Crucial Needs, Weak Incentives

Social Sector Reform, Democratization, and Globalization in Latin America

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Chapter 8

Piecemeal but Innovative: Health Sector Reform in Peru

Christina Ewig

When Alberto Fujimori assumed the presidency of Peru in July 1990, he faced a nation crippled by economic crisis and civil war. As a result of the desperate economic situation and political instability, the nation's health system was also in shambles. President Fujimori's initial objectives were

This chapter has benefited from comments from Joan Nelson and Robert Kaufman, participants in the Woodrow Wilson Center Workshop on Health Reform, two anonymous reviewers, and those who attended a presentation of this research in Lima at the offices of the Department for International Development, United Kingdom, on July 25, 2000, which was organized by Victor Zamora. This chapter is partially drawn from Ewig (2001). The author is grateful to the Fulbright Foundation, the Institute for the Study of World Politics, the Ford Foundation, and the Duke University–University of North Carolina Program in Latin American Studies for financial support for the dissertation research. She is also grateful to those who offered interviews and resources during her research period, and to committee members and colleagues who have read or commented on this portion of her research in its previous versions.

economic stabilization and the control of the powerful Sendero Luminoso (Shining Path) rebel group.

By 1993, with successes on both counts, the government's attention moved toward modernization of the state, including the health sector. Government officials rebuilt and redesigned the health sector, implementing reforms that drew on international reform currents including decentralization, targeting, and the incorporation of market mechanisms. Access to primary health care expanded greatly. Incentives for primary health providers were altered to increase productivity and efficiency. And private competition was introduced into the social security health system.

Peru's health reform consisted of a series of piecemeal measures—a set of not very integrated policies that addressed different parts of the health system and that were developed by separate teams of policymakers. Peru's reform mode was similar to that of Argentina, but it stands in sharp contrast to the comprehensive restructuring undertaken in Colombia or to the creation of a unified health system Brazil.

Political and Economic Context

Peru's economy in the 1980s was inflationary and burdened by debt obligations.[1] Orthodox stabilization had been the accepted tool of economic adjustment in Peru and elsewhere since the 1950s, but in the early 1980s had failed to stabilize the economy (Thorp 1996). The government of President Alan García Pérez, of the populist Alianza Popular Revolucionaria Americana Party (APRA) that took office in 1985, attempted an alternative to orthodox stabilization programs. García implemented a combination of exchange rate stabilization, price freezes, and wage controls, and he declared that no more than 10 percent of export revenues would go toward debt repayment. In the short run, this heterodox policy met with success. But by the end of his term, the experiment had utterly failed. By 1990, the annual inflation rate was 7,650 percent (INEI 1992), and Peru had lost credibility in the eyes of international creditors as a result of its debt moratorium.

As Peru faced spiraling economic crisis, it also confronted a powerful political threat. A number of rebel groups had gained strength throughout

1. The annual inflation rate in 1985 was 163.4 percent (cited in Thorp 1996, 63).

the 1980s, in particular the violent Shining Path.[2] In the early 1980s, Shining Path had established strongholds in several provincial areas. By the late 1980s, the group began to rock Peru's capital, Lima, through acts of sabotage against banks and government buildings, car bombs, and political assassinations. By 1990, Peru had endured years of civil war and severe human rights abuses by both the military and the rebels.

Candidate Fujimori, a political unknown before the 1990 presidential elections, ran on a platform that stressed the ineffectiveness of traditional political parties and a desire to avoid economic shock. Less than a month after taking office, in August 1990, Fujimori reversed position and implemented a draconian economic stabilization program that stabilized the economy but did so with little to no safety net. Fujimori's shift also entailed a sudden change in government personnel. By 1991, he had exchanged many left or center-left political appointees for persons with more economically conservative outlooks. The shock therapy also raised the status of the Ministry of the Economy, which had worked closely with the president on stabilization. Economic shock was a success in the medium term, and Fujimori returned Peru to good credit standing by restarting debt payments.[3] Thus, in the 1990s international financial institutions renewed ties with Peru, first in economic and later in social policy reforms.

In addition to successful economic stabilization, in 1992 intelligence forces captured the leader of Shining Path and effectively controlled the threat of Shining Path thereafter. The twin achievements of economic and political stabilization gave Fujimori substantial popularity throughout much of the 1990s. However, a stable but stagnant economy and a lack of a clear constituency demanded that he take steps to ensure continued support. His rule became increasingly authoritarian. Early in his tenure (1992), he staged a military-backed self-coup and closed the Congress until international pressures forced him to restore formal democracy. Political parties became fragmented and weak as a result of legal reforms, and due to public dissatisfaction. The weakness of parties left few political challengers, and

2. The full name is the Partido Comunista del Perú por el Sendero Luminoso de José Carlos Mariátegui, or Communist Party of Peru in the Shining Path of José Carlos Mariátegui.

3. In the short term, the effects of the shocks were horrendous. Inflation in August 1990 hit an annual rate of 21,316.3 percent (Cuanto, Webb, and Baca 1991), and pushed the working and middle classes into poverty. Only a weak social safety net existed to ease these costs. In the medium term (one to five years later), inflation did drop and level off dramatically, to rates near 10 percent annually (INEI 1996).

many of the adversaries that did appear were either threatened or bought off, often by Fujimori's close adviser and intelligence chief, Vladimiro Montesinos.

By the end of his tenure, Fujimori's power rested in part on support from the military and in part on support he gleaned through "neopopulist" tactics of directly providing material benefits to those groups—primarily poor people—from whom he sought political support in return.[4] Both of these power resources were used in the campaign leading up to the April 2000 elections, when Fujimori ran for a constitutionally disputed third consecutive term. Fujimori and his military supporters effectively controlled the news media while courting popular sectors through populist giveaways of land titles and other benefits. Outside observers such as the Carter Center attributed dirty campaign tactics to Fujimori's slim electoral victory in April 2000. The opposition pushed for a runoff, which was granted, but the president prevailed in an election international observers refused to monitor.

In September 2000, a congressional representative leaked to the public a videotape showing an opposition congressional member being bribed by Montesinos to join Fujimori's party. The video release set off a chain of events that led to Fujimori's resignation and his flight to Japan in November 2000.[5] A transition government led by Valentín Paniagua followed Fujimori's resignation, until new elections were held in April 2001. The winner, Alejandro Toledo of Perú Posible, was sworn in as president on July 28, 2001.

The Health Sector before Reform

The Peruvian health sector before reform faced a number of problems typical of Latin American countries. Health spending was low and inequitably distributed. The sector was highly segmented, resulting in duplicate coverage and inefficiency. The public health system run by the Ministry of Health was hierarchical and organized around vertical single-disease programs. Finally, health indicators placed Peru in the low to middle range among Latin American countries.

4. Funding for these populist projects were derived from the privatization of state-owned industries that freed up cash that was in turn spent by the president. This unlikely combination of populism and neoliberalism has been dubbed "neopopulism" (see Roberts 1995; Weyland 1996).

5. For a review of the events leading to his resignation and the transition government, see Conaghan (2001).

Viewed over the long term, Peru spent the most on health care in the 1970s and early 1980s. Health budgets then dropped severely with economic crisis in the late 1980s, hitting a low point in 1990–91. Beginning in 1992, health spending began to recuperate, but by the end of the 1990s spending had not matched levels of the precrisis period. The per capita spending by the central government on health (calculated in December 1990 nuevo soles) was 19.4 soles in 1970s, 21 soles in 1980, 2.2 soles in 1990, and 7 soles in 1994 (MINSA 1996a, 26). Between the state public health system serving poor and uninsured people and the state social security health system serving formal-sector workers, the public system was hardest hit by the economic crisis, with a budget in 1990 of just 15 percent of that spent in 1980 (MINSA 1996a, 26).

While general health sector spending rose as a percentage of gross domestic product in the 1990s, Ministry of Health budget figures show a relative decline in spending in the public health system for the latter part of the decade (see table 8.1). The Ministry of Health's budget fell from 9.7 percent of the national budget in 1996 to 4.9 percent in 2000.[6] This tapering off indicated the limits of health spending based on nonrenewable funds gained from privatizations of state industries. National revenues from privatizations were very high in 1994 and 1996, ranging near or above $2 billion. Since 1997, revenues have been in the range of between $250 million and $500 million per year.[7] It also could be due to the slowing of the national economy and the low priority placed on health spending.

6. The 1996 figure is from MINSA (1996a, 20); the 2000 figure is my calculation based on budget information in MEF (2001).

7. Although I document here the direct contributions of privatizations to the Ministry of Health, one should also keep in mind that this relationship is not necessarily direct; monies from privatization spent in other sectors may have effectively freed more general revenues for the health sector in the mid-1990s. The Ministry of Health did not see the benefit of funds from privatizations until 1995, when it received relatively minor contributions. Funds from privatizations initially went largely to Fujimori's populist programs, like FONCODES, and to the Ministry of Defense. In 1998 and 1999, MINSA received a more significant share, 12 percent and 13 percent of all privatization revenues that were spent in those years; in 1999, it leapt to 23 percent. In 2000, its proportion declined to 7 percent. (Percentages calculated by the author from Ministry of Economy and Finance reports: MEF 1999a, 1999b, 2000, 2001, 2002c, 2002d.) Although the proportion of the MINSA budget from privatizations grew significantly in the middle to late 1990s, the budget itself only grew moderately. In 2000, a Fiscal Stabilization Fund was established, in which the majority of funds from privatizations are saved for poverty alleviation in low growth years, and the rest go toward debt payments (MEF 2002b). As a result, in 2001 no privatization funds went toward health.

Table 8.1
Social Expenditures and Health Expenditures, Peru, 1990, 1994, and 1999 (percentage of gross domestic product)

Total Expenditures	1990	1994	1999
Social	3.3	5.8	6.8
Public health	1.03	2.23	2.4

Sources: For social expenditures, CEPAL (2000, 140); CEPAL División de Desarrollo Social, base de datos sobre gasto social. 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. 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.[8] The large majority of the population (73.8 percent) had no insurance at all (MINSA 1996a, 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 21.8 percent of the population was covered by the state health insurance plan, at the time called the Instituto Peruano de Seguridad Social (IPSS, now ESSALUD). The private sector, the third major area after public and pay-as-you-go provision, in 1994 insured only 1.5 percent of the population (MINSA 1996a) (see figure 8.1). Segmentation has resulted in a duplication of health services and marked inefficiency across the sector as a whole.

Figure 8.1 outlines insurance patterns, not overall financing. Insurance patterns mask the significant numbers of people 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, as listed in table 8.2.

Table 8.2 shows that the private sector accounted for more than one-third of financial flows—much of this on an out-of-pocket basis. Also, despite the fact the public sector served a much larger portion of the population (74 percent, plus a good number of insured people who opted to use Ministry of Health public services over their assigned IPSS social security

8. Although initial reforms of the Fujimori administration 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.

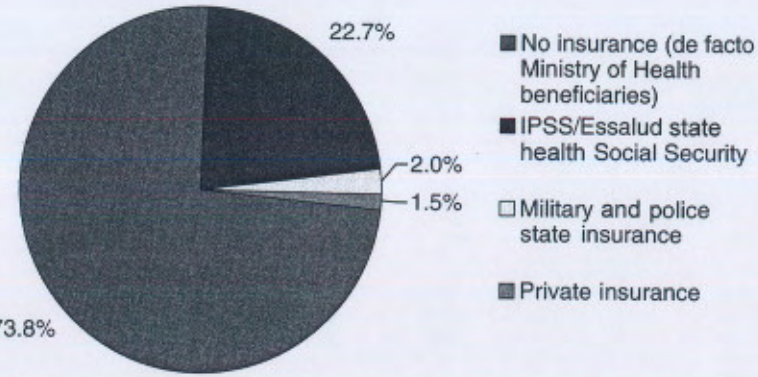

Figure 8.1. The Distribution of Health Coverage in Peru, 1994

Table 8.2
Peru's Sources of Health Care Finance (thousands of December 1995 nuevo soles)

Year	MINSA and Regions	IPSS/FFAA	Private Sector	Total
1992	888,097	1,256,471	1,406,084	3,550,652
Percent	25.01	35.39	39.60	100
1994	1,094,646	1,501,610	1,518,537	4,114,793
Percent	26.60	36.49	36.91	100

Note: IPSS = Instituto Peruano de Seguridad Social, the state social security system; FFAA = health system for the Police and Armed Forces; MINSA = Ministerio de Salud del Perú.
Source: Programa de Fortalecimiento de Servicios de Salud et al. (1997, 35–36).

security services),[9] it received disproportionately low financing. In short, the distribution of financial support for health services across the separate systems was highly inequitable.

Related to spending across sectors, there also existed severe regional inequities in spending patterns. Public-sector, state Social Security, and private spending were all concentrated in Lima, the area of Peru with the least incidence of poverty. In 1994, those areas with the greatest health needs and least ability to self-finance these needs (generally the poorest, most rural regions) received the lowest proportion of state health expenditures.[10] In addition, public spending has historically been disproportion-

9. Those persons who have health insurance use a MINSA public health facility 13.4 percent of the time that they require health care (MINSA 1996a, 24).
10. See Tamayo and Francke (1997, 38–39).

ately spent on more complex levels of care, to the detriment of primary level care. In 1994 nationally, 54 percent of public health expenditures went to hospitals, 33 percent to primary level care, and 13 percent to administration (Tamayo and Francke 1997, 64–65).[11]

The Ministry of Health itself has historically operated as a highly centralized and vertical institution. Initial efforts to decentralize began in the 1980s. Regional health authorities (Direcciones Regionales de Salud) linked to the ministry existed for some time prior to any reforms. In the 1980s, these authorities were given the responsibility for regional health programming, for administering personnel, and for financial and material resources on a regional level.[12] However, these served a largely bureaucratic function, not one of devolution of power (Becerra Hidalgo 1988, 46). These regional authorities later gained substantial power under the decentralization to regional governments begun by President García. Responsibilities for health care provision, including all material and fiscal resources, were devolved in this law directly to regional governments.[13] With regionalization, the Ministry of Health maintained the responsibility to develop national health policy—but essentially lost the power to implement it beyond Lima. Regionalization was implemented in the first years of the Fujimori administration.

In addition to its centralized form, the Ministry of Health was historically organized around "vertical" programs that focused on single health issues, such as tuberculosis and malaria.[14] Parallel vertical programs resulted in resource duplication and poor quality due to their focus on single health issues rather than integrated health services. Reforms of the sector in the 1990s tried to change these and other problems.

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

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

13. The regional governments were dissolved under Fujimori. The regional health authorities—variously called Regiones, Sub-Regiones, and now Direcciones de Salud—have persisted. More recently, Toledo has reconstituted regional government.

14. Vertical programming is in part a result of historic collaboration with international agencies that were concerned with eradicating particular diseases, and thus initially funded these kinds of programs within Latin American health ministries. E.g., the Rockefeller Foundation provided substantial funding for eradicating malaria in Peru and elsewhere and thus influenced the early organization the health ministry (see Cueto n.d.).

Table 8.3
Basic Health Indicators for Peru, 1980–2000

Indicator	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 rate[a]	81	72	60.5	51.3	49.2	40.4
Under-five-year mortality rate[a]	126	—	75[b]	72.4	69.9	61.2 (1999)
Maternal mortality rate[c]	—	—	—	185	185	185
Fertility rate	4.5	4.0	3.7	3.2	3.2	2.8

Note: A dash in a cell means that the data are not available.
[a]Estimated figures, deaths per every 1,000 live births.
[b]World Bank data.
[c]Reported rate, deaths per every 100,000 live births.
Sources: For 1980 and 1985 data, World Bank, World Development Indicators, 2001. For 1990, 1994, 1995, and 2000 data, Pan American Health Organization, Special Program for Health Analysis, Regional Core Health Data Initiative, Technical Information System, 2001.

Peru's health indicators place it at the low to 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. Much of the improvement is likely due to rapid urbanization rather than to improvements in health services in this period.[15] The major indicators are given in table 8.3. The data for 1994 are provided as the baseline before major reforms were introduced that same year.

The major areas of health concern in Peru are infant mortality, under-five-year mortality, and maternal mortality. Each of these mortality indicators is much higher in rural than 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 percent of children age six to nine years suffered from chronic malnutrition. Among adults (age 15–59 years), infectious diseases are a leading cause of death, and diseases of the circulatory system are a primary cause of death for the population over sixty. Among communicable diseases, there are rising rates of malaria, leishmaniasis, dengue, and selvatic yellow fever, which in 1995 reached epidemic proportions. AIDs and tuberculosis rates also rose dramatically toward the end of the 1990s. On the

15. Thanks to Kurt Weyland and Deborah Brautigam, who brought this point to my attention. This hypothesis would need to be statistically tested with data on urbanization.

environmental front, of particular concern for Peru are deaths due to traffic accidents, and poor air and water quality.[16]

The Politics of Sector Reform, 1994–2000

The lack of vision for Peru's health sector reforms can be partly explained by looking at the broader national context at the time. The Fujimori administration was successful in so-called first-wave, or economic reforms, but (with the exception of pension reform) it stopped short of comprehensive second-wave reforms that would deepen economic reforms and reform social sectors—such as education, justice, housing, and health.[17] Health was a relatively low priority for Fujimori, except to the extent that it dovetailed with Fujimori's two social policy darlings: his Lucha Contra la Pobreza (Fight Against Poverty) and his promotion of education.[18] As a result, health reform largely remained the domain of Ministry of Health policy elites. These had the "green light" of the president, as one informant put it, but they worked within a political context in which there was little political opportunity for major reform.[19] Health reform will only progress to the extent that a larger state reform process is under way.

The piecemeal nature was also in part a result of the isolation within which reforms were developed—small groups of five to ten specialists were appointed by ministers to develop a particular reform. These groups generally eschewed interaction with members of civil society who might challenge their principles or their know-how. They worked apart from other professionals within the Ministry of Health—and even in isolation of other reform teams. The result was a potpourri of reforms that sometimes came into direct conflict with one another, and which were implemented to varying degrees.

When Fujimori first took office, his ministers of health largely focused

16. This paragraph is summarized from PAHO (1998, country chapter on Peru).

17. For a review of progress on state reform in the 1990s in Peru see Abusada et al. (2000).

18. For those readers interested in education reforms, it should be noted that Fujimori's interest in education stemmed primarily from his interest in using it as a tool of populism, not from an interest in education reform. E.g., he used school construction to bolster political support. There were reform efforts made in education, but as in health, these were only partially successful.

19. Interview by author with an anonymous member of the team that oversaw the overall health sector reform plan, Lima, March 11, 1998.

on continuing the process of the decentralization of Ministry of Health services begun under the García government. Ministers from 1991 to 1993 experimented with participatory forms of decentralization, following models outlined by the Pan American Health Organization. These experiments were short-lived. More lasting health reforms of the Fujimori administration began under the leadership of Minister Jaime Freundt-Thurne, whose team devised dual centralized and decentralized health delivery strategies in 1993, which began to be implemented in 1994. These were the targeted and centralized Programa de Salud Básica para Todos (Basic Health for All Program, PSBT) and the decentralized Programa de Adminstración Compartida (Shared Administration Program) that oversaw the Comités Locales de Administración en Salud (Local Health Administration Committees, CLAS).

This last program, which came to be known simply as CLAS, devolved administrative (and some fiscal) responsibility to community members elected or appointed to a board that jointly administered individual or networks of public health centers. In contrast to previous sector reforms, these reforms began to integrate neoliberal principles and strategies, such as the targeting of resources for greater efficiency and the use of employee incentives to generate higher productivity. The PSBT program was premised on the concept of targeting the poorest areas first. Both programs made a radical change in labor practices, contracting doctors, nurses, and other health professionals and renewing these contracts on the basis of performance rather than utilizing the traditional state labor system of permanent "named" positions.

All these programs emphasized increased access to primary care in poor communities. Although linked financially and later administratively within the ministry, the PSBT and CLAS programs, due to their opposing centralized and decentralized approaches and thus political implications, became competing and conflicting reforms within the overall public health system. Despite their contradictions, PSBT and CLAS were among the most successful reforms in that these were the backbone of the reconstruction and modernization of Peru's public health system, which had fallen into complete crisis in the previous decade. By 2001, CLAS and PSBT together accounted for 98 percent of all primary level health care establishments in the public system.

Much of the effort in the first years of reform (1993–96) was spent on PSBT and CLAS and the reconstruction of the dilapidated health care system. It was not until 1997 that other major reforms and reform proposals

surfaced.[20] The first of these was the Ley de Modernización de la Seguridad Social en Salud (Modernization of Health Social Security Law), which allowed private health care providers to compete with the state health social security system. This reform was in many ways a completion of first-wave economic reforms. Efforts to pass the law began in 1991. Political obstacles, detailed below, slowed its progress until it passed in its final form in 1997. The next major health reform was introduced just a few months later, in July 1997. This was the Seguro Escolar Gratuito (SEG, Free School Health Insurance). SEG was a presidential initiative that grew out of Fujimori's personal interest in improving education; its impetus had little to do with health.

By the end of the decade, a number of additional reform proposals were put forward and piloted. These included contracts between the Health Ministry and some hospitals to promote greater efficiency through payment for service arrangements; the creation of health networks among differing levels of establishments to promote sharing of equipment and resources; and the development of a social insurance plan for infants and mothers (Seguro Materno-Infantil, SMI). The latter was the idea of outside lenders, and it was implemented by the outgoing Fujimori administration and the transitional Paniagua government. These reforms were implemented with only variable success. The hospital reforms were implemented in only a select number of hospitals; the networks did little to change existing inter-establishment relations (in many ways it amounted to a simple name change of intermediary administrative units); and the maternal-infant insurance program was implemented poorly. SMI was subsequently folded into the school health insurance program by the transition government, thus diluting much of its original focus.[21]

The International Financial Institutions and Health Sector Reform

The influence of the international financial institutions (IFIs) on the politics of Peru's health sector reform is understood best as agenda setting (Bachrach and Baratz 1962; Schattschneider 1960; Lukes 1974; Livingston 1992). Agenda setting is a process whereby certain issues or approaches are placed on the political agenda, while others are effectively closed out. In the

20. Elsewhere (Ewig 1999, 2001), I argue that the reform of the family planning program should be considered a reform. This reform began in 1996, but I will not include it in the present discussion.

21. I thank Alicia Yamín for her clarification on the status of the SMI reform.

case of Peru, IFIs first determined whether Peru's government could pursue social policy reforms at all, and second defined reform as based on neoliberal principles. Through loan agreements, IFIs approved of state spending on social policy, and later these also financially supported reform efforts, thus influencing the shape of these policies.

The major social policy strategies advocated by the IFIs—targeting, decentralization, private-sector competition, and the separation of the financing and provision of state services—were all evidenced in Peru's reforms. Via publications, conferences, training workshops, and person-to-person contact, the IFIs suggested that these were the appropriate and viable reform strategies. Though influential, the IFIs were not directly involved in the day-to-day development or implementation of reforms. The IFI representatives that I interviewed claimed a supportive role only, without intent to influence or condition health reform. Peruvian policymakers also guarded their autonomy from direct IFI interventions—often blocking the success of those reforms pushed hardest by the IFIs. Thus, though evidence of IFI influence is obvious at the level of the broad, neoliberal-inspired intellectual currents that informed the individuals on the various health reform teams, there existed some room for country-level innovation within the broader neoliberal paradigm.

In 1993, when Peru's economy was beginning to stabilize, the IFIs approved a social spending plan presented by the Peruvian government. Bureaucrats working in Peru's prime minister's office had outlined a plan for targeted spending in the 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, toward a longer-term social policy plan. In October 1993, the minister of economy and finance took this conceptual document to a meeting with the Paris Club creditors, who were enthusiastic about the plan. Their support was significant in two ways. First, it signaled a shift toward support of social policy spending by creditors that up until this point had advocated cuts in Peru's state expenditures. Second, this meeting was key in convincing the Ministry of the Economy and Finance to also support social spending.[22]

Although Paris Club approval allowed the Peruvian government to spend on social policy, the IFIs soon after began to play a more direct role in health reform. The most significant was the financial role of the Inter-

22. This is from an interview by the author with Luis Manrique, formerly affiliated with the national policy on targeting of social spending, Lima, February 18, 1998.

American Development Bank (IDB). The IDB cooperated with Japan to finance the Programa de Fortalecimiento de los Servicios de Salud, the Program to Strengthen Health Services. During the 1990s, this program funded the teams of Health Ministry consultants that spearheaded health reform from within the ministry.[23] The World Bank, the U.S. Agency for International Development (USAID), and the Department for International Development of the United Kingdom (DFID) also played supportive roles in the reform effort. The World Bank funded a major targeting project within the ministry, the Programa de Salud y Nutrición Básica, or the Basic Health and Nutrition Program. USAID personnel led workshops on health reform for ministry members, began pilot reform initiatives, and funded short studies of aspects of the health sector. DFID worked to build the technical capacity of Peruvians engaged in designing reforms. In comparison with the large sums of money lent by the IDB, these efforts were much smaller in scope.

When the loan for the Program to Strengthen Health Services expired at the end of 1998, it was not renewed. The IDB, which was unsatisfied with the progress made under this loan, sought other ways to support the reform process. In 1999 it teamed up with the World Bank to support two reforms that both institutions agreed held the most promise: CLAS and maternal-infant insurance.[24] CLAS was considered a success by most outside evaluators, and high rates of maternal mortality were a significant problem. Both of these programs also faced significant opposition within the Health Ministry. The reasons for opposition to CLAS will be detailed below. In the case of maternal-child insurance, the opposition stemmed at least in part from the fact that the program did not have strong advocates from within the ministry and had been introduced from the outside by the IDB.

Four Reform Initiatives

This section delves into the national dynamics of health reform, tracing the policymaking process of the major health reforms developed in the 1990s:

23. The funding consisted of a $68 million loan from the Inter-American Development Bank, a $20 million loan from the Overseas Economic Cooperation Fund of Japan, and a $10 million from the Peruvian national treasury.

24. This is from an interview by the author with an anonymous World Bank official, Washington, October 8, 1999, and from the World Bank's Public Information Center Operational Document on this structural adjustment loan, which is available at www.worldbank.org/pics/pid/pe64080.txt.

targeting through PSBT, decentralization to communities through CLAS, the introduction of private-sector competition into social security health care via EPSs, and free health insurance for children on public schools, SEG.[25]

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

Targeting was one of the first major and lasting reforms of the health sector of the 1990s. Targeting in the health sector stemmed from an overall national social policy orientation favoring targeting as a strategy, outlined in the above-mentioned document presented to the Paris Club. In the health sector, the major targeting initiative became the Basic Health for All Program, PSBT. The targeting policy was partly in reaction to the social deficit that Peru's population faced as a result of economic crisis and civil war. Thus, there was some urgency behind the reform, which was passed in December 1993 as one article of the extensive 1994 budget law. This article allowed the release of funds for a number of targeting initiatives, health being just one.

No other legislation was required, and thus PSBT was developed from that point on within the Ministry of Health by a team of five appointed by the then–minster of health, Freundt-Thurne. The reform targeted a basic package of primary health care services to the poorest Peruvian communities. It involved an inflow of resources to these communities, in terms of clinic construction, personnel who were attracted to poor and remote areas by competitive salaries, and medicines and medical supplies. Once implemented in 1994, the program expanded rapidly.

By emphasizing primary-level and preventative care, the program drew on policies advocated by public health experts. It also borrowed from neoliberal tenets by introducing private-sector models into public systems. In particular, PSBT health professionals were hired under a private-sector labor regimen. Unlike traditional state health workers who held "named" positions and were virtually immune to job loss (but also paid poorly), health professionals hired under the PSBT program were hired on short-term contracts, which would be renewed based upon productivity levels. Though the PSBT workers were paid competitive salaries, they forfeited job stability and benefits—they received no health, pension, vacation, or even sick day benefits.

25. The introduction of fees was another major reform that is still in force, but it is not discussed here. Fees were introduced during the economic crisis period as a way to help the public health establishments survive in a time of major budget slashes.

The new employment regimen was the most radical aspect of this reform, and it sets Peru apart from the other cases in this volume. The private-sector employment model was implemented in a number of program areas of the Health Ministry, including CLAS and among the reform consultants themselves. In PSBT, however, contracts were extremely short (three to six months, with no benefits, compared with the one-year contract of CLAS professionals with benefits) and productivity expectations were high—across the board. For example, persons working in rural areas with low population density had the same productivity requirements as those working in densely populated, high-demand urban areas.[26] With quotas to meet and jobs on the line, efficiency was successfully promoted, but there were no incentives to provide high-quality care.

The fact that such a radical change in employment practices was possible in Peru's health sector, but not in the other countries considered in this volume, is explained by national and sector-specific factors. The flexible labor contracts were part of a larger national process of labor reform that began in 1991, in which labor laws were radically revised from the most protective in the hemisphere to among the most flexible.[27] Major changes included easing of restrictions on terminating employees, the elimination of tripartite bargaining, and—significant for the health sector—the liberalization of the use of temporary contracts. The 1991 Ley de Fomento de Empleo allowed the use of temporary contracts for up to three years per employee, and in 1995 this was extended to a five-year period. PSBT used exclusively temporary contracts for its health staff.

A number of important changes were made regarding unions as well, two of which affected the health sector. One was a shift from sector-level bargaining to firm-level bargaining. This meant that with the above-mentioned regional decentralization of the health system in 1989-90, the ministry health care union, the Federación de Trabajadores del Ministerio de Salud (Federation of Ministry Workers), had to bargain with each regional director, not the ministry as a whole. The union of health professionals that worked for the ministry thus became ineffective and nearly dissolved. Second, strike days were no longer paid days, thus reducing the incentive to strike or to maintain a strike.

26. As a result, there were also high incentives in the rural areas to lie on productivity sheets.

27. The information in this paragraph on national labor reform is drawn largely from Saavedra (2000).

In the early 1990s, Peru also had an overabundance of young health professionals seeking work. These unemployed professionals, not affiliated with unions, welcomed the well-paid work opportunity that PSBT presented. The program effectively opened an alternative health labor market to the scarce "named" positions in IPSS and the Ministry of Health. The health care unions at the time, the above-mentioned Federation of Ministry Workers and the Asociación Nacional de Médicos del Ministerio de Salud (Association of Doctors of the Ministry of Health, ANMMS) did nothing to challenge the change. The ANMMS formed part of the national doctors guild, the Federación Médica (Medical Federation). The Medical Federation opposed reforms in the Social Security health system, but it ignored the new hiring regimen in the ministry and did not organize the workers hired under that system.

In addition to changing labor relations, PSBT changed health sector politics between the central and regional authorities. The PSBT program recentralized the financing of health services, because funding for this program came through the central ministry to the regional authorities rather than directly from the Ministry of the Economy and Finance to the regions as the rest of the health budget was channeled. Increased central funding changed the balance of power within the health sector, increasing the power of the 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; in 1995, PSBT accounted for 23 percent of the total budget spent by the regional authorities charged with delivering health care services.[28] The program was financed entirely by the national treasury, and central health authorities took pride in its independence from foreign financing.

The impact of PSBT on primary level public health care in Peru is notable when measured by its level of coverage—by the end of 1998, the program covered 89 percent of all primary level public health establishments. The percentage of centers covered by PSBT has since dropped, to 79 percent in 2001, owing to the fact that some of these centers converted to the CLAS model, an alternative form of health center administration discussed in the next section.[29]

28. This is from Francke (1998, 35).

29. These data were provided by the former director of the CLAS program, Ricardo Díaz Romero, February 19, 2001.

Decentralization: The Shared Administration Program (CLAS)

At about the same time that 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 came to be known simply as CLAS, after the local health administration committees it created. The CLAS policy was created in the same context of urgency as PSBT. Yet it represents a different approach—the decentralization of resources and administration. The form of this decentralization is particular. Rather than decentralizing health care administration to municipal governments, as in the cases of Colombia and Brazil analyzed in this volume, CLAS involved decentralization of local health post administration to community representatives. Of the six representatives that sit on the CLAS board, the community elects three and the chief doctor of the local health post appoints the other three. Those selected by the doctor are drawn from health-related community organizations, such as mothers' clubs and soup kitchens.

Each health center that converted to the CLAS model legally became a private nongovernmental organization (termed *personería jurídica*). Though legally private and independent, each CLAS center was dependent on the Health Ministry (in the case of the Lima CLAS) or its regional health authority (in the case of provinces) for its main budget, primarily for salaries. CLAS's health center infrastructure also remains state property. CLAS centers were free to spend as they saw fit all the income they raised through fees for services, within basic ministry guidelines. This financial flexibility led many CLAS centers to improve their infrastructure and hire additional staff members. CLAS members were required to approve a local community health plan each year, a component that urged greater responsiveness of health services to community circumstances.

Finally, the health workers in the CLAS centers were hired directly by the CLAS members, who evaluated these workers on at least an annual basis. This provision in the policy effectively increased worker productivity and their responsiveness to the community, because their supervisors were local community members able to monitor their activities on a daily basis.[30] 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, received regular benefits such as vacation

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

and pension contributions—though for this privilege their salary scale was lower than that of their PSBT counterparts.

The CLAS policy was developed entirely within the Ministry of Health by a small reform team appointed by the Minister Freundt-Thurne. The team at first consisted of eight people and was eventually reduced to three.[31] This three-person core team wrote the Supreme Decree signed by the president that created CLAS.[32] Freundt-Thurne supported the project within the ministry, and he successfully sought the support of the president, whose signature was required on the Supreme Decree to make the reform legal.[33]

CLAS was tied financially to PSBT, receiving its funds from the same budget line approved by Congress for targeting, as part of the same health sector restoration effort. As a result, it did not need to go to Congress for inclusion in the budget. Thus, many key state players, such as Congress and the Ministry of the Economy and Finance, played no role. Also, President Fujimori's interest in the policy was only improvement in health services; that this "was CLAS or not CLAS was not important."[34] In short, the formulation process proceeded simply from a minister-appointed reform team 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 (e.g., Peru's new Constitution had barely passed in a referendum in 1993, and this low support was widely perceived to indicate a lack of public confidence in the Fujimori administration). Doctors' and health workers' associations initially viewed the CLAS policy as an attempt to privatize public health care, given the legally private status of each CLAS center. Opposition to the reform came from various associations of health professionals. The Colegio Médico, Peru's equivalent to the American Medical Association, issued a statement in opposi-

31. This is from an interview by the author with an anonymous member of the original CLAS formulation team, Lima, April 8, 1998.

32. This is from an interview by the author with Carlos Bendezú, a member of the three-person CLAS formulation team, Lima, March 17, 1998. The author also interviewed an anonymous member.

33. This is from an interview by the author with Juan José Vera del Carpio, director of Program of Shared Administration (CLAS), MINSA, Lima, April 23, 1998, and from an interview by the author with Jaime Freundt-Thurne, former minister of health, Lina, April 15, 1998.

34. Interview with Freundt-Thurne.

tion to CLAS after the Supreme Decree was first issued. This association and the Medical Federation opposed the reform due to its potential to privatize 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."[35] In addition, the Federation of Ministry Workers, fearing the negative impact further decentralization would have on the unity and viability of their union, vocally opposed the measure.[36]

The formulators of the CLAS policy simply avoided discussion with opposition groups, and they 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."[37] According to Freundt-Thurne however, taking a low-profile approach was not necessarily a strategy to avoid opposition—it was simply how the ministry reform teams worked.

The international arena played a support role in the development of the CLAS reform. The idea of community participation in health center administration came from publications by the World Bank and UNICEF. One policymaker involved in the formulation of the CLAS policy emphasized the importance of the World Bank's publication of *World Development Report 1993* on health care financing and UNICEF's 1990 book, *The Bamako Initiative,* on the experience of community participation in health administration in Africa.[38] The influence of these publications demonstrates the linkages between policy elites in Peru and international discourses on health reform.

In addition to these discursive influences, the reform team members were funded through international sources, specifically the above-mentioned Inter-American Development Bank loan. In addition, a small amount of international funding from USAID allowed the team 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 coverage as PSBT

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

36. Interview with Vera.

37. This is from an interview by the author with Carlos Bendezú, consultant to the Program to Strengthen Health Services, MINSA, Lima, March 17, 1998.

38. Interview with Bendezú. See UNICEF 1990 on UNICEF's Bamako Initiative.

did, CLAS was piloted in a few regions. The expansion of CLAS depended upon the will of the autonomous regional health authorities. Some of these were enthusiastic and implemented the program widely, while others saw further decentralization as a political threat to their authority and refused to implement it either well, or at all. Thus, CLAS was implemented unevenly. By 1997, three years into the program, CLAS covered only 10 percent of all primary level health establishments connected to the Ministry of Health—a far cry from the 72 percent coverage of PSBT, which started at about the same time.[39] Positively, slow piloting allowed the reform to be tested and modified, responding to the needs of staff and community members, before expanding further.

As was noted above, CLAS and PSBT worked toward modernization of the public health system in two opposing forms—one via greater centralization and one via decentralization to community members. Although PSBT was accepted in part due to the substantial resources it provided, CLAS was rejected by many local doctors and regional directors who refused to give up their power to local community members whom they did not recognize as their peers.

When Freundt-Thurne left the minister's office, CLAS began to lose its high-level position in the ministry, and regional directors and policy elites within the ministry who opposed CLAS found ways to slow its progress. For example, the reform that proposed joining a number of establishments into a network that shared equipment and was supervised by a contracted manager was viewed as a reform incompatible with the independent nature of CLAS. Opponents of CLAS seized upon this inconsistency, and CLAS expansion was halted for much of 1998 and part of 1999.

The World Bank and Inter-American Development Bank, who viewed CLAS positively, coordinated parallel loans in 1999 that required CLAS to be expanded. Even with the strong support of the IFIs, CLAS still faced an uphill battle. In early 2000, CLAS had begun to expand once again as a result of the loan requirements. In mid-2000 however, the Fujimori government's minister of the economy and finance cut the CLAS program budget significantly, leading to the resignation of the director of CLAS. As of 2001, CLAS had grown from 10 percent of health centers and posts to 19 percent.[40] In the first year of the Toledo government, CLAS centers were

39. The data are from *Data Social* 4, no. 6 (Instituto Apoyo), and from MINSA (1996b).

40. The data were provided by the former director of the CLAS program, Ricardo Díaz Romero, February 19, 2001.

once again expanding, but they were not mentioned in that government's health sector reform plans. As of this writing, it is hard to gauge whether CLAS will survive the Toledo government's proposed decentralization of health care services to municipalities.

In sum, in the case of CLAS, we see significant support from IFIs. However, government officials used a number of tactics to thwart CLAS expansion and the intentions of the lenders. The chief issue in the case of CLAS was power—the program significantly democratized power relations within the health sector, and thus faced the most resistance.

Market Competition: Health Provider Entities (EPS)

Whereas the role of the state in health care provision expanded with the PSBT and CLAS programs aimed at poor people, the reform of the Social Security health system, serving the middle and working classes, reduced the role of the state as a provider. It did so by allowing private health care companies to offer health care provision to workers previously only covered by the state Social Security system.

In the early 1990s, Ministers Freundt-Thurne and Yong Motta made unsuccessful bids to create Health Service Organizations (Organizaciones de Servicios de Salud, OSS) on the heels of pension reform. In 1991, the OSS reform was passed by legislative decree, but it was never implemented due to strong opposition from organized labor, retired persons, and health care professionals.[41] The plan thus lay dormant until Marino Costa Bauer—a former insurance executive explicitly appointed to see the reform's passage—was appointed minister. In 1996, the president passed a second legislative decree, based on a modified version of the OSS policy developed by Costa Bauer's team, and titled Health Provider Entities (Entidades Prestadoras de Salud, EPS) rather than OSS. This time, opposition members of congress protested that this decree was unconstitutional, because it extended beyond the powers that Congress had granted the president for decree-making authority; they had authorized decrees related to privatization but not to reforming the Social Security system.

Ultimately, the proposal passed through Congress as the Modernization of Health Social Security Law in May of 1997 (Ley de Modernización de Seguridad Social en Salud). Peru's weak party system and presidential control of Congress at the time made passage of the law through Congress

41. Legislative Decrees are decrees made by the president within a specific policy area authorized by the Congress.

relatively trouble-free, and Congress made few changes to the 1996 decree. Neither the passage of the OSS bill by legislative decree nor the EPS bill, despite the fact that the latter finally passed Congress, allowed for more than a few hours of public debate on this reform.

The final reform allowed private networks of health clinics and hospitals, Health Provider Entities (EPS), to compete with the state Social Security health system for workers' health care coverage. 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 above.[42] As a result of resistance to all-out privatization (the route taken with pensions), the initial 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, for example. In addition, as a cost-containment measure, 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 percent of a worker's pay), 25 percent goes to EPS while 75 percent goes to the state system, ESSALUD.

This reform to the social security system faced much greater resistance than the public system reforms for a number of reasons. Although IPSS covered a smaller portion of the population (only 23 percent of the population, compared with the 74 percent covered by the Ministry of Health), it affected more organized sectors of society, including workers and Social Security health system workers, who remained better organized than public health sector workers. Second, because this reform initially mirrored the reform of the pension system privatized previously, the opposition was primed to oppose a reform of this type. Finally, whereas an important subgroup of health workers saw substantial benefit in the ministry reforms described above, and these reforms brought an increase in health services for the poor populations involved, the reform of the social security sector

42. This is from an interview by the author with Raúl Torres, head of the committee charged with monitoring the reform of health social security, Lima, February 25, 1998 (first interview). The author also interviewed an anonymous general on the MINSA reform team, Lima, February 23, 1998.

implied job and resource loss for the state Social Security system. The opposition to the reform failed to stop it, in part because many white-collar workers wanted a choice in health care options, and the improved health care quality that EPS reform promised. In large part, however, the reform progressed to implementation because the Fujimori administration used every political tactic possible to see it succeed despite opposition.

Targeted Insurance Schemes: Free School Health Insurance (SEG)

In July 1997, the Seguro Escolar Gratuito (again, SEG, Free School Health Insurance) reform was introduced. Unlike all the other health sector reforms, SEG fell outside both the neoliberal policy discourses and the traditional process of policy formulation by policy elites within the executive branch. SEG was clearly a presidential initiative motivated by populist presidential politics.

The SEG reform provided free health care coverage through Peru's public health system to all children, preschool through age seventeen years, enrolled in Peru's public school system. The insurance offered broad coverage that promised to increase economic access to health care. It was also targeted to the extent that primarily poor people and the lower classes attend Peru's public school systems. The major objectives of the reform, however, were not related to health but to education. Free health insurance for schoolchildren was to encourage parents to enroll their children in school and to act as a disincentive for children to drop out. From a public health perspective, by targeting an age group that is considered to be low risk compared with other age groups, the reform made little sense. If better health outcomes were the goal, this money would be better spent on children in the age range from birth to five years, who face the greatest health risks. For the president, however, it made political sense.

President Fujimori announced SEG in his July 1997 Independence Day address to the nation. SEG was an extension of his ongoing interest in education. (He had been using school construction in poor communities as a populist tool for some time.) His special consultants on education policy conceived of the concept, and his address was the first notice given to the Ministry of Health officials of the reform.[43] The ministry—charged with developing the specifics of the reform and launching it, all in the space of a

43. This is from an interview by the author with Ulisis Jorge Aguilar, director of Seguro Escolar Gratuito, Lima, January 19, 1999, and from a conversation with Victor Zamora of DFID, Lima, July 22, 2002.

month—assembled a small team of consultants to design and implement the program. Ulises Jorge Aguilar, a former head of a regional health authority, led the team.

According to Jorge, the process he led of formulating the SEG program "surged from his strong authority," where he "ordered things." Not only was input not invited from civil society but the advice of other reform teams and program administrators within the ministry was rejected.[44] As a result of the president's strong support for 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 to the measure (though there were no clear "losers" in this case to protest). Nor did legal institutions pose barriers, as the program proceeded without any legal basis for the first two years of its existence.

SEG was also independent of international influence. The program's formulation and implementation was funded entirely through the national treasury. Only after over a year of implementation did one international agency, UNICEF, begin to take an interest in the program and support it in small ways.[45] The program was implemented at fairly low cost. Even after being combined with the maternal infant insurance in 2000, the two programs accounted for 5 percent of the budget of the Ministry of Health (MINSA 2002, 20). The closed policy formulation process however led to a lack of understanding of the reform by both parents and health care providers that bogged down health services delivery under the program for the first year. In subsequent years, the program did increase the health insurance coverage of children significantly.[46]

Conclusion

Peru's health care reform process during the 1990s was piecemeal. The lack of a vision for reform stems from the fact that, other than pension reform, second-wave state reforms were largely incomplete in Peru, and from the very insulated manner in which these policies developed. Health sector reform could only progress to the extent that a broader state reform process

44. Interview with Jorge.

45. Interview with Jorge.

46. In 2001, the combined Seguro Escolar and Seguro Materno covered 4,602,000 individuals. In February 2002, these programs were folded into the more comprehensive Seguro Integral de Salud (SIS, Integral Health Insurance) ("SIS Necesita S/.127 Millones Más Para Brindar Mayor Cobertura," *Gestión Médica,* February 2003).

was under way. The two most dramatic reforms in the health sector, the employment and Social Security reforms, were either part of first wave reforms or strongly linked to these. The change in employment regimen, incorporated most vigorously in the PSBT program, from a public- to a private-sector model was made possible by a national level effort to make labor laws more flexible. The introduction of private-sector competition into the social security sector via EPS was also a significant reform, and one that was initially linked to the reform of pensions, a second-wave reform with strong ties to first-wave economic reforms due to the savings incentives built into private pension portfolios. The EPS reform was slowed by well-organized opposition for a remarkably long time, but it eventually did progress to implementation. In contrast to successful first-wave reforms, the reform of the social sectors, or second-wave reforms, were incomplete or incomprehensive under Fujimori—not only in health, but also in other social sector areas.

Another reason for the piecemeal character of health reform in Peru was its closed policy process—small groups of five to ten people worked on one reform, with little or no dialogue with groups concurrently working on separate reforms, or with those who had developed previous reforms. Moreover, political parties, civil society, and municipalities played a very minor, if any, part in the process. Greater democracy and dialogue may have led to a unified vision by forcing consideration of the underlying philosophy and how different reform ideas might coalesce or conflict—as occurred in Brazil and Colombia, where there were broad, encompassing reforms.

Despite the fact that the Fujimori regime is now widely recognized as having been authoritarian, the closed policy process is not unique to that period. Even outside the authoritarian Fujimori period, Peru's health politics has always been to some degree isolated—from the tactics of cooptation that led to the creation of the social security sector under President Óscar Raymundo Benavides Larrea in the 1930s, to the interventionist role played by the Rockefeller Foundation that influenced the fledgling public health sector in the 1920s and 1940s. The closed nature is reinforced by Peru's political institutions and legal system that do not require that all policies pass Congress and thus become open to greater public debate.

The implications of a closed process are rapid policy formulation that dodges opposition. But closed processes can result in conflicting policies, as the four cases detailed above noted—for example, between CLAS and PSBT, and CLAS and the networks. Top-down policymaking also risks a lack of consensus around reforms, or a misunderstanding of reforms. The CLAS program has faced both of these—a lack of political support and a severe lack of understanding of the way in which the reform works, its objectives, and its positive results. Thus, many oppose the reform not only due to the consequences it has for their own power but also due to faulty information. This lack of understanding and consensus contributed to the various stoppages in CLAS expansion.

Rather than a unified vision, policy elites seemed to share some common basic objectives for the sector—specifically modernization, efficiency, and equity. Modernization of the sector was in response to the crisis situation of the health system in the early 1990s. The PSBT and CLAS programs were designed to bring a basic level of health care to communities that had little or none. Funds for this modernization were available as a result of recent government sales of state industries. Modernization of the sector also helped to promote Fujimori's image as a leader who delivered. CLAS and PSBT incorporated some important strategies for increasing efficiency as well. The new employment regimen was a major reform; it gave strong incentives to PSBT staff in particular to achieve high productivity. CLAS staff were on a contracted regimen, but oversight by a community board was an innovative and effective mechanism for not only encouraging greater efficiency but also higher-quality work. Both were forms of targeting, a strategy of using health care resources more efficiently by offering them to those who need services most. The SEG reform, although derived from populism, was also a form of targeting—only children in public schools were eligible. Finally, the EPS reform intended to spur greater efficiency and quality in the social security sector by introducing market competition. Many policy elites also had the objective of increasing equity, but equity defined as a minimum standard of services for all (a basic needs approach), rather than a more egalitarian vision of a unified system or similar quality of care for all.[47]

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47. On competing definitions of equity in the field of health care, see Wagstaff and van Doorslaer (1993).

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Part Two

The Politics of Education Sector Reform