



## The Challenge of Health Reform: Reaching the Poor

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### SHARED ADMINISTRATION PROGRAM AND LOCAL HEALTH ADMINISTRATION ASSOCIATIONS (CLAS) IN PERU

The early morning flight from Lima was a bit bumpy as the National Technical Coordinator of Health for the Shared Administration Program flew north along the Pacific shoreline. He looked up from his reading as the stewardess offered him a snack box and a drink. "I'll have juice, thank you", he said as his thoughts raced to the rural communities he would soon be visiting. The approach was still wobbly, but the landing smooth. A DISA (1) driver and vehicle were waiting as he walked out of Piura airport into the hot sunlight and embarked on the 40-minute ride to Sullana.

He was going to Sullana at the request of Dr. José Leyton Abad, DISA Director of the Sub-Regional Health Department of Luciano Castillo. Dr. Leyton was responsible for developing a plan for the expansion of CLAS (2) the new form of organizing primary health care services that allows a legally-created non-profit community organization to oversee management of a health facility. Dr. Leyton received the Coordinator graciously in his office. He started right off,

"How shall we proceed with our expansion plan for the Shared Administration Program in my department? Should we encourage individual health facilities to develop their own CLAS associations, or shall we promote the formation of aggregate CLAS, so that several health facilities are conglomerated into one single large CLAS? For a while I thought the Ministry of Health was not going to go ahead with this Program. Now they want us to do a major expansion. Things are really moving along with the health reform, but it really changes our role here in the DISA, and these different options are difficult to sort out, especially since the community has become an actor in making these decisions and we have to consider their opinion now. I also have to consider how to proceed in urban and rural areas, since they are so different in many ways. It seems obvious that I can't

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(1) DISA = *Dirección de Salud* (Regional or Sub-regional Health Department)

(2) CLAS = *Comité Local de Administración de Salud* (Local Health Administration Committee).

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This case was prepared by Dr. Laura C. Altobelli, DS Consult, with the collaboration of Jorge Pancorvo, Universidad de Piura, as the basis for class discussion. It is not meant to either endorse or criticize the programs or decisions which it describes. The elaboration of this case has been sponsored by the World Bank, however the views and interpretations of this document are only those of its authors.

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use the same criteria for both places. And you know, I'm having a hard time getting some of the long-time personnel in my office to change their ways with these new forms of organizing the health services."

The health care reform has been in the design phase for over four years. One of the main manifestations of reform that has been actually put into action and tested in the field is the Shared Administration Program (*Programa de Administración Compartida – PAC*). PAC is the overall program, with CLAS as the non-profit local health association composed of elected community members who collaborate in the management of health centers and health posts within a legal framework. In question is the organizational model that CLAS should take at the local level. The Ministry of Health central level has recently been disseminating the idea of an evolved model of CLAS in an "aggregate" form due to its strengths in terms of administrative efficiency, and its potential for a more effective referral system for levels of care. Opinions of some actors in the health sector, community members, and outside experts are that the local population will have more chance for empowerment and be more likely to utilize the services when each health facility has its own individual CLAS.

## **Country Background**

Located on the central Pacific coast of South America, Peru has a diversity of geographical and climatic conditions, including coastal deserts, remote Andean mountain ranges, and the upper to lower Amazon River basin. From the 1940s to the 1970s, Peru grew from a 70% rural agricultural economy of 7 million inhabitants, to an economically developing and urbanizing population with a growing urban middle class. The 1970s and 1980s brought stagnation to the country and massive rural to urban migration as a result of distorted politics, terrorism, and spiraling hyperinflation.

Since 1992, the country has defeated terrorism and stabilized both economically and politically. However, Peruvian society remains characterized by an expansive gap between the rich and the poor. Seventy-one percent of the current population of 25 million inhabitants is now urban, with a majority living in crowded peri-urban settlements that lack basic services. Lima accounts for nearly half of the entire urban population. Unemployment and sub employment affect well over half of the urban population. The rural agricultural economy has been neglected. Governmental priorities this decade have included expansion of basic education and health services for the poor and improvement of roads, water systems, and other conditions for repopulation and rural development. Macro-economic conditions, which had been greatly improving since the mid-1990s, have been subject in the past year to a recession partly due to international economic factors.

Despite these difficulties and the persistence of urban-rural disparities, health indicators show a continual improvement (see Exhibit 1). Infant and child mortality have improved by more than 25% since 1991, but rural rates are still double those of urban areas. Deaths in infants and children due to infectious diseases have been reduced substantially due to improved hygiene, better access to health services, improved clinical management of diarrhea and acute respiratory infections, and greater immunization coverage (especially measles). Infant mortality rates remain unchanged for conditions related to the perinatal period, including birth injuries, poor newborn care, and maternal conditions that result in prematurity and low birth weight.

Chronic malnutrition in children has been reduced considerably in both rural and urban areas, though the decrease has been proportionally greater in urban areas (from 26% to 16%) than in rural areas (53% to 40%) in the five-year time period. Rural areas concentrate child mortality and malnutrition due to a combination of much lower maternal education, poverty, and poor physical, cultural, and economic access to health services. Rural community-based integrated health promotion programs utilizing well trained and supervised health promoters have been successful in empowering communities and improving mothers' child-care and feeding behaviors and reducing barriers to seeking formal health care, reducing malnutrition and mortality. These types of programs are still on a small scale. Compared to other Latin American countries, Peru's infant mortality rates are higher than should be expected based on its GNP per capita (according to estimates by the World Bank).

Population growth has slowed from nearly 3% in the 1960s to 1.9% in 1996, not far from the Latin American average of 1.5%, though these averages disguise rural-urban differences. The average number of children born to a woman in her lifetime in 1996 was down to 5.5 for rural women and 2.8 for urban women. Maternal mortality is among the highest in the region, with little improvement in rates over the past 10 to 15 years. Priority has been given only recently to Safe Motherhood interventions. Nationally, 44% of births still occur at home. In rural areas, this figure rises to 85% or more due to cultural as well as educational and cost barriers. Rural health centers and health posts are generally poorly staffed and ill-equipped to deal with obstetrical emergencies. High maternal mortality rates in Lima are hypothesized to be associated with adolescent pregnancies and illegal pregnancy terminations.

### **Health Sector Reform**

Social investment has increased tremendously over the past ten years, with about 20% of this going to the health sector (see Exhibit 2). The Peruvian health system has recovered significantly from collapse due to terrorism and hyperinflation in the late 1980s and early 1990s. In the three years since 1994, the supply of primary care clinics rose by two-thirds, and their hours of operation were extended. Primary care positions for health professionals increased by nearly 55%. As a result, use of health services increased by over 55%, with 90% increase in rural areas. These changes were responsible for some of the improvement in child health indicators during that period.

The Peruvian health sector is an amalgam of public and private sector institutions. Public sector includes the Ministry of Health (MoH), the Social Security Institute (formerly IPSS, currently ESSALUD), and health services for the armed forces and police. A relatively small private sector finances and delivers care. The MoH is the largest provider of services, supporting 86% of all primary care facilities and 67% of all hospital beds. At the same time, primary care services production is extremely low, with a national average of 1-2 consultations per health worker per day. MoH hospital bed occupancy rates are also far below standard, despite the unmet need for services. MoH urban hospital outpatient services are generally full from the perceived higher quality of primary care services provided by hospitals as opposed to health centers or health posts, while MoH inpatient services are underutilized due primarily to the cost barrier for both urban and rural target populations who are neither insured nor can afford private care. Rural populations have additional cultural barriers of fearing hospitals as places where people go to die, fearing shame and embarrassment, and other factors. Even considering the recent expansion, Peru has one of the lowest rates of GDP expenditures and per capita expenditure on health in the region, while maintaining one of the highest rates of public sector coverage (see Exhibit 3).

Health sector reform goals are to improve efficiency of services, quality of care, and equity. Major challenges still facing the sector are: 1) how to continue to reduce the gap between the health status of the poor and the non-poor; 2) how to increase the resources assigned to provide care for the poor; and 3) how to increase efficiency in the use of these resources.

Selected reform efforts since the early 1990s have been successful. Those that have failed have been attempts at sector-wide reform. The most successful innovations have been related to the expansion of primary health care services through the Ministry of Health. One of these is the subject of this case study.

### ***Ministry of Health Primary Care Services Reform***

A major change occurring early on in the health reform process, in 1994, was the initiation of a program called Basic Health For All (PSBPT – *Programa de Salud Básica para Todos*). This was set up with a management unit parallel to the normal MoH administrative offices. The program received large budget allocations of fresh funds from the public treasury, which were used to directly hire professional health teams (physicians, nurses, nurse-midwives, dentists, and health technicians/auxiliaries) under a new form of short-term contract that was not under the purview of private law, but allowed higher salaries to be paid than those for public servants. For the first time, health professionals were given an incentive to seek employment in underserved poor peri-urban and rural areas. A tightly organized financial and information management system allowed large budgets to be transparently and efficiently distributed to the regional health offices for direct transference to payees. This system virtually bypassed the normal transfer of funds, which would pass through several stages, from the public treasury to regional governments, to regional health offices, and finally to the payee. Budgets for vertical health programs, such as those for immunizations, acute respiratory infection control, diarrheal disease control, family planning, and others, were soon incorporated into the same system to improve efficiency in funds administration.

### **Shared Administration Program (PAC)**

As a component of the PSBPT program, a small pilot project was initiated in mid-1994 to implement a strategy to deliver primary health care services with the active participation of the community. The main goal was to test public resource transfers to a private sector entity, with the aim of improving the quality of expenditure, improving quality of care, and securing the participation of the local population to be served. Its name was the Shared Administration Program (PAC – *Programa de Administración Compartida*). This program represented an important turn-about in government attitudes toward community participation. Peru has a long history of community organizing for survival through years of poor economic growth and inefficient government services. Grass-roots organizations that fill the public support gap in helping to meet people's basic needs had been widespread. Ironically, these organizations had nearly always met with a certain level of distrust from the public sector. By 1993, Peru's hyperinflation, terrorism, and international isolation were finally being defeated. The health sector, though, was still in a state of collapse, being understaffed, under-equipped, and underutilized. Peruvian authorities began to recognize that social services were not going to advance without a substantial increase in funding and/or new mechanisms for administration. And they were willing to pilot test a new scheme to transfer

public funds to a private entity controlled by the community for the administration of community health services. PSBPT and PAC were incorporated under an administration umbrella called PAAG (*Programa de Administración de Acuerdos de Gestión*). A simplified flow chart is shown in Exhibit 4 to distinguish the personnel payments flows (the largest budget portion) for PAAG programs as compared to traditional public sector employees. As a temporary program, PAAG is directly dependent administratively on the office of the Vice Minister of Health, and funding is received directly from the Ministry of Economy and Finances.

By December 1997, after three and half years, 548 CLAS had been legally incorporated in 26 of the 32 health regions/subregions. These CLAS administered 611 peripheral health facilities, or about 10% of those in the country. About 29% of these were health centers, and 71% smaller health posts. By that date, a freeze was placed on the incorporation of new CLAS, due to a combination of funds shortage and lack of political support. Given the circumstances, the technical/administrative PAC team at the central level did all it could to maintain and consolidate the development of the existing CLAS. A new phase of expansion began in January 1999 when 700 additional health facilities were incorporated into the PAC program. However, during the interim period of 1998, a major crisis brewed in the MoH, which put into jeopardy the very existence of PAC.

Despite the expansion of primary care services to even remote parts of the country with professional health teams and improved physical facilities, many of the poor remain without care due to direct or indirect costs. Most MoH facilities exonerate fees for a certain percentage of patients (usually about 10-15%), but all others are required to pay nominal fees for most services. Exceptions to the rule include services covered under the national vertical programs: acute respiratory infections control, diarrheal disease control, family planning, tuberculosis, and other programs for which the regional health administration office or UTES does bulk purchasing of inputs. The exonerations are covered by a 10-15% mark-up on costs charged to other clients by the health facility. An intermediate level of bureaucracy in each region is the UTES (*Unidad Territorial de Salud*). Several of these operate in each Regional or Sub-regional Health Department, depending on size. They have traditionally collected the money earned by each health facility from charging fees. The money is used to purchase inputs that are then distributed to each health facility. Left-over funds are used frequently for the monthly "food basket" for UTES workers. Under PAC, the UTES no longer have this role, since supplies are purchased directly by the CLAS. Due to community control of fee setting and purchasing, CLAS offer a greater proportion of exonerations and subsidized fees than non-CLAS facilities in low-income rural populations -- Quintiles I-III, or Strata C and D. (see Exhibit 6). Data in Exhibits 6 and 10 also show that urban CLAS and non-CLAS had similar levels of full exoneration, but CLAS were able to charge less overall due to a greater volume of patients.

### ***How CLAS works***

CLAS are private, non-profit legal institutions that are community-administered around a health center or post. Each CLAS has seven members who form the general assembly. Six are community members and the seventh is the health facility manager, usually the chief physician, who participates in all decisions of the CLAS and completes the co-management approach. From the six community members, a 3-member Board of Directors (*Consejo Directivo*) is elected. All community members work on a gratuitous basis for a period of three years, after which new members are elected. Members can be replaced before time due to breach of responsibilities.

Two types of contracts are signed between the legal representatives of CLAS and the Regional Health Office. The first is the Shared Administration Contract, which provides the CLAS with the infrastructure, equipment, medicines, and personnel posts for the completion of the Local Health Plan. This contract is renewable every three years. The second is a Management Contract for the provision of services based on the Local Health Plan, with annual renewal based on achievement of health goals. By virtue of this contract, CLAS are held responsible for ensuring the attainment of health goals for the population in its jurisdiction.

CLAS duties and voluntary activities involve work with health providers, with community members, and with institutions and agencies outside the community. Working with health providers, CLAS members participate in the following:

- Collaborating on a community health diagnosis.
- Helping to set health priorities for the community.
- Reviewing, approving and monitoring activities of the Local Health Plan.
- Approving the budget to implement the plan, and monitoring all expenditures.
- Receiving funds transferred from the MoH to deposit in a commercial checking account.
- Deciding on amounts of fees-for-services, and determining exonerations from fees.
- Writing checks on the CLAS bank account to pay bills and salaries of health workers.
- Hiring and firing personnel contracted by the CLAS.
- Monitoring quality of health services, including how personnel treat patients.
- Monitoring work attendance and other obligations of health personnel.

Working with the community, CLAS members serve to:

- Assist health personnel in promotional activities in the community, i.e. using the loudspeaker to make community announcements.
- Promote health care demand by communicating directly with community members to orient them about services available in the health facility, and convincing them to go there (appealing to their feelings, e.g., “Go there for my sake, to show you’re my friend”).
- Serve as links between community health promoters / indigenous health workers and the health facility.
- Serve as links between other community organizations and the health facility.
- Ensure equity of access to services of the most needy members of the community.
- Stimulate the community to acquire healthier behaviors and lifestyles.

With outside institutions and agencies, CLAS have the authority to:

- Sign agreements with other public and private agencies to obtain additional funding for infrastructure, medicines, training, and other health activities, as well as other complementary community services, such as water and sanitation systems, roads, and other intersectoral support. In this way, CLAS can potentiate the resources provided by the MoH to implement the Local Health Plan.

Dr. Muñoz, head physician and CLAS manager for Tambogrande Health Center in Luciano Castillo, remarked: “There are two things that stand out and are the basis for the progress that has been achieved. There has been an improvement with regard to CLAS. The first is that since there has been community participation, they have become more conscious

of the health needs of the population and need to improve the health facility. And the second is that given them practical decision-making powers has served to improve things. This does not mean that we don't need the Sub-region. There are rules and a contract with them. I'll give you a simple example. When purchasing supplies, we used to follow the request procedures of the Sub-regional Health Department. The Department had to do their studies, decide who to attend to first, all in due time, of course, but not as quickly as we can do it now. Our operational capacity has improved. I'd say, on the basis of these two factors, our work with CLAS has been very satisfactory."

The responsibilities of CLAS translate into social control of health services delivery. CLAS are given the power to contract health personnel and other workers for the health facility; therefore, CLAS can require personnel to treat community members well and improve their quality of care. CLAS are given the power to make decisions on how funds (whether transferred public treasury funds or fees paid for services) should be utilized. They should, therefore, tend to use resources with more efficiency, since they can better determine the needs and priorities of their own community and have an incentive to obtain more for less. CLAS are composed of community members who know best which families in the community are the most needy; therefore, CLAS also have the capacity to improve equity in health care delivery, although many need orientation on this important aspect. As a local institution, CLAS help to ensure the sustainability of health and other social development programs in the community (see Exhibit 5).

Major benefits of the CLAS model derive from the fact that the community is empowered to exercise social control over the delivery of health services. CLAS alone does not represent community participation in health. Rather, CLAS is a facilitator of community participation. Through its conferred authority and responsibilities, CLAS facilitates empowerment of the community. This empowerment, in turn, creates a more favorable environment for the community to act in a wider protagonist role in collective and individual health activities and behaviors. Exhibits 7a and 7b contrast the potential for community empowerment under CLAS and under traditional public administration.

### ***Crisis for the Shared Administration Program in 1998***

By mid to late 1997, Ministry of Health officials at the central and regional levels were divided on either side of wanting to see PAC die or see it continued. Rumors were rife about problems with PAC. Accumulated evidence of problems made people doubt the validity of the entire program. On the other hand, some central-level officials and health workers in the field were quite enthusiastic about CLAS. Evaluations suggested important levels of community satisfaction with their new role in helping to run their community health services. Data provided some evidence that CLAS facilities achieved greater coverage of services than non-CLAS facilities. Nevertheless, there was a palpable feeling in the MoH that the program could easily be disbanded.

### ***Sources of doubt about the CLAS model of health care organization***

Major problems identified in the Shared Administration Program (PAC) created many doubts about the validity of the program, and led to a lack of political support from a number of influential decision-makers. These problems could be categorized as occurring within the public health sector, among professional health personnel, and within some CLAS themselves.

*Problems within the health sector.* Situational analyses, undertaken by several outside consultants, showed that regional health authorities, and some central-level authorities, lacked information about PAC in terms of how it worked and what their responsibilities were toward the program. A lack of a clear mandate on PAC from the Minister of Health was an indirect signal to regional authorities that PAC was not important and could be ignored. At the same time, PAC was set up to function from the central level, bypassing the regional health authorities by transferring funds directly to communities. The PAC central office did not have the resources to do direct monitoring and supervision of each and every CLAS, and Regional Health Offices were not specifically assigned the task, nor a budget for it. As a result, monitoring and supervision of individual CLAS sometimes fell through the cracks. Specific problems occurring in some CLAS that could have been solved were left to fester. These were the problems that were eventually heard in Lima, creating many doubts about the PAC program.

*Concerns among health personnel.* Lack of information made public-employed physicians with lifetime tenure feel their security threatened by the “privatization” of health care. In truth, the law allowed CLAS to contract additional personnel under private law, while public-employed personnel were untouched. The latter could even benefit from supplemental contracts with CLAS that paid them to extend their daily working hours. Since CLAS personnel contracts are under the purview of private law, they include social security and health insurance benefits, paid vacation time and sick leave, while most other personnel in peripheral health facilities under contract with PBSPT have short-term contracts with fewer benefits.

*Operational problems in individual CLAS.* Certain problems came up in some CLAS in the early years due to three main causes. First and foremost was the unfamiliarity of health personnel and CLAS members with personnel and financial management as they related to private sector law. When problems were not identified promptly and solved with the necessary assistance of local health authorities, they eventually could fester and create a bad image of the CLAS model. Another problem area was inexperience or lack of training of health facility managers (i.e. chief physicians) to carry out their new management tasks and use public health principles for community health diagnosis and planning. Most physicians are not trained in either management or public health. When regional authorities were not committed to CLAS, they could easily postpone the problems and not provide the necessary support via training or supervision. Frequently, DISAs did not have additional funds to provide CLAS support as required.

*Problems with the conceptualization of community participation.* There were problems in the conceptualization of community participation on the part of health authorities and health workers. The long history of community participation in Peru led people to have certain expectations of CLAS that were not immediately fulfilled, causing them to dismiss the program altogether (see comments in Exhibit 8).

External observers have argued that it is too great an expectation that the mere existence of a CLAS will immediately improve community participation. Rather, the delegation to CLAS of control over public resources and services creates a greater *potential* for stimulating community participation and empowerment over time. The level of empowerment achieved in a community through PAC depends on a constellation of factors. Factors of importance include:



- 1) The extent to which CLAS members are democratically elected so that true leaders are chosen.
- 2) The personal capability, management training, and leadership characteristics of the health facility manager.
- 3) Effectiveness of efforts to orient and/or motivate the community to take advantage of the opportunities for participation.

Other factors of importance are:

- 4) Permanence of health personnel in a particular community, and
- 5) Consistency of supervisory and administrative support from Regional/Sub-regional and UTES health officials.

According to Dr. Carl E. Taylor (3), international expert in community health, the traditional top-down public administration was not being completely replaced by a new concept of “bottom-up” administration under PAC. Rather, both sides (public and private) had new roles and it was important to clearly define these, since problems occurred mainly when roles were not explicitly specified. Dr. Taylor has encouraged functional analysis of roles at each health sector level that would provide a re-determination of roles on all administrative levels on the public side.

### *Differences between urban and rural CLAS*

CLAS have been found to work better in the less-poor urban settlements, where clients can afford to pay higher fees-for-services, fewer indigents require exoneration of fees, and a greater level of formal education provides a pool of community members with management skills. The higher level of self-generated income to supplement government transfers allows the urban CLAS to hire more health personnel, update physical facilities, and purchase medical, laboratory, and computer equipment and supplies. Improved management and accounting results from better-qualified community members who get elected to CLAS. Many of these are retired schoolteachers or other professionals. All of these factors contribute to the growing success of CLAS. Eventually, a CLAS-run health facility attracts clients who previously preferred receiving services in hospital outpatient clinics, local private physicians, or a commercial pharmacy where most medicines are routinely sold without prescription (see Exhibit 9). One of the criticisms of CLAS has been the tendency in some to create mini-hospitals with advanced clinical and laboratory services requested by the community, while giving less attention to outreach into the community for prevention and promotion. Others argue that secondary or tertiary care capabilities with higher resolute capacity are frequently required to save lives in many areas that are two or more hours travel time from the nearest hospital.

Some CLAS have been able to do both. As a result of satisfying community demand for good quality curative care, they have gained credibility and leadership to more effectively work in the community. Besides, with more clients visiting the facility, more are reached directly with promotional health education and preventive services.

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(3) Professor Emeritus of International Health of the Johns Hopkins University School of Hygiene and Public Health.

The creativity of the population to solve its own problems has few limits under the CLAS model. A prime example is the Health Post of Chiclayito in Piura, on the north coast of Peru, which serves a poor peri-urban town that began as a squatter settlement. At the behest of the CLAS and the community, the health post personnel provide training to schoolteachers, the school parents' association, schoolchildren, community volunteers (who identify and refer cases to the post), admission orientation for patients at the post, and continual re-training of health personnel. The CLAS has strong leadership and a powerful ability to mobilize the community. Community committees have been organized for environmental sanitation, family planning promotion, and others. These committees meet frequently with the CLAS, report their activities to other community organizations, and present trimester evaluations to the Community Assembly. All of these meetings are attended by the health post manager to sensitize social actors in other sectors to their roles in the shared goal of a "healthy community". Complaints and suggestions from the community are sought and acted on by the CLAS, which further strengthens the identification of the community with the health post. The health facility is advertised by various means. One strategy was to create and support the CLUB-CLAS, equipping soccer teams (in the 'Child' and 'Women' categories) to compete in local tournaments. Social marketing is considered highly important by the CLAS, and its primary strategy is quality of care with diffusion by satisfied customers. Revenues from fees have increased so much that the health post has built a second floor and is providing a wide range of good quality clinical services. Surrounding health facilities were complaining that clients were leaving their jurisdictions to seek health services in the Chiclayito Health Post (4).

Rural CLAS and their health facilities face a different set of circumstances. The rural population is generally much poorer and less well educated than the urban population. Purchasing power is low and a high proportion of users require exonerations. The self-generated income of rural facilities is therefore similarly low. Unless higher transfers are received from the MoH, rural CLAS are unable to make the necessary investments to improve the types of services provided (either through purchasing equipment or contracting more personnel) or to improve and maintain the infrastructure. Physical accessibility is an issue when rural households are dispersed. Some are several hours' walk from the nearest health post, where perhaps only a health technician is assigned to deliver services, with few medicines in stock. Cultural accessibility is frequently a major barrier to the use of health services, involving people's perceptions of the severity and curability of their illness, the opportunity costs and trade-offs of seeking health care in relation to other family and work responsibilities, and the resolute capacity of the health facility, and their expectations of how they will be treated by the health provider. Rural women especially fear male providers of women's health services. In general, health providers tend to be poorly prepared to approach rural populations in a way that will create confidence and more accessible services. All these factors compete with the confidence people already have in traditional healers and indigenous medicine. The necessary skills for managing a CLAS may be scarce among rural community members. On the positive side, many communities have systems of internal organization and leadership. Many have formed community health committees either spontaneously or through previous projects with public or private agencies. Experience amply confirms that trained community members (health promoters) can successfully serve as links between the outside world and the internal life of a community, with positive effects on health behaviors and health status.

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(4) Source: Ocaña V. and Gonzales C., "An experience to achieve increase in coverage of health services", Report prepared by the Chief and Assistant Chief Physicians of the Chiclayito Health Post under the Shared Administration Program, Chiclayito, Piura, Peru. July 1997.

Given the less favorable conditions and the greater need for health education and health care in rural areas, support for rural CLAS needs to be greater than for urban CLAS.

***Coverage, production, satisfaction, and equity for clients in CLAS versus non-CLAS primary health facilities***

Analyzing data from PSBPT (see Exhibit 10), CLAS was found to have a higher concentration of intramural services than non-CLAS (1.69 vs. 1.50). PSBPT had a higher rate of extramural services (.23 vs. .11), and both programs had similar per capita rates for preventive and promotional activities. CLAS facilities had a larger average population in their jurisdiction than PSBPT facilities, and at the same time CLAS had 25% greater service coverage (74.7% versus 59.7%). These data showed the significantly greater productivity of CLAS over non-CLAS facilities. A breakdown of the same data by strata according to the Departmental Poverty classification showed similar findings in all strata, including the lowest.

Population survey data, from 1997, showed that people living in population centers with CLAS health centers and posts sought care more frequently from them than from other sources of care such as hospitals and commercial pharmacies (see Exhibit 9). People living in non-CLAS communities preferred using hospitals or commercial pharmacies to the local health center or post. These differences existed in nearly all socioeconomic strata as defined by quintiles of per capita expenditure.

A more recent national evaluation showed that indicators of clinic organization, quality of care, and equity were improved in CLAS facilities versus non-CLAS health facilities. CLAS clients had less waiting time and a greater level of comfort than non-CLAS clients. In the poorest rural areas with a poverty classification of C and D, CLAS provided free services to a higher proportion of non-paying clients than did non-CLAS facilities. The opposite was the case in non-poor rural areas classified as A and B, where the non-CLAS exonerated a higher percentage of clients than the CLAS.

**Arguments as to type of CLAS: aggregate or individual facility**

Since community participation and social control are such an important part of the strength of PAC, the option to create an Aggregate CLAS vs. an Individual CLAS brings up several important issues, which boil down to an argument of increased administrative efficiency versus increased citizen participation. MoH officials' concern is not, really, centered on CLAS for urban health facilities. There has been sufficient experience to show that CLAS is a successful organizational model for urban and peri-urban primary health care facilities where there are skilled community members to carry out CLAS functions and the population has greater purchasing power. Also, each urban primary health care facility serves a large concentrated population so there is no need to include more than one facility in a CLAS. The main issue is how best to develop rural health services using the strengths of the CLAS model.

***Differences between Individual CLAS and Aggregate CLAS***

*Individual CLAS* – This is the simplest scheme for CLAS. One health facility has a manager, usually the chief physician, who calls upon the community organizations and inhabitants within its jurisdiction to nominate and vote on three members of the CLAS, while the

manager selects three more, for a total of six community members. Funding for the health facility is received and deposited into a commercial bank account held by the CLAS. The signatures of both the CLAS manager and the treasurer (a community member) are required on all checks written to pay staff, purchase equipment, supplies, medicines, maintenance, etc. The facility has a local health plan (LHP), which serves as the basis for the contract with the Regional/Sub-regional Health Department. Implementation of the LHP in the community is monitored by the CLAS. Simple monthly financial statements are submitted by the CLAS to the Regional/Sub-regional Health Department, and yearly audits are held.

*Aggregate CLAS* – More than one health facility (ideally 5 or 6, though this has varied considerably to date) are incorporated into one network administered by one CLAS. Each facility has a local health plan. These are joined into one aggregate health plan, which serves as the basis for the contract with the Regional/Sub-regional Health Department. Several different approaches to aggregation can be taken:

- 1) A number of health facilities, originally established as individual CLAS, join together in one aggregate CLAS. Communities with individual CLAS may have to decide to dissolve their own CLAS so as to join the aggregate CLAS.
- 2) One or two facilities that were originally individual CLAS join with other "new" facilities to create one aggregate CLAS. Again, individual CLAS dissolve to form the aggregate.
- 3) A series of health facilities which are associated with each other in terms of geographic accessibility and resolute capacity for patient referrals join together into a first time CLAS. The most complex facility is nominated as the CLAS headquarters, where the health physician is the CLAS manager. Six individuals for the CLAS General Assembly are chosen from among communities in the jurisdiction of the network facilities. If more than six facilities are in the network, some will not be represented in the CLAS General Assembly. Facilities without representation may rotate membership on the three-year renewal of the CLAS "Consejo Directivo".

How one can judge whether a rural health center or post should be incorporated as an individual or aggregate CLAS? and, how can the choice be presented to rural communities in a balanced and unbiased way so they can make the final decision on which model of CLAS to establish? Regional Health Department personnel are asking for decision-making criteria. As Dr. Leyton pointed out, "I want to provide the same level of services to the person living in the smallest village as we do for the person living in town next to the health center. How can I do it?"

The following arguments on these questions were derived from conversations and meetings with Ministry of Health officials, at the central and regional levels, and with the community.

## ARGUMENTS IN FAVOR OF AGGREGATE CLAS IN RURAL AREAS

### **Improvement of Patient Referral Systems**

- Where small rural health facilities have few or no professional health personnel and little medical equipment or medicines, a network of CLAS will encourage the referral of patients to a higher complexity health facility to solve more difficult health problems. As stated by a PSBPT Coordinator:

“For me (the issue of Aggregate or Individual CLAS) will always be in the resolute capacity, not just the presence of sufficient funding for the execution of activities. I need a team of health professionals. Suppose that I assign funds to a facility, and that I have to contract all the resources; that is that we are going to have health posts with populations of 500 inhabitants that have a physician, nurse, midwife, etc. In the Aggregate CLAS you can just keep the health technician, and in one of the facilities you have a basic professional health team. It's more rational. The team can be, also, itinerant {among the network facilities}.”

### **Lower Start-Up and Maintenance Costs**

- Lower costs for creating one private non-profit entity, instead of five or six different entities. The average legal costs of incorporation and inscription in the public registry per CLAS is close to US \$500. In addition, there are costs for community orientation, ensuring democratic elections of CLAS members, and training in management for health personnel and community members in each CLAS.
- Lower costs for hiring one accountant to do one yearly financial balance, than to do five or six financial balances per year.
- An administrator could be hired to carry out management functions for all the health facilities within one aggregate CLAS, thereby allowing medical personnel to dedicate most of their time to health provision and promotion.

### **Less Training, Monitoring, and Supervision Required**

- It may be easier for the regional-level DISA to supervise, monitor, and evaluate one CLAS in place of 5 or 6 CLAS.
- Some rural communities with health posts may not have community members with the educational background or experience to be able to undertake the administrative tasks required for CLAS. This situation requires increased expenditures on orientation, training, visits to other CLAS, intra-regional meeting participation, etc.

An MOH official, at the central level, made the following comment: “Health posts within aggregate CLAS will be able to get more outside assistance from the municipality and NGOs for doing community outreach. This will result also in greater ‘equity’ by having the main CLAS facility distribute the money as needed around to the different facilities in the group.”

## ARGUMENTS IN FAVOR OF INDIVIDUAL CLAS IN RURAL AREAS

### **Empowerment and Social Control**

- Communities need to feel that they have some ownership over their own health facility in order to be empowered to act.
- A full board of directors elected from the community is more physically available to make daily visits to the health facility to monitor attendance of health personnel, check on personnel, logistic and maintenance needs of the facility, and discuss the issues in a prompt manner on a weekly or more frequent basis.
- Both health personnel and community members have more interest in developing linkages between the health facility and the community since the social control is more direct.
- With aggregated CLAS, each facility has at most one single community member who is part of the leading CLAS. The participation of the whole community depends on that one person for channeling information to the CLAS, thus reducing the likelihood of community members getting actively involved in self and community-related health activities.
- Health personnel in facilities that do not house the aggregate CLAS administration may not be stimulated by the community to provide better quality services, treat people better, do more community outreach, etc.

### **More Management by Community**

- Money earned by fees-for-service is invested directly in the health facility based on decisions by the facility's own board of directors.
- Part time professional personnel can be contracted to provide services one or more days per week, with attendance supervised by community members.
- Many of the aggregate CLAS that have been formed so far were originally individual CLAS. That explains some of the enthusiasm of central level MoH officials for the greater management efficiency of the aggregate, since the community-health facility links were already established and maturing in the individual establishments.

In a rural health post that formed a distant part of an aggregate CLAS, the president of a community health committee was asked about how it would work if the health post were to form its own CLAS. He gave the following opinion, remarking on his own leadership experience:

“A strict administration is already in the making. Look at who is speaking. I've been the Governing Deputy. Then, I was president of the public school. Elected three times. It's through performance that one is elected or not elected. Now, I'm the health committee president and secretary of the community development committee. Since early on I have held these positions and I have to give time and some responsibility to them, and one shows one's responsibility especially in a very demanding administration.”

## Greater Equity

- It has been shown that rural CLAS are delivering health services in a more equitable manner to the poorest segments of the rural population. The explanation is that CLAS members who live in the community know which are the most needy families. They can encourage those families to seek care and also direct health personnel to visit those families in their homes.

Aggregate CLAS have been in existence since early 1999. They have not been able to prove themselves yet with hard data that demonstrates better productivity, efficiency, or other operational benefits over individual CLAS.

A statement by Dr. Carl E. Taylor may provide further viewpoints of the decision between Aggregate and Individual CLAS:

“Health care reform in the CLAS Program in Peru has special challenges and complexities that will not be helped by simplistic solutions. It is at this stage that many other national efforts that were remarkably successful in their early stages became disappointing failures when efforts were made to go-to-scale. So far the responsible decision makers have been showing great wisdom in careful balancing of alternative options. The critical decision point now is whether scaling-up should follow the organizational pattern of Aggregate CLAS or Individual CLAS. These decisions will determine whether innovative reform continues or whether services lapse back to previous patterns. The underlying and very sensitive question is whether convenience for health professionals is considered as being competitive with the convenience and welfare of people and communities or whether both can be rationally optimized.”

During his night flight back to Lima, the Coordinator’s thoughts were in a whirl. He had a lot to think about, as he had to prepare his personal recommendations for presentation to the Minister in a meeting three days away. It seemed clear to him that the CLAS approach for community health improvement had been proven valid and was, today, mainly a matter of refining policy and organizational issues. The major questions now were related to what strategies should be taken for the expansion of CLAS in order to maintain their strengths for improving community health while scaling up to the national level. Should the Ministry encourage rural individual health facilities to develop their own CLAS associations, or promote the formation of aggregate CLAS, so that several health facilities are conglomerated into one single large CLAS? What kinds of guidelines related to CLAS should be passed along to the Regional Health authorities? □

## Exhibit 1

SHARED ADMINISTRATION PROGRAM AND  
LOCAL HEALTH ADMINISTRATION ASSOCIATIONS (CLAS) IN PERU

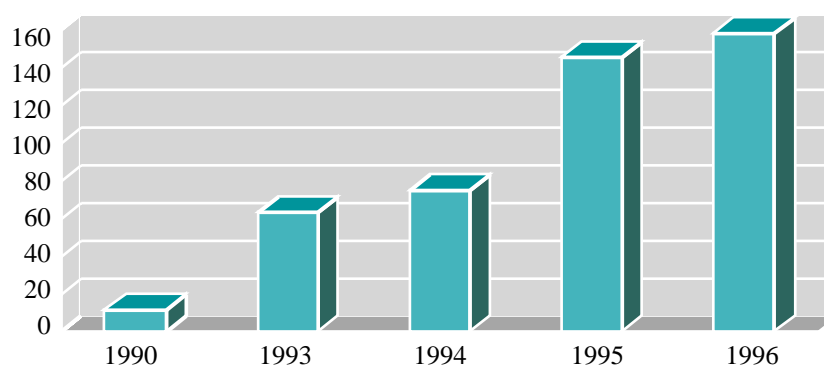
**Health Indicators, Peru 1991-1996**

	1991 Total	1996 Total	1996 Rural	1996 Urban
Infant mortality rate (per 1000 live births)	60	43	62	30
Under 5 mortality rate (per 1000 live births)	80	59	86	40
Chronic malnutrition (% of children >5 years)	37	26	40	16
Maternal mortality ratio (per 100,000 live births)	298	265	292	308 (Lima) 213 (Other)
Total fertility rate	4.0	3.5	5.5	2.8
Life expectancy in years	64	68		
Post-neonatal mortality rate (per 1000 live births)	29	19	28	13
Neonatal mortality rate (per 1000 live births)	29	24	34	17

Source: National Demographic and Health Survey (ENDES), carried out in 1992 and 1997.

## Exhibit 2

**PERU – Social Investment Per Capita in New Soles, 1990-1996**



Source: Ministry of the Presidency. Elements of the focalized strategy for the war against extreme poverty 1996-2000, dated 1996.

## Exhibit 3

**International Comparison of Health Expenditures (circa 1994)**

	Peru (1994)	Bolivia (1994)	Brazil (1994)	Colombia (1994)	Ecuador (1994)	México (1994)	Nicaragua (1994)	Panama (1994)
Health to GDP ratio (%)	3.7	7.1	4.6	7.4	5.3	4.2	8.6	67
Per capita expenditures on health (US\$)	80	54	163	143	78	182	37	199
Per capita expenditures on health (\$PPP)	156	194	264	477	259	311	174	457
Public share (%)	60	58	40	40	39	56	61	70

Source: Peru – Improving Health Care for the Poor. World Bank Report No. 18549-PE, 1999.

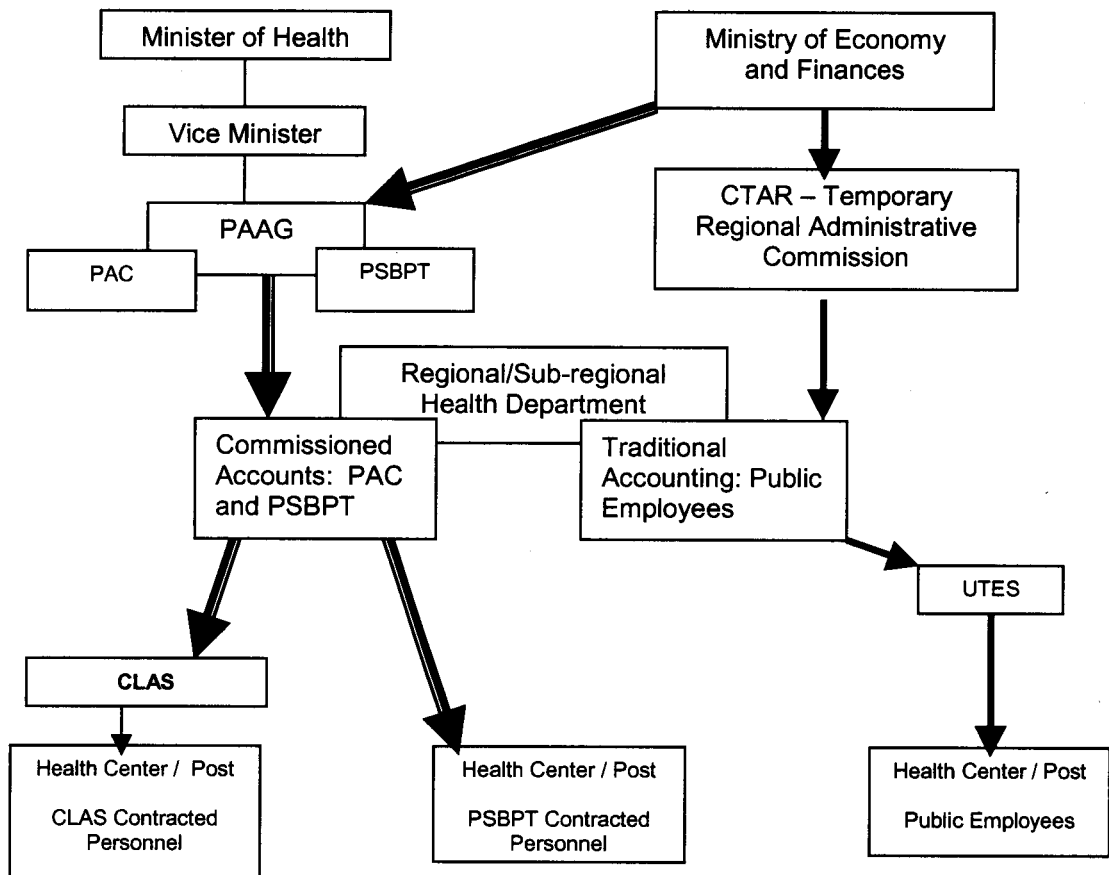
Notes: Conversions to US\$ based on official exchange rates. Purchasing Power Parities (PPPs) are exchange rates used to convert local currency into US dollars taking into account price differences across countries.



Exhibit 4

SHARED ADMINISTRATION PROGRAM AND  
LOCAL HEALTH ADMINISTRATION ASSOCIATIONS (CLAS) IN PERU

**Simplified Flow Chart of Personnel Payments  
in Three Current Types of Ministry of Health Administration**



PAAG = Program for Administration of Management Agreements.

PAC = Shared Administration Program.

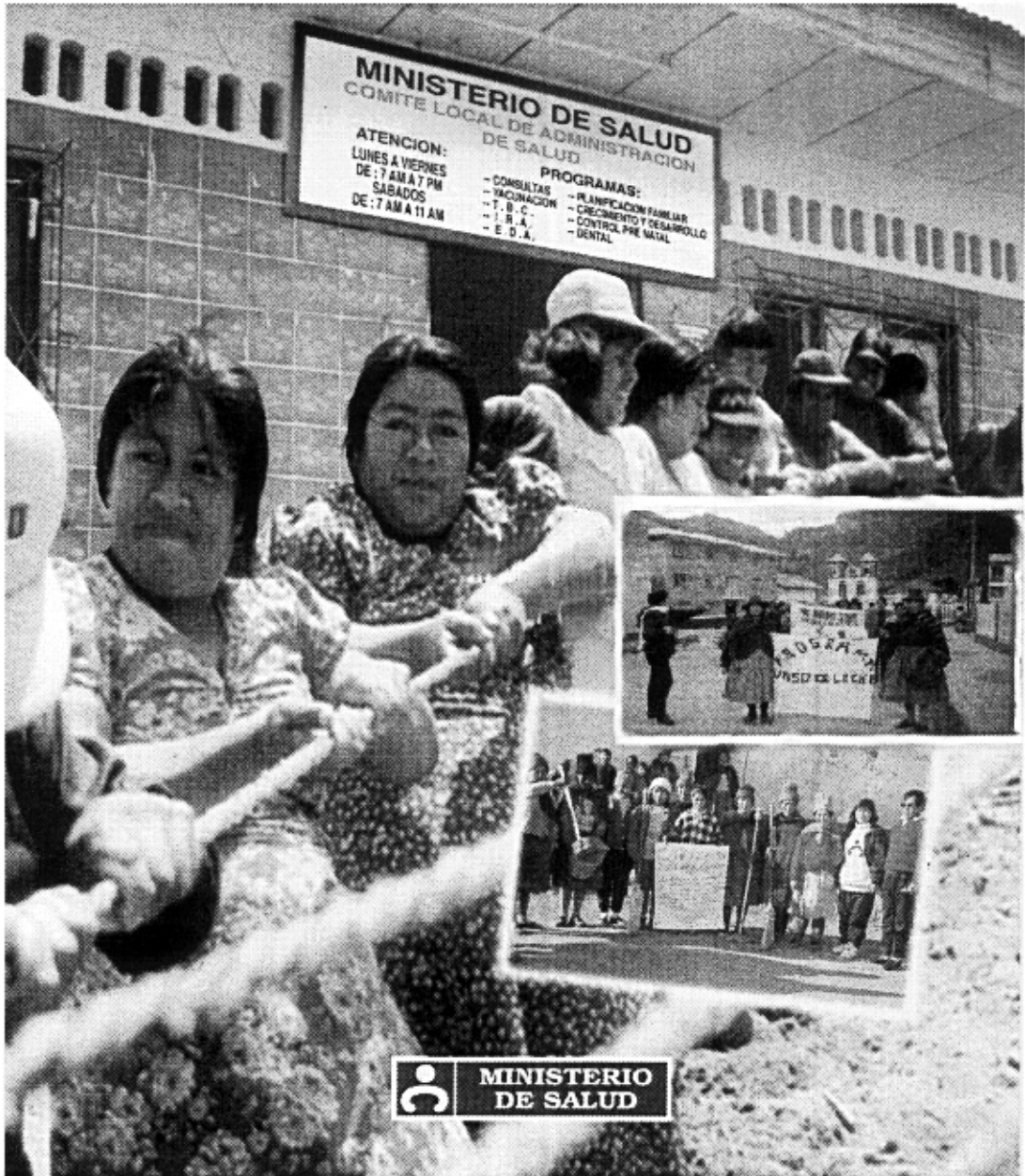
PSBPT = Program for Basic Health for All .

UTES = MoH Territorial Health Administration Unit.

Exhibit 5

SHARED ADMINISTRATION PROGRAM AND  
LOCAL HEALTH ADMINISTRATION ASSOCIATIONS (CLAS) IN PERU

**Rural CLAS Photo: Community members at work**



## Exhibit 6

SHARED ADMINISTRATION PROGRAM AND  
LOCAL HEALTH ADMINISTRATION ASSOCIATIONS (CLAS) IN PERU

**Cost of Consultation for Persons Attending CLAS and Non-CLAS  
Health Centers/Posts, by Quintile of Per Capita Expenditure**

**a. Urban areas outside of Lima/Callao**

	Quintile I		Quintile II		Quintile III		Quintile IV		Quintile V		TOTAL	
	Non CLAS	CLAS	Non CLAS	CLAS	Non CLAS	CLAS	Non CLAS	CLAS	Non CLAS	CLAS	Non CLAS	CLAS
S/. 0 (No cost)	23.5	33.3	12.0	16.6	23.5	15.1	18.3	27.0	16.4	29.7	18.2	21.7
S/. 0.1 – 2.0	8.1	33.3	24.5	16.6	6.6	54.7	2.8	27.0	6.8	40.5	11.5	39.1
S/. 2.1 +	68.4	33.3	63.5	66.7	69.9	30.2	78.9	46.0	76.8	29.7	70.4	39.2
TOTAL	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
N=	14385	3514	71306	7036	71072	24102	49954	17378	20595	7513	227312	59543

**b. Rural areas**

	Quintile I		Quintile II		Quintile III		Quintile IV		Quintile V		TOTAL	
	Non CLAS	CLAS	Non CLAS	CLAS	Non CLAS	CLAS	Non CLAS	CLAS	Non CLAS	CLAS	Non CLAS	CLAS
S/. 0 (No cost)	29.4	37.2	23.8	12.6	15.6	45.8	28.3	8.1	0	0	25.5	26.7
S/. 0.1 – 2.0	39.6	50.6	32.7	58.9	23.2	9.3	24.0	30.3	40.0	100	35.0	46.2
S/. 2.1 +	31.0	12.2	42.6	28.4	61.3	44.8	47.8	61.6	60.0	0.00	39.5	27.1
TOTAL	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
N=	242823	32359	110934	19229	59866	8602	16504	10027	7598	1620	437725	71837

Source: Altobelli L, "Health reform, community participation, and social inclusion: the Shared Administration Program". Lima: UNICEF-Peru. August 1998.

Data from the National Living Standards Survey (ENNIV) 1997, Instituto Cuánto, SA.  
Mid-1997 exchange rate: US\$1 = S/. 2.66 new soles

Exhibit 7a

SHARED ADMINISTRATION PROGRAM AND  
LOCAL HEALTH ADMINISTRATION ASSOCIATIONS (CLAS) IN PERU

Model of the functioning of the shared administration program (PAC)

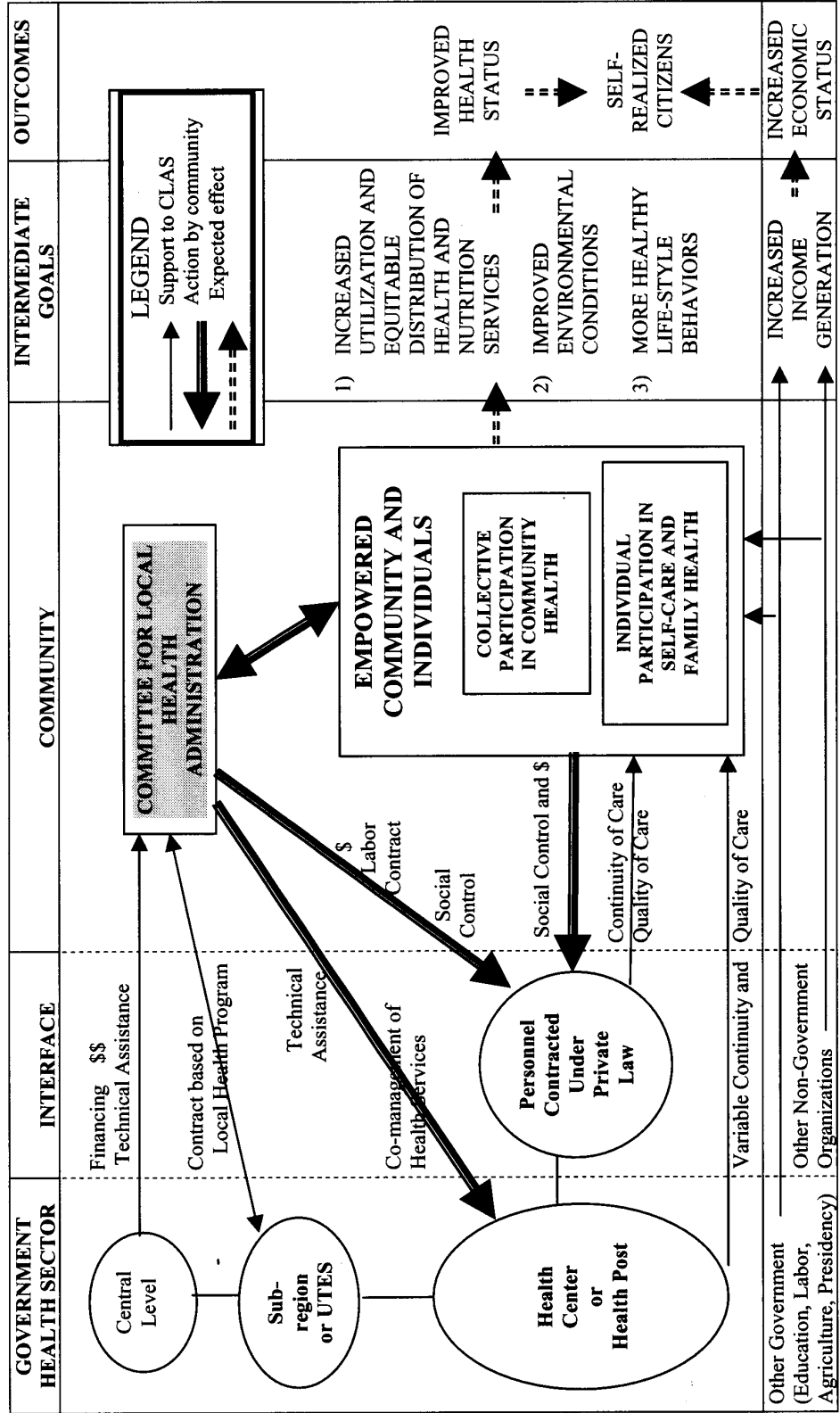
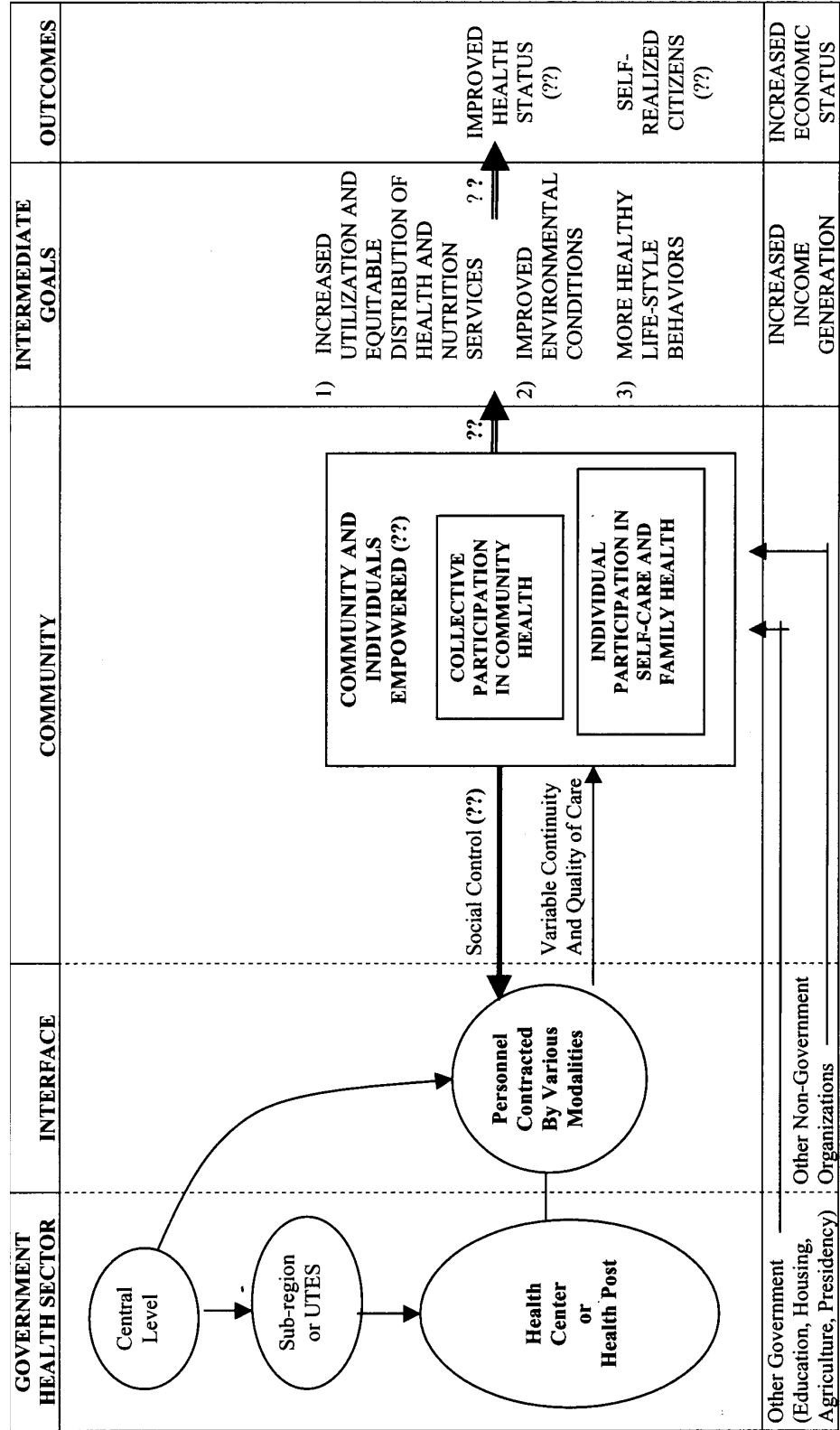


Exhibit 7b

SHARED ADMINISTRATION PROGRAM AND  
LOCAL HEALTH ADMINISTRATION ASSOCIATIONS (CLAS) IN PERU

Model of the functioning of a health facility with public sector administration



## Exhibit 8

SHARED ADMINISTRATION PROGRAM AND  
LOCAL HEALTH ADMINISTRATION ASSOCIATIONS (CLAS) IN PERU

“Community participation has rarely met the expectations of health planners/professionals around the world. The reason for this failure is that community participation has been conceived in a paradigm which views community participation as a magic bullet to solve problems rooted both in health and political power. For this reason, it is necessary to use a different paradigm which views community participation as an iterative learning process allowing for a more eclectic approach to be taken.”

Source: Rifkin SB (1996) “Paradigms lost: toward a new understanding of community participation in health programs”, *Acta Trop* 61(2): 79-92.

## Exhibit 9

**Source of Care Among Persons Seeking Care in Communities  
With or Without CLAS, by Quintile of Per Capita Expenditure**

**a. Urban areas outside of Lima/Callao 1997**

	Quintile I		Quintile II		Quintile III		Quintile IV		Quintile V		TOTAL	
	Non CLAS	CLAS	Non CLAS	CLAS	Non CLAS	CLAS	Non CLAS	CLAS	Non CLAS	CLAS	Non CLAS	CLAS
Hosp. MoH*	33.9	13.6	21.3	24.9	20.9	18.7	17.6	4.6	15.9	21.6	20.5	15.6
Hosp. IPSS*	14.5	0	20.7	19.9	23.8	20.3	34.6	31.3	22.4	37.3	25.7	25.2
Hosp. Other*	0	0	1.8	10.1	2.0	9.9	4.9	1.0	6.1	0	3.4	5.2
MoH Center*	16.6	29.0	24.2	25.3	18.8	27.3	12.1	28.8	7.5	19.4	15.6	27.0
Pharmacy	23.4	25.2	19.5	0	19.6	0.7	19.0	19.0	11.7	6.6	17.4	7.7
Other*	11.7	32.0	12.6	19.9	14.8	23.1	12.9	15.2	35.5	15.1	17.4	19.3
TOTAL	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
N=	86869	12089	295521	27842	377182	86168	406826	60216	274878	38737	1524046	229997

**b. Rural Areas**

	Quintile I		Quintile II		Quintile III		Quintile IV		Quintile V		TOTAL	
	Non CLAS	CLAS	Non CLAS	CLAS	Non CLAS	CLAS	Non CLAS	CLAS	Non CLAS	CLAS	Non CLAS	CLAS
Hosp. MoH	12.2	16.2	18.9	18.3	21.4	7.9	12.9	5.5	5.5	32.9	14.8	13.5
Hosp. IPSS	2.1	3.5	5.9	8.5	8.5	5.5	8.0	5.9	24.0	11.5	4.9	5.7
Hosp. Other	0.6	0	1.5	0	0.5	5.2	3.1	0	0	0	1.1	0.9
MoH Center	51.0	52.3	40.1	50.2	36.1	29.3	20.9	36.3	25.7	22.9	43.2	45.8
Pharmacy	15.6	11.1	10.4	2.1	8.6	0	24.4	38.5	18.1	0	14.6	10.6
Other	18.4	16.5	23.1	20.8	24.9	52.2	30.9	13.9	26.7	32.8	21.5	23.5
TOTAL	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
N=	475897	61916	276446	38289	165502	29374	79000	27659	29622	7095	1103165	172310

\* MoH = Ministry of Health; IPSS = Social Security Institute; Other Hospital includes armed forces and police health services and private hospitals; MoH Center includes primary care facilities -- health centers and health posts; Other includes church-related health facility, private physician, community post, private home, traditional healers.

Source: Altobelli L, "Health reform, community participation, and social inclusion: the Shared Administration Program". Lima: UNICEF-Peru. August 1998.

Data from the National Living Standards Survey (ENNIV) 1997, Instituto Cuánto, SA.

## Exhibit 10

SHARED ADMINISTRATION PROGRAM AND  
LOCAL HEALTH ADMINISTRATION ASSOCIATIONS (CLAS) IN PERU

**Comparison of Health Services Production Data in Health Facilities  
With and Without Civil Participation through CLAS - Peru, 1997**

	Facilities With CLAS*	Facilities in PSBPT** Without CLAS
No. of Health Centers	175 (29%)	598 (13%)
No. of Health Posts	436 (71%)	3851 (87%)
Distribution of facilities by economic strata:	%	%
Level D (Extremely poor)	22	38
Level C (Poor)	40	34
Level B (Regular)	35	18
Level A (Acceptable)	2	10
No. of inhabitants within jurisdiction of facilities (T)	2,652,442	11,759,002
Average no. of inhabitants per health facility	4,341	2,643
Total no. of persons attended:	1,980,658	7,014,621
% of total population that received any services	74.7%	59.7%
Intramural services delivered:		
Total no. of services (IN)	4,474,405	17,338,849
Average rate of services per inhabitant (IN/T)	1.69	1.50
Extramural services delivered:		
Total no. of services delivered (EX)	284,252+	2,658,797
Average rate of services per inhabitant (EX/T)	0.11+	0.23
Preventive and promotional activities:		
Total no. of services delivered (PPA)	1,880,410	8,188,078
Average rate of services per inhabitant (PPA/T)	.71	.70

\* CLAS = Comité Local de Administración de Salud (Local Health Administration Committee)

\*\* PSBPT = Program of Basic Health for All.

+ Extramural services in CLAS were under-reported due to a difference in reporting requirements.

Source: Altobelli L "Comparative analysis of primary health care facilities with participation of civil society in Venezuela and Peru", Seminar on Social Programs, Poverty and Citizen Participation, Inter-American Development Bank State and Civil Society Division. Cartagena, Colombia. March 1998.

Data: Information system of the Program for Basic Health for All (PSBPT).