

The Politics of Health Sector Reform in Peru¹

Christina Ewig

cewig@email.unc.edu

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Health sector reforms in Peru, despite nearly a decade of reform efforts, are best described as piecemeal. The reform project itself lacked a comprehensive vision, and the resulting policies often either conflicted with each other, or with the stated overall goals of health sector reform: “a reform with equity, efficiency and quality”.² Major health indicators, moreover, show improvement in health status, but these improvements are not substantially different from improvements in non-reform, and even crisis periods of the health sector. The less than robust outcomes of health sector reform in Peru are the result of multiple political factors and processes. These factors fall in two primary levels: the level of national politics and that of the macro-political context. In the first level, one can trace competing interests and tactics among different political actors, including presidents, finance ministers, ministry bureaucrats, and leaders in civil society such as heads of health workers and labor unions. The behavior of these national players however, was influenced by a macro political context of regional trends toward economic and political reform, the related growing influence of International Financial Institutions (IFIs) on social sector reforms, and national and regional democratization. Yet, in spite of competing national interests and macro political factors, the politics of Peru’s health reform policy process was largely insulated within the bureaucracy. This insulated mode of policy-making led to conflict between policies in the implementation stage, and ultimately, the piecemeal character of Peru’s health reforms.

This paper provides an overview and analysis of the politics of Peru’s health sector reform process of the 1990s, thus tracing the variables and processes that led to the weak reform policies in place today. The paper begins with a general overview of the

sector, including reform context, spending patterns, structure of the sector and basic health indicators. This is followed by an examination of the macro-political factors that influenced the reform process. I then shift to the national level politics involved, tracing the formulation of four major reforms. The last section of the paper comments on the politics of implementation, and how conflicts among policies at the implementation phase has affected the overall reform content and emphasis.

Background & Overview of Peru's Health Reform

Health sector reform in Peru began in 1991 with the introduction of fees for services in most Peruvian public health establishments, and hospitals in particular. This reform was less a strategic reform than a response to the enormous economic crisis facing Peru when President Alberto Fujimori Fujimori was elected in April 1990. Upon election, President Fujimori faced soaring inflation of 7,650% per year (INEI 1992), and a country whose credit rating was undermined by the debt moratorium policies of the previous President, Alan García Perez. Fujimori took little interest in social policy in his first two years in office and during this time the already weak state health system rapidly collapsed under the stress of economic crisis and civil war.³ Spending on social programs in 1991 was just less than one quarter of that spent in 1980, and health spending was at a rate of only 23.5% of that spent in 1980.⁴ Between the state public health system serving the poor and uninsured and the state social security health system

² This is part of the title of MINSA 1996, the major guide to Peru's health reform.

³ Shortly after the transition to democracy in 1979, the state faced a number of guerrilla insurgencies. The strongest of these was the guerrilla group *Sendero Luminoso*, or the Shining Path, which gained strength throughout the 1980s. The Shining Path concentrated its war in the rural areas, slowly making its way to Peru's capital, Lima. Rural and peripheral urban state health clinics, as a part of the state were considered part of the enemy. As a result, the Shining Path regularly attacked clinics.

serving formal sector workers, the public system, overseen by the Ministry of Health (MINSA) was hardest hit, with a budget of just 15% of that spent in 1980 (MINSA 1996 p. 29). Fujimori's economic shock therapy, set into motion in August 1990 by his first finance minister Juan Carlos Hurtado Miller, was among the harshest of the South American countries (Iguñiz 1998 p. 27). This led to further de-financing of health institutions, which suffered throughout the economic adjustment period. Thus, the introduction of fees for services, begun in 1991, was a stop-gap measure to help desperate health establishments self-finance until economic stabilization was achieved.

By 1993, the economy had begun to stabilize, the privatization of state industries provided the state cash to spend on social services, and IFIs such as the International Monetary Fund (IMF) and World Bank, and Inter-American Development Bank (IDB) had begun to see the importance of human capital investment in the areas of health and education. Each of these factors allowed Peru to embark on more carefully planned structural reforms of the health sector, beyond the introduction of fees. This concerted effort at reform began in 1993 with the planning of a number of primary level reforms, most of which were implemented in early 1994, followed by a major reform of the social security health system in the mid to late 1990s.

Peru's health reform under the Fujimori administration can be loosely divided into three general phases. The first phase consisted of primary-level health service restoration and reform (1993-5) including the introduction of two major competing reform strategies: targeting through the Basic Health for All Program and decentralization of clinic administration to community boards through the CLAS

⁴ The above figure is of actual currency spent on social programs; S/2,009,487 in 1980 versus S/490,001 in 1991 (in 1991 currency) (Portocarrero and Aguirre 1992 p. 98.)

program. In the second phase of a few important sector-wide reforms were introduced—including the reform of the social security health system—and there was a focus on planning (1995-1998). The third phase, in which Fujimori's continued tenure in office was questionable due to election campaigning, can be characterized by dormancy (1999–2000). The subsequent Toledo government has yet to make substantive changes to health reforms put in place by the Fujimori administration, or to develop reforms very different from its predecessor.

Health Spending & Sector Structure

Spending on health in Peru was most generous in the late 1970s and the early 1980s, until the state was struck by the combination of economic crisis and civil war. This spending however was, and largely continues to be, inequitably distributed geographically, across sub-sectors of the state health system that serve different socioeconomic groups, and according to health complexity level. When compared to other Latin American countries, Peru's spending on health in the 1990s ranked among the lowest (PAHO 1994).

Viewed over the long term, the per capita spending by the central government on health (calculated in December 1990 soles) was 19.4 soles in 1970s, 21 soles in 1980, 2.2 soles in 1990 and 7 soles in 1994 (MINSA 1996 p. 26 based on data from INEI and MEF). The following table provides data on social and health expenditures as a percent of GDP through the 1990s. In general, social and health expenditures began at extremely low levels in the 1990s (among the lowest in the hemisphere). The rates of spending climbed through the 1990s, so that by the end of the decade they were double that of

1990. These spending levels however do not yet match the spending on health in the pre-economic and political crisis period of the 1970s and early 1980s.

Peru, Social Expenditures and Health Expenditures

	1990	1994	1999
Total Social Expenditures, % of GDP	3.3	5.8	6.8
Total Public Health Expenditures, % of GDP	1.03	2.23	2.4

Source for social expenditures: CEPAL 2000, *Panorama Social de América Latina 2000-2001*, p. 140 CEPAL División de Desarrollo Social, base de datos sobre gasto social. Source for health expenditures: World Bank, World Development Indicators database, July 2001.

Similar to most Latin American countries, Peru's health system is highly segmented into separate systems that serve separate populations.⁵ In 1994, the population could be divided into three main groups according to health coverage: those with no insurance, those with state-provided health insurance, and those with private insurance.⁶ The large majority of the population in 1994 (73.8%) – the year in which major reforms began to be implemented – had no insurance at all (MINSa 1996 p. 18). The majority of these depended upon the network of public health posts, clinics and hospitals overseen by the Ministry of Health and its decentralized regional authorities. About 25% of those without insurance did not use any formal means of health services (MINSa 1996 p 24), relying instead on pharmacies, market vendors, traditional healers and homemade herbal

⁵ For a history of the evolution of Peru's health system see Ewig 2001, Chapter two.

remedies. About 21.8% of the population in 1994 was covered by the state health insurance plan, at the time called the Instituto Peruano de Seguridad Social (IPSS, now ESSALUD), with another .9 paying into both the state IPSS plan and a private insurance. In addition to these, about 2% of the population was covered under state military or police health coverage – which possess its own network of hospitals and clinic. The private sector, the third major area after public and pay-as you go provision, in 1994 insured only 1.5% of the population (MINSAs 1996).

The above numbers refer to insurance patterns, and do not represent overall financing. In particular, the insurance rates mask the significant numbers of each of these groups that utilized private sector health services on an out-of-pocket basis. The proportion of financing of these three major areas is best observed through financial flows in each sector, outlined in the table below.

Peru, Financial Flows Through Separate Sectors of Health

(In Thousands of December 1995 Peruvian Soles)

	MINSAs & Regions	IPSS/FFAA	Private Sector
1992	888,097	1,256, 471	1, 406, 084
(percentage)	(25.01)	(35.39)	(39.6)
1994	1,094,646	1,501,610	1,518, 537
(percentage)	(26.6)	(36.49)	(36.91)

Source: Programa de Fortalecimiento de Servicios de Salud et al. 1997. p. 35-36.

⁶ Although initial reforms date back to 1991, 1994 marks the beginning of major reform efforts in the sector. The Encuesta Nacional de Niveles de Vida (ENNIV) of 1994 also provides more extensive data than the ENNIV of 1991.

These numbers show first, that the private sector accounts for over one-third of financial flows – much of this on an out of pocket basis.⁷ These numbers also demonstrate that despite the fact the public sector serves a much larger portion of the population (about 74%, plus a good number of insured people that opt to use MINSA public services over their assigned IPSS social security services⁸) it receives a disproportionately low proportion of financing. In short, the distribution of financial support for health services across the separate systems is highly inequitable.

Related to spending across sectors, one can also identify regional inequities in spending patterns. Public sector, state social security and private spending are concentrated in Lima, the area of Peru with the least incidence of poverty. In contrast, in 1994 those areas with the greatest health needs and least ability to self-finance these needs (generally the poorest most rural regions) receive the lowest proportion of state health expenditures.⁹ Public spending has historically been disproportionately spent on more complex levels of care, to the detriment of primary level care. In 1994 nationally, 54% of public health expenditures went to hospitals, 33% to primary level care, and 13% to administration (Tamayo and Francke 1997 p. 64-65).¹⁰

Governance of the Sector: Centralization and Decentralization

⁷ One further clarification is in order: the quality of the private sector is highly varied. It can range from a shabby plywood dental office of a dentist working in the informal sector to a sleek clinic in an upscale neighborhood. The private financial flows recorded here are formal sector, thus representing a greater proportion of the better quality private-sector services.

⁸ Using census and national survey data the Ministry of Health (MINSA) determined that those persons who have health insurance use a MINSA public health facility 13.4% of the times that they require health care (MINSA 1996 p. 24).

⁹ See Tamayo and Francke, 1997 pp. 38-39.

¹⁰ It is notable that these national proportions combine relatively high levels of hospital spending in Lima (at a rate of 70%) to low levels of hospital spending by the regions (46%). Lima also has much higher administrative costs, 21% of its spending, versus 8% of regional spending going to administration. (1994 data in Tamayo and Francke 1997, p. 64-65.)

Historically Peru's health system was highly centralized. Reforms in the early 1990s began a process of decentralization, only to have further reforms in the mid-1990s fiscally re-centralize the system to some degree, while administratively allowing for greater decentralization. In short, in the early part of the decade of 2000, Peru's health system has a mix of centralized and decentralized features.

Regional health authorities (*Direcciones Regionales de Salud*) had existed for some time prior to any reforms. In the 1980s, these authorities were given the responsibility of regional health programming, and to administer personnel, and financial and material resources on a regional level.¹¹ In essence, in the 1980s, these served a purely bureaucratic function; not one of devolution of power (Becerro Hidalgo p. 46). These regional authorities later gained substantial power under the radical decentralization to regional governments begun by President Alan García. Health Minister Paul Caro Gamarra, under García, set into motion the regionalization of health care codified in Decreto Legislativo 584 (April 16, 1990). This law ordered a separation of health care planning and provision. Responsibility for health care provision, including all material and fiscal resources, were devolved in this law directly to regional governments.¹² The Ministry of Health maintained the responsibility to develop national health policy– but essentially lost the power to implement it. This decentralization to regional authorities, written into law under Garcia, was implemented under the Fujimori administration. Two Health Ministers under Fujimori, Carlos Vidal Layseca (July 29 1990 -March18, 1991) and Victor Paredes Guerra (November 7 1991 – August 27 1993),

¹¹ These responsibilities are outlined in Ley de Organización del Sector Salud, Decreto Legislativo 70, Lima, April 1981.

dedicated a large part of their administrations to the democratization and decentralization of health care.¹³ The most important result of these decentralization efforts of 1990-1992 was that the regional health authorities receive their budgets directly from the Ministry of Economics and Finance (MEF). As a result, without any fiscal power, MINSA was forced to rely solely on influence to convince regional authorities to implement centrally-developed national health strategies – including the national reforms that it would develop around 1994.

Nested atop the previous decentralization to regional authorities came additional reforms. A number of attempts were made by both Ministers Vidal and Paredes to “democratize” health care through community advisory boards (under Vidal) and citizen participation modeled on similar European reforms, with a program called “ZONADIS” (under Paredes). These Ministers were not novel in their approach – they built upon the emphasis of the Ministers under García who, following global public health trends, placed emphasis on primary care and community participation. Neither of the above participatory reforms would last however.

More lasting reforms of the Fujimori administration began under the leadership of Minister Jaime Freundt-Thurne, whose ministerial team devised dual centralized and decentralized health delivery strategies in 1993, which were implemented in 1994. These were the targeted and centralized PSBT program and the decentralized CLAS program that devolved administrative (and some fiscal) responsibility to community members.

¹² Ultimately, the regional governments were never effective, and were dissolved under Fujimori in the late 1990s (1998?). the regional Health authorities – called the Rgiones de Salud, and the Sub-Regiones de salud depending on the particular moment, remained.

¹³ DS 002-92-SA and its accompanying Reglamento de Organización y Funciones del Ministerio de Salud, passed under the Paredes administration outlines the separation of functions between the central Ministry and the Regional authorities.

Although linked financially and later administratively, these two programs due to their opposing approaches and political implications, would become competing reforms within the overall public health system. These reforms moreover, formed part of the overall neoliberal approach that the administration had begun to take regarding reform of the state, in contrast to the previous reforms.

These reforms served to on the one hand to fiscally centralize the sector once again while on the other hand, continued to administratively decentralize it. The PSBT program wielded a substantial amount of money for the rebuilding of a debilitated national health infrastructure. It also used this money to pay competitive salaries to attract personnel to work in marginal rural and urban areas. Because PSBT was run out of the Central Ministry and offered substantial resources to the regional authorities, it served to balance to some degree the fiscal powers between the regions and the central health administration. The CLAS program creates boards composed of community members and the local health clinic head doctor that are charged with administering their local health clinic. This reform served to decentralize administration of local health clinics directly to communities (in contrast to many decentralization reforms in the region that decentralized to municipalities.) While the CLAS could use the income earned through user fees for clinic improvements and innovations of the board's design, the primary budget for these clinics – principally staff salaries – was provided by the central Ministry.

Health Status

Peru's basic health indicators place it at the low-middle range among Latin American countries. Since 1980, these indicators have steadily improved, in spite of the difficulties faced by the public health system in the 1990s. Major indicators are outlined in the table below. The data for 1994 is provided as the basic baseline before major reforms were introduced that same year.

Peru, Basic Health Indicators

	1980	1985	1990	1994	1995	2000
Life expectancy at birth	60	63	65.8	67.4	67.7	69.2
Men	58	61	63.5	65.0	65.3	66.8
Women	62	66	68.2	69.9	70.2	71.8
Infant Mortality*	81	72	60.5	51.3	49.2	40.4
Under 5 mortality rate*	126	--	75**	72.4	69.9	61.2 (1999)
Maternal Mortality Rate [†]	--	--	--	185	185	185
Fertility rate	4.5	4.0	3.7	3.2	3.2	2.8

* Estimated figures, deaths per every 1,000 live births.

† Reported rate, deaths per every 100,000 live births

** World Bank data

Source of 1980, 1985 data: World Bank, World Development Indicators 2001. Source of 1990, 1994, 1995, 2000 data: Pan American Health Organization, Special Program for Health Analysis, Regional Core Health Data Initiative; Technical Information System. Washington DC, 2001.

The major areas of health concern in Peru are infant mortality, under-five mortality and maternal mortality. Each of these mortality indicators is much higher in the rural than the

urban areas. Maternal mortality for example, while at a rate of nearly 200 per 100,000 live births in the urban areas, rises to 448 per 100,000 in rural areas. Diseases that are most likely to lead to infant and under five mortality are respiratory infections and intestinal infectious diseases. Also of concern for children is chronic malnutrition. In 1993, 58% of children 6-9 suffered from chronic malnutrition. Among adults, (ages 15-59) infectious diseases are also a leading cause of death, and diseases of the circulatory system are a primary cause for the population over 60. Among communicable diseases, there is a concern of rising rates of malaria, Leishmaniasis, and selvatic yellow fever, which in 1995 reached epidemic proportions. AIDs and tuberculosis rates are also rising in recent years. On the environmental front, of particular concern for Peru are deaths due to traffic accidents, and poor air and water quality.¹⁴

The Macro Political Context of Health Reform

In Peru the health reforms of the 1990s best fit the pattern of “second wave” reforms, in that these were a follow-up to economic adjustment and involved the reform of state institutions with the objective of increasing both the efficiency and equity of state social service delivery. This period of reform in Peru saw substantial involvement of International Financial Institutions (IFI’s) (also characteristic of second-wave reforms), in addition to the traditional participation of bi-lateral and international aid agencies in social policy areas.¹⁵ Health reform, moreover, took place during a phase of political democratization in the Latin American region, and ostensibly a liberalization of politics

¹⁴ The above data is summarized from PAHO 1998, country chapter on Peru.

¹⁵ The involvement of IFIs such as the World Bank and Inter-American Development Bank in social policy areas is new in the case of Peru and Latin America more generally. International agencies,

in Peru as well. In hindsight, the Fujimori regime is now widely recognized as authoritarian. Until the sudden collapse of his government in 2000 due to charges of electoral fraud and widespread corruption— most political observers, in Peru and abroad, had at least hoped for increased democracy in Peru and in Peru’s state reform efforts as well. In this section I address three macro political factors that influenced Peru’s health reform efforts in the 1990s: the role of regional and national structural adjustment, the influence of IFIs, and democratization.

While the stated objectives of Peru’s health reforms were to achieve equity, efficiency and quality, the context of the structural adjustment within which Peru’s reforms took place rendered efficiency the objective of highest priority. This context included an ideological shift toward neoliberalism (especially within Fujimori’s ruling Cambio 90 party), a change in the types of personnel hired by the Ministry of health, and a growth in the influence of IFIs in social policy areas, including health. Each of these factors led to an emphasis on improving the efficiency of state health services. Under other contextual and ideological circumstances, such as the pre-economic crisis and reform periods, equity was a much higher priority— even if in rhetoric and not in outcome.

The emphasis on efficiency was part of a larger ideological shift in favor of neoliberal approaches to economic and social reform. While neoliberalism implicitly assumes that market-orientation will lead to equity through a trickle-down effect, its tenets are much more explicit regarding increased efficiency. Prior to Fujimori, the García and Belaúnde elected governments, and the military governments before that, had

such as the Pan American Health Organization, USAID – and earlier precursors such as the Rockefeller Foundation have had a long standing influence on Peru’s health system.

emphasized state-led economic growth and allowed only minor economic liberalization. The ideological shift towards neoliberalism occurred following Fujimori's election in 1990, and his rapid turn-around from rhetoric against economic shock during the campaign to the implementation of one of the harshest neoliberal economic adjustment programs in the region. The ideological change toward neoliberalism was facilitated in part by the rebuke by IFIs of the previous President, Alan Garcia's, debt moratorium policies and the failure of his heterodox economic approach to inflation control. The IFIs refused to give Peru credit or good credit standing as long as moratorium policies continued, while the heterodox policies led to rampant inflation, rather than the hoped for soft-landing adjustment. Fujimori returned Peru to good credit standing by re-starting debt payments, and the success of his economic shock program over the medium term cemented the ideological shift within the Cambio 90 party, and in society more generally, towards market oriented solutions to economic and social problems.¹⁶

In the years to follow, some political parties would question the Fujimori government's market orientation, particularly in social policy arenas such as health and education. Yet, the presidentialism of the Peruvian political system, the steps taken by Fujimori to weaken opposition parties, and rampant corruption resulting in the buying-off of opposition leaders, meant that while Fujimori was in power, the Cambio 90 neoliberal economic orientation remained steady. The continuation of the market-oriented approach under President Alejandro Toledo underlines the degree to which neoliberalism has ideologically taken hold in Peru.

¹⁶ In the short term the effects of the shocks were horrendous – they drove inflation to even higher levels, pushing the working and middle classes into poverty, and all without a social safety net to ease these costs. In the medium term however (one to five years later) inflation did drop and level off dramatically, to current rates of about 10% annually.

The macro-economic reform context and the above ideological shift also brought with it a change in the character of the personnel hired by the state. Generally speaking, one can see a rise in technocrats trained in either economics or engineering in major government positions (Conaghan 1998). This change is related to the broader macro-political context of post-structural adjustment. Following economic crisis, and in a non-inflationary but stagnant economy, economists and technically oriented engineers have been prized, as persons with the “know-how” to carry-out reforms that will promote economic stability and growth. This applies not only to economic reform, but increasingly social reform areas such as health, where top bureaucrats are no longer only medical doctors, but also business-oriented professionals. This was perhaps best demonstrated by Fujimori’s choice of Marino Costa Bauer, an insurance businessman, as Minister of Health during the mid-1990s. Costa Bauer was the first non-medical doctor to ever hold this position.

These ideological and personnel changes are reflected in the priorities of health reform, where reformers had clearer ideas of how to make health care more efficient, while strategies for achieving objectives of equity and quality were not as well formulated. Efficiency objectives were achieved by applying private sector models wherever possible. For example, in the case of health social security reform, networks of private hospitals and clinics are now allowed to compete for worker’s health insurance with the previously state-dominated social security health system on a company by company basis. In the case of the state public health care system, where the potential for profit is low due to the low income levels of the population served, private sector strategies such as short-term contracts for doctors and nurses renewed based upon

productivity levels were introduced into the public health system. Decentralization of administration of local public health clinics to community boards called *Comités Locales de Administración en Salud* (CLAS) was also carried out in part with the objective of making health clinics more efficient. While some policies, such as targeting of health resources and the CLAS program, aimed to achieve both efficiency and equity objectives, by in large these reforms succeeded to a greater degree on efficiency measures.¹⁷ Meanwhile, improvements in the quality of health services were virtually ignored by reformers.

The ideological shift toward neoliberalism and its focus on efficiency is closely linked with the growing influence and interest of IFIs in not only economic but also social reform areas. The economic adjustment period in Peru and Latin America was largely conditioned by IFIs such as the International Monetary Fund, through policy-based lending. As Peru and other Latin American countries have begun to reform social policy areas such as education and health, IFIs such as the IMF but especially the World Bank and Inter-American development Bank (IDB) have continued to take active interest. The interest of IFIs in health and education in part stems from their own shift in emphasis towards promoting good governance and building human capital, which they now view as building blocks for economic development (see Hunter 2000). As Nelson has argued however, the expertise of the IFIs remains largely economic, and not social (Nelson 1999 and 2000). Therefore, their influence serves to reinforce some objectives over others – such as efficiency, which is more readily applicable through liberal economic theory than equity.

¹⁷ See Ewig 2001 for an evaluation of the equity outcomes of these two programs.

The first signal of the influence of IFIs on Peru's social policy began in 1993, shortly after Peru's economic adjustment. Bureaucrats working in Peru's Prime Minister's office had outlined a plan for targeting spending in the key social policy areas of health, education, justice, and emergency food aid. Although skeletal, the plan marked a departure away from the safety-net approach to social spending that had been dominant in the first years of the decade, towards a longer-term social policy plan. Upon the urging of staff from the Prime Minister's office, in October of 1993, the Minister of Economy and Finance took this conceptual document to a meeting with the Paris Club creditors. The Creditors were enthusiastic about the plan. Their support was significant in two ways: first, it signaled a shift towards support of an social policy spending by creditors that up until this point had advocated cuts in Peru's state expenditures. Second, this meeting was key in pushing the Ministry of Economy and Finance to also support social spending; a change that was critical for reasons discussed below.¹⁸

While the above interaction was significant in that it allowed the Peruvian government to spend its own money on social policy areas, IFIs soon after began to play a more direct role in health reform. Perhaps the most significant was the financial role of the Inter-American Development Bank (IDB) in supporting Peru's health reform. The IDB cooperated with Japan to finance the *Programa de Fortalecimiento de los Servicios de Salud*, the Program to Strengthen Health Services. This program, during the 1990s, lead health reform within the Ministry of Health. The project was financed by a US\$68 million loan form the IDB, a \$20 million loan from the Overseas Economic Cooperation Fund of Japan, and US\$10 million from the Peruvian national treasury. The funds largely

¹⁸ Interview by author with Ing. Luis Manrique, formerly affiliated with the national policy on targeting of social spending, February 18,1998, Lima.

were used to hire teams of consultants — as many as forty at a given time – to assess the state of health services in Peru and to devise strategies for their reform.

In addition to the IDB, the World Bank and USAID also played a role in health reform, though by financing of their own reform projects and personnel that collaborated with the government, rather than directly financing government efforts at reform. The World Bank funded a major targeting project within the Ministry over the course of the mid- to late 1990s, the *Programa de Salud y Nutrición Básica*, or the Basic Health and Nutrition Program. This program was staffed by personnel hired by the Bank who operated the program from offices located in the Ministry of Health. It targeted a number of geographic areas deemed by socioeconomic indicators to be most needy, and introduced new initiatives in local public health clinics, such as training in integral health services and collaboration with local non-governmental organizations (NGOs). USAID, similarly, hired staff members who operated out of offices in the Ministry of Health. These personnel led workshops on health reform for ministry members and began pilot reform initiatives, such as privately-run, but state-owned, health clinics. The objective of both the World Bank and USAID initiatives was to model health reforms, with the idea that success in any one area may spread to the health system as a whole. Compared to the large sums of money lent by the IDB, these efforts were much smaller in scope.

The influence of IFIs over health sector reform is best viewed as agenda-setting. The IFIs gave a green light for the progress of reforms and for state spending on social policy. Moreover, they influenced the shape of these policies. The major social policy strategies advocated by IFIs: targeting, decentralization, private sector competition, and the separation of the financing and provision state services are all evidenced in Peru's

reforms. Yet, while influential, the IFIs were not directly involved in the day to day development or implementation of reforms. IFIs representatives interviewed claimed a support role only, without intent to influence or condition the health reform process. Peruvian policy makers as well, guarded their autonomy from direct IFI interventions. Thus, while evidence of IFI influence is obvious at a macro level through the similar form that Peru's policies took to those recommended by IFIs, there existed some room for country-level innovation within the broader neoliberal paradigm.¹⁹

One side effect of the growth in influence of IFIs on national economic and social policy has been to elevate the political power of the Ministry of Economy and Finance (MEF). The urgency of economic adjustment in the context of economic crisis placed the MEF at the center of political power. With the shift towards social policy reform, MEF remained politically central, due to its ability to provide or veto funding for government programs. As illustrated in the interaction described above between Paris Club creditors and the MEF, MEF approval can signal a green light for social policies. In that case, once the MEF was convinced by Paris Club creditors that social policy spending would be acceptable, and even positive in creditor's eyes, social policy programming and reform was allowed to commence. Conversely, a lack of MEF approval can also serve as a barrier to policy advancement or implementation.

The involvement of the MEF is limited to funding approval – it has not engaged in actual policy design in social policy areas. This fiscal power without policy knowledge can at times result in difficulties. For example, in the fall of 2001, during the transitional Panigua government (the temporary government which oversaw governance and elections after Fujimori stepped down), an economic downturn forced major cutbacks

¹⁹ This interaction is more specifically outlined in the policy cases in the following section.

in the national budget. One program targeted for cuts by the MEF was the CLAS community health administration program – the administratively decentralized, but fiscally centralized program mentioned previously. Without adequate knowledge of the program’s design, the MEF cut the CLAS budget and CLAS medical staff end-of-year bonuses, arguing incorrectly that the CLAS should be self-financing.²⁰ This action was a major blow to a reform initiative deemed quite successful by most outside evaluators.²¹

In addition to the structural adjustment context and the influence of IFIs, a final macro political factor affecting Peru’s health reform is the regional and national transition to democracy. Although the Fujimori regime is now widely viewed as authoritarian, his tenure in office did depend on elections, and his legitimacy on positive public opinion polls. Thus, some dynamics of democracy do apply to Peru in the 1990s. Moreover, viewed over the long term, Peru’s democracy has expanded and strengthened over time, at least by the measure of electoral participation. Women were given suffrage in Peru in 1955 (among the last of Latin American countries to grant women the vote) and illiterates voted for the first time in 1980, the first presidential election following the military dictatorship. Thus, as of 1980, the electoral dynamic changed significantly as the poor, indigenous, rural population who comprise the majority of illiterates, gained a political voice. While the electoral significance of these groups should not be overstated (Lima remains the major concern of politicians) during Fujimori’s tenure, and evidenced in the electoral campaigns of 2000 and 2001, politicians increasingly are courting this sector of the population.

²⁰ Ricardo Romero Díaz, former Director (“Responsibilidad Técnica”) of the Programa de Administración Compartida, MINSA. Telephone Communication with author, February 19, 2001. This action by the MEF may also reflect part of a larger power struggle in the health sector over the CLAS program, discussed later in this paper.

In addition to the change in electoral laws, the attention that Fujimori gave to provincial areas of Peru was in response to two other factors. First, Fujimori sought the political support of poor, rural areas in part in an attempt to break the stronghold that the Shining Path guerrillas held in many poor, remote regions precisely due to decades of government neglect. Second, when a number of rural areas voted against Fujimori's new constitution, submitted to popular referendum in 1993, substantial numbers of poor rural people opposed it. While the constitution did pass, its near defeat due to rural and poor opposition cued Fujimori to respond to this political constituency.

In the health sector, the same two factors, combating *Sendero Luminoso* and courting political support of poor rural people, helped to spur the government to direct social policy resources to poor areas, rural and urban. While this populism is best seen in the education sector, where the government went on a school construction binge, a significant number of health clinics were also constructed in 1993 and 1994. The fact that IFIs insisted that social funds be directed towards the poor, provided additional incentive to direct health resources to poor communities.

Meanwhile, state health resources shifted away from traditionally politically strong and organized middle classes and workers served by the social security health system, ESSALUD. The major reform in this sector was to introduce private sector competition in to the social security health system through the creation of "*Entidades Prestadoras de Salud*" or Health Provider Entities. These were private networks of clinics and hospitals run by the major existing health insurance companies in Peru. This reform faced strong resistance in particular from labor unions and health worker associations. Their efforts at resistance failed for a number of reasons that will be

²¹ See Altobelli 1998a and 1998b, Cortez 1998, Ewig 2001.

outlined below. Two reasons relevant to the macro political context were, first, these groups had been significantly weakened as a result of economic adjustment, labor in particular by the labor market liberalization imposed by the Fujimori government. Second, Fujimori –relying primarily on polls – was able to bypass the need for the political support of most organized groups, including political parties and labor unions, and seek approval directly from the unorganized populace.²²

The National Politics of Reform

The above discussion of macro political factors has already mentioned some of the major actors involved in Peru's reform process. International creditors and the Ministry of Economy and Finance, while not involved in the nuts and bolts of reform, had the broader power of signaling a go ahead for the reform process. The semi-authoritarian character of the Fujimori regime (described in greater detail below) limited the pool of political actors involved in the reform process, essentially reserving much of the decision-making regarding reform for bureaucratic elites. Yet, because the regime relied on the popular approval particularly in poor communities, and was heavily influenced by IFIs, one can observe that much of the effort in health reform was placed on reaching the poor.

This section delves further into the national dynamics of health reform, tracing the policy-making process of the major health reforms developed in the 1990s: targeting through the Basic Health for All Program, decentralization to communities through the CLAS program, the introduction of private sector competition into social security health care, and health insurance for children on public schools. These policy cases will show

²² On Fujimori and his reliance on polls, see Stokes 1995 and Conaghan 1995.

that much of health reform policy-making remained isolated within the bureaucracy. One reform area, that of health insurance for public school children, was created as a result of substantial presidential involvement. Only one reform faced a significant legislative battle, that of the social security health reform. Thus, political parties and congress played a minor role in overall health reform. Civil society as well, partially because of the insulated reform process, was not very active in either supporting or opposing most reforms, and failed to stop the one reform that it did actively oppose.

Targeting the Poor: The Basic Health for All Program (PSBT)

Targeting was the next major and lasting reform of the health sector of the 1990s following the introduction of fees for services. It was the first reform that took a longer-term view as opposed to the essentially crisis response of the introduction of fees.

Targeting in the health sector stemmed from an overall national social policy orientation favoring targeting as a primary strategy, outlined in the above-mentioned document presented to the Paris Club. In the health sector, the major targeting initiative became named the *Programa de Salud Básica Para Todos* or the Basic Health for All Program (PSBT). While longer-term in strategy, the targeting policy was still reacting to the social deficit that Peru's population faced as a result of economic crisis and civil war. Thus, there was some degree of urgency behind the reform, which was passed in December of 1993 as one article of the extensive 1994 budget law. This article allowed the release of funds for a number of targeting initiatives, health just one of a range social policy areas.

No other legislation was required for the targeting reform to proceed, and thus it was developed from that point on within the Ministry of Health by a team of five appointed by the then Minister of Health, Jaime Freundt-Thurne. The reform developed by this team targeted a basic package of primary health care services to the poorest Peruvian communities. It involved a major inflow of resources to these communities, in terms of clinic construction, personnel who were attracted to poor and remote areas through competitive salaries, and medicines and medical supplies. Once implemented in 1994, the program expanded rapidly, covering 70% of primary level care state establishments by 1998.

The program drew, on the one hand, on policies advocated by public health experts, by emphasizing primary level and preventative care. On the other hand, it borrowed from neoliberal tenets by introducing private sector models into public systems. In particular, health professionals hired by this program were placed on what is called a private sector labor regimen. Unlike traditional state health workers who held “named” positions and were virtually immune from job loss (but also paid very poorly), health professionals hired under the PSBT program were hired on short three to six month contracts, renewed based upon productivity levels. While the PSBT workers were paid competitive salaries, they forfeited job stability and benefits — they received no health, pension, vacation or even sick day benefits.

The PSBT program also changed health sector politics between the central and regional authorities. The PSBT program served to re-centralize financing of health services, as funding for this program came through the central ministry to the regional authorities, rather than directly from the MEF to the regions as the rest of the health

budget was allocated. This changed the balance of power within the health sector, increasing the power of the central ministry. Yet, the resources that PSBT brought to the decentralized regional health authorities meant that these autonomous regional authorities also welcomed and supported the program. The program was financed entirely by the national treasury; and central health authorities took pride in its independence from foreign financing.

In part because of its insulation of the policy process, but also the form of organization of the health sector professionals, the PSBT reform received virtually no reaction from organized sectors of civil society. Earlier in the decade the major health worker's union in the public health system had been seriously weakened by the decentralization of the ministry health system into regions. Without a central body to negotiate with, they lost much of their force. As a result organized health professionals were concentrated in the social security health sector, and were focused on the planned reforms for IPSS, rather than Ministry health programs. Those workers that did oppose PSBT, wanted to preserve the tradition of "named" positions. Yet, the new positions created by PSBT helped to alleviate high unemployment among health care professionals, many of whom were young, recent graduates. Unable to obtain the scant number of "named" positions, these contracted PSBT workers would develop a vested interest in the new, reformed health sector, which was the source of their employment, rather than the standard Ministry system. This amounted to a generational split among health care workers, with older workers defending the status quo, while younger workers saw in reform the opportunity for work. This split, and the weakness it caused for the health workers unions, is particularly important because organized health professionals have

been the most strident opponents of health care reform in Peru and elsewhere (Savedoff et al. 1997 p. 26).

Decentralization: The Shared Administration Program (CLAS)

At about the same time the Basic Health for All Program was developed in the Ministry of Health by one reform team, another small team was working on a policy called the Shared Administration Program. This program has come to be known simply as the “CLAS” program (*Comités Locales de Administración en Salud*), after the local health administration committees that this policy produced. The CLAS policy was created in the same context of urgency as the PSBT program. Yet, it represents a different approach — the decentralization of resources and administration.

Decentralization is yet another major international state reform trend. The form of decentralization implemented in Peru’s CLAS policy is particular however. Rather than decentralizing health care administration to municipal governments as was the case in Chile, or decentralization of administration and resources to autonomous regional branches of the ministry of health as Peru carried-out in the late 1980s, the CLAS involve decentralization of local health post administration to community representatives. Half of the total of six representatives are elected by the local community, and half are selected by the chief doctor of the local health post from health-related community organizations. As a result, this reform emphasizes not only decentralization but also the long-advocated public health strategy of community participation. While the reform does allow for some decentralized administration of financial resources, it is largely administrative rather than fiscal decentralization.

Each health center that converted to the CLAS model became legally a private, non-governmental organization (termed *personería jurídica*) with its own by-laws written by the community board and approved by the Ministry of Health before being inscribed in the public register. While legally private and independent, each CLAS is dependent on the Ministry (in the case of Lima CLAS) or its regional health authority (in the case of provinces) for its main budget, primarily for salaries. The CLAS' health center infrastructure also remains state property. The CLAS is free to spend all the income it raises through fees for services as they choose, as long as such spending decisions fall within basic Ministry guidelines. This financial flexibility has led many CLAS to improve their infrastructure and hire additional staff members. CLAS members are required to approve a local community health plan each year, a component of the policy that urges greater responsiveness of health services to individual community circumstances. Perhaps most importantly, the health workers in the CLAS centers are hired directly by the CLAS members, who also evaluate these workers on at least an annual basis. This provision in the policy effectively increases worker productivity and their responsiveness to the community because their supervisors are local community members able to monitor their activities on a daily basis.²³ These workers, like PSBT workers, are contracted, but are generally contracted for a year rather than a few months at a time. In addition, CLAS workers, unlike PSBT workers, receive regular benefits such as vacation and pension contributions; though for this privilege their salary scale is lower than that of their PSBT counterparts.

²³ Altobelli (1998a) compared productivity levels in CLAS and non-CLAS centers, and found CLAS productivity levels to be higher.

The CLAS policy was developed entirely within the ministry of health by a small reform team appointed by the minister at the time, Dr. Jaime Freundt-Thurne. The team at first consisted of eight people, and was eventually reduced to three.²⁴ The team was led by an engineer with a specialty in rural development (but no experience in health care), Juan José Vera del Carpio. This three-person core team wrote the supreme decree that eventually the President signed and that created the CLAS program.²⁵ Minister Freundt was important to this formulation process to the extent that he politically supported the project within the ministry, and also succeeded in getting the support of the President, whose signature was required on the supreme decree that made the reform official and legal.²⁶

The CLAS was tied financially to the PSBT program, receiving its funds from the same budget line approved by the congress for targeting. As result, it did not need to go to congress for inclusion in the budget. As part of the same health sector restoration effort, once the Ministry of Economics and Finance (MEF) had approved the PSBT's budget, the CLAS, as a sub-unit of this budgetary line, was free to proceed as well. Thus, many key state players, such as congress and the MEF played no role at all in the development of the CLAS program. Also, President Fujimori's interest in the policy was only that there generally be improvements in health services; that this "was CLAS or not CLAS was not important".²⁷ In short, the formulation process proceeded simply from a

²⁴ Interview by author with Anonymous 11, a member of the original CLAS formulation team, Lima, April 8, 1998.

²⁵ Interview by author with Carlos Bendejú, member of the three-person CLAS formulation team, Lima, March 17, 1998. Also interview Anonymous 11.

²⁶ Interview by author with Juan José Vera del Carpio, Director of Program of Shared Administration (CLAS), MINSA, April 23, 1998, and interview by author with Jaime Freundt-Thurne. Former Minister of Health by Christina Ewig. April 15, 1998, Lima.

²⁷ Interview Freundt-Thurne.

Minister-appointed reform team within the line bureaucracy to the President for passage as a Supreme Decree.

There was no institutional point in this process that allowed for wider discussion of the policy, either with congress and its political parties or with organized groups in civil society. At the time, the opposition to the government was fairly vocal and strong. (Peru's new constitution had only barely passed in a referendum in 1993 for example, and this low support was widely perceived to indicate a lack of public confidence in the Fujimori administration.) Doctor's and health worker's associations initially viewed the CLAS policy as an attempt to privatize public health care. Certainly, like PSBT did, the CLAS would change their labor status from a public to a private sector regimen. In addition, doctors in charge of individual health centers stood to lose, and did lose, a fair amount of discretionary authority in health center administration when the policy reform forced these doctors to share administration with community members.

Opposition to the reform came from various associations of health professionals, as those most affected by the reform. The *Colegio Médico*, Peru's equivalent to the American Medical Association, issued a statement in opposition to the CLAS after the supreme decree was first passed. This association, and Peru's doctors' guild, the *Federación Médica* opposed the reform due to its potential to privatize financial administration of the local health posts. As a member of the Medical Federation explained, when the policy was introduced "we were not in agreement with giving the community the responsibility to finance health services, in other words the possible privatization of health services or self-administration."²⁸ In addition, the Federation of

²⁸ Interview by author with Ricardo Díaz Romero, member of the board of directors of the Medical Federation (*Federación Médica*), Lima, February 14, 1998.

Ministry Workers (*Federación de Trabajadores del Ministerio de Salud*), fearing the shift that the CLAS implied from a public to private work regimen and what further decentralization would imply for the unity and viability of their union, vocally opposed the measure.²⁹

The formulators of the CLAS policy simply avoided discussion with opposition groups however, and did not let opposition stop or slow the reform. As one of the three central reform team members stated: “We never responded. We simply took a very low profile”.³⁰ According to Minister Freundt-Thurne however, taking a low-profile approach was not necessarily a strategy to avoid opposition, though it may have turned out that way in the end. Instead, it was simply how the Ministry reform teams worked:

The CLAS was made with a very low profile, not because we wanted to avoid the opposition educational reform had experienced or something like that. We did it that way because that was the way we worked. We did not want to make fireworks and come out in the papers.

Thus, in the formulation of the CLAS program, there were neither institutionalized access points for civil society to influence the political process, nor were policy elites within the Ministry willing to discuss the project widely. The latter was not due to strategic reasons, but out of a lack of interest in democratic consensus building in general.

The international arena played a support role in the development of the CLAS as a policy reform. The idea of community participation in health center administration came from international policy discourses, specifically through publications by the World Bank and UNICEF. One of the policy innovators involved in the formulation of the CLAS

²⁹ Interview Vera.

³⁰ Interview by author with Carlos Bendezú, Consultant to the Program to Strengthen Health Services, MINSA, March 17, 1998. Lima.

policy emphasized the importance of the World Bank's publication of the 1993 World Development Report on health care financing. This publication influenced the CLAS reform team to the extent that it reviewed world health care reform trends and pointed to the importance of an orientation towards preventative health and efficiency in health care spending. In addition, this informant stated that the CLAS reform team also drew ideas from a publication on the UNICEF experience of community participation in health administration Africa.³¹ The influence of these publications demonstrates the international linkages between the bureaucracy in Peru and the international sphere.

In addition to these discursive influences, the reform team members and their consultants were funded through international sources. Salaries of CLAS reform team members (as well as other policy elites within the Ministry) were paid through the above mentioned Inter-American Development Bank (IDB) loan to strengthen health services. In addition, a small amount of international funding from the United States Agency for International Development (USAID) allowed the CLAS to hire a foreign consultant in the development of the policy. Funding for the implementation of the CLAS program, like PSBT, came entirely from the public treasury, with no international financial support.

Upon implementation, rather than seeking national geographic coverage as the PSBT did, the CLAS was slowly piloted in a few regions. The expansion of the CLAS depended largely upon the will of the autonomous regional health authorities. Some of these embraced the CLAS concept enthusiastically, implementing the program widely, while others saw further decentralization as a political threat to their authority, and

³¹ Interview Bendezú. The publication is UNICEF 1990, on UNICEF's Bamako Initiative, which spanned 18 African countries as of late 1991 (World Bank 1993 p. 159.)

refused to implement it either well, or at all.³² Thus, the CLAS were implemented in an uneven fashion around the country. Positively, slow piloting allowed the reform to be tested and modified over time, responding to the needs of both staff and community members who were administrating the centers, before expanding further.

Market Competition: Health Provider Entities (EPS)

Efforts and plans to reform the social security health sector, then called IPSS (now ESSALUD), also commenced under Minister Freundt-Thurne. Opposition from congress and from organized sectors of civil society —especially labor unions, health worker guilds and retired persons—succeeded in substantially slowing the progress of this reform. The reform was introduced in a number of different forms and through a number of legal channels, and was successfully challenged, until it finally passed as the *Ley de Modernización de Seguridad en Salud* in May of 1997, under Minister Marino Costa Bauer.

The reform essentially allowed private sector networks of health clinics and hospitals, called *Entidades Prestadoras de Salud*, or Health Provider Entities (EPS), to compete with the state social security health system for workers' health care plans. As a result of resistance to all-out privatization (the route taken with pensions) the reform was substantially modified. First, it simply introduced competition to the state system, rather than privatization. Second it allowed for “solidarity” among workers, in that workers as a whole in each company vote on which health provider will obtain a company health insurance contract. Company by company selection, rather than individual selection, avoids potentially different plans for different types of workers —management and labor

³² Cajamarca and Tacna are two regions where the CLAS expanded most rapidly.

for example. In addition, as a cost-containment measure, the EPS provide only primary and secondary care, while more expensive complex care is reserved for the state system. As a result of this final measure, of the paycheck contribution (9% of a worker's pay), 25% goes to the EPS while 75% goes to the state system, ESSALUD.

This reform faced much greater resistance than primary sector reforms for a number of reasons. First, it affected more highly organized sectors of society, including workers and health workers in the social security health system who remained better organized than those in the public health sector. Second, because this reform initially mirrored the reform of the pension system privatized previously, the opposition was well-prepared to oppose a reform of this type. Finally, whereas an important subgroup of health workers saw substantial benefit in the ministry reforms described previously, and these reforms brought an increase in health services for the poor populations involved, the reform of the social security sector implied job and resource loss for the state social security system. Ultimately the opposition to the reform failed to stop it. In part because some sectors supported the reform — white-collar workers, in the service industries for example, looked forward to a choice in health care options, and the promise of improved health care quality that the EPS reform would bring. In large part however, the reform succeeded to implementation because the Fujimori administration used every political tactic possible to see it succeed despite opposition.

Attempts at reforming this social security health system were made under both Ministers Freundt-Thurne and Yong Motta in unsuccessful bids to create “Health Service Organizations” (*Organizaciones de Servicios de Salud*, OSS).³³ The basic concept of the

³³ Freundt-Thurne in fact became minister on the heels of an announcement by the previous minister, Dr. Victor Paredes Guerra, that he would not support a reform of IPSS.

OSSs, and the similarly designed “Health Provider Entities” (*Entidades Prestadoras de Salud*, EPS) which ultimately succeeded as a reform under Minister Costa Bauer, was to create a private-sector alternative to the existing, state health social security system.

Similar to the PSBT and CLAS reforms, the failed OSS and successful EPS proposals were devised by small reform teams appointed by the Minister. The EPS team furthermore was funded through the IDB loan mentioned previously.³⁴ Minister Costa Bauer, formerly an insurance executive, was selected by the President expressly to guide the passage of the EPS reform after previous versions had failed. The OSS and EPS laws had been passed on two prior occasions by the President via legislative decrees, yet were never implemented and were hotly protested.³⁵ The first case, in 1991, the OSS proposal that was passed was never implemented. The reason for not proceeding with this law was timing, the law passed on the heels of the reform of Peru’s pension system, and the opposition that the pension reform raised made it difficult to proceed with another reform that would simultaneously affect the same institution, IPSS.³⁶ The reform was also considered by some government officials to be poorly designed.³⁷ As a result, the law sat until a decision was made by Minister Freundt-Thurne in conjunction with the President to not allow the law to proceed to the regulation stage.

In 1996, the president passed a second legislative decree, this time in modified form, and titled the Health Provider Entities (EPS) rather than OSS. For the President, the EPS reform was a politically expedient means to both forward reform and to further

³⁴ Interview by author with Raúl Torres, head of the committee charged with monitoring the reform of health social security, Lima, February 25, 1998 (first interview). Also, interview by author with Anonymous 12, general MINSA reform team member, Lima, February 23, 1998.

³⁵ Legislative Decrees are decrees made by the President within a specific policy area authorized by the Congress. For discussion of the Peruvian legal system, see Chapter 3 of Ewig 2001.

³⁶ Interview Fruendt-Thurne.

³⁷ Interview Freundt-Thurne.

weaken one political support base of his opposition, unions. Opposition members of congress protested that this decree was unconstitutional, because it extended beyond the powers the congress had granted the President for decree making authority; they had authorized decrees related to privatization, but not reform of the social security system. Ultimately, the proposal was forced to pass through the congress as the Modernization of Health Social Security Law in May of 1997 (*Ley de Modernización de Seguridad en Salud*). The weak party system and presidential control of congress however made passage through the congress relatively trouble-free. While the proposal ultimately passed through congress, congress made few changes to the proposal developed by the Costa Bauer's reform team.

Neither the passage of the OSS bill by legislative decree, nor the EPS bill, despite the fact that the latter ultimately passed through the congress, allowed for more than a few hours of public debate on this reform. One of the leaders of the health sector reform effort in the Ministry of Health commented to me that of all of the reforms during the Fujimori administration, the Modernization of Health Social Security was the “most jealously guarded”.³⁸ According to this informant, it was guarded in part due to a fear of opposition, but also due to authoritative personal styles and a belief that this team had the “answer”, to which a public debate could not possibly contribute. By not allowing for debate, both the OSS and EPS laws posed the risks of widespread public suspicion of the program, which did ultimately stop the first law and delayed the implementation of the second for nearly two years, until the Spring of 1999.

³⁸ Interview by author with Anonymous 5, member of team that oversaw overall health sector reform, MINSA, April 17, 1998, Lima.

Targeted Insurance Schemes: Free School Health Insurance (SEG)

In July 1997, in the same basic political and economic context in which the final EPS law had passed, the SEG, or Free School Health Insurance reform, was introduced (*Seguro Escolar Gratuito*). Unlike all of the other health sector reforms, the SEG fell outside of both the neoliberal policy discourses that had influenced health sector policy formulation under the Fujimori administration until that date, and the traditional processes of bureaucratic policy formulation. Free School Health Insurance was clearly a presidential initiative and motivated by populist presidential politics.

The Free School Health Insurance reform provides free health care coverage through Peru's public health system to all children, pre-school through age seventeen, enrolled in Peru's public school system. The insurance offers broad coverage that promises to increase economic access to health care. It is also targeted to the extent that primarily the poor and lower classes attend Peru's public school systems. The reform was expected to encourage parents to enroll their children in school by providing health insurance as an incentive. However, by targeting an age group that is considered by most health analysts to be at lesser risk than other age groups, the reform made little public health or efficiency sense. (Most public health experts see children in the 0-5 year age range as facing the greatest health risks). Furthermore, SEG went against the grain of the major health sector reform objective until this point: to reduce the state's role in direct health service provision.

President Fujimori announced the creation of the Free School Health Insurance program in his July 1997 Independence Day address to the nation. The concept for the

reform reportedly was first conceived in the Ministry of Education,³⁹ but the President's announcement was the first notice given to Ministry of Health officials of the reform. It was the Ministry of Health who was charged soon after the speech with developing the specifics of the reform and launching it, all in the space of a month. A small team of consultants were assembled to design and implement the program. This team was led by Dr. Ulises Jorge Aguilar, a former regional health authority, who as of April 2000 remained charged with the program.

According to Dr. Jorge, the process he led of formulating the Free School Health Insurance program “surged from his strong authority”, where he “ordered things”. This process was so closed that not only was input not invited from civil society, but the advice of other reform teams and program administrators within the ministry were eschewed.⁴⁰ As a result of the President's strong support of the reform and this authoritatively-led reform team, the SEG reform proceeded from announcement to implementation rapidly – in less than a month – with no time for either support or opposition the measure. (Though there were no clear losers in this case to protest in any event). Nor did legal institutions pose any barriers, as the program proceeded without any legal basis for the first two years of its existence.

The SEG was also independent of international influence. The program was funded entirely through the national treasury, with no help from international sources. Nor did any international entity participate in the formulation of the program. Only after

³⁹ Interview by author with Ulises Jorge Aguilar, Director of Seguro Escolar Gratuito, January 19, 1999, Lima

⁴⁰ Interview Jorge.

over a year of implementation did one international agency, UNICEF, begin to take an interest in the program and support it in small ways.⁴¹

Consequences for Implementation

All four of the above decision-making processes, while there are variations among them, were generally very closed, in large part because the bulk of the formulation process remained confined to a small team within the bureaucracy. The closed nature was true both institutionally — few policies passed through political institutions that allowed for greater debate such as Congress— and in terms of the work style of these teams which ranged from self-described “authoritarian” (SEG) to simply too concerned with rapid timing to consider a wider dialogue (PSBT). Of the four policies, only the national version of targeting and the EPS passed through the legislature, a forum that would require debate, and even those debates were resisted by policy-makers in a number of ways. The national targeting initiative that led to PSBT was buried as one article in an extensive budget law. The EPS law received more deliberation in congress, but two prior attempts to by-pass the congress altogether demonstrate the formulators’ resistance to opening-up the legislation to dialogue. The lesser legal status of the supreme decree used to pass the CLAS and the lack of legal basis altogether for the SEG made legislative debate unnecessary, and as a result discussion of these reforms remained within the confines of their bureaucratic reform teams.

The insulated formulation process within the bureaucracy was compounded by the institutional character of the Peruvian state, which lacked the formal mechanisms for both democratic dialogue and accountability even when policies leave the realm of the

⁴¹ Interview Jorge.

bureaucracy (Ewig 2001). Joan Nelson (2000) divides the social policy reform process into four phases. Phase one consists of getting a reform on the agenda. Phase two involves getting executive branch support. Phase three consists of ensuring legislative support, and phase four involves the implementation of the reform. These are accurate phases; yet, in an executive-dominant political system like that of Peru, phase three of policy formulation —legislative approval— is much less important than phase two, executive branch support. This is due to a legal system that favors presidential and executive powers, a weak party system, and under the Fujimori government, a divided civil society. Some “policy space” is available to policy elites in most political contexts — a space free from influence of either interest groups or international influence (Grindle and Thomas 1991 pp. 7-8). In Peru, the semi-democratic and executive dominant political system allows for a particularly wide policy space in which policy elites can maneuver. It is wider principally because there is less of a perceived or real need to consult with interest groups outside of the bureaucracy in the formulation of policy.

The formulators described in this paper were also purposely guarded. The fact that these teams not only “jealously guarded” their policy proposals from dialogue with civil society, but also at times guarded them from dialogue with other parts of the health sector bureaucracy had significant consequences for the implementation of these reforms. A closed policy-making style in the formulation stage of reforms that involve a complex number of actors ignores the importance of building up both public and institutional support. In the case of the EPS reform, the most visible and contested reform of the four reviewed here, a lack of dialogue with civil society meant successive failure of attempts to pass the policy, and in the end, very slow implementation. Whereas most reforms may

take six months from passage of policy to implementation (and some, like SEG as short as a month) the EPS implementation took nearly two years. As one top policy maker commented on the EPS law, “There the reform stays. It does not produce if there is not a climate of confidence, or if that confidence is not constructed”.⁴²

The lack of intra-institutional dialogue in the process of formulating both the SEG and the CLAS created undue confusion within the bureaucracy as well as in communities when it came time to implement the policy. As one policy maker in the Ministry commented to me, “I don’t think the Minister even knew about SEG until he heard the President announce it on television”.⁴³ The SEG was implemented so rapidly, and with so little consultation, that it created severe conflicts with other reforms in progress, in particular the PSBT program. The extensive paperwork required by the SEG to determine a child’s eligibility competed with the health worker’s time to fulfill productivity levels demanded by the PSBT program. In addition, the SEG program set its own payment structure for reimbursement of the health posts for their work, a system that health professionals complain does not value either their time or the resources required to sustain the policy. As a result, some health clinics have refused to serve children coming for SEG-covered care either at all, or at the busiest times of the day.⁴⁴ These conflicts, absorbed by health care workers, also result in reduced quality of health care delivery. In addition to these conflicts within the health system, the public had little understanding of the program during the first years of its implementation. Many citizens, as late as the

⁴² Interview Anonymous 5.

⁴³ Interview by author with Anonymous 10, affiliated with overall reform process, April 3, 2000, Lima

⁴⁴ Of eight clinics where I conducted extensive interviews and community surveys, two restricted the times that children were allowed to come for school health insurance care.

second year of its implementation, did not know that the SEG was a benefit available to their children.

The lack of dialogue within the bureaucracy was an impediment for the CLAS program as well. As a complex program requiring the cooperation of regional health authorities, health center staff members, and community members, its stealth-like formulation made implementation confusing for many. Health centers and regional authorities were presented with the new policy with few guidelines on how to carry it out. One CLAS worker, employed since the founding of that CLAS, explained that the staff and community members were given some explanation of the new model “but these were not sufficient. Along the way we have had to reinterpret or try to interpret what they wanted.”⁴⁵ Four years into the program, as I carried out my fieldwork evaluating this program’s implementation, there was still confusion among staff members and communities regarding issues as basic as how to handle finances and shared management. Moreover, there were regional authorities that clearly ignored the “shared” part of this Shared Administration Program.⁴⁶ A lack of Ministry – Region dialogue in the formulation stage contributed to this confusion upon implementation, and also allowed regional authorities, threatened by the policy, to either only selectively implement it, or not implement it at all. This lack of intra-institutional dialogue ultimately contributed to the severe conflict and stoppage that the program faced in 1997 and 1998.

⁴⁵ Interview by author with David C. Aguinaga. Coordinator of Community Participation. CLAS Juan Pablo II, July 22, 1998, Lima.

⁴⁶ This was the case, for example, for the regional health authority of Ayacucho in the Spring of 1999, when it ignored the CLAS’ decisions to renew contracts with its professional staff including its chief local doctors, and simply replaced these staff without discussion with the local CLAS members.

Insulated policy making is seen as advantageous by policy-makers because it allows them to advance their political project without fear of a policy issue becoming “politicized”, and consequently slowed or stopped by public debate or protest. As one of the formulators of the CLAS policy commented on the strategy during the CLAS policy formulation, “...this issue could not be politicized, because if it became politicized it would fail.”⁴⁷ Rather than viewing dialogue as a positive step towards strengthening the support for a policy and democratic procedures more generally, “politics” is viewed as negative and rife with unproductive conflict. The lack of input into the policy process means that the selection of policies is almost entirely dependent on a small group of unelected technocrats. Furthermore, the lack of dialogue, as outlined above, can result in difficulties when the policy reaches the implementation stage.

The formulation process, among reformers that are quite literally invisible to members of civil society, makes the intervention of civil society quite difficult. Not only are these reformers hidden, and purposely secretive within the bureaucracy, but they change with a high degree of frequency. Even as I conducted my fieldwork, over the course of a few years, the top administrative and reform positions changed with such regularity, that a contact one day was useless the next. As a member of a Lima-based feminist NGO active in health care reform issues expressed to me: “in 1994 we calculated that the average permanence of a head of a program was seven months. You coordinate, and arrive at an agreement with one, and the next one arrives, and it is as if none of that coordination existed”.⁴⁸

⁴⁷ Interview Juan José Vera del Carpio, Lima, April 23, 1998 (2nd interview).

⁴⁸ Interview by author with Ana Guezmes García, coordinator of the Health and Reproductive Rights Program of the Flora Tristán Women’s Center, Lima, March 18, 1998.

Surprisingly, while the reformers themselves have rotated with frequency, the reforms they created have persisted. Some, like the PSBT, have consolidated as the dominant model of primary health care across the country. Others, like the CLAS, continue to face resistance and have experienced much slower expansion, but also persist. Peru's reforms as a whole however, as a result of these political dynamics, are still best regarded as piecemeal.

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