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The Neoliberalisation of the City – Between Continuity and Novelty in Producing Inequalities in Accessibility to Healthcare in Lima

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Abstract

This article means to analyse the effects of the neoliberalisation of the healthcare system in Lima, in terms of socio-spatial inequalities. An examination of the construction of this system will contribute to set out the context in which neoliberal policies were applied in the 1990s. These policies led to an increase in socio-spatial inequalities, due to the fact that the State had foregone healthcare spatial planning in favour of an evolution based on financial opportunities, one-off projects and private sector development. Moreover, the recent evolution of the healthcare system contains new forms of inequalities which can be perceived as a qualitative rupture from forms of urban injustice. The proposed accessibility analysis insists on the political dimensions of this evolution and on its spatial materialisations, while taking a critical look at the modes of urban production.

Key words: socio-spatial inequalities, accessibility to hospitals, neoliberalisation, urban production, Lima

Introduction

With currently over 9 million residents, Lima[1], the capital of Peru, experienced accelerated development during the second half of the 19th century, characterised by the fact that the State and the authorities could no longer manage the growing urbanisation and the production of inequalities affecting urban space (Matos Mar, 2012). The 1990s were the decade of Peruvian

[1] We are talking here about the city of Lima and Callao which, together, make up a large urban area divided into two administrations: the Province of Lima (which includes almost 90% of the total population) and the Region of Callao.

economy liberalisation, according to *El Otro Sendero*[2] by H. De Soto (1987), as the solution to the economic crisis of the 1980s, poverty and informality. Initially supported by authoritarian and ultraliberal Peruvian President A. Fujimori (1990-2000), this political project marked the beginning of a phase of strong economic growth and global poverty reduction, as well as a phase of regression of the welfare State and public services.

In this context, the effects of neoliberalisation are analysed from the evolution of the healthcare system in Lima. We will be examining the social and political history of health infrastructures with a view to shedding light on urban dynamics: "the evolution of the healthcare system in fact tells us the story of the city" (Defossez *et al.*, 1991, p.138). What are the effects of neoliberal policies and how do these contribute to the production of socio-spatial inequalities in Lima?

This article relates at first the construction of the healthcare system, which already contained inequalities before the liberal watershed. Among the different healthcare services coexisting in Lima, the focus was on public and private hospital structures, the most symbolic elements of the system and the most representative of its evolutions. Besides public or private hospitals, other healthcare structures occupy more or less important places in the system, primary healthcare structures (community care structures without hospitalisation, city doctors) or pharmacies in particular.

We then propose to examine at two different levels the impact of neoliberalisation on accessibility to these hospital structures. The first level examination concerns the increase in socio-spatial inequalities due to the fact that the State had foregone healthcare spatial planning, to its evolution based on specific projects and private sector development. This examination relies on an analysis of inequalities as far as accessibility to hospitals is concerned. Accessibility is understood as the potential to access hospitals and not as the actual measure of attendance (Bonnet, 2002). While accessibility depends on a set of geographic, economic, social or cultural constraints, in this article we prioritise location criteria and the economic conditions of the population based on health insurance systems. Inequalities are then highlighted by comparing distances to hospitals and the distribution of population groups benefiting from distinct insurance systems.

The second level examination means to highlight the new forms of inequalities engendered by actual health service policies. These inequalities result from the

[2] *El Otro sendero* (*The Other Path*) is a reference to the terrorist organisation of the Shining Path and to the armed conflict of the 1980s and the 1990s in Peru.

recent choices of healthcare system organisation, characterised by a growing division and the search for profitability. In this sense, they constitute a qualitative rupture with forms of urban injustice which come in addition to existing inequalities.

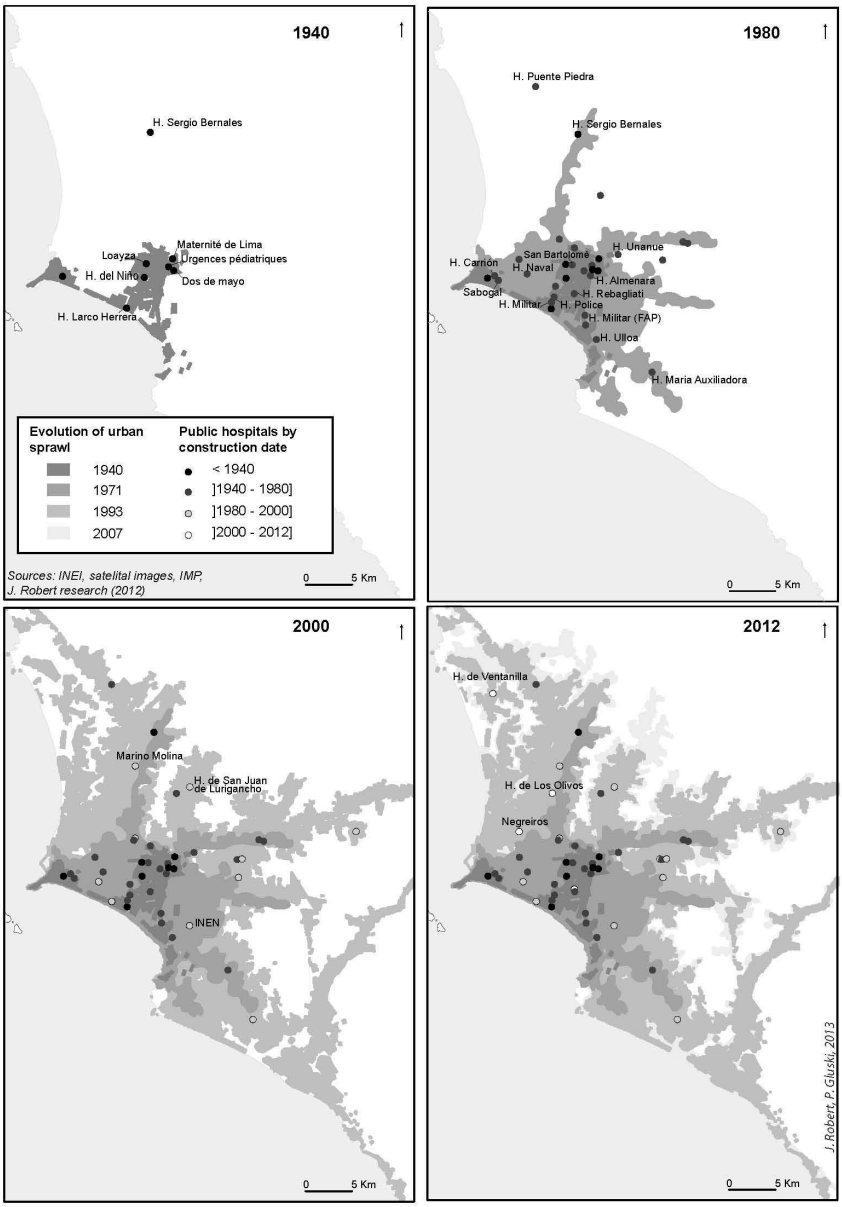
Analysing the evolution of the healthcare system and associated inequalities will help us to define territorial organisation logics as well as control and/or social discrimination logics (Salem, 1995; Ménard, 2002). It will also help us to examine the political dimensions of this evolution and forms of spatial materialisation, while taking a critical look at urban production methods.

1. Construction of the Healthcare System in Lima from the Beginning of the 19th Century to Date

It is necessary to re-examine the construction of this system, in order to situate the context of the liberal Peruvian policy watershed initiated already at the beginning of the 1990s. Five phases, affected by different crises, mark the evolution of the main public and private health structures: the Ministry of Health (MINSA), the social security system (Esalud, that concerns only salaried workers and their families –it was implemented in 1999 in place of the Instituto Peruano del Seguro Social which had been created in 1936), armed and police forces, and the private sector[3].

Map 1: Establishment of Public Hospitals and Urban Growth in Lima

[3] Information on how long these healthcare structures have been in existence comes from The Health Ministry and the National Register of Healthcare Establishments (RENAES – 2011), and was complemented by surveys conducted in these actual establishments. Concerning private clinics, information comes mainly from the web pages of these establishments.



From the Middle of the 19th to the Beginning of the 20th Century: the First Large Hospitals in Lima

The first phase saw the construction of the first major hospitals from the middle of the 19th century (Map 1). At the time, they were considered by hygienists and the population as one of the main agents of contamination: "*the refuge of the destitute… like a place where one goes to die rather than get cured*" (Pardo, in Lossio, 2002, p.82). Although Lima benefitted from economic prosperity linked to the *guano* trade (bird droppings sold as fertilizer) that led to the strong

economic growth of the country between 1840 and 1870, it saw the arrival of cholera and the reappearance of the yellow fever, particularly with the epidemics of 1868 which killed 10 % of the Limenian population (around 10,000 residents). This epidemic provoked a double change: first of all the implementation of public and urban planning hygienic measures which were unknown until then (creation of green areas, canalisation of watercourses, establishment of sewerage systems, destruction of the wall of Lima in 1869); and secondly the improvement of sanitary infrastructures, with the construction of the modern hospital Dos de Mayo in 1870. At the end of the 19th century, three major establishments were managed by the Welfare Society, a society that had been created in 1825, and that was in charge of orphanages, hospices and hospitals (they were previously managed by religious orders but that lost power following the country's Independence in 1821): the Maternity Hospital of Lima, the Hospital Dos de Mayo and the Hospital Loayza – were still used to quarantine rather than cure.

From the beginning of the 20th Century to the 1940s: The Institutionalisation of Health

At the beginning of the 20th century, healthcare was being institutionalised. The Ministry of Health was created in 1935, the healthcare system evolved and hospitals were transformed under the influence of medical development. It then became a recourse for everyone; although until then it had been used only by the most destitute (wealthier people had resorted essentially to doctors doing house calls). This led to the development of two types of establishments: the first type consolidated healthcare in the central part of town, such as the Hospital del Niño in 1929. The second type was more specialised and situated on what was then the outskirts of the city, and adopted the quarantine functions of the hospitals from the city centre. This is the case of the Sergio Bernales Hospital in 1939, which was situated in the far North of the city and was specialised in the treatment of TB, or the Larco Herrera Hospital in 1918, a psychiatric institution situated near the coast. The number of sanitary structures remained relatively limited until the end of the 1930s.

From the 1940s to the 1980s: the State Confronted with an Unprecedented Social Demand

The population of Lima and Callao, which counted 645,000 residents in 1940, was multiplied by seven in 40 years. This rapid population growth, due to the rural exodus from the poor countryside, was accompanied by an extension of

urbanised areas. For lack of low cost housing, newcomers invaded public or private areas. Informal settlements pushed the boundaries of the city and the State, which had been caught off guard, ended up having to sort out the situation (Deler, 1974; Driant, 1991; Calderón, 2005). In 1956, 120,000 people occupied the *barriadas* of Lima (Matos Mar, 1977). The extent and rapidity of urbanisation thwarted any attempts at urban planning.

In the health sector, growth was accompanied by the construction of large infrastructures to try to meet the new social demand: 16 of today's 23 main hospitals were erected during that period. Military and naval hospitals were built in 1955, a police hospital in 1959 and an air force hospital in 1971, under the military government of Velasco (1968-1980). It was also during that period that the three large hospitals of EsSalud were built: first the Almenara Hospital in 1941, then the Rebagliati Hospital in 1956, and finally the Sabogal Hospital in 1978. These came to reinforce the healthcare offer of the Health Ministry that also built several establishments (Carrión Hospital in 1941, Paediatric Emergencies in 1947, the Unanue Hospital in 1948, as well as the Santa Rosa and San Bartolomé Hospitals in 1956), all of them situated in the central part of the city. The building of large establishments on the outskirts of the city by the Health Ministry only began from the 1970s onwards. The building of the Casimiro Ulloa Hospital in the south, and especially that of the Maria Auxiliadora Hospital managed to meet the growing demand from spontaneous estates that had received the support of the State in Villa El Salvador (Calderón, 2005). Smaller hospitals also came into being in San Juan de Lurigancho or, still, in Puente Piedra (in the north), illustrating the will of the authorities to accompany the essentially popular urbanisation of the outskirts. At the same time, the former establishments that were used for quarantine at the beginning of the century, were caught up with urbanisation and transformed into general hospitals.

From 1980 to 2000: The Liberal Watershed in a Context of Crises

The 1980s and the 1990s saw major public investments being stopped in a context of economic and political crisis aggravated by terrorism. This period which was marked by the first structural adjustments and a reduction in public budgets, was accompanied by the liberalisation of the economy which had been promoted by A. Fujimori's government (1990-2000) as being the only alternative to the crisis.

The cholera epidemic of 1991 precipitated the evolution of the healthcare system. This health crisis which spread in 14 countries, caused 300,000 cases,

110,000 hospitalisations and 2,840 deaths in Peru, where over 90 % of cases were listed (Suarez & Bradford, 1993), affected the Peruvian healthcare system which was already suffering from the structural adjustments initiated at the end of the 1980s: "*The health system has never been so ill*" (Reyna & Zapata, 1991, p.55). Despite the extent of the crisis and the way it was dealt with in the media internationally, the cholera epidemic was a "lost opportunity" as far as renovating the healthcare infrastructure of the city was concerned (Cueto, 2009, p.254). What it did, rather, was to give the government in place an opportunity to emphasise its neoliberal policy, tending towards a "culture of survival" (Cueto, 2009): renouncing the universal social cover, stigmatising marginal groups, ending free medical service in public hospitals and privatising services, reducing the budget of the Health Ministry especially for its preventive activities, giving priority to short term solutions and State aid, as well as vertical, authoritarian and fragmented interventions.

Also, for 20 years, save for exceptions such as the creation of the National Cancer Institute in 1987 (INEN), no major establishment had been built while the city was steadily expanding to host a constantly growing population: it increased by 40 % between the censuses of 1981 and 1993, and the annual growth rate was maintained at 2.7 from 1993 to 2007. In 1990, close to two million inhabitants, i.e. one third of the population of Lima, occupied the popular suburbs on the outskirts of the city, on the hillsides and in the desert areas (Driant, 1991). The population of these areas reached more than 3 million inhabitants at the beginning of the 2000s, i.e. 40% of the inhabitants of Lima (Riofrío, 2004). For lack of large infrastructures, priority was given to the construction of smaller establishments, closer to the populations: 38 of the main health centres of the Health Ministry – community-based healthcare establishments without hospitalisation services or with very limited ones – were built during that period. At the same time, the extension of existing hospitals was carried out to meet a growing demand.

During the same period, the first high standing private establishments began to appear in the 1950s, and went through accelerated development from the 1980s onwards: 26 of the 39 major private clinics of Lima saw the day between 1980 and 1990. Growth in the private healthcare system corresponded to an increase in the living standard of an increasing number of Limenians.

From 2000 to 2012: New Investments and a Withdrawn State

The 2000s were marked by the resumption of public investments associated with post-terrorism political stabilisation, and with an unprecedented phase of

economic growth due to oil and mining activities. EsSalud built two major hospitals in 2000 and 2009 (the Negreiros and the Marino Molina) in the northern part of the city, thereby meeting an increase in the number of health insured in that sector. EsSalud also built five smaller hospitals, including one geriatric and one specialised in cardiovascular diseases. The private sector created eight new clinics. These investments, based on profitability, met a well-identified demand (social security insured for EsSalud and well-off populations for the private sector). During that period, the Health Ministry remained withdrawn, except for limited investments. A 40-bed hospital was built in Ventanilla (far north) in 2007, and a new paediatric hospital should soon be in operation. It was initially planned for 2011, then delayed and pushed to July 2013. Due to the difficulties from the public sector, today there is talk of the establishment of a public-private partnership to manage this hospital.

At the same time, the decentralisation process brought on new actors. The municipalities of districts and provinces invested in the health sector by establishing small community-based structures that required little investment. Community-based healthcare is paid for by establishments of local significance, with little or no hospitalisation capacity, and which offer mainly consultation and emergency services. This tendency could also be seen with EsSalud which built 11 Basic Primary Care Units (UBAP) from 2009 onwards.

Today, in a context where living conditions appear to have improved, and where national economic growth[4] has been reinforced, a fact most welcomed by international organisations (such as the Inter-American Development Bank and the World Bank, among others) and evaluation agencies, the tendency observed in Lima is that of a withdrawal of the central State which is contributing to reinforcing socio-spatial inequalities.

Table 1: Evolutions of the healthcare offers vs demographic growth in Lima and Callao between 1940 and 2012

	1940	**1980**	**2000**	**2012**
Population of Lima and Callao*	910585	5189290	7757300	9450585
Increase in population during this period	+ 4 278 705	+ 2 568 010	+ 1 693 285	
Number of public hospitals	8	31	38	47

[4] The growth rate of the Gross Domestic Product in 2011 is 6.9% and is 6.3% in 2012 (http://www.mef.gob.pe/index.php?option=com_content&view=article&id=266&Itemid=100606).

Increase in the number of hospitals during this period	+ 23		+ 7	+ 9
Number of beds accumulated**	3347	11 673	12 349	12 915
Increase in the number of beds during this period	+ 8326		+ 676	+ 566
Number of beds for 10 000 inhabitants	36.8	22.5	15.9	13.7
Evolution of the number of beds for 10 000 inhabitants during this period	- 14,3		- 6,6	- 2,2

* 1940, 1981, 1993 and 2007 INEI population censuses and INEI estimate calculated in 2009 (INEI, 2009)

** The number of beds corresponds to the currently known capacities of each establishment since their creation, and therefore overestimates the number of beds in those days. Indeed, the majority of hospitals underwent extensions.

The evolution of the healthcare system confronted with accelerated urbanisation, has been pointing out the degradation of the healthcare offer in the entire urban area. While new infrastructures were built during the 1980s to deal with demographic growth, building was slowed down in the 1990s, which corresponds to the liberal development policy watershed. Beyond the bias concerning the number of hospital beds, the degradation of the healthcare offer in relation to the demand is undeniable: the ratio dropped from 22.5 beds for 10,000 inhabitants in 1980, to 15.9 then 13.7 in 2000 and 2012 respectively. With this retrospective analysis of the healthcare system, we are able to read the current situation as the result of a liberalisation of policies promoting inequalities. We now need to analyse their consequences in terms of socio-spatial inequalities.

2. Contrasting Outskirts Marked by Socio-Spatial Inequalities in Accessibility to Hospitals

The generalised withdrawal of the public authorities as underlain by a neoliberal logic, leads to their neglecting their role as developers and town planners to the benefit of a development by project with no holistic vision. We can see on the one hand a concentration of means in the central hospitals, and on the other the privatisation of the sector. These two processes are producing an increase in the inequalities in accessibility to hospital structures, linked on the one hand to the spatial distribution of the offer on the territory, and on the other to the population's economic capacity for accessing healthcare.

Concentration of the Means in the Central Hospitals

Managing healthcare as funding opportunities arise favours the concentration of investments in certain places, to the detriment of the search for a more equitable distribution of equipment on the territory.

This translates first of all into means being concentrated into central establishments, some of which being literally transformed from quarantine places into general hospitals with high tech equipment, while the infrastructure is not always adapted. This tendency is reinforced by the financial and administrative autonomy of hospitals, which favours their competition and limits the redistribution of investments guaranteeing greater spatial justice. As such, we see limited interventions usually given impetus by hospitals themselves, without co-ordination, as financing opportunities arise.

As such, 17 of the 23 main hospitals have undergone at least one extension since their construction. The Unanue Hospital, for example, was built in 1948 outside the consolidated city, as a TB treatment centre. It was transformed into a general hospital in 1960 and the number of beds was reduced from 960 to 640 to set up operating theatres. A new emergency service was built in 2007, and a pharmacy in 2008. The presence of pharmacies in hospitals can be explained by the fact that patients have to buy themselves the medicines prescribed by the doctors. The Dos de Mayo Hospital experienced a similar evolution. Built in 1870, it was extended in 1970, re-equipped in 1991, in 1998 and in 2009. Currently, a new building dedicated to intensive care is about to be inaugurated, thanks to a foreign donation[5]. The same goes for the Loayza Hospital which is benefiting from a Chinese donation, and the Maternity of Lima which, in 2001, inaugurated a Peruvian-Japanese building. The Sabogal d'EsSalud Hospital, built in 1978, was extended in 1985 with prefabricated buildings used as hospitalisation services. A new consultation space was built in 1990 and, in 2009, a third floor was added to the main building (in plywood so as to prevent overloading the original building). These adaptations, by tapping into existing resources to improve existing hospitals in the central area, were carried out to the detriment of other potential investments, as with for example the construction of new establishments on the outskirts of the city. This meant effectively an increase in inequalities between the town centre and the outskirts.

[5] Some of the doctors working in this hospital think that it is a white elephant (a non-representative showcase of reality), in that the emergency and hospitalisation services are saturated, and it lacks personnel.

Photo 1: Emergency Service at the Puente Piedra Hospital (Health Ministry) Awaiting a Second Floor

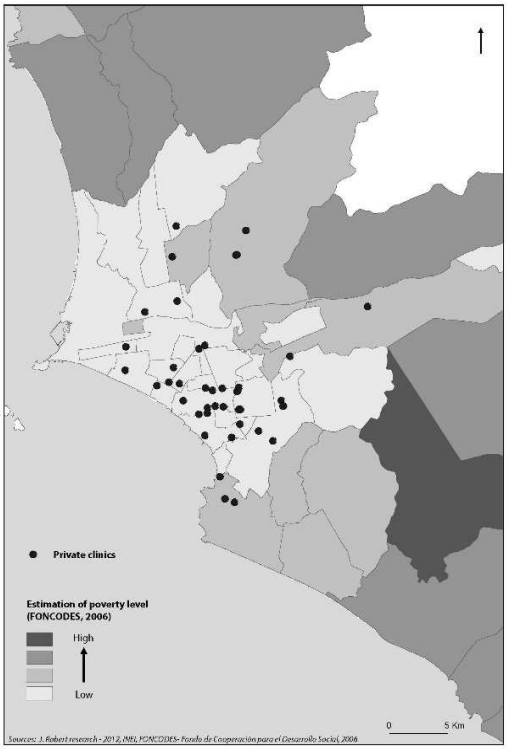
Smaller hospitals are also concerned. Built initially as health centres (i.e. without hospitalisation), many infrastructures were accredited *a posteriori*. Indeed, the Puente Piedra Hospital for example was built in 1970 as a health centre, and became a hospital in 1980. In 2003 and 2004, a pharmacy and a laboratory were built, as well as an emergency service, extended later in 2009 (Photo 1). Today this hospital counts around one hundred beds. The Hospital of Ventanilla, built in 2007, already reinvested into a new building to deal with saturated emergencies. At least 45 local health centres have undergone extension works.

While the adaptation of healthcare establishments meets the demand, it also presents negative aspects. This is the case of the structural vulnerability of the built environment, caused by modifications brought to buildings or the construction of additional floors, which is all the more problematic in an urban area subjected to earthquakes (D'Ercole *et al.*, 2011). These adaptations also emphasise the functional vulnerability of medical establishments. Some of the buildings which were built over 50 years ago are no longer adapted to their function.

The Privatisation of Healthcare

The privatisation of healthcare takes on several forms. The most obvious is the multiplication of high standing private clinics in response to an increase in well-off populations requiring quality service concomitant with the degradation of the public offer. Today, around forty clinics offer hospitalisation services, and represent a capacity of around 1 700 beds. These clinics are mostly found in privileged suburbs, where their clientele lives (Map 2). They also open up to new markets towards the outskirts, mainly north of the urban area which constitutes one of the most dynamic sectors in terms of economic activities. In the end, this hyper-segregative private offer only benefits a limited spatially concentrated population group.

Map 2: Private Clinics and Poverty Level at the District Levels



Another privatisation method has actually been observed in public hospitals. Already at the beginning of the 1980s, the main hospitals under the Health Ministry resorted to this method in order to finance their operation. Paying clinics were built within four large Ministry establishments and in the Military Hospital. They were administered by the hospital which used the profits with redistribution in mind (this type of system has also been seen in France). These clinics offered the same services, but in a differentiated space, according to the financial capacities of the patient. This method has recently been abandoned, due in particular to other private clinics complaining about unfair competition.

The privatisation of health concerns a whole set of small private establishments intended for the lower classes and situated, for most of them, near large public hospitals. These clinics offer in particular X-ray and ultrasound scan services at reduced prices, so as to take in patients from public hospitals which are often saturated.

In addition to the generalised commodification of health, privatisation has been producing a form of segregation in terms of access to healthcare. All the private establishments, and high standing clinics in particular, are following a

profitability logic and only slightly contribute to covering the territory in healthcare equipment.

Socio-Spatial Inequalities in Accessing Hospital Structures

An analysis of inequalities in accessing hospital structures relies on two aspects[6]: the distribution of infrastructures on the territory, and the different population groups according to the type of health insurance they have access to. Highlighted inequalities are of two types: geographical, depending on the location of healthcare structures, and economic, depending on health insurance types.

Three major groups are distinguished among the populations of Lima, according to their health insurance (Map 3). Health insurance determines the establishments each group has access to:

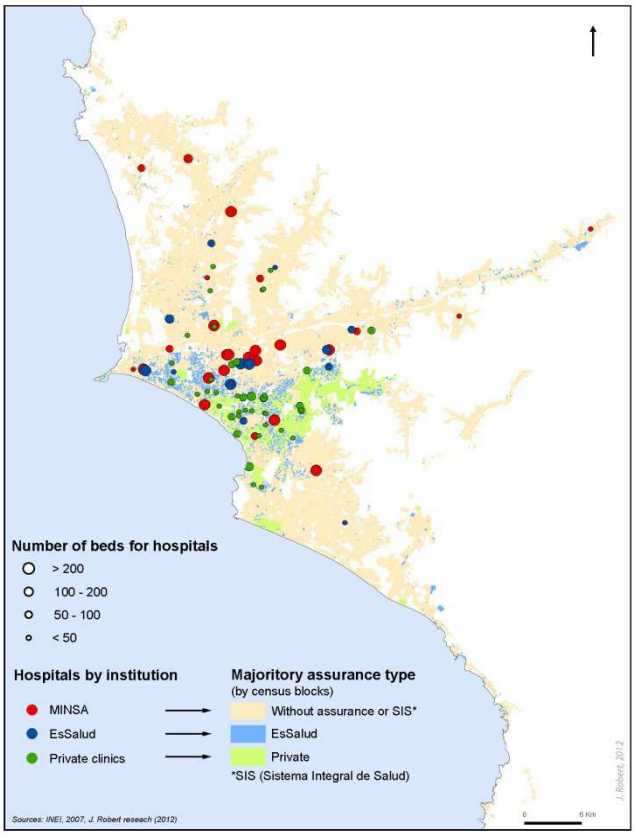
- The group having access to Health Ministry establishments: it includes the population with no health insurance whatsoever, i.e. close to 5 million people (57.6 % of the population in the capital city), and that which has access to the Integral Health System (SIS), the insurance system of the Ministry reserved exclusively for the most disadvantaged populations, i.e. around 550,000 people in 2007 (6.6%). These two population types are put together in this group because we consider that they resort as a priority to Heath Ministry establishments due to cost issues (compared to private clinics) or access right issues (EsSalud establishments only take on patients benefitting from social security). The very large number of people without health insurance is to be associated with the universal health cover objective that was abandoned during the 1990s, in addition to employment informality and casualization. The percentage of workers without social security or benefitting from legally compulsory protection was 54.9 % in 1980. While this percentage dropped to 53.8 % in 1995, it increased again to 61.3 % in 2000 (CEPAL data: Comisión Económica para América Latina y El Caribe, in Portes and Roberts, 2004). Although improvements were made to insure the most disadvantaged populations (with the Health Ministry today announcing one and a half million insured at the SIS in Lima and Callao, i.e. close to 15% of the population and more than double the figure of 2007), most of the 9 million residents of the

[6] The existing gap could be put into perspective by taking into consideration the quality of transport services and transport costs which can be crippling for the popular classes. Social and spatial practices could also be taken into consideration, but we do not have any data on the subject.

capital city are still not insured, and offering basic insurance cover to the entire population is not a political priority.

- The group having access to EsSalud establishments concerns those who benefit from social security on the account of their job, i.e. 24 % of the population or more than 2 million residents.
- The group having access to private clinics concerns residents who benefit from private insurance. This group represents 12 % de la population, i.e. just over one million people.

Map 3: Type of Health Insurance and Hospital Structures in Lima / data from the population census of the National Institute of Statistics and Data Processing of Peru (INEI) (2007)

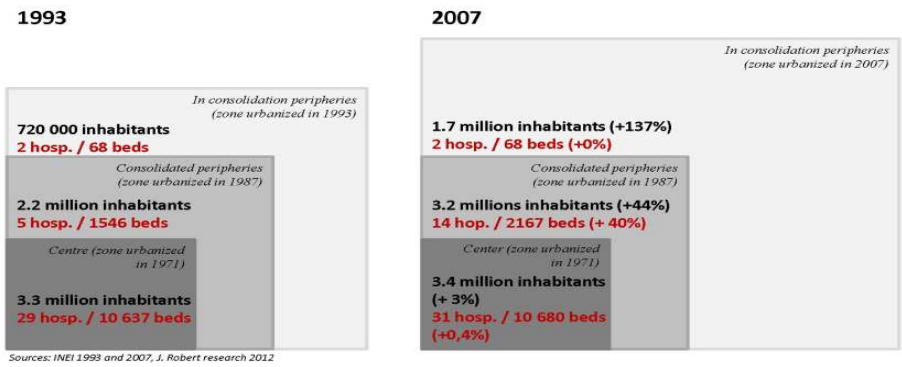


Health insurance illustrates very strong inequalities between the town centre and the outskirts. Town centre is where one finds those who are privately insured and who live in well-off suburbs, as well as the beneficiaries of EsSalud who live in consolidated suburbs. People without insurance and disadvantaged groups benefitting from the SIS, i.e. all the people who resort essentially to the

public services of the Health Ministry, are relegated to the outskirts of the city. EsSalud hospitals and private clinics are spatially adequate as far as potential demand is concerned, both being concentrated into the central part of town. Conversely, the distribution of Health Ministry hospitals is unequal, leaving the outskirts where one finds mainly the population with no health insurance or benefitting from the SIS, under-equipped.

This mapping highlights not only spatial differentiations, but also obvious social inequalities resulting directly from a segregative evolution of the healthcare system, which was exacerbated in the neoliberal context of the 1990s already. As such, a multi-level healthcare system was being created, with the equipment being concentrated in the central part of town, to the detriment of a more equitable territorial cover. This system evolution contributed to an increase in inequalities between the centre and the outskirts of town (see Figure 1).

Figure 1: Compared Evolution of the Population and the Number of Beds in the Public Hospitals of Lima Between 1993 and 2007



The compared evolution of the population and the number of beds in public hospitals these last years, shows that in response to new demands, the healthcare system was not being developed equally. The construction of eleven new establishments (adding up to around 700 beds) between 1993 and 2007, reinforced the healthcare offer in the "central part of town" and in the "consolidated outskirts" (both areas being already urbanised in 1971 and 1987 respectively), thereby matching the population increase in the consolidated outskirts in particular. It is also in these areas that the capacity of the large

hospitals which existed already had been reinforced, and that a hyper segregative private offer had been developed. The new outskirts, corresponding to areas which had been urbanised from 1987 onwards, experienced the highest growth (with more than one million or so inhabitants in 14 years), and no apparent hospital infrastructures. Where these areas concentrated populations without insurance or with SIS, these were also the areas with the least options. As a result, the outskirts appeared marginalised with an insufficient healthcare offer, which was taken care of almost exclusively by the Health Ministry. In the end, this evolution of the healthcare system highlighted the disadvantaged status of the populations living on the outskirts with, among other things, access to housing being made more difficult and poverty worsening.

3. New Forms of Inequalities: Upsetting the Healthcare System

Beyond the aggravation of socio-spatial inequalities in terms of accessibility to hospitals, one can also observe quality issues in the nature and operation of healthcare services. In a context of decentralisation, the healthcare system is subjected to increasing complexity, through the multiplication of actors and the fragmentation of the system. The initiatives which have been set up, as justified by public sector deficiencies, represent one-off solutions that do not resolve structural problems.

Multiplication and Fragmentation of Initiatives

The decentralisation process provides for the management of Health Ministry structures by regional and local governments. This became effective in 2009 for Callao and is ongoing for Lima. With decentralisation comes the problem of division between these two political entities which share the urban territory. Before decentralisation, the Health Ministry was responsible for planning the healthcare system at the national level and therefore on the entire urban area. The transfer of skills to the regions has been reinforcing the division between the two entities, while the main hospitals of the capital city are playing a role at the metropolitan or even national level. This break-up in skills has been contributing to an increasing politicisation of the healthcare system management, subjected to electioneering logics, to the detriment of a holistic vision concerning the needs of the urban area. It also questions the balance of power between local administrations and the main hospitals that insist on remaining autonomous. While decentralisation means the implementation of medium-sized projects and original systems, it also shows its own limitations as soon as large-scale projects need to be tabled.

Provincial and district municipalities have also been investing in the health sector by equipping themselves with more or less important structures, in addition to the current offer. The system of Solidarity Hospitals ("*Hospitales de la Solidaridad*"), created in 2004 by former Mayor of Lima Luis Castañeda (the former Director of the IPSS), is being reused today by Susana Villarán who was elected in 2010. It is currently composed of around twenty establishments, with more on the way. The services offered are essentially consultations and diagnostics, as reinforcement to what is being offered to the local community. However, in this case, there is no hospitalisation, as otherwise suggested by the name "solidarity hospitals". These establishments are managed by a decentralised public organisation of the municipality of Lima (SISOL: *Sistema Metropolitano de Solidaridad*) which supplies the infrastructure, looks after the administration and determines tariffs. Infrastructures, which are relatively basic, are established on municipal premises, in rented buildings and in containers placed in public areas. Proper medical services are delegated through contracts with doctors or service companies supplying their own equipment, and with the doctors being paid per consultation. While it offers a practical and faster service (with prices matching those of the Health Ministry[7]), this system benefits from strong social acceptance[8]. Very recently, structuring efforts have been undertaken with the Health Ministry, in order to follow up on medical files and to undertake to reimburse the medical expenses of SIS patients. On the same model, the regional government of Callao has set up three *Chalacos* (name given to the residents of Callao) hospitals, also in the form of equipped containers. While, following decentralisation, this regional government is responsible for Health Ministry establishments, it maintains the two systems separately. At the local level, districts have also been creating health structures. This is the case of the district of Los Olivos which, in 2006, inaugurated a municipal hospital with a different kind of set up: the infrastructure is the responsibility of the municipality while the personnel come from EsSalud. Other districts set up small-sized healthcare centres, often in containers in public areas. These initiatives which are increasingly frequent, remain limited and are run separately, with no link between either administration.

[7] One consultation in general medicine in an establishment of the MINSA usually costs between 5 and 10 Peruvian Soles (one Euro equal around 3 Soles). In a Solidarity Hospital, it usually costs between 6 and 8 Soles.

[8] During the municipal electoral campaign in 2010, a rumour according to which the current Mayor wanted to stop this service provoked great criticism in the press: (http://elcomercio.pe/politica/642814/noticia-susana-villaran-nego-que-vaya-eliminar-hospitales-solidaridad)

The multiplication of systems is justified by the social demand for community-based and quality healthcare suffering from the lack of capacity of public infrastructures managed by the Health Ministry and EsSalud, but contributes directly to de-structuring the general system. The new systems created reflect the evolution of the political choices oriented towards a logic of decentralisation, private operation and service profitability, rather than towards planning and reinforcing the public health service.

One-Off Solutions for Fundamental Problems

The solutions offered are more like temporary measures than basic reforms, in extending the "culture of survival" generalised after the cholera crisis of 1991 (Cueto, 2009). Initiatives such as the Solidarity Hospitals of the municipality of Lima have been making up for the insufficiencies of the subsidised public healthcare system, by meeting a community-based demand, the reason why they benefit from high social acceptance. Included in the 2012-2025 Development Plan devised by the municipality of Lima, these Solidarity Hospitals have become the standards of public authorities. During participative workshops, civil society representatives were able to define places where the municipality was to set up new establishments. It is with the blessing of the population that a parallel system intended for the disadvantaged is being established, to the detriment of the public improvement policy planned by the public health service, a policy which guarantees a certain equity and spatial justice in terms of access to healthcare. Indeed, the Health Ministry manages 389 healthcare posts and centres (primary healthcare establishments with no hospitalisation) on the entire metropolitan territory. The management of 49 out of 389 establishments was transferred to the Callao Region within the framework of the decentralisation process. Finally, these new infrastructures are in competition with Health Ministry establishments abandoned by the public authorities. Yet, once the decentralisation process has been completed – which is planned by the end of 2013 – these local administrations, which are setting up "container hospitals", will be responsible for managing hospitals as well as healthcare posts and centres currently managed by the Ministry.

The Health Ministry system, although it is accessible to the poorest groups and covers the entire territory thanks to a network of community-based establishments, today appears neglected despite the need for funds. Recently, the shortcomings of the four large public hospitals of the capital city, the lack of beds and obsolescence of equipment in particular, have been highlighted by

the Government Accounting Office (C*ontraloría General de la República*[9]. This difficult situation also concerns the conditions under which health professionals are hired, which have been degraded by the neoliberal policies of the 1990s, and are recognised as one of the priorities among the strategic orientations of the policies of the Health Ministry (2007). The shortcomings of the public service are also affecting the EsSalud system. Recently, the doctors of the Rebagliati Hospital – the largest in Lima (EsSalud) – complained about the personnel being exposed to tuberculosis due to saturation in emergencies, mentioning several cases of contagion[10]. In 2012, the doctors' strikes at the national level, concerning the working conditions (salaries, types of contracts), paralysed EsSalud then the Health Ministry for several weeks.

One needs to question the means required with a view to implementing a more egalitarian system. While initiatives born of the decentralisation process are proposing an alternative to the public systems of the Health Ministry and EsSalud, they do not solve the problems linked to the working conditions of health professionals (doctor protection, consultation pricing, etc.), and question whether structures are adequate as far as health conditions and healthcare quality are concerned, particularly in the case of equipped containers. These basic questions are de facto outshined by the omnipresence of the problem posed by the saturation of the traditional public services. In the end, these initiatives come up as being complementary to and at the same time in competition with the public system. They favour the dissipation of efforts and distribution of funds, to the detriment of a takeover of the public sector which, should it be the subject of a voluntarist policy, could lead to an improvement in healthcare services and spatial justice. Indeed, the healthcare posts and centres of the Health Ministry are the ones suffering from a lack of means in equipment and personnel, while they represent the widest territorial coverage.

As such, although they are justified by an important social demand and by the shortcomings of the subsidised public service, the recent evolutions of the healthcare system have been contributing to the creation of new inequalities, through a form of casualization of the healthcare offer and by favouring a disarticulated system.

In the end, the neoliberal watershed of the 1990s led to the establishment of a multi-tier healthcare system. In an interview conducted during the presidential

[9] http://elcomercio.pe/actualidad/1484300/noticia-contraloria-detecta-graves-deficiencias-sanitarias-falta-equipos-hospitales-lima

[10] El Comercio, 12 June 2012, Rebagliati Doctors Demand a State of Emergency for Reasons of Tuberculosis -http://elcomercio.pe/lima/1427258/noticia-medicos-rebagliati-piden-declaratoria-emergencia-tuberculosis

campaign of 2011, a candidate summarised the matter as follows: "We have a 5th class which is the EsSalud [for salaried employees benefitting from social security], a 6th class which is the Health Ministry and a 7th which is Integral Health System (SIS) [social security for the poorest] and a 1st class which corresponds to the [private] clinics of San Isidro and San Borja [well-off districts of Lima], and there is nothing in between." (Kuchinsky P.P., *Caretas*, 17 March 2011). Recent evolutions contribute to the fragmentation of this system, by offering limited solutions and without questioning the system in depth. This system contributes to reinforcing existing inequalities, materialised by a strong contrast between the centre and the outskirts of town, with the centre being modern, rather well-off and well equipped, and the outskirts being popular and neglected by the public authorities.

Conclusion

An analysis of the healthcare system led us to look at the effects of neoliberal policies applied as early as the 1990s in the city of Lima. As mentioned by W. Ludeña, the absence of a regulating State and existing inequalities have marked the history of Peru since her independence (Ludeña, 2011). Nonetheless, the fact remains that the effects of neoliberal policies are reflected in the organisation of the healthcare system. Neoliberal logics rely on the search for profitability, decentralisation, service privatisation and the management of one project at a time, to the detriment of a territorial vision and spatial justice in accessibility to healthcare. These policies are reflected in the reinforcement of inequalities between the centre and the outskirts of town, and contribute to the casualization of the living conditions of the disadvantaged sections of the population by creating a multi-tier system, disarticulated, with no political project fully tackling social and spatial inequalities.

As such, the effects of neoliberalisation are felt beyond the conditions of poverty or access to employment, as shown by Portes and Roberts (2004) for Lima, and affect the entire urban operation and the living conditions of the population. They contribute to the reinforcement and creation of new inequalities. These evolutions, illustrated through the conditions under which residents have access to hospital structures, in the end reflect injustice in terms of access to the city, by marginalising certain spaces and groups.

Analysing the evolution of the healthcare system in Lima accounts for urban and political phenomena taking place at the national or even global level, the effects of which have a direct impact on the living conditions of the population. As such, this political geography makes it possible to take a critical look at the

modes of urban production. It focuses on the role of the State and public authorities, which appear as the sole possible guarantors of spatial justice, against an urban production which favours competition, the management of local one-off projects with no global evaluation of needs and relying on the local level, i.e. unequal and competing territories. At the same time, this positioning questions the increasing number of initiatives on the resilience of towns and societies, via the reinforcement of adaptation capacities and the development of skills and local practices. It is the underlying ideological positioning behind these initiatives and, more generally, the current policies, which is placed here at the centre of the discussion.

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