Commentary

Leadership Politics and the Evolution of the Universal Health Insurance Reform in Peru

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Abstract—Peru is now on a path toward achieving universal health coverage (UHC), with 87% of its population covered by health insurance. This paper describes the politics surrounding the agenda setting and policy formulation process that led up to the adoption of Peru’s Universal Health Coverage Act in 2009, which has been instrumental in expanding coverage. This reform established a mandatory health insurance system, which includes an Essential Health Benefit Package (Plan Esencial de Aseguramiento en Salud—PEAS) that is financed by three health insurance schemes (subsidized, contributory and semi-contributory). Collectively these schemes are intended to cover the entire population of Peru. In exploring the politics of the health reform process, the commentary applies the Political Economy of Health Financing Framework, presented in this special issue. It does so from the point of view of a participant in the reform process. Some broader lessons emerge that extend beyond Peru regarding the changing nature of the leadership roles in each phase of the policy cycle. In particular, the analysis highlights the importance of a consensus building process across a range of political stakeholders to set the health reform on the policy agenda and as well as to preemptively identify and resolve disagreements that might arise in the legislative phase.

INTRODUCTION

The Universal Health Coverage Act of Peru was approved 10 years ago in 2009. Marking the 10th anniversary of the reform is a good opportunity to retrospectively analyze and understand the policy process, including the main actors and their dynamics. This analysis provides important lessons for future reforms both in Peru and elsewhere. The reform established a universal health insurance mandate, including an Essential Health Benefit Package (Plan Esencial de Aseguramiento en Salud—PEAS) to be financed through three types of schemes (subsidized, contributory and semi-contributory) to allow for gradual coverage expansion to the entire population.
To date, 87% of Peruvians have health insurance coverage and financial protection has improved as a result of lower catastrophic and impoverishing health expenditures. However, significant gaps persist across the health system and further reform is needed to both the delivery and financing systems. This commentary describes the politics surrounding the agenda setting and policy formulation process that led up to the adoption of Peru’s Universal Health Coverage Act in 2009. To examine the politics of this health reform process, the commentary applies the Political Economy of Health Reform Framework, described in this special issue. It does so from the point of view of a participant in the agenda setting stage of the reform process, as the author is the former Minister of Health from 2012 to 2014 who was ultimately responsible for implementing the reform. What emerges is an account of how leadership politics were employed to both build consensus and coalitions, as well as overcome opposition in the agenda setting phase (2004–5).

OVERVIEW

The uninsured share of the Peruvian population has decreased from 63% in 2004 to 13% in 2018 (Figure 1). Health expenditure per capita has risen continuously since 2004, after a prolonged stagnation period, including an increasing proportion coming from public sources (Figure 2).

A Blinder-Oaxaca demand model used to estimate the differentials in health care access between different population groups in Peru from 2004 to 2014 found that the access gap to health services has dropped significantly: from 23.2% of the population in 2004 to 3.6% in 2014.

Financing protection for health care has improved with the incidence of catastrophic spending declining since 2012, from 3.9% to 2.9% of the population over the same time period. The incidence of impoverishing spending has decreased from 0.35% to 0.20% of the population (Figure 3).

The purpose of this commentary is to understand the political economy dynamics that helped to support these policy shifts and expansion of coverage in Peru.

BACKGROUND

The deep economic crisis that occurred in the late 1980s led to the adoption of a severe structural adjustment plan to deal with economic collapse. The social sectors were particularly hit by the significant fiscal contraction. In the case of the health sector, budget cuts left the operation of public health facilities without sufficient public funding. User fees were charged to provide supplementary financing to the health sector, particularly in hospitals and health centers in urban areas and segments where patients had a greater relative capacity to pay. This in turn

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FIGURE 1. Population Covered by Health Insurance
EsSalud: Social Security. SIS: Comprehensive Health Insurance. Source: ENAHO (National Household Surveys).
contributed to a higher concentration of health workers in urban areas as compared to rural areas. As a consequence, significant economic barriers to accessing public health services emerged. By the mid-1990s only 23.6% of the population was covered by health insurance, most of whom were in the formal sector with access to social security. Equity concerns related to the large uninsured population led to the creation of tax-financed health insurance schemes to extend health protection to poor segments not covered by social security. Thus, in 1997 the Free School Insurance (SEG) and the Maternal and Child Insurance (SMI) were created as part of the Ministry of Health.

The SEG covered all public-school students. In addition to providing health coverage, it had among its objectives to contribute to the decrease in the dropout rate in public schools. The SMI targeted pregnant women, puerperal women, and children up to 3 years of age, particularly of poor populations, as a way to reduce maternal and infant mortality. These schemes covered 9.3% of the population combined.5

![Figure 2: Health Expenditure per Capita by Financing Source (soles of 2007)](image1)

Source: National Health Accounts. Ministry of Health, Peru

![Figure 3: Catastrophic and Impoverishing Household Expenditure (% of Population)](image2)

Source: Peruvian Institute of Economics (2017) Review and proposals for health reforms. Lima, Peru.
In 2002, a democratic transition occurred, and the government merged SEG and SMI into the Comprehensive Health Insurance (SIS). The coverage of SIS was extended to the poor population.

**THE UNIVERSAL HEALTH INSURANCE REFORM**

The creation of the SIS in 2002 had reinforced the policy of public health insurance for the poor. Coupled with the democratic transition, a favorable situation emerged for the discussion of health reform and its financing.

For analytical purposes, the beginning of the process of universal insurance reform was 2004, and the stages of reform are characterized from that point (Table 1).

Table 2 maps the presence of the main actors in each stage based on the typology proposed by the Political Economy of Health Framework. A clear pattern emerges, with the number and density of stakeholders, as well as their vested interests and influence, increasing from the design to implementation phases. This mapping confirms the complexity of the implementation of the phase of reforms. While this is an important finding in need of further analysis, this commentary does not focus on the implementation stage of reform.

The absence of processes and engagement with beneficiary politics (the public and final users of health care) highlights the need for further analysis and incorporation of end users into the dialogue around reform to ensure policies are responsive to need.

This commentary briefly describes the political factors and the applied leadership strategies that emerged in the first two reform stages: agenda setting, policy formulation, and legislative adoption.

### TABLE 1. Stages of the Health Insurance Reform in Peru

| Stage                  | Agenda Setting | Formulation and approval | Implementation |
|------------------------|----------------|--------------------------|----------------|
| Period                 | 2005–2006      | 2006–2008                | 2009–2011      |
| Milestones             | Approval of the Agreement on Political Parties in Health | Multiplicity of legislative proposals on health reform | Approval of the Universal Health Coverage (UHC) Act and the Essential Health Insurance Plan |
| Interest groups        | UHC Pilots     | Legislative Decrees      |
| Bureaucratic politics  |                | MOH Regional Governments |
| (within the government)|                | MOH Public Providers     |
| Budget politics        | Political parties MOH | MOF Congress MOH |
| Leadership politics    | Political parties Congress | MOF MOH Multisectoral Implementation Committee |
| Beneficiary politics   |                | MOF Presidency Congress MOH |
| (end-users)            |                |                          |
| External politics/     |                |                          |
| Academia (technical support) |    |                          |

Note: The overarching objective of the reform process was to achieve universal health insurance coverage for the whole population.

### TABLE 2. Main Actors according to Stages of Health Insurance Reform in Peru

| Stage                  | Agenda Setting | Formulation and approval | Implementation |
|------------------------|----------------|--------------------------|----------------|
| Period                 | 2005–2006      | 2006–2008                | 2009–2011      |
| Milestones             | Approval of the Agreement on Political Parties in Health | Multiplicity of legislative proposals on health reform | Approval of the Universal Health Coverage (UHC) Act and the Essential Health Insurance Plan |
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| Leadership politics    | Political parties Congress | MOF MOH Multisectoral Implementation Committee |
| Beneficiary politics   |                | MOF Presidency Congress MOH |
| (end-users)            |                |                          |
| External politics/     |                |                          |
| Academia (technical support) |    |                          |

Table 2 maps the presence of the main actors in each stage based on the typology proposed by the Political Economy of Health Framework.
Agenda-setting Stage

The key players in the initial phase of reform were 18 political parties along with Peru’s development partners. The Ministry of Health worked to respond to agreements reached by political parties.

The political party representatives, with the support of relevant development partners, met and established the health reform priorities in Peru, and over the course of a year discussed quantitative and qualitative information related on the status of the health system in Peru, as well as other countries that had undergone health reform during democratic transition periods (such as Chile). This process included dialogue to identify points of interest and consensus, which were expressed in the 2006 Agreement of Political Parties in Health (Acuerdo de Partidos Políticos en Salud—APPS). The APPS was a statement on the overall direction of the health sector reform and laid the ground for 2009 Universal Health Coverage Act.

Development partners facilitated the space for dialogue across technical teams from the 18 political parties. This dialogue helped to build commitments and agreements about health reform and facilitated legislative action. The APPS dialogue process took place in advance of any elections. The political parties convened health experts to elaborate the reform in their government plans. This included adhering to the new electoral regulatory framework that required parties to present a government plan document to the National Office of Electoral Processes (ONPE). The ruling party was represented by a member of its Executive National Committee, who was also the Chief Director of the SIS with direct links within the Ministry of Health.

The APPS was a space where information was exchanged about the country’s health situation, with national and international specialists providing their perspectives and expertise on health policies and reforms. This first phase of dialogue began in March 2005 and ended in March 2006 with the signing of an agreement document on eight central health issues including child health, maternal health, communicable diseases, decentralization in health, health insurance, financing, citizen participation, and access to medicines. Sixteen of the eighteen parties that participated endorsed the APPS Statement through their authorities, general secretaries, or presidents.

There were several factors that contributed to the success of the APPS process. First, the internal organization of the APPS established plural coordinating committees, each headed by the representative of governing party. This forum facilitated communication and coordination with public decision makers. Second, the shared design and programming of the activities across parties fostered transparency and built consensus around the reform proposals. Third, this process established a “public health community” that included health representatives of the different parties with expertise from their professional and academic activities.

Formulation and Approval Stage

The 2006 presidential election generated a variety of proposals, the majority of which fell under the APPS umbrella. The main actors in the formulation stage were the political parties and the Congress—in particular, the Health Commission—and the MOH (see Table 3).

| Dimension | Political economy factor | Strategies that emerged |
|-----------|--------------------------|-------------------------|
| Agenda setting of the universal health insurance reform (UHR). 2005–2006 | Favorable political climate, (political transition and “appetite for reforms”). Previous progress (SIS). Availability of technical assistance. | Shared political leadership. Facilitation of priority setting and consensus building processes by development partners. |
| Leadership politics | Main challenge: Placement of UHR in the policy agenda |
| Formulation of the universal health insurance reform (UHR). 2006–2008 | Divergent thinking process (more than 10 legislative proposals were drafted by the political parties). | Leadership for guiding a convergent thinking process. |
| Leadership politics | Main challenge: Convergence to a health reform act |
| Approval of the universal health insurance reform (UHR). 2008–2009 | Support from the President. Ministry of Health leadership. Congress leadership. | MOH leadership. Mobilization of the support of political parties. |

TABLE 3. Political Economy Factors and Strategies Related to Leadership Politics
This period was characterized by political competition as well as consolidation and collaboration. There was a need to differentiate electoral “promises” by the various political parties during the election campaign. Once the new government and congress were in office the President of the Health Commission of Congress promoted and managed a consolidation process across the range of these legal proposals. This process allowed Congress to ultimately arrive at the bill that was approved in 2009. The process was one of convergent thinking in that all parties were able to agree on a common reform proposal. The MoH played a key governance role by mobilizing the support of the President, as well as of the political parties to approve the Act.

REFLECTIONS

Diverse leadership strategies are needed at different points of a reform process. Multiple skills are required to manage the politics of a reform process. Leadership skills should be further researched to contribute to improve capacity for self-reliant and institutionalized development.

In the agenda-setting phase, a shared political leadership strategy emerged that was possible because of trust and respect between the APPS members. This is a very elusive condition, from an instrumental variable perspective, and provides reflection about the centrality of these attributes of political interaction. This process served to bring together health representatives from a diverse range of political parties as a way to share information and facilitate dialogue in advance of a legislative process. The output of this collaborative effort was a policy statement with health reform objectives to serve as a basis for policy interventions.

In the policy formulation and approval phase, diverse proposals emerged during elections, with competition becoming a hallmark of the formulation of the Universal Health Insurance Act. However, to ultimately pass the Act, convergence and compromise were needed. A closer look at the balance between divergent and convergent thinking in policy making is a promising area of inquiry. This phase ultimately had to produce a roadmap, both for the technical agenda and for political/social strategies to make reform implementation feasible. In the approval phase of the Act, the political commitment of the APPS participants was critical, as well as the MOH’S ability to develop the President’s interest and support for the health financing reform Act and budgetary commitments.

CONCLUSIONS

Health financing reforms towards universal coverage are contentious and require leadership and facilitation to move forward. Three concrete lessons emerge from the experience of advancing and adopting the Universal Health Coverage reform in Peru. These include:

1. The need for multi-faceted strategies;
2. The importance of political leadership to build convergence of political commitment around a single reform plan in the face of a large and diverse set of policy proposals;
3. The role of authoritative and decisive action when approval is needed.

The experience of Peru shows how a consensus-building process can place a topic in the public policy agenda and reduce disagreements in the legislative adoption phase.

DISCLOSURE OF POTENTIAL CONFLICTS OF INTEREST

No potential conflict of interest was reported by the author.

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