Peruvian in different health sectors.



Source: SUSALUD; INEI – Encuesta Nacional de Satisfaccion de Usuarios en Salud 2015.

Figure 5. User satisfaction with received services, by insurance subsector, 2014 and 2015. SIS affiliated people receive attention in the health facilities that belong to the Ministry of Health (MINSA) which include the "Posta".

6.2. Ability to seek

Following Levesque, this dimension encompasses personal and social values, culture, gender, and autonomy. "Culture" also refers to the user's perception regarding the respect with which they are handled in the health facility, also the respect for their "culture, beliefs, language" (Defensoria del Pueblo 2007, 164).

6.3. Ability to reach

To evaluate geographical access to SIS health facilities from the demand side, the Defensoria del Pueblo 2007, asked SIS beneficiaries whether their perception regarding time invested in order to

reach health facilities is positive or negative (Defensoria del Pueblo 2007). Levesque splits this dimension into living environments, transport, mobility and social support.

Although the Peruvian government has built new health facilities to reduce the geographical barriers and to guarantee access to the population, especially to those who live in the most remote areas, the population may not consider the amount of health facilities enough. Still the population must have transport to these facilities, which may be difficult (in certain cases), especially if they must transport relatives that are either disabled (or too heavy), or in "case of emergency". Even when some facilities may be nearby in some cases, there is the possibility that some physical barriers can prevent access to such facilities, for example rivers without bridges, broken bridges, lack of accessibility for patients in wheelchairs, and so on.

Regarding ability to reach, in the Lima setting, distances are not so large, and, in most cases, people have the ability to reach the care they need. However, this might not always be relevant in cases when health facilities are closed because of supply side problems.

6.4. Ability to pay

As mentioned before, SIS is an insurance system aimed to cover the health care costs of the poor and the extremely poor. Each group has a different sub-scheme, (see Chapter 4). SIS fully subsidizes costs for the extremely poor, who lack the ability to pay. The semi-subsidize scheme for the poor, demands a small insurance contribution to be covered. (Defensoria del Pueblo 2007, 164).

6.5. Ability to engage

Levesque et.al. (Figure 1 in chapter 2) splits this dimension up into empowerment, information, adherence and caregiver support.

It can be argued that individuals are empowered when they have all the necessary tools to take decisions. In the case of health, individuals should be informed to such extent that allows them to make proper decisions about their health. According to some studies SIS users perceive that they do not have enough opportunity to engage in decision making regarding them (MINSA 2007).

To improve the health of SIS users, improve sanitation conditions and prevent diseases, access and availability of information (MINSA 2007) play a key role. (MINSA 2007, 188). Access to this information must be easy to understand. In a study that evaluated the performance of SIS in 2007 (MINSA 2007), some of those interviewed struggled to understand the information that health personal provided to them. This situation was caused by either use of technical language or, because the users lacked knowledge about health topics. Some users also reported "lack of materials (pictures, maps, graphs) that could help them improve their knowledge regarding health topics". All of this may lead to a difficult relationship between health personnel and users. The fact that some users do not get information from health professionals about health topics may only be the tip of the iceberg that hides an even bigger problem: inefficient and untrained health personnel (a supply side problem).

Information can be qualified as *good, regular* and *bad.* According to a study by *Defensoria del pueblo* 2013. Peruvians believe that good information must be clear (tailored to the receiver), relevant (about what patients inquire) and non-hesitant (Defensoria 2013). *Bad* information, apart from being unclear, is insufficient, or too technical. Health personnel often use technical terminology to explain health topics which is not understandable for users (Defensoria, 2013). Scarcity or lack of good information about health topics cause to lack of engagement from the patient to continue treatments and activities related to improve his or her health.

Regarding caregiver support, users report that they perceive that they receive support from caregivers when caregivers answer their questions in a timely manner. According to information from the *Defensoria* 2013, users do not always feel that they obtain support from the caregivers. Some of them reported that the attention they received was either too fast, cold, and/or that they did not get a proper explanation about their diagnosis and when patients asked for further explanations about their diagnosis, their doubts were not solved.

Chapter 7: METHODS.

A qualitative investigation of perceived access to SIS-financed health care services among marginalized groups in Lima

We now move on to the new empirical material collected for this master thesis. Not all the barriers that people face when they try to access health care insurance or simply to access adequate health care services can be found in any of the existing information. This section explains the chosen methodology, what I have chosen as a target population and the sample size of the population. This part also explains why I have chosen to conduct the interviews in two different settings, how the empirical material was analyzed and the ethical considerations for this study.

7.1. The choice of method research (design)

A study's method can be either quantitative, qualitative or mixed. The purpose of this study is to investigate the challenges and barriers SIS users perceive when they access health care services. To answer this research question, a qualitative design was chosen since I am interested in the perception that users have of barriers to access.

Both quantitative and qualitative research designs can shed light on the access to health care among marginalized urban groups. I am interested in the perceived facilitators and barriers to access using Levesque et.al.'s general framework on dimensions on the "demand side" as a point of departure. Doing a representative survey would far exceed the resources I have available for a master thesis. Besides, a questionnaire delving into the many dimensions of access might fast become either too long, or too superficial. For these reasons also I have chosen a qualitative research design. A qualitative design will not be representative for the urban poor, but it might go deeper into the perceptions people have of eventual barriers and facilitators.

Information was obtained through semi-structured interviews (see appendix for the interview guide). Semi-structured interviews have the capacity to "make use of the knowledge-producing potentials of dialogues by allowing much more leeway for following up on whatever angles are deemed important by the interviewee" (Brinkmann 2013, 21). It helps focus on the issues that want to be tackled by the research. "Semi-structured interviews also give the interviewer a greater chance of becoming visible as a knowledge-producing participant in the process itself"

(Brinkmann 2013, 21). Open questions were used to obtain eventual extra information that was not anticipated by me.

7.2. The choice of two settings

I opted for two sets of qualitative interviews. In the first set, I contacted Prof. Zoila Gonzalez from the Sociology Department at the National University, "Federico Villarreal" in Lima**.** National University "Federico Villarreal" is one of the oldest in Perú, it is a renown and well-established university in located in Lima, that was founded in December 1959. The university began with four Faculties and at the present has 18 faculties, 60 undergraduate schools, one post-graduate school, one pre-university center, and a Distance Education Center (UNFV 2017). Prof. Gonzalez is part of the Faculty of Social Sciences where together with her students have experience in performing interviews to marginal groups in Lima. I asked whether they would be willing to conduct my interview guide and she agreed. 20 interviews were conducted in this fashion. (See details further down about the procedure.)

In addition to interviewing people at their place of residence and about their perception and experiences with SIS and Posta, I decided it would be pertinent to interview people at the time when they were using health care services, to get their fresh impressions immediately on site. This would shed additional light on take-up problems. For this empirical material, I decided to travel to Lima myself, and apply the same interview guide in another setting. Rather than to go door-to-door in a marginal district, I choose a primary health care facility in Lima (a Posta) which caters primarily to SIS members or to uninsured and interviewed those who were there for medical advice or treatment. Five interviews were conducted. Thus, the first set of interviews asked respondents about their eventual experience with SIS and with using SIS-related health services when they were in their homes (and thus were not in the process of using health care services or their eventual SIS health insurance membership). The other set, by contrast, interviewed respondents who were about to use health care facilities (the interviews were in the Posta waiting room. The idea was that these two sets of interviews would supplement each other. Just like in the setting of Carabayllo district, most users at the Posta were female. The chosen district was Lince, a more middle-class district.

7.2.1. The choice of Lima and Carabayllo District

As it was pointed out previously in the introduction. Lima is characterized by its rapid urbanization, increased in its poverty rate and pronounced inequality. Therefore, a study of this setting is important to assess and study the situation.

The selection of Carabayllo District was because of its high poverty rate, making it one of the poorest districts in Lima. Besides, it has a high rate of informal workers, which makes its population fit in the characteristics I was searching for this study.

"Carabayllo is the most extensive district in Lima" (IPERU 2016). It is also one of the most important districts in Lima.

7.2.2. The choice of a Posta in the district of Lince.

The main reason to conduct the interview guide in a Posta on the district of Lince and not in Carabayllo was personal security. I conducted the interviews by myself, which is why I prefer to do it in a district that I know well and where I feel safe. In addition, as will further be shown in the empirical material, not all users of a Posta necessarily choose the Posta closest to them, although this is formally the rule. Also, among the respondents at the Lince Posta there were patients from other districts, including Carabayllo.

7.3. Target group and sample size

The target group for this study is the population without a formal job or a steady source of income., extremely poor, or poor without health insurance or affiliated to the SIS scheme. The target group is the same for both settings, door-to-door and Posta. For the door-to-door, twenty people were interviewed: fourteen were female and six were male. For the Posta, five people were interviewed: three of them were women and two of them were men.

7.3.1 The door-to-door target group for interviews

Perú was always my setting choice for these interviews. I then contacted a professor in Lima and explained the purpose of this study. Prof. Zoila Gonzalez from The National University "Federico Villareal" accepted to contribute and was enthusiastic about collaborating with some of the interviews. Prof. Gonzales has an excellent overview of the situation regarding Public Health care, but she had never done a study about this theme, which is also part of the reason she became

interested in the project. Details were agreed via Skype-videocall and later in person, when I met her in Lima.

I prepared and provided Prof. Gonzalez with the interview guide and she made the selection of which of her students would conduct the interviews going door-to-door in Carabayllo. Students were in their third bachelor year in Sociology studies at the Federico Villarreal University. The criterion the professor followed when choosing the students was their previous grades and skills like proactivity, willingness to collect data, flexibility to use research tools and their social aptitudes. Prof. Gonzalez said, “I chose them because they are not afraid to interview, they interact well with other people and they are good at breaking the ice with strangers”. Previous field work collecting empirical material allowed the professor to identify these skills in selected students. Given these assurances, I felt that it was safe to leave the supervision of the students in the hands of Prof. Gonzalez rather than to travel to Lima to supervise the data collection myself.

The empirical material was collected in three days, twice in a Saturday and once in a Wednesday. The students and professor had been in the selected district previously. They identified Saturday as a good day to collect such interviews, since the target group is then easy to find, and more willing to participate. The reason why the research team had to use a weekday in addition (Wednesday), was to be able to locate and interview the people who had been absent the previous two Saturdays.

Prof. Gonzalez explained to me that the target group was willing to participate, curious about the study, agreed about the relevance of the topic, and curious about the results. They reported to the students conducted the interview guide and to the professor about their desire to receive news about the results of the study. I might visit Perú in the future to provide my findings to them, but there are no plans at the time being due to monetary reasons.

After agreeing on the setting, the target group, which students would conduct the interview guide and which days would be better in order to collect the most reliable empirical material, Prof. Gonzalez proceeded to obtain the permissions required to do the field work and collect the material, permission from the Norwegian Center Data (NSD) was also necessary and I will explain these procedures later on this chapter.

The professor and students communicated to pertinent authorities in the community about their intention to conduct a set of interviews for a study in Norway. Both the students and the

professor had conducted interview guides previously for other studies, in the same district, so some people in the district were already familiarized with the students and professor, which probably influenced their level of trust towards them. Prof. Gonzalez and I hope this would lead to deeper and more sincere information collected from the interviewees.

After informing the population about the conduction of a new set of interviews, the students and professor identified households that were either poor or extremely poor, those who do not have a formal job or a steady source of income. Information of households was based on previously collected data that had been obtained when conducting earlier research projects.

The students and professor explained to the selected group that they were free to choose whether to answer the interview guide or no, and the rejection to participate would be respected. Only after making this point clear and getting their consent, did they begin to conduct the interviews. Interviewees consented verbally and their confirmation was their participation on the interview guide.

The empirical study done by the professor and her students investigated the perception of the health care system by respondents in the marginalized district of Carabayllo, as seen from the respective of people who are not immediately in the process of using the health services that coverage of SIS scheme makes them entitled to. This study tells us about perceived barriers to take-up (low utilization), of people who live in the "marginalized district". The target group of SIS scheme is the most vulnerable, the poor, extremely poor, the informal workers. Participants selected for this study are those that belong to this group.

7.3.2. The interviews at the Posta

A *Posta* is a primary health care facility. There are several Posta in Lima. The chose *Posta* was the Health care center of Lince. The motive for conducting extra interviews at Posta was because most people who use health services at a Posta tend to belong to the target group relevant for this study (those likely to be entitled to SIS). Thus, the opportunity to find significant data for this study was high. Among the potential participants at the Posta were some people covered by the EsSalud insurance scheme (see chapter 3). I did not interview them, because this study is not about EsSalud's users; although they sometimes obtained services in the *Posta*, their life situation differs. Therefore, they were discarded.

When interviews were conducted, few people were at the health care center. To select the sample these were the criteria I used:

1. Women or men over 30 years that would seem to be waiting for medical consultation.
2. Same or similar amount of male and female participants.
3. Availability of time, making sure that potential interviewees were not in rush.
4. Willingness to answer honestly.

When I approached the participants, I did the following:

1. Made a brief presentation of myself to the participant, including my name, background, and general information.
2. I explained about the study and the interviews, and the purpose of conducting an interview in the *Posta.*
3. I explained that I followed ethical considerations to protect their privacy, highlighting that participants did not need to provide either name, last name, ID number or other personal information, apart from age.
4. I asked explicitly if they were willing to participate answering the interview guide. Once they would agree, I explained the importance of answering honestly and how their opinion may contribute in the improvement of public health care services, especially those belonging to the Ministry of Health.

I consider relevant to highlight that while I was doing the interviews at the *Posta* (5 interviews), I felt necessary to add follow-up questions. For instance, in the case of:

When you used the Posta medica, which aspect/characteristic did you find positive and which aspect negative?

"The waiting time is too long.

What is your general opinion about the national health system, **Public health care services and the integral insurance of health**?

"*When one is insured the waiting time is too long, while when you pay, you get attention faster.*

What is your general opinion about SIS and public health care facilities?

Same interviewee replied: *it is a good option to everyone to can receive attention in the hospital, since some have not resources"* (40-year-old housewife).

When I started to conduct the interviews, I decided to add my own knowledge of using a *Posta.* This strategy resulted in a more open, trustful and honest interview, more like a common conversation. After I told an interviewee about my own knowledge, the interviewee felt free to say even more. For instance, when I asked:

When you used the Posta medica, which aspect/characteristic you found positive and which one negative. Please explain.

Did you have any bad experience?

What is your general opinion about the national health system: Public health care services and the Integral insurance of health?

The initial answer from most of the interviewees were limited to *it is good, everything is fine, I find everything positive, yes, I did not have any unpleasant experience, I think is a good option*. But since my knowledge is that not all studies show that everything is good at SIS installations, plus since I had already received information from the interviews that were conducted door-to-door, I could ask relevant follow-up questions. The response from the interviewees was often different from being very limited and short to being wider and more nuanced. For example:

When you used the Posta medica, which aspect/characteristic you found positive and which one negative.

First response was: *"everything is good, they give you free attention. I had to wait long outside but now I am the next patient"* (32-year-old female, working mother).

I then asked: **Who will get attention? You or your child?** The women replied: "*my child".* The child was wearing a school uniform. So, I asked:

Is he going to school after his appointment? The patient replied:

> *"I wanted to take him to school after his consultation with the doctor, but we are still waiting, and I don't know how much longer we have to wait, I don't know if the doctor is sending get the laboratory results or something else. Also, I haven't been to work yet because I am here. I have been here many hours; I am already here so I won't go because I do not want to lose one more day of work".* (32-year-old female, working mother).

If I had not adjusted the interview with follow up questions that were suited to their situation, I would not have gotten this kind of critical information, and it would have been lost.

7.4. Data analysis

Creswell 2014 provides a chart with the steps to follow in order to analyze the collected data (see Figure 5 below). Although, the figure suggests a linear, hierarchical approach, he also states that while analyzing data, the figure becomes more interactive (Creswell 2014, 196).

To begin the analysis of the collected data, I opted to adjust the chart on Figure 6, in this chapter, 7. The first logical steps mentioned by Creswell are to organize and transcribe the interviews. (Creswell 2014, 197).

I started then by copying or transcribing from the scanned interviews I received and collected myself, so that they could be further analyzed more easily once they were converted to text form. Later, I organized the interviews and then I read and re-read the collected information, as Creswell suggested, to get an overview of what the interviewees had provided me while the interviews were conducted.

Although the figure can be used just as a guide, I found that at the time I was analyzing the collected data, it was best to use the guide made by Creswell step by step. Therefore, the next step I followed was to code the data, which is described as the "process of organizing the data by bracketing chunks and writing a word representing a category in the margins (Rossman & Rallis, 2012-Creswell 2014, 197-198) using this procedure, themes were generated that are presented in Chapters 8 and 9. The coding of the data also generated "description of the setting" (Creswell, 199) Finally, all the themes were applied to describe the situation and conceptualize the findings regarding challenges and barriers for SIS users.

The analysis then proceeds by using Levesque et.al.'s theoretical framework of access to health care services, which I have used throughout this thesis. The interviews conducted door-to-door and the interviews conducted in the Posta are analyzed together.

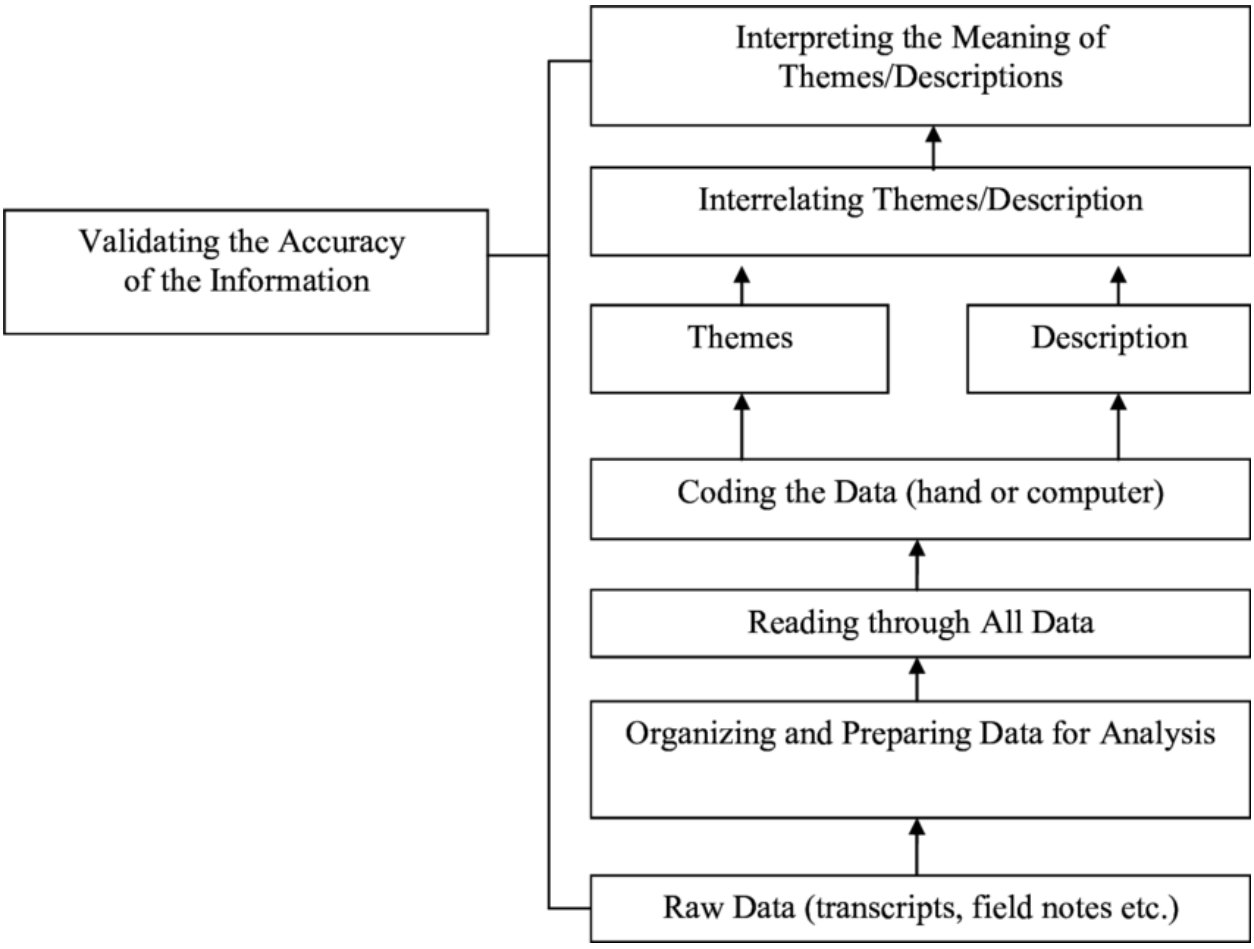


Figure 6. Data Analysis in Qualitative Research (Creswell, 2014)

7.5. Ethical considerations

Before this project started, I obtained approval from the Norwegian Center Data (NSD). As stated by Creswell 2014 "researchers need to protect their research participants to develop a trust with them" (Creswell 2014, 92). To protect the participants of the interviews, all interviews were anonymous. Both the door-to-door interviews and the interviews conducted at the Posta. In both

cases neither name, ID number nor address of participants was asked. Personal questions were about the age of the participants, their job, and whether they had children or not. Before the interviews were conducted, the following process was followed:

Prof. Gonzalez who was in charge of the door by door interviews, took contact with the community leader to explain what the topic was about, its intention, who was doing this research and how the professor had planned with me to conduct the interviews.

Typically, poor districts have small and informal neighborhood councils called *juntas vecinales* that have a community leader. Prof. Gonzalez spoke to the community leader of the district of Jicamarca where these interviews took place and explained about the door-to-door activities and received feedback on possible participants. Information was repeated to participants on the day the interviews took place.

Students were forbidden to take photos, record or use any other method than pen and paper to collect data. Interviews guide were printed beforehand, students and professor wrote down verbatim the answers of the participants while they were responding the interview guide. When the collection of empirical material was finished, Prof. Gonzalez scanned all the interviews and then sent them to me.

If any of the students that performed the interviews want to have access to collected data, they have to ask the professor, who will then in turn ask me if they can have access to it or not. The same applies in case Prof. Gonzalez wants to use the collected data for other studies, she will request my authorization as well.

In the case of the interviews conducted at the *Posta*, I did not ask for either the name, last name, or ID of the participants. I explained to them the purpose of the study. Just like before, the only tools to collect data were pen and paper. I wrote down verbatim what interviewees said, and I transcribed in quotas that can be found on Chapter 8.

All the collected data is stored in my personal laptop, which requires a password to enter.

Chapter 8: FINDINGS

This section is about the opinions and impressions collected from the target group while they try to access public health care services.

8.1. A preview of the results

Figure 7 show the results obtained from the interviews.

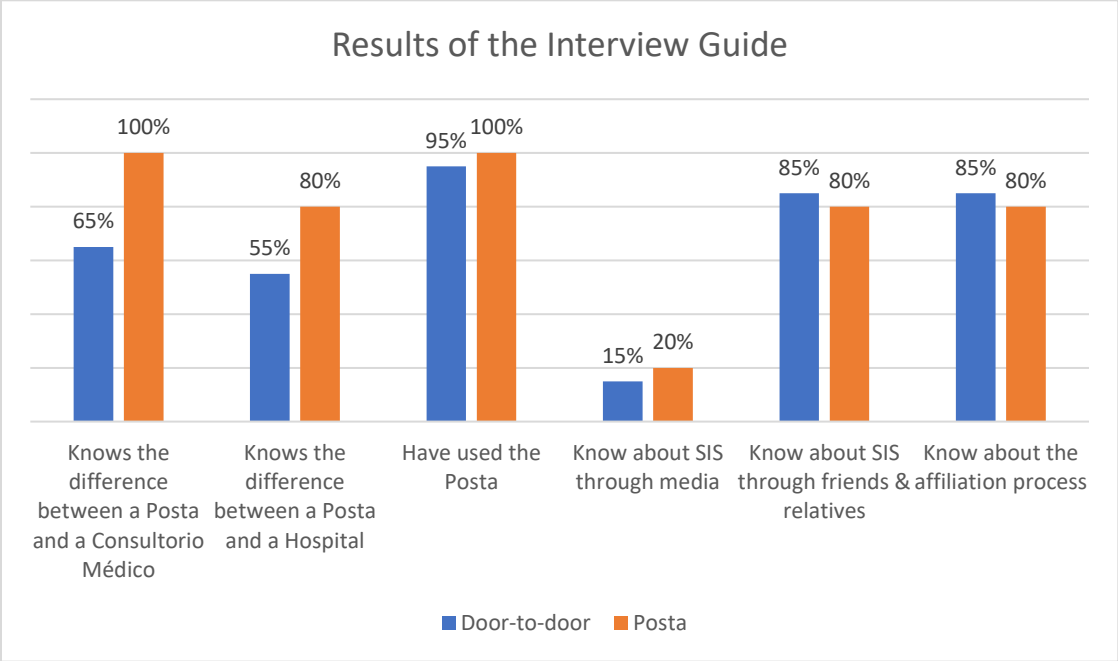


Figure 7. The results are based on 20 interviews door-to-door and 5 interviews from the Posta

8.2. Findings from door-to-door interviews

We distinguish between challenges related to the ability to perceive, seek, reach, pay and engage with health service personnel (cf Figure 1 in chapter 2). At the same time, the answers given by interviewees will indicate how they perceive the approachability, acceptability, availability & accommodation, affordability and appropriateness of the services the health personnel provide.

Consequently, we have put these supply-side dimensions in parenthesis as we go through the five dimensions of access.

8.2.1. Challenges related to ability to perceive (including perceived approachability)

Information is the very first dimension that must be fulfilled in order to have "access", consistent and adequate information on where to get health services when in need, plus being informed about the existence of a health insurance scheme (SIS) that makes health services affordably also for the poor.

Interviewees were asked if they knew the differences between a Posta (primary health care facility) and a hospital (secondary health care facility for more complex or expensive treatment). Not all the interviewees knew that there was a difference. However, in a related question: **in which circumstances can you resort to the Posta and a hospital?** Most of the interviewees (17 out of 20), could still explain in which occasions they could resort for attention in the Posta and in which occasions they could resort for attention at the hospital. Here are some of their comments when asked about the difference between Posta and a hospital:

"*I do not know the difference between a Posta medica and a hospital"***.**

In which circumstances can you resort to the Posta and hospital?

*"The hospital when one has a serious disease" (*28 years old female informal worker).

On one occasion, one of the interviewees replied:

"Both are the same, to cure. Both are when I am sick" (35 years old female peddler).

Do you know the difference between a Posta medica and a hospital?

"No".

In which circumstances can you resort to the Posta and hospital?

"Hospital when I have a serious disease" (28 years old female food seller).

Do you know the difference between a Posta medica and a hospital?

"*No, both are the same".*

"*I don't know the difference between Posta medica and hospital."*

In which circumstances can you resort to the Posta and hospital? "

To hospital when I have a serious disease" (40 years old foreman)

Some of the interviewees were not able to answer similar questions about the difference between the *Posta* (which a public primary health care is facility) and a *Consultorio Médico* (which a private health care facility). Some responses were:

"*I don't know"* (46 years old male).

"*I do not know the difference"* (28 years old housewife and mother of two children).

"*I don't know"* (40 years old foreman)

"Both are the same" (55 years old housewife).

However, most of the interviewees knew about this difference and answered:

"The consultorio is private and the Posta is public" (36 years old female street market's seller).

All the interviewees knew about SIS insurance scheme. Regarding how they got knowledge about the scheme, seventeen of them (including men and women), told that either a friend or a relative told them about the scheme. Further two said that they got information about SIS at the health facility, and only one through from the radio.

*"I know about SIS through relatives" (*26 years old female student).

"*Through relatives"* (52 years old housewife).

"*From the radio"* (37 years old male seller)

"*Through friends"* (28 years old female seller)

"*Through the Posta"* (47 years old female merchant).

Regarding the knowledge of the interviewee about the difference between a *Consultorio Médico*[4] and the *Posta,* thirteen have knowledge about the main difference, and seven informed they unknown the difference.

Do you know the difference between the *Posta* and a *Consultorio Médico*?

[4] It is a private health care provider

Those who know the difference said:

"*In the Consultorio Médico I have to pay, but not in the Posta*" (40 years old housewife).

"*The Consultorio is private and the Posta is public, free"* (37 years old housewife).

"The Posta is a public service and the Consultorio is private" (52 years old housewife).

Those who were not able to say the difference, they express:

"Both are the same" (35 years old female seller).

"I do not know" (30 years old informal male worker).

"I do not know" (46 years old male driver).

It is particularly relevant that users are aware of the difference between a *Posta* and a *Consultorio Médico*, since Posta is a public health service provider and the *Consultorio Médico* is a private service that must be paid by the user. Lack of knowledge from the part of users may lead to catastrophic health expenditures for households because of OOPs.

Answers were mixed concerning the information users had about the affiliation procedure:

Can you explain briefly about the process you must follow to register for SIS and the requirement to fulfil to be registered and use the services that SIS offer?

"*I do not know"* (26 years old female student).

"*I have to bring my ID and the receipt of water or electricity"* (52 years old housewife).

"*I have to bring the receipt of water or electricity and not have other insurance"* (28 years old female food seller).

"*Bring the receipt of water or electricity and not have other insurance"* (26 years old female worker).

"*I think they request for the ID and copy of each one. Him and the wife"* (37 years old male seller).

"*One must present ID, receipt of water or electricity and not earn more than 1500 nuevos soles (500 USD)"* (20 years old housewife).

"*I do not know, my mother helped me"* (30 years old male, works in what he finds).

"I do not know, my wife did it" (46 years old male driver).

The finding that most interviewees got information from friends and relatives rather than from mass media is in line with a classic finding in diffusion theory. (Rogers 2003).

Information about the screening procedure. Thee interviewees had knowledge about their right to free affiliation to the SIS scheme due to their status of poverty. They explained that they had the right to register to SIS scheme because they have no resources to pay for health services. The majority of the interviewed received this information because their friends or relatives informed them about it, and not because a SIS worker explained about this. They did not mention the existence of other SIS-related insurance schemes (see chapter 4). Challenges related to ability to seek (including perceived acceptability)

Most of the interviewees were female. Probably because women are more likely to be home during the days when interviews were conducted, and also because women showed more interest in being interviewed. All interviewed females (14 out of 20) stated that they knew the procedure to follow in order to be affiliated to SIS and could accurately explain the steps needed. Only half of the interviewed men (3 out of 6) knew the procedure on how to become affiliated, the rest only had knowledge about SIS and were affiliated, but it had been their close relatives (2 wives and 1 mother) who affiliated them to SIS.

This information coincidences with statistics from the ENAHO 2015, where affiliation rate is higher for females than for males, and the average of insured female is 53% and only 47% for males (ENAHO 2015)

8.2.2. Challenges related to ability to reach (including perceived availability and accommodation)

Geographical location. None of the interviewees referred to this as a problem. Difficulty to access to health facilities due to their location was not mentioned. For this study, according to what the interviewees referred, this does not represent a challenge.

Appointment mechanism and opening hours. Before I conducted the interview guide, I decided to experiment with acquiring access to the *Posta* myself to try to get an appointment. I arrived at around 12.30. I was stopped by a security guard who promptly informed me that everybody was gone for the day at the *Posta* and I would have to return the next day at 5 am to

make an appointment. After this, I explained that I was there to interview patients. He informed me that the *Posta* was empty. I did not believe him, but I kindly requested him to let me in. He did and indeed, the waiting room at the *Posta* was empty and only one consultation room was open.

I returned the following day at 9 am. I conducted the interview guide at the Posta that day, but I was surprised to find that the opening hours at the *Posta* were so brief. Doctors begin attending patients at 8 am and they typically finish around 10 (as reported from one user). In some cases, doctors leave the *Posta* before they finish seeing their patients.

This type of information did not emerge as a take-up problem in the Carabayllo setting, with interviews door-to-door. It illustrates the fruitfulness of doing similar interviews at different sites for the same research question. The new and relevant information illustrates how interviews done in one context (door-to-door) does not exhaust relevant information; that changing the context may lead to new information coming forward.

8.2.3. Challenges related to ability to pay (including perceived affordability)

As described in previous chapters affordability includes both direct, indirect and opportunity costs.

SIS affiliated interviewees referred indirect costs as food they must purchase while waiting in the health care installations, and opportunity costs like missing working days (and thus pay), or not sending their children to school, or having to return to the health facility later because they could not get attention. It can be stated that the main cost, according to these informants, is the long waiting time to be affiliated to SIS scheme and to obtain attention while at the health facility.

In the question regarding whether the interviewee is affiliated to SIS scheme or not, one informant states:

> "*I'm not registered, because I don't have time and one must have enough time to do it. But I want to be registered because my family would get free consultation too*".

This represents opportunity costs (because of the time invested to get affiliated) and also has risk of future direct costs, since in case he and/or his family get ill, they must cover the health expenses out of their pockets.

One interviewee stated that she prefers other insurance, which creates direct cost to her, (non-subsidized scheme) to avoid the slow service at SIS:

> "*The service is too slow; I have other insurance because the service at SIS is too slow*" (26 years female).
>
> *"When you're insured the waiting time is too long, but if you pay, you get attention faster"* (40 years old housewife).

To avoid indirect and opportunity cost, those affiliated to SIS might prefer to pay out of pocket if they have economic capacity, which also creates direct cost. Implicitly, these respondents suggest that health personnel give priority to patients who pays out of pocket to those who carry SIS insurance. This could be a topic for further research. Lack of medicine is another direct cost. One interviewee stated:

> *"The nurse told me they did not have medicines and I must buy them"* (36 years old female seller of vegetables in the street market).

The most common negative side that interviewees referred, is the long waiting time at SIS health care centers. It can be concluded that long waiting time to become affiliated, to obtain health consultation, and lack of medicine are sources of direct, indirect and opportunity costs that must be carried also by patients who have SIS insurance coverage.

8.2.4. Challenges related to ability to engage (including perceived appropriateness)

Some of the interviewed complained about the attitude of the staff, or absent medical personnel. But some of the interviewed seemed to contradict themselves. For example:

> **When you use the Posta. Which aspect/characteristic did you find positive/negative? Please explain.**
>
> *"The nurse did not treat me well, because the doctor was not there, the doctor didn't arrive".*
>
> **Did you have any bad experience?**
>
> *I did not have any unpleasant experience.*

What is your general opinion about the National Health System? Public Health Services and the Comprehensive Insurance of Health?

"Sometimes I don't trust that they can cure me".

(40 years old female clothes washer).

Before the interview guide was conducted in the Carabayllo setting I had assumed that many of the people interviewed door-to-door would not be registered in SIS insurance scheme. However, as seen above, findings were different. All of them knew about SIS. Interestingly, females interviewed for this study were better informed than men regarding how to register at SIS. The difference between men and women in their knowledge regarding SIS might be a topic for further research.

Another assumption I had was that many of those interviewed had never been in a health care facility due to economic barriers. However, all the interviewees told they had been in a health facility previously.

Third, I assumed those who knew about SIS had obtained information about its existence and the right to be registered for free through television. However, most of the interviewees told they knew about the scheme through friends and relatives. One female stated that she got informed through the radio broadcast, and two people said they learned about it while visiting the Posta. Finally, none of the interviewed people at their households complained about the distance to access health care facilities, which I assumed would be a complaint.

8.3. Findings form the interviews conducted in the Posta.

Answers given to students who did the door-to-door interviews were often short. Those interviewed seldom expanded their answers. Partly because of this reason, I decided to do additional follow-up interviews myself. As explained earlier, I decided to do interviews – using the same interview guide – but in another setting, i.e. at the waiting room in a Posta. Below are the responses that five people interviewed (3 women and 2 men), presented according to the same framework for access to health care.

8.3.1. Challenges related to ability to perceive (including perceived approachability)

Transparency. There are two types of *Filtrations*, the first refers to queues at the heath care center, and to people who get appointments at the *Posta* without arriving on time, or that get consultation before others who arrived earlier (priority treatment). The second is defined on the SIS scheme as population that does not fulfill the requirements of SIS and still get access to enjoy SIS benefits (Defensoria del pueblo 2007).

Interviewees refer that they observed the filtration of families or individuals in the subsidized SIS scheme. According them, the filtered individuals do not fulfil the requirements to belong to the subsidized regime of SIS. Interviewees also refer the observation of filtrations in the queues for appointments.

To recapitulate, the requirements to belong to the subsidized SIS insurance scheme are to be registered as poor or extremely poor in the data bases of the General Household Register (Padron General de Hogares (PGH)) of the household focalization system (SISFOH), and not be insured in other health insurance.

Two of the interviewees claimed to know of cases were both requirements were not met. They claimed to know of filtrations of people who are not poor and are registered anyway at the National Household Survey (ENAHO), and also have experienced that others were given priority on the queue because of some friendship or other connections with health care or administrative personnel at the Posta or at ENAHO.

This finding suggests irregularities from the supply side, i.e. that they serve first people they know, or those who can pay out of pocket. Irregularities from the *demand side* are also identified. The Posta where the interviews were conducted belongs to a middle-class district. Mostly of interviewed (4 out of 5), did not live in this district. All of them were living very far from the *Posta*. This interview guide took place at the Posta in Lince district; however, I was able to detect residents from the Carabayllo district attending this Posta. The travelling distance between the Lince and Carabayllo districts is almost two hours. This is inconsistent with how Posta are supposed to be assigned. It is clearly stated on the SIS website that affiliated people should be assigned automatically to the nearest Posta to their homes (SIS 2011). This means that people who live in the Carabayllo district should be attending the Carabayllo Posta. This is extra information identified only at the Posta site, but not on the door-to-door interviews.

Information. Regarding the user's level of information, the interviewees knew the difference between private and public health care centers. Regarding their level of information about the differences between hospital and Postas, their level of information was rudimentary.

> "*I go to the Posta when I have fever, my son has diarrhea, something soft (sic). I go to the Posta for a serious illness. If I need a surgery I go to the hospital, I don't know more" (*36-year-old housewife).

Regarding how those interviewed were informed about the existence of SIS and their right to become affiliated for free due to their economy status, two of the interviewees said that they got information in the Posta. One stated:

> "*When I came to the Posta to get attention for my child the nurse asked me whether I had insurance or not, I said no. She asked me if I had a job and I said no, then she asked if I had money, when I answered no, the nurse told me to not be a fool and get affiliated because me and my child can have free insurance if I don't have money. She sent me to the administrative office and there they told about the procedure so I can have free access to SIS installations" (*36 years housewife).
>
> *"I went to the Posta for attention and the personnel told me about it"* (55 years old housewife).

Yet another interviewee stated:

> "*Miss, I have been paying taxes all these years, that is why I have right to have insurance" (*68 male pensioner).

Regarding how well SIS users are informed about the procedure to follow to become affiliated. All the interviewees explained to me that they must bring the electricity bill and the national identity document. Just one interviewee added that one must also be registered in another public organization first (ENAHO, SISFOH), and only after that can they apply to become a SIS user.

> *"I must bring my receipt of electricity or water, ID, and register. Since she doesn't pay, SIS personal went to her house to verify if she belongs to the group who do not pay any fee".* (55 years old housewife).

I also identified affiliated to SIS scheme who did not have accurate information about the affiliation procedure:

> "*My wife told me about SIS, she affiliated me and herself. I think one must bring the electricity bill (long silence), the national identity document"* (65 years old male).

The last quote may further indicate that getting knowledge about SIS, and health care matters in general, is seen as "gendered competence", i.e. something more culturally acceptable for women to use time and energy to understand and know.

8.3.2. Challenges related to ability to seek (including perceived acceptability)

SIS users referred that in some cases, health and/or administrative personal are rude and impatient when users ask something administrative or about any kind of procedure. They answer in a bad way or even worse, they pretend they not hear users. *"I came to my appointment and the doctor did not even touch me, he (doctor) just prescribed me paracetamol".* The same patient also said *"I feel like doctor did not even want to touch me and was feeling uncomfortable with my questions. Senorita (miss) if I go to doctor is because I want to know what I have, and I want the doctor to explain me my symptoms"* (65 years female pensioner).

Gender. Most of the users at the Posta were female, and as consequence also most of the interviewees. Two of the three females that were interviewed were at the Posta we not there to get attention themselves, they were instead bringing their child to be attended. Both females and males had an idea about the process to be registered in SIS scheme. One man that was waiting to obtain consultation said:

> *"My wife registered me in SIS scheme. I think one must bring electricity bill, ID, and one more document. I know now they are also requiring that one must be registered in the ENAHO system" (60 years old male).*

All females did the register's procedure, not only for themselves but also for the rest of the including their husband and children.

This finding may suggest that women have fewer problems to access health care, and/or than men leave it to women in the households to gather such information.

8.3.3. Challenges related to ability to reach (including perceived availability and accommodation)

Some of the interviewees told me that on many occasion doctors are not available, and they as users do not get any explanation for their absence.

Geographical location. Although no interviewee complained or mentioned distance as a barrier to access health care one stated:

"I have to wake up very early to be in the Posta on time, because I live far away".

I thought about this answer. Why do some users travel so long to access to a SIS health care center if users should get attention in the closest SIS health care center to their household? Perhaps because they assumed that the quality in the Posta in a middle-class district would be better. This is a topic for further research.

Appointment mechanism and hours of opening. The interviewees explained that in order to book an appointment, the opening hours at the Posta are from 8 to 10 am. Most *Posta* have these opening hours. It is necessary to book an appointment in person, and on the same day. For instance, if a user wants an appointment for Monday, it is necessary to be at the Posta the same Monday. Since there are seldom enough consultation times for all those who show up in the morning, patients must be at the *Posta* as early as 5 or 6 in the morning, just to ensure they would be able to book an appointment or to book an appointment with the doctor of their preference. If patients arrive exactly at 8 am, which would seem reasonable since it is the normal opening hour, there is very little chance the patient will get an appointment at all, because it will be fully booked with all of those who arrived from 5 to 6. Then they will have to come back the day after or another day. The following story was told by a SIS user:

> *"I live very far from the Posta, so I have to wake up at 4 am so I can manage the queue at 5 or 6 am. If I arrive after 6 am, my chance of obtaining an appointment is reduced"* (60 years old male)

The procedure to book appointments is usually "first come, first allowed to book an appointment and then first served". However, this is not always the case. Some patients referred to have seen *filtrations* of people who either come late and that get appointments before people who arrived earlier (as written in one quota). The situation gets worse for some affiliated people, when they

arrive, they count and know they are the second in the queue, but by the time they enter the *Posta*, they are fifth or sixth. Interviewees also explain that before they enter (right before opening hours) *Posta* workers come outside and start providing order numbers (queue numbers). The numbers are meant to ensure that people get appointments in the order of arrival. Here is precisely when users report a mismatch on the number, they get from Posta workers, and the place in the queue they know they should get.

Why is this relevant? Because they can a) lose their chance to obtain an appointment that day in case they would be number 20 in queue, and then inside the Posta they might get number 30 for example. Or b) they might lose their chance of obtaining consultation with the doctor of their preference (that might also be the one they trust or who is familiar with their health).

> "*I was in the queue at 6.30 am, and I was number 5 in the queue, before we entered to the Posta a nurse came outside and gave us numbers written on a piece of paper to show which order we would be. The nurse gave me number 10, I complained about it, but nobody helped me"* (65 years old female pensioner).

It might be that people have friendship with good the personal of the Posta and/or it might be because health personal prioritized those who pay-out-of-pocket (Defensoria del Pueblo 2007). The opinion of those interviewed was that those who are filtrated in the queues have connection with either administrative personnel or health personnel.

Such practices, or even the suspicion that it exists, can represent a barrier since it may discourage the attempt to get access to health care in the first place.

8.3.4. Challenges related to ability to pay (including perceived affordability)

Direct, indirect and opportunity costs. Lack of instruments, materials, and/or medicine. SIS members referred that although they can get a transfer to other public health service institutions in the case where there is lack of the specialist in the nearest *Posta*, sometimes equipment is lacking or in maintenance, or there are not enough tools, or medicine, to provide attention to them, and then patients must provide some of them themselves. For instance, one informant refers:

> *"At the Posta where I am assigned, they did not have the equipment to take a dental X-ray that I needed. They then transferred me to a hospital to get this X-ray, when I arrived there,*

> *the dentist asked for the plate to take the X-ray, I said I didn't know I had to bring it, so the dentist had to reschedule a new appointment. I have to take another day off work and use the time to find a place to buy the plate. Pharmacies at the hospital don't have the plates or other tools or the prices are more expensive than in other places. Also, I have to save money to buy the plate, and I cannot afford it, but my tooth hurts so I have to do it"* (65 years old female)

Interviewees referred lack of medicines on the day of their consultation, the problem is that if patients do not get their medicine on the day of consultation, they get nothing from the *Posta* and have to purchase it themselves (those who can afford it). Patients are unable to search in other public pharmacies or to be called when their medicine arrives and come back another day to collect it. The only option in case they want to get the medicine the same day and this is not available at the pharmacy of the *Posta*, is to buy it themselves. In case they do not have the resources for it, they must book a new appointment to obtain a new prescription and then can they collect their medicine, again without being sure if the medicine is there on their second appointment.

Consequently, lack of medicine, tools, equipment, and human resources cause direct, indirect and opportunity costs for SIS users. Also, long waiting times, re-scheduling of appointments, and waiting times to be sent to a specialist represent costs. Despite being a member of SIS insurance system for the poor, there are several costs that accrue to the poor when they seek access to health care.

8.3.5. Challenges related to ability to engage (including perceived appropriateness)

As stated above, some of the informants experienced that they sometimes need to wait a long time to obtain health care. Once they finally get attention, the quality of service can be perceived as poor.

> *"I've been waiting 2 hours for the dentist. I hope the dentist won't go home before my appointment. A few days ago, I came to my appointment and after waiting several hours, the nurse came out to the waiting room and told us the dentist would not see more people that day. When I asked the nurse why, she said that the doctor had left".* (65 years old female pensioner).

An interviewee referred that only a few of the medical personnel that provide attention, did it with quality and did satisfy their expectations. The informant described that a satisfactory consultation must include a thorough examination, sufficient time during consultation, complementary tests, and prescription of medicine. The informants were seeking constantly better attention to satisfy their health needs.

> "*The doctor here is very good, she checks you meticulously, other doctors don't even touch you. They just see you and give you paracetamol. She (doctor) spends good time while you are in consultation with her, that is why I come here. But to get an appointment with her you must come very early. I woke up at 4 am to be able to be in the queue at 6 am, otherwise, quotas for an appointment with her just flies away (get empty very fast)"* (65-year-old female, pensioner).

I had assumed that interviewees at the *Posta* would mention distance as the most relevant barrier to access health care, after the economic barrier. However, they did not complain about this. What interviewees complained about or highlighted as a drawback was the *appointment mechanism* and *opening hours* at the *Posta*. Most of those interviewed said that the waiting time to be attended at SIS facilities is too long. It is slow to get consultation; it is slow to get an appointment with the specialist in the case users require it. They also said that consultation in the *Posta* can mean that they spend the entire day in the facility, missing hours of working time, missing attendance of children to school, and having unexpected expenses, as the purchase of food, for example. This again illustrates the existence of *indirect costs* and *opportunity costs*.

Three interviewees complained about the fact that they had to arrive very early at the *Posta* in order to secure an appointment and on the same day. Thus, getting up early enough to secure an appointment represented a barrier, not because of the travel distance to the *Posta*, but because the amount of consultations and the schedule offered on the same day are determined at the beginning of each day. It depends on which patients are early enough to secure an appointment before the working day is over.

According to the Ministry of Health in 2013, it is possible to book appointments online. However, this seems to vary in every Posta and their own resources. When the interview guide was conducted (December 2017), neither users nor the security personnel at the Posta informed

me of this option. It would be fair to assume the people in the district of Carabayllo are unaware of this option as well, because they also complained about the amount of time spend at the *Posta*.

8.4. Limitations of the study

In all qualitative studies, some will claim that due to the lack of representative numbers and statistics, qualitative interviews are not a scientific tool. It has also been claimed that the knowledge qualitative interviews provide is not "objective" and even that it lacks reliability because it is subjective on human perceptions and judgment and the sample size for qualitative studies tends to be small. Qualitative studies cannot be generalized in a statistical sense (Brinkmann 2013). In response to such critical remarks, one of the strengths of qualitative interviews is the detailed information about the circumstances, and the context people are in, and of the meanings themselves ascribe to their situation and their circumstances. With special reference to access to health care, it is precisely the subjective perception and judgement of barriers and facilitators that are important for understanding how people behave (in this case: their health seeking behavior). Further, although findings cannot be generalized in a statistical sense, they may provide a scope for theoretical generalizations. Thus, in this study, I have relied to a large extent on Levesque et.al.'s theoretical framework for comprehending access as a process comprising many dimensions. The findings from the interviews both illustrate how these dimensions are important and help deepen our understanding of how they influence perceived, as well as actual, access among members of the SIS target group.

A qualitative study is potentially shaped by the research's background, culture and experiences (Creswell 2014, 186). Also, as stated by Creswell "the research process for qualitative researchers is emergent" (Creswell 2014, 186). This study is not an exception. At the beginning of the study I was expecting certain findings, the results of the interviews were different which made me direct the research questions in a new direction. This study is the result of reflexivity and emergent design features of qualitative research.

Ideally, I would also interview health providers to make a comparison with the information SIS users provide. The number of interviews at the *Posta* could have been larger, to have a bigger sample size to compare with the information collected in the door-to-door interviews. By interviewing even more people new information might have been collected. However, the people

who were selected to be interviewed seemed to feel special to be chosen when they saw that not so many were selected. It seems they felt their opinion was really being considered, this feature might have influenced the interview situation which provided real and throughout information; people were willing and interesting to talk to and I got a richer material than if I had only relied upon the shorter door-to-door interviews.

Following these arguments about qualitative studies and because of the sample size, this study cannot be generalized. However, as argued by Creswell 2014, the greatest strength of qualitative data is its validity and its unique steps to analyze the data, analysis that is unique and detailed.

Chapter 9: DISCUSSION OF FINDINGS

In this chapter, I analyze the results and attempt to provide possible explanations of the barriers faced by facilitators and SIS beneficiaries while they: perceive health care needs, seek health care, reach health care, pay and engage. I explore the ongoing health reforms that are taking place in Perú, which governmental bureaus are involved in the process and the main objectives that these reforms wish to achieve. I also discuss the importance good health has for governments, families and so on.

As stated in the introduction, based on the increased importance of urban poverty in middle-income countries, and using Lima as the site for the study, the main research question in this thesis has been:

How can access to health care for marginalized urban groups be conceptualized and investigated?

-What are the perceived problems by these groups to access health care services?

This study has the aim to identify the challenges that such groups must face to obtain effective access to health care. I wanted to look at the issue primarily from the demand side, but the supply side enters indirectly through how it is perceived by the those in demand of health care. Although users referred that they can access health services and they know about the existence of SIS insurance scheme for the poor, they face challenges when reaching these services.

In order to analyze the different dimensions in access, I decided to use the conceptual framework of access to health care by Levesque, Harris and Russel (Figure 1, chapter 2). In this framework, the authors define access as "the functional relationship between the population and medical facilities and resources, and which reflects the differential existence either of obstacles, impediments and difficulties, or of factors that are facilitators for the beneficiaries of health care" (Levesque 2013, 3). The scale of the challenge varies from dimension to dimension.

9.1. Perception of health care needs

According to previous studies I referred to in chapters 5 and 6, there is an important minority that are not covered by any health insurance scheme, including not being covered by the bottom-floor health insurance for the poor, SIS. However, among the interviews conducted for this study, lack

of knowledge of SIS did not come across as a problem or barrier. Most of the interviewees also perceived their need for health care and had basic information about the system. However, there was a gender dimension in regard to information: women were generally better informed, and they also took the initiative on behalf of the men in their household. One interpretation is that gender might influence the perception of health care needs. Another interpretation is that to collect and be aware of health care information is regarded as the *women's responsibility* within the household. These assumptions are due to higher number of better-informed females about the registration process to SIS scheme than among males, also males said that it was often their partners who had taken care of the registration process.

When analyzing the factors that in the utilization and seeking for health care services, earlier studies have shown that females both seeks and use more care services (Galdas, Cheater and Marshal 2005). Our interviews similarly indicated that women know more about health care and seek it to a larger extent than males.

According to Galdas, Cheater and Marshal 2005 one of the most important determinants of utilization of [health] services is family planning but also motherhood.

9.2. Ability to seek

Negative experiences, information from friends and relatives about bad experiences and/or negligence, were perceived as inefficiency from health care providers, lack of tools at the health facility, suspicion that people with who pay money (pays out of pocket) are served first at the health care facilities, are features that reduce the trust people have in public health care.

Consequently, such perceived features of the health system may prevent users from seeking public health care. Gender is also influential in the motivations behind the seek for health care. Females were more active in seeking care than men. At the Posta, most patients were women. Women were often in charge of the affiliation process to SIS, both for themselves and their closest relatives. This finding is not new, previous studies regarding care-seeking behavior that compare men and women, have found that females typically seek health care (primary health care in particular), more often than men (Galdas, Cheater and Marshal 2005).

One possible explanation why woman seek more for health care than men is motherhood. Women visit health care facilities during and after pregnancy, making female more in the habit of receiving health care services. Other explanation is due the concept of “traditional masculinity and/or masculinity beliefs” (Galdas, Cheater and Marshal 2005, 621).

It is tempting to speculate the unevenness in seeking care between men and women, but evidence is not enough to construct a strong and unique justification of this behavior (Galdas, Cheater and Marshal 2005).

9.3. Ability to reach health care

People interviewed for this study were able to reach health care. However, the way they reached it was not without big efforts from their side. The interviewees reported that they had to get up very early to reach the health facilities, only to find a long queue waiting for them. If they were lucky, health and/or administrative personal would treat with respect, patience and kindness; otherwise, they would have to endure being treated without proper respect or would endure discrimination because of their economic status or they lack important contacts within the health facility. In some of the cases, they would get very brief consultations, unclear explanations about their symptoms or diagnosis and would finish their consultations feeling more confused. In addition, sometimes there would not be enough materials, tools, equipment or medicines available.

The worst-case scenario was reported from one of the interviewees who said that the general practitioners or specialists would be absent, so the perception of low-quality services is a barrier both to seek and to reach health care.

The reason for the lack of materials, equipment and/or medicines at public health facilities could be related to the small budget for social programs in Perú. An OECD report from the Peruvian health system 2017, shows that Perú spent 5.5% (OECD 2017b, 43). This number is low compared to other Latin American countries, such as Colombia and Ecuador, who spend 8% of their GDP as average (OECD 2017b) and OECD countries spend an average of 6.5% (OECD 2017b). Such a small budget is due to its low tax revenues (Cotlear 2006, 10). health insurance programs, such as SIS, receive only 11% of the total budget of the MINSA budget (Cotlear 2006, 134) or 7% when regional budget is included.

Another possible reason for the brevity of consultations of SIS users might be because of the small tariffs imposed to the service providers. Also, frontline providers may face pressure to increase their productivity, although this can mean the delivery of short and superficial consultations with users. How might small tariffs influence the periods of the consultations of affiliates to SIS? First, small tariffs mean providers do not receive enough when they provide services to SIS users, which in turn would explain why they try to see them as briefly as possible. Small tariffs may also lead to priority given to those who pay out-of-pocket. In addition, personnel at the health facilities may feel that SIS users are responsible for their low wages, which can make them feel that it is acceptable to offer low quality services.

The payment method from SIS to the service providers thus emerges as a possible explanation for low quality health care, and indirectly for higher access barriers. SIS insurance system pays health providers only after they have provided their service (reimbursement system). In later years SIS experienced a reduction in its budget. The consequence of this was that SIS had a debt to its health providers for a time. Although the debt was later paid, it caused "a longer-term problem of trust in this system" (World Bank 2016, 32) from the health provider side. Providers may be cautious to treat SIS-covered patients as they fear there may be new delays in the future before SIS pays its debts to them. This might influence the way health personnel treat those who have insurance coverage through SIS.

Creation of new contract schemes like *nombrado* (lifelong contract for health personnel) may be important. This kind of contract guarantees that health personnel are hired for life in the public sector, without fear of losing their jobs. Few instances like medical negligence or corruption would terminate their contract. (Municipioaldia 2016). Health personnel that operate under these kinds of contracts might also have reduce interest in providing high level quality services to their patients, because they know they cannot lose their jobs even in cases of poor performance or short consultations.

Performance of medical personnel is monitored by the Intergovernmental Commission of Health, however, there is room for improvement. Lack of monitoring is not only related to health service performance, but also in lack of monitoring "expenses, salaries, and the location of health personnel" (Cotlear 2006, 109), i.e. lack of cost-tracking systems. Cotlear 2006 argues that low

performance at Peruvian public health facilities is due to “the government’s failures to monitor performance and enforce work rules” (Cotlear 2006, 191)

However, problems on the supply side are not uniquely responsible for access problems. “Inability of users to perceive or react against service deficiencies” (Cotlear 2006, 191), “to perceive the poor quality of service received and [to] have lacked the organizational capacity to press for improvement” (Cotlear 2006, 192), are also factors that may contribute to low performance and low quality of health services delivery.

In this context it must be stressed that the limited number of interviews is not enough to state to which extent this criticism is generally valid. Also, not all our interviewees were equally negative of the treatment Although some interviewees referred their expectations as not satisfied, however, when interviewees were asked general questions about their satisfaction with public health care services and SIS, they indicated the scheme as a good option, and helpful.

9.4. Ability to pay direct, indirect and opportunity costs

Utilization of public health care services was high among SIS affiliates in the data sample. For the interviews at the Posta this was so: Those who did not utilize services, were simply not there. However, utilization is not synonym to access with quality. Due to the lack of instruments to provide care, and/or lack of medication in the adjoined public pharmacies, the utilization of health services can cause direct costs to users. The distance to health facilities imply transportation costs. The long waiting time and reschedule of consultations represents opportunity costs. Distance causes expenses in the transport to health facilities. Once people are at the facility and waiting on the queue, they may feel hungry and/or bored, even worse if they have children with them, then this may lead to extra food expenses or other things while waiting on the queue, and also once inside while waiting for their consultation. Many interviewees said they had to take the day off work so they could attend health facilities. Since most of the interviewees are independent and informal workers, this also has consequences in the form of opportunity costs. While they are in the health facility, they are losing income, income they would not be able to recover.

All the interviewees report utilization of public health services as SIS affiliates. Although many identified critical issues in the delivery of care, SIS affiliates are still using these services.

The findings from the interviews are somewhat contradictory. On one side, users are informed about the difficulties they find once at the health facility, and all the costs access to public health services as SIS users mean to them. However, they also indicated that the leading factor for them to use public health services is their perceived free cost. They believe SIS is a good option because it is advertised as free. They seem to be grateful for the service, as they might perceive free access to health services as a favor. However, they also complain about the many hours they have to spend at the Posta, the long distances, and the fact that they have to purchase their own medicine sometimes. These features cause direct and opportunity costs.

None of the interviewees said they would stop using public health care services due to negative experiences. This may however simply because they have nowhere else to go, where they can get cheap or free health care from professional health personnel.

9.5. Ability to engage with health personnel

Some of the interviewees at the Posta were obtaining health attention in a health facility different from the one in their own district. It was explained in Chapter 4.2 that affiliated people should be assigned to the nearest Posta to their homes (SIS 2011). Interviewees at the Posta told me they were affiliated to the SIS scheme and did not pay for consultation. They reported as much as two hours of travel time, and that they live in other districts of Lima. In Lima it is not possible to spend two hours traveling inside the same district, even if the patient decided to walk.

A perception that service at SIS health care center is mediocre or uneven may be one of the reasons why some SIS beneficiaries are seeking attention in other health care centers even if the latter are further away, in order to increase the probability that they get the service they search for. If so, it might be a problem if "unpopular" Postas do not suffer any negative consequences if users go elsewhere. In principle, an "unpopular" Posta might achieve a lighter workload – and hence an easier situation for the staff – if users go elsewhere. This possibility has not been possible to investigate given the limited resources available for data collection in this master thesis, but it could be a topic for future research.

As it is defined by Levesque, appropriateness is the delivery of services with proper quality at the right time (Levesque, Harris and Russell 2013). Although, interviewees sometimes referred

that appropriateness of public health services is low, due long waiting time, lack of tools, health personal, and health personal's behavior, they still used them, or were planning on using these services.

Some of the reasons they still use services might be because they know about the importance of health, and that the alternative – not to use the services – is much worse. According to the 2000 World Development Report of the world bank about poverty, "the poor consistently noted the importance to them of maintaining good health" (Skolnik 2012, 52).

Other possible justification for the use of the SIS health services, although lack of ultimate performance, can be the lack of options. In Perú the only channel the poor can access to health services is through the SIS, since the SIS have not competition and consequently, the poor have not choices, then SIS do not have the pression that incentive it to do rapid improvements delivering high quality in health services.

As it is stablished by Le Grand 2007 choice and competition "promotes responsiveness to users' needs and wants; it provides incentives for providers to provide higher quality and greater efficiency and it is likely to be more equitable" (Le Grand 2007, 42). Consequently, improvement of the public domain will be more than obvious (Le Grand 2007).

Conclusions

In this thesis I analyzed the utilization, perception, and access to health care services within the low-income individuals in Lima, focusing on the public offer of health care services by SIS. Assumptions made before the study that match the literature proved. to be true, and at the same time, several new unexpected aspects emerged:

d) Despite the socio-economic status of the strata of the population analyzed, they have access to public health care services.
e) The quality and type of health care services they have access to is however, poor and unequal in the sense that it requires engagements and unforeseen out-of-pocket payments for certain services.

f) The improvements foreseen by the reforms to the health care service in Perú has not brought a perceivable effect on the effective access to health care for the poorest.

In summary, utilization of public health services through the SIS scheme is high in Lima. However, the access to these services is not free of challenges and barriers, which should be further addressed.

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Appendices

Appendix 1: Interview Guide (English)

1. Gender:
2. Age:
3. Occupation:
4. Do you have any children? If yes, how many?
5. Who do you live with?
6. Do you know the difference between a Posta medica and a hospital?
7. In which circumstances can you resort to the Posta medica and the hospital?
8. Do you know the difference between a Posta medica and a Consultorio Médico? Please explain it briefly.
9. Have you or your relatives ever used the Posta medica?
10. When you used the Posta medica, which aspect/characteristic did you find positive and which one negative. Please explain.
11. Do you know about the Integral Insurance of Health that allows you and your relatives to receive medical attention either for free or for a monthly fee of 40 nuevos soles if you and/or your relatives get sick?
12. Why are you and/or your family not registered?
    How do you know about SIS? Did you get this knowledge from friends, relatives, newspaper, radio, tv, or others? Please elaborate about how you got this information.
13. Can you explain briefly about the process to follow to be affiliated to SIS and the requirements needed to be able to use the services that SIS offers?
14. Describe your any bad experience you have had at the health's center.
15. What is your general opinion about the national health system: Public health care services and the Integral insurance of health?

Appendix2: Interview guide (Spanish)

1. Sexo:
2. Edad:
3. Empleo:
4. Cuantos hijos tiene:
5. ¿Quienes viven con usted?
6. ¿Usted sabe la diferencia entre la posta médica y el hospital? ¿Por ejemplo, en que circunstancias puede acudir a la posta medica o al hospital?
7. ¿Usted sabe la diferencia entre la Posta y un Consultorio Médico? Por favor explicar.
8. ¿Alguna vez usted se ha atendido en la posta medica?
9. Cuando usted acudió a la posta medica, que aspecto le pareció bueno y cual le pareció malo.
10. ¿Alguna vez ha escuchado acerca del Seguro Integral de Salud? El cual permite que usted y sus familiares (esposa(o), hijos) puedan acceder gratuitamente o por una cuota mensual de 40 soles a atención médica, ¿en caso usted o algún familiar se enferme?
11. Por qué usted y/o su familia no está registrada en el SIS?
12. ¿Como se entero acerca del SIS? Amistades, familiares, televisión, radio, afiches. Por favor explique cómo se enteró del Seguro Integral de Salud.
13. ¿Me puede explicar brevemente acerca del proceso que debe seguir para registrarse al Seguro Integral de Salud y de los requisitos necesarios para poder registrarse y hacer uso de los servicios que el SIS brinda?
14. Describa alguna mala experiencia cuando usted acudió al centro de salud.
15. Cuál es su opinión acerca del sistema nacional de salud: servicios públicos de salud y el seguro integral de salud.

Appendix 2. NSD Approval.

Einar Øverbye
Postboks 4 St. Olavs plass
0130 OSL O

Vår dato: 05.09.2017 Vår ref: 55239 / 3 / L H Deres dato:
Deres ref:

Tilbakemelding på melding om behandling av personopplysninger

Vi viser til melding om behandling av personopplysninger, mottatt 03.08.2017. Meldingen gjelder prosjektet:

55239	Main factors that hinders utilisation of public health coverage in extremely poor populations in marginal urban areas in Perú
Behandlingsansvarlig	Høgskolen i Oslo og Akershus, ved institusjonens øverste leder
Daglig ansvarlig	Einar Øverbye
Student	Mayra Elizabeth Urquizo Gonzalez

Personvernombudet har vurdert prosjektet, og finner at behandlingen av personopplysninger vil være regulert av § 7-27 i personopplysningsforskriften. Personvernombudet tilrår at prosjektet gjennomføres.

Personvernombudets tilråding forutsetter at prosjektet gjennomføres i tråd med opplysningene gitt i meldeskjemaet, korrespondanse med ombudet, ombudets kommentarer samt

personopplysningsloven og helseregisterloven med forskrifter. Behandlingen av personopplysninger kan settes i gang.

Det gjøres oppmerksom på at det skal gis ny melding dersom behandlingen endres i forhold til de opplysninger som ligger til grunn for personvernombudets vurdering. Endringsmeldinger gis via et eget skjema. Det skal også gis melding etter tre år dersom prosjektet fortsatt pågår. Meldinger skal skje skriftlig til ombudet.

Personvernombudet har lagt ut opplysninger om prosjektet i en offentlig database.

Personvernombudet vil ved prosjektets avslutning, 31.07.2018, rette en henvendelse angående status for behandlingen av personopplysninger.

Dersom noe er uklart ta gjerne kontakt over telefon.

Vennlig hilsen

Marianne H øgetveit Myhren
L ise Aasen H averaaen

K ontaktperson: L ise Aasen H averaaen tlf: 55 58 21 19 / L ise.H averaaen@nsd.no
Vedlegg: Prosjektvurdering
K opi: Mayra Elizabeth Urquizo Gonzalez, lamb_mgff@hotmail.com

Personvernombudet for forskning

Prosjektvurdering - Kommentar

Prosjektnr: 55239

PURPOSE

The purpose of the project is to investigate various barriers to utilisation of Public Health care for the poor in marginal Districts in Lima, Perú.

SAMPLE

The sample consists of households which are extremely poor, and can thus be considered as part of a vulnerable group.

For information about research on vulnerable groups, please see:

https://www.etikkom.no/en/library/topics/research-on-particular-groups/vulnerable-groups/

RECRUITMENT

The sample will be recruited through a door-to-door method. The Data Protection Official presupposes that the recruitment process is conducted in a manner that fulfils the requirement of voluntarily participation and confidentiality.

INFORMATION AND CONSENT

According to the notification form, participants will receive verbal information about the project and give consent to participation. In order to satisfy the requirement of informed consent of the law, the participants must be informed of the following:

- which institution is responsible (Oslo and Akershus University College, Oslo, Norway)
- the purpose of the project/the research question(s)
- which methods will be used to collect personal data (personal interviews)
- what kind of information will be collected
- that information will be treated confidentially and who will have access to it
- that participation is voluntary and that one may withdraw at any time without stating a reason
- the expected end date of the project (31.07.2018)
- that all personal data will be anonymized or deleted when the project ends
- whether individuals will be recognisable in the final thesis/publication- contact information of the student and supervisor

The student must ensure that the participants have understood the information and participate voluntarily. This implies that the information is provided in a language that the informants understand. The student is responsible for ensuring that a valid consent is given.

COLLABORATION

In the notification form it is stated that the project is a collaboration between Oslo and Akershus University College and the Federico Villarreal National University in Lima. Oslo and Akershus University College is the responsible data controller. The Data Protection Official for Research presupposes that the responsibility for processing personal data has been formally clarified between the institutions.

SENSITIVE PERSONAL DATA

According to the interview guide, sensitive information regarding the informants' health condition can be provided. We therefore take into account that sensitive personal data can be registered.

THIRD PERSON

According to the interview guide, the informant might be asked to provide information regarding family members' or friends' health. We therefore take into account that sensitive information regarding third persons will be registered. The student is required to provide

information about the project to the third person. This information may, for example, be provided by the informant orally or in writing.

INFORMATION SECURITY

The Data Protection Official presupposes that the researcher follows internal routines of Oslo and Akershus University College regarding data security. If personal data is to be stored on a private computer, the information should be adequately encrypted.

END OF PROJECT AND ANONYMIZATION

Estimated end date of the project is 31.07.2018. According to the notification form all collected data will be made anonymous by this date.

Making the data anonymous entails processing it in such a way that no individuals can be recognised. This is done by:

- deleting all direct personal data (such as names/lists of reference numbers)
- deleting/rewriting indirectly identifiable data (i.e. an identifying combination of background variables, such asresidence/work place, age and gender)
- deleting digital audio files