# Peruvian lessons for the transition from MDGs to SDGs

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With respect to the welfare of children and mothers, the transition from the Millennium Development Goals (MDGs) to Sustainable Development Goals (SDGs) is sometimes perceived as risky. The relevant MDGs had a focus on interventions to address maternal and child health, while the focus of the SDGs is expanded to "ensure healthy lives and promote wellbeing for all at all ages".[1] This transition raises two concerns: a broader set of priorities might dilute the attention on maternal and child health, and the broader priorities of the SDGs require the use of more complex implementation instruments than those used in the past. A Countdown to 2015 case study in Peru by Luis Huicho and colleagues[2] published in *The Lancet Global Health* might provide findings that help countries transition to the SDGs.

Peru had huge success improving health outcomes during the Countdown years to 2015. Peru was ranked first globally among 75 low-income and middle-income countries in the reduction in neonatal mortality and second in the reduction of under-5 mortality; stunting prevalence was cut in half; and equity in health-care use and in health outcomes improved significantly. Huicho and colleagues[2] carefully examined the determinants of this success in their study, concluding that many stars were aligned: Peru enjoyed a period of unusually rapid economic growth which coincided with a transition from authoritarianism to democracy, and with the modernisation of the anti-poverty programmes; long-term trends in the education level of mothers, total fertility rate, and urbanisation were also favourable. All of this led to a striking reduction in poverty which fell from 55% of the population in 2001 to 23% by 2014 and provided a fertile ground for the stellar improvement in health outcomes.

In the 2000s, health-sector policies in Peru anticipated the shift towards the SDGs by moving away from an exclusive emphasis on maternal and child health and from the use of vertical programmes. In the mid-1990s, Peru had relied on vertical programmes to earmark money, staff, information systems, and efforts to ensure that the statements of MDG priorities translated into high levels of coverage for the MDG interventions. Around the turn of the 21st century, Peru integrated the narrow vertical programmes into a broader programme for primary health care. A few years later, the challenge of steering this new primary care programme was made greater by a process of decentralisation that left the Peruvian Ministry of Health with few instruments to influence the implementation of health policy by the newly autonomous regions.

Peru used three types of tool to influence the behaviour of health-care providers in the new context. First, in the early 2000s it created a public insurance scheme to enrol poor mothers and their children, and to reimburse providers for services given to its beneficiaries. After a few years, during which the skills required to pay providers and enrol targeted beneficiaries were refined, the scheme was widened into the Integrated Health Insurance scheme (SIS); expanding its benefit package beyond maternal and child health, and expanding its coverage to include poor and vulnerable populations of all ages. This expansion was made possible by the use of methods of personal identification and of targeting that had been developed outside the health sector.[3]

Second, management contracts were used to facilitate a dialogue about results between the national Ministry of Health and the new regional authorities, with numerical targets prioritising maternal and child interventions. Managerial efforts were also launched to facilitate a dialogue between the local managers of health, social protection programmes directed towards mothers and children, and local authorities. These efforts were built on a new consensus that the fight against poverty was an essential element of development, that the effectiveness of programmes should be measured, and that the ultimate measure of success of antipoverty programmes should be the reduction of child mortality and of stunting.[4] Third, the Ministry of Finance created a new, centrally managed so-called budget for results.

The health sector was used to test the new budget; former staff from the Ministry of Health were hired by the Minister of Finance to implement the information system, based on their experience managing the vertical programmes during the 1990s. The government then recentralised a substantial portion of the health-sector budget, placing decision making for the budget with the Ministry of Finance and assigning responsibilities for implementation of the budget to deconcentrated budget units.

Which of these instruments should other countries consider for the transition from MDGs to SDGs? The first, SIS, eliminates copayments for their beneficiaries and provides price signals and financial incentives to managers of clinics and hospitals. The second (management contracts) aims to influence the priorities of regional authorities, and the third (a centrally managed budget) to direct the operation of district level budget operators. It is difficult to disentangle the specific influence of the three instruments. However, significant tension exists between the health-sector authorities who implement SIS and the management contracts, and the managers of the budget for results who see the other side as obstacles and competitors, rather than as complements.

Assessment studies for the effect of these instruments only exist for SIS. Findings from the most recent study[5] corroborated those from previous studies linking SIS with improved access for the poor, and finding that the introduction of SIS increased the probability that a poor person was treated by a formal health-care provider when sick by over 40% and the use of diagnostic testing by poor people by a third.[5] These findings are consistent with a review of 42 impact evaluations[6] showing that around the world, the main beneficiaries of inclusive health insurance programmes are poor people.[6] We have found no rigorous third-party impact evaluation studies for the central budget for results.

Countries looking for instruments that could be rapidly adapted to their circumstances might also wish to focus on programmes similar to SIS. Findings from a recent study of low-income and middle-income countries implementing pro-poor universal health coverage policies showed that 18 of the 24 countries studied used systems similar to SIS—designed to eliminate user fees and to reimburse providers for services delivered to poor and vulnerable people.[7] By contrast, none of these countries used a budget for results like the one used in Peru. Countries considering the transition from MDGs to SDGs and looking to Peru for lessons will find plenty of useful information in Huicho and colleagues' Peru Countdown to 2015 case study.[2] They might also wish for more research attempting to disentangle the effects of the many stars that were aligned during Peru's Countdown to 2015.

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1 UN General Assembly. Transforming our world: the 2030 agenda for sustainable development. Resolution adopted by the General Assembly on Sept 25, 2015. http://www.un.org/ga/search/view_doc.asp?symbol=A/RES/70/1&Lang=E (accessed May 3, 2016).
2 Huicho L, Segura ER, Huayanay-Espinoza CA, et al. Child health and nutrition in Peru within an antipoverty political agenda: a Countdown to 2015 country case study. *Lancet Glob Health* 2016; **4:** e414–26.
3 Francke P. Peru's comprehensive health insurance and new challenges for universal coverage. UNICO Studies Series; number 11. Washington, DC: World Bank, 2013. https://openknowledge.worldbank.org/handle/10986/13293 (accessed April 15, 2015).
4 Cotlear D. Making accountability work: lessons from RECURSO. En breve, number 135. Washington, DC: World Bank, 2008. https://openknowledge.worldbank.org/handle/10986/10270 (accessed May 3, 2016).
5 Neelsen S, O'Donnell O. Progressive universalism? The impact of targeted coverage on healthcare access and expenditures in Peru. Tinbergen Institute 16-019/V, 2016. http://dx.doi.org/10.2139/ssrn.2753122 (accessed May 3, 2016).
6 Giedion U, Alfonso EA, Diaz Y. The impact of universal coverage schemes in the developing world : a review of the existing evidence. Universal Health Coverage (UNICO) studies series, number 25, 2013. Washington, DC: World Bank.
7 Cotlear D, Nagpal S, Smith OK, Tandon A, Cortez RA. Going universal: how 24 developing countries are implementing universal health coverage reforms from the bottom up. Washington, DC: World Bank Group, 2015. http://documents.worldbank.org/curated/en/2015/09/25018544/going-universal-24-developing-countries-implementing-universal-health-coverage-reforms-bottom-up (accessed May 3, 2016).