

EDITORIAL

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The potential of municipalities in primary health care and its impact on the health of the Peruvian population

El potencial de las municipalidades en la atención primaria de salud y su impacto en la salud de la población peruana

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The recent pandemic starkly demonstrated the fragility of our Peruvian healthcare system. We did not have appropriate tests for the diagnosis of COVID 19, there were not enough ICU beds (1.6 per 100,000 inhabitants, while Argentina had 18.9) and we only had 270 ventilators nationwide when Chile had 1,600 and Argentina 8,500. There were not enough intensivists and only 2 hospitals had an oxygen plant. We know the result: more than 216,000 deaths, Peru being the country with the highest death rate globally. Hospitals were saturated, tents, stretchers and wheelchairs were placed in the corridors, free spaces were insufficient, there were no oxygen balloons and people died outside the hospitals. This scene will be engraved in many of us. Within this tragedy, we must highlight the resilience of the health personnel who, despite the serious deficiencies, worked hard and paid for it with many lives. In the case of medical personnel, 500 physicians died from the virus.

This undoubtedly contributed to the fragmentation of the sector, which did not allow for adequate articulation, efficient information management and inefficient use of resources. There was also a lack of coordination between the central level and the regional governments, especially with the regional health directorates (DIREAS, for its acronym in Spanish). In addition, public spending on health in our country corresponds to 3.5% of GDP and total health spending to 5.2%, while in Latin America it is 7%. Per capita health expenditure in Peru, at US\$ 767, lags behind the countries of the region⁽¹⁾. In other words, we have a chronically underfunded sector. The health infrastructure gap exceeds S/. 58,000 million⁽²⁾. It has been almost a year since, thanks to the vaccination campaign, the number of serious cases and deaths has fallen to levels close to pre-pandemic. However, the new variants and sublineages of the virus produce peaks of contagion from time to time.

The decision to close the first level of care contributed greatly to the saturation of hospitals. Health centers and health posts at the national level were understaffed and lacked the necessary infrastructure and supplies. But this resource should not have been abandoned; it could have been reorganized under a community strategy, training personnel for timely diagnosis and isolation, creating temporary care centers (CAT, for its acronym in Spanish) at the local level, before the prefabricated centers or the Pan-American Village were created.



But we are in 2022 and it is worrying that the first level of care has not recovered and remains at 47% of its capacity, in terms of care. We have 8,148 health facilities (EESS, for its acronym in Spanish) at the first level of care, of which 722 are in Lima⁽³⁾. Not only is the low productivity of this level of care of concern, but it is also necessary to improve its infrastructure, reformulate it and prioritize it in order to provide comprehensive, family and community care that includes a greater proportion of chronic and non-communicable conditions through Integrated Health Networks (IHN). We must move from a welfare system to a preventive one. According to a recent study, 97% of primary health care facilities have inadequate installed capacity⁽³⁾. Likewise, their number should be reduced and they should be recategorized, strengthening the 748 strategic facilities that have already been identified at the national level, which would be those that operate 24 hours a day and offer ambulatory and emergency care, with a laboratory, imaging center and a small operating room for minor procedures.

Having presented this general framework of our health system and its response to the urgent health needs of the population, there is one actor that should contribute, but does not, to improving services, especially at the first level of care, and that is the local governments. Let us take the example of Lima. One of the pending tasks of the Municipality of Lima from its regional government competencies is to assume the leadership and management of the first level of health in Lima, that which is closer to the neighbors and which groups together some 400 health centers under the responsibility of 4 directorates of integrated health networks (DIRIS, for its acronym in Spanish) of the Ministry of Health (MINSA, for its acronym in Spanish) (the 722 mentioned above also involve Lima provinces). Not to be confused with the Metropolitan Solidarity System (SiSol, for its acronym in Spanish), a hybrid system, public in the institutional aspect and private in the delivery of the service -everything is paid for-, which belongs to the Municipality of Lima. Another is the public health system, which is the basis of a just society.

Although it has been mentioned that there are gaps and long-standing problems, the main aspect of the first level is its organization and management in the territory. 400 health centers are a potential that has not been exploited and that

can generate synergies that are not seen from the sectoral responsibility. In Peru, the process of decentralization of the State began in 2002 but did not culminate throughout the country. Successive municipal governments of Metropolitan Lima deliberately did not assume the leadership of the education and health sectors in their territorial area which, according to the mandate of the approved Law, they should have assumed responsibly. For the development of the health of the inhabitants of Lima, a Metropolitan Health Authority of Lima (AMS, for its acronym in Spanish) is needed, which to date does not exist.

In the absence of this authority, some district municipalities have organized themselves to improve health services in their districts. Among them is the Municipality of San Borja which, within the framework of the Organic Law of Municipalities Law 30855, the National Multisectoral Health Policy 2030, Peru Healthy Country, devised the Smart City Health, created the Health Management with the Public Health Unit and the Health Services and Citizen Services Unit. And under the integrated health networks (RIS) Law, two axes were worked on: providing integrated services and addressing social determinants.

It all started after the pandemic when the information they received from the Ministry of Health (MINSA) on infected, hospitalized, or dead people was not correct or was outdated. They then applied the technology that was already in use in intelligent fences and heat maps for crime risk areas or intelligent gates to identify vehicle license plates. They were able to obtain real and true information on their territory of 110,000 inhabitants. They carried out a cadastre that included the social determinants of health, population density, birth rate, fertility, disability, vulnerable population, those with chronic diseases. With respect to COVID 19, the positive cases, those hospitalized, the deceased. They used geo-referencing and vulnerability mapping. Capitated and bundled payments for health care were established. They set up an exchange of services between the Municipality, EsSalud and MINSA, bringing them together in the same environment, which they called the Family Clinic. They implemented a Dental Health Center, the first municipal rehabilitation center and an oxygen plant. They used telemedicine for consultations, home care services, vaccination campaigns, anemia detection, and a fleet of ambulances. All this



working with a District Health Committee. The results were a medical coverage of 70% of the population and a low mortality rate of 2.9%.

The example of San Borja should be replicated in other municipalities. Thus, in addition to the above, let us imagine the impact it would have on our specialty and women's health. In minors and adolescents, to know if they are protected against human papillomavirus (HPV); women of reproductive age, if they have a Pap smear, if they have had a mammogram. To know their reproductive intentions, contraception. To determine our pregnant population, if they are vaccinated, if they have anemia, if they are having their check-ups, if they have received counseling for warning signs. If they are close to term, where are they going to be attended. Postpartum and newborn monitoring. In other words, an infinity of care that would have a determining impact on the sexual and reproductive health of our women.

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