DECENTRALIZATION TO IMPROVE HEALTH CARE FOR THE POOR

Case Study in Peru

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EXECUTIVE SUMMARY

There is a public debate on decentralization issues in today's Peru. Despite the affirmation by most Peruvian opinion-makers that decentralization must be at last adopted and implemented during the next presidential period (2001-2006), there is no solid agreement about the "why" and the "how" of decentralization both within parties and in Peruvian society more broadly. In response to this public interest, former President Fujimori announced twice the government's intention to further decentralize administration of the education and the health sectors. There has been another proposal for health decentralization presented to Congress during the current transitional government. None of these initiatives were ever implemented. As a result, health decentralization is still on the agenda as the country prepares to elect a new President in June 2001. Although few concrete ideas have been offered about ways in which decentralization as a whole can be advanced in Peru, the health sector has been successfully running a participatory scheme for sector decentralization with Local Health Administration Committees (CLAS). Besides, the central government through its social fund (FONCODES) manages a special fund for financing community social infrastructure, including health facilities.

In order to promote a broad-based national dialogue on decentralization, the World Bank undertook an Institutional Governance Review with a focus on the issue of decentralization. Among a number of different studies within the review, a case study on health sector decentralization was included.

The current document is a case study of the health sector in which an assessment is offered of the current status of health decentralization with options for designing and implementing an appropriate decentralization strategy. Specific objectives of the paper were to (1) summarize the current status, main problems, and best deconcentration or decentralization practices for the provision of health services, (2) identify the relation between communities and each level of government for financing and providing health services at the local level, (3) assess coordination (or lack thereof) between levels of government, and (4) present distribution of public health resources by levels of government and main autonomous agencies.

This report provides an overview of the current status of health policy and programs in the public health sub-sector in Peru within the context of its historical development into a fragmented system, and how this has resulted in poor progress in health status indicators and distributive inequities. The current functioning of the Shared Administration Program is discussed, with an assessment of past and current proposals to decentralize public sector health service administration to municipalities, and an alternative proposal to strengthen the current system that would improve the future feasibility of inserting the health sector into a broader decentralization policy if such is implemented by the government.

Conclusions include the following:

- Central level health sector policies are needed for reforms to support decentralization, including such issues as:
  - Prioritization of reaching the poor,
  - Prioritization of health education for behavioral change, water and environmental sanitation, control of emerging and reemerging diseases, and other issues that require multisectoral interventions,
  - Strategic planning and consistent leadership guidance from the highest levels of the Ministry of Health,
  - Streamlining of financing and budgeting processes,
  - Epidemiological surveillance and integrated information systems for tracking needs, planning, and measuring progress in meeting the needs,

- Hospital financing and management policies to ensure improved access of the poor to hospital services,
- Strengthening and expansion of the CLAS model to provide higher quality and more efficient delivery of primary care by the public sector,
- Institutionalization of targeted programs (such as PSBPT and food assistance programs) to reduce their vulnerability to fiscal or political crises,
- Reorganization of the functional structure of the regional level (DISA) of the Ministry of Health to better reflect role in governance and internal control of the system, rather than in implementation or financing,
- Establish human resource policies for the health sector that promote continuity and quality of care through provision of incentives.

- Decentralization of primary health care services in the health sector: CLAS is the major strategy to be piloted that has shown promise for the improvement of effectiveness, efficiency, equity, and quality of health services. Combined with other reforms such as the Maternal-Infant Insurance Program, CLAS is positioned to be the centerpiece the reform strategy. The issue is how to strengthen the CLAS model itself, including strengthening of its support system from higher levels of the sector, especially the DISA, and coordination with other government sectors, including municipal governments. CLAS can serve as the focal point of community development through local generation of projects, given that CLAS Associations are private non-profit entities that can receive grants and donations from any source, in addition to transferences of public resources. Other social programs such as FONCODES should work more closely with CLAS in the future, since the permanence of the CLAS Association provides a sustainable framework for development activities.

- Decentralization of health promotion activities to municipalities: Due to the recognized administrative weakness of most district municipalities, but given a potential political will to include them in decentralization of the public sector, the current recommendation is to incorporate municipalities in health actions in iterative stages to build capacity over time, treating decentralization to municipalities initially as a small reform. An abrupt transfer or "dumping" of administrative responsibilities on municipalities for all aspects of health facility financing, management and service delivery, due to the complexity of the task, has a high risk of reducing the effectiveness, efficiency, equity, and quality of health services delivery in the short and medium term. The proposed alternative is to revalidate the municipal responsibilities in population, health, and environmental sanitation, as described in Article 66 of the *Ley Orgánica de Municipalidades*, which imply an important role in health promotion. The work of municipalities with communities and community-based organizations provides them with immediate channels for health promotion, given technical assistance from the Ministry of Health on priority topics. Their current role in sanitation and environmental protection infrastructure should be expanded to include community education campaigns in health prevention on the same issues. "Management agreements" between the health sector (DISAs) and municipalities should appropriately specify objectives, monitoring and evaluation systems, technical content and priorities, and incentives for the attainment of "Health Community – Health People" designation. Big reforms involving decentralization of health would best occur when there is: (a) an adequate financing system at the central level with sufficient resources, as well as intersectoral coordination to either increase public resources to municipalities to implement health and sanitation-related activities and/or to provide legislation to facilitate municipal capacity to increase their resources; and (b) appropriate training and placement of human resources in DISAs, networks, municipalities, hospitals, and primary health facilities who are prepared to implement or control the reforms. One could argue that no reforms should take place unless there is a high probability that health coverage and impact will be improved as a result.

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ACRONYMS

CLAS	Comité Local de Administración de Salud (Local Health Administration Committees)
CTAR	Consejo Transicional de Administración Regional (Interim Council for Regional Administration)
DIGEMID	Direccion General de Medicamentos, Insumos y Drogas
DIGESA	Direccion General de Salud Ambiental
DISA	Dirección de Salud (Departmental Health Office)
ESSALUD	Peruvian Institute for Social Security (formerly IPSS)
FONCODES	Fondo de Compensacion y Desarrollo (Fund for Compensation and Development)
GOP	Government of Peru
IEC	Information, Education and Communication
INEI	Instituto Nacional de Estadistica e Informatica
INS	Instituto Nacional de Salud
MEF	Ministerio de Economia y Finances
MIPRE	Ministerio de la Presidencia
MOH	Ministry of Health
NGO	Non-governmental organization
OGA	Oficina General de Administración
OGE	Oficina General de Epidemiologia
OGP	Oficina General de Planificación
OFICE	Oficina de Financiamiento, Inversiones y Cooperación Externa (Office of Financing, Investments and External Cooperation)
PACFO	Programa de Alimentacion Complementaria para Familias en Riesgo
PFSS	Proyecto de Fortalecimiento de Servicios de Salud (Health Services Strengthening Project)
PROMUDEH	Ministerio de Promoción de la Mujer y Desarrollo Humano
PSBPT	Programa de Salud Básica Para Todos (Basic Health for All Program)
PSNB	Proyecto de Salud y Nutrición Básica (Basic Health and Nutrition Project)
P2000	Project 2000
SEG	Seguro Gratuito Escolar (School Health Insurance Program)
SEPS	Superintendencia de Entidades Prestadores de Salud) (Superintendence of Health Service Delivery Entities)
SMI	Seguro Materno-Infantil (Mother-Child Insurance Plan)
SPP	Sistema de Programación y Presupuestación (System for Programming and Budgeting)
USAID	United States Agency for International Development
UTES	Unidades Territoriales de Salud (Territorial Health Units)
WHO	World Health Organization

PRESENTATION

Decentralization is one of the most noteworthy advances in institutional reforms in Latin America. Governments throughout the region have embarked on decentralizing some aspects of political power, fiscal resources or administrative functions to sub-national governments in order to strengthen democratic governance, as well as responsiveness and efficiency of public services. In this regional panorama, Peru finds itself among few Latin American countries where advance in decentralization has been negligible, despite some attempts in the past. There is an important public debate on decentralization issues in today's Peru. Despite the affirmation by most Peruvian opinion-makers that decentralization must be at last adopted and implemented during the next presidential period (2001-2006), there is no solid agreement about the "why" and the "how" of decentralization both within parties and in Peruvian society more broadly.

In order to promote a broad-based national dialogue on decentralization in Peru, the World Bank undertook an Institutional Governance Review with a focus on the issue of decentralization, under the responsibility of Yasuhiko Matsuda, Public Sector Specialist, Poverty Reduction and Economic Management Unit, Latin American and the Carribbean Region, and Fernando Rojas, Lead Public Sector Management Specialist, LCSPS. The objective of the review was to stimulate a broad-based dialogue among civil society before entering specific policy dialogue with the government, and thus provide a seed for an informed and sustained national dialogue among key stakeholders.

The plan of action for the Institutional Governance Review was:

- Two studies on sector decentralization (health and water) that summarize the current status, main problems and best deconcentration or decentralization practices for each one of the sectors
- One budget management study that summarizes current rules and practices for policy making and implementation regarding distribution of central government and autonomous agencies budget resources to municipalities and communities, with emphasis on health and water sectors
- One study that summarizes current practices regarding the role, revenues and responsibilities of the intermediate (i.e., regional) level of government (CTARs)
- One study that summarizes available information regarding fiscal and management capacity by type of municipality and proposes a new classification of municipalities for purposes of distribution of revenues (including central government transfers) and responsibilities
- Four simultaneous focus groups to collect key stakeholders' (experts and representatives of civil society) perspectives
- Workshops and dissemination activities to support continued dialogue on the decentralization policy and process.

The case study on the health sector was prepared by Dr. Laura C. Altobelli, Consultant, with the assistance of Dr. Ricardo Diaz R., ex-coordinator of the Shared Administration Program. The report is based on a review of documents, interviews with central level officials from the Ministries of Health and Economy & Finance, the Decentralization Commission of the Peruvian National Congress, health sector externally-financed project personnel, regional health office (DISA) personnel in Lambayeque and North Lima, provincial municipality of Chiclayo, district municipalities in Jose Chiclayo and Los Olivos (North Lima), a private research institute conducting decentralization studies, and the current and previous deans of the *Colegio Medico del Peru*. Many thanks are given to all of those who collaborated.

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Case Study on Peru

1. INTRODUCTION

In the international health field, decentralization has been promoted as general goal within health reform movements to strengthen the delivery of health services in terms of improved equity, efficiency, quality, and financial soundness. The rational for decentralization includes such assumptions as: certain decisions should be transferred closer to the people who seek government services, local decisions are more appropriate and therefore more acceptable and cost-efficient, and administrative costs are reduced. Decentralization has been promoted as an assumed good, but the question has still not been answered as to whether decentralization is the answer for all countries to achieve these goals (Bossert, 1997). Experiences of decentralization of health systems in at least five Latin American countries, Brazil, Chile, Colombia, Bolivia, and Nicaragua, provide a point of reference for thinking about potential models of decentralization for Peru. These have not been systematically evaluated to know what has been the impact on health of the decentralization processes in those countries. A World Bank analysis of fiscal decentralization in African countries showed that higher fiscal decentralization was consistently associated with lower infant mortality rates, especially in poor countries, and in environments with high levels of corruption (Robalino et al, 2001).

The main issues that should be considered for a model of decentralization in health are: a) what level of choice is transferred from central institutions to institutions at the periphery of health systems, b) what choices local officials make with their increased range for discretion, and c) what effect these choices have on the performance of the health system in terms of reaching the central objectives of most health systems which are, in the case of the Peru Ministry of Health (MOH, 1995), improving efficiency, quality, and equity.

The main challenges identified for the Peruvian health sector have been: 1) how to reduce the large gap between the health status of the poor and that of the non-poor, 2) how to increase the resources assigned to provide care for the poor, and 3) how to increase the efficiency in the use of these resources (World Bank, 1999). Although hospital administration and financing is still an important issue to be resolved, Peru should not lose sight of the need to improve delivery of basic health services to the poor.

In Peru, a decentralized health program called the Shared Administration Program has been piloted since 1994, which contains elements of transferring decision-making to the community health administration committees (CLAS) and provides a range of choice at the lower levels. With 20% of all peripheral health services currently under CLAS management, evaluations have shown how efficiency and quality have resulted from the model. The questions still remain as to whether other modes of decentralization, such as to municipalities or to other levels on the periphery, could further contribute to decreasing the gap in health status between the poor and the non-poor, and to increasing the availability of resources for the neediest populations. Another way to ask the question is, what basic health care models are needed for universally reaching the poor, and is decentralization the best way to ensure the efficiency, equity, and quality of that care?

Proposed laws on the decentralization of health services in Peru have been presented to Congress in 1999 and again in 2000, both giving district municipalities complete administrative control over health centers and health posts. These proposals have not prospered.

There are actually several health care systems in Peru. In addition to the public sector served by the Ministry of Health, these include the Armed Forces Health Services, the Social Security Institute serving employed persons through employer contributions, and the private health care system. The public sub-sector of health is the main focus of this report, as it has responsibility for health care for the poorest 60% of the population.

The present document provides an overview of the current status of health policy and programs in the public health sub-sector in Peru within the context of its historical development into a fragmented system, and how this has resulted in poor progress in health status indicators and distributive inequities. That is followed by a discussion of the current functioning of the Shared Administration Program, an analysis of past and current proposals to decentralize public sector health service administration to municipalities, and an alternative proposal to strengthen the current system that would improve the future feasibility of inserting the health sector into a broader decentralization policy if such is implemented by the government.

2. SITUATIONAL ASSESSMENT OF PUBLIC HEALTH IN PERU

2.1 Overview of Health Systems Development

Government investment in health care for the poor before the 1990s

Up to the decade of the 1980s, health care delivery focused on hospitals. A limited number of primary care facilities were poorly staffed and equipped. Donor-funded projects in the late 1970s and early 1980s financed primary health care to strengthen primary health care, though little investment was made in infrastructure or equipment of peripheral facilities. Slow public sector administration made donor funding difficult to implement, with poor sustainability. Low health care coverage was due to scarce availability and poor quality of primary facilities, causing patients to bypass that level for hospitals where quality of care was perceived as better. Briefly in the mid-1980s, a government policy promoted primary health care under ex-Minister of Health Dr. David Tejada, though without changes in administration or financing. His policy met with resistance from a variety of actors within the health sector, and he left office before much progress was made in its operationalization.

Collapse of the health sector between the mid 1980s and early 1990s

By the end of the five-year term of ex-President Alan Garcia (1985-1990), the health sector was virtually collapsed due to: a) severe hyper-inflation, b) bankruptcy of the public treasury, c) severe reductions in social sector spending, d) a near absence of donor-funding in the health sector, and e) closure of many peripheral health facilities in rural areas forced by terrorism. Frequent strikes of physicians and the health worker union compounded the health care delivery problems. Due to lack of financing, MOH health services had to begin collecting fees for services, previously free-of-charge, to cover basic operating costs. Requirements were made that income from fees be deposited in special accounts utilized by Territorial Health Units (UTES) to bulk purchase supplies for redistribution to health facilities. In practice, much of the money was never returned to health facilities, maintaining them in dire straits, and the continued charging of fees created economic barriers to care for the poorest populations.

Plurality of the health delivery system

The health sector is an amalgam of public and private health services, including the public sector (covering 68% of the population and administered by the Ministry of Health), ESSALUD (26% of the population), Armed Forces and Police Health Services (2.3%), and the private sector (4.1%). Considering the 68% under the responsibility of MOH, an estimated 12-15% do not receive any services (according to the OGP). In times of economic crisis or loss of insurance coverage from unemployment, groups served by either ESSALUD or the private sector migrate to MOH public services due to lower costs especially for hospital services, while the MOH budget allocation remains stable at historical levels. The floating target population of MOH is not well served by a rigidly stable budget.

As shown in Table 1, the MOH is the major source of both ambulatory and hospitalization services for all income levels. Over half of all hospitalization for the richest sector is provided by the MOH, showing little targeting of public health financing. The high level of use of the private sector by the poor is primarily accounted for by informal use of commercial pharmacies and traditional medicine in place of formal medical care.

Table 1
Providers of Health Care in Peru by Region and Socioeconomic Strata,

	Ambulatory					Hospitalization				
	MOH	Essalud	AF/P*	Private	Total	MOH	Essalud	AF/P*	Private	Total
Lima	36	20	4	40	100	53	26	8	13	100
Other urban	40	25	2	33	100	67	26	0	7	100
Rural	60	5	1	34	100	81	12	0	7	100
Quintile 1 (poor)	68	4	1	28	100	85	0	0	15	100
Quintile 2	52	12	1	34	100	71	27	0	3	100
Quintile 3	53	15	1	32	100	65	26	0	9	100
Quintile 4	40	23	4	33	100	63	29	0	8	100
Quintile 5 (rich)	26	25	3	47	100	58	18	8	17	100
TOTAL	**44**	**18**	**2**	**36**	**100**	**65**	**23**	**2**	**9**	**100**

AF/P = Armed Forces and Police Health Services
Source: Peru - Improving Health Care for the Poor, 1999, based on ENNIV 1997.

Centralized health sector governance and administration

Since the 1980s, health administration has become more centralized. Functions that were previously delegated to regional governments have been returned to the central level of the MOH where functions of governance and regulation have been expanded to include direct administration of programs and projects. Vertical health programs as discussed below are one manifestation of vertical governance and administration. Other manifestations of centralization include the following:

- ***Weak human resources policies***. This has resulted in the politization of most high level positions in the Ministry into appointed "*cargos de confianza*" that come with no requisites for previous knowledge of or experience in the public health sector. Term of office also depends on political considerations. The consequence is a short-term vision of sector goals, difficult continuity of long-term projects or policies, a tendency to mediocrity in technical work

combined with an implicit suppression of personal creativity, and uncertainty that results in paralysis or delays in policy implementation.

- ***Vertical decision-making and no consultation with stake-holders***. Legislative initiatives of the MOH in recent years have focused on issues of secondary importance. For example, the creation of a Superintendence of Health Service Delivery Entities (SEPS) to reform and regulate private sector insurance as an alternative choice to the mandatory payroll withholding for ESSALUD coverage benefits employed persons, but does nothing to improve equity and efficiency of health care for the poor.

- ***Creation of vertical administrative structures parallel to the formal system***. Health programs focalizing social investment for the national *Lucha Contra la Pobreza* utilizing vertical administrative systems to ensure rapid deployment of resources to under-served populations resulted in a series of structures parallel to the formal health administration system. While effective in achieving its goals of population coverage with equity and efficiency, the parallel structures (including PSBPT and FONCODES) further centralized financial, administrative, and technical decision-making, and allowed problems in the formal system to be ignored.

- ***Lack of strategic planning at any level of the health sector.*** MOH has long claimed the role of *rector* of the health sector, including responsibility for ESSALUD, the armed forces health services, and the private sector. To date, however, the structure of MOH does not assign that role to any specific office, and the function is not carried out.

Emphasis on vertical health programs since the late 1970s

International health focus in developing countries from the late 1970s on has been on financing implementation of vertical programs, including especially growth monitoring, oral rehydration therapy for diarrheal diseases, breastfeeding, and immunizations (GOBI). The vertical program strategy initiated in the U.S. Congress, and was later adopted by WHO and UNICEF to replace their 1978 Declaration of Alma Ata integrated primary health care approach. The focus was on specific childhood diseases, and not on prevention (except for immunizations which received the major emphasis and largest budget due to donor financing). Major improvements were achieved in prevalence and mortality for diseases subject to vertical programs, especially diarrheal diseases. MOH began to address the issue of acute respiratory illness (ARI) in 1992. Family planning received major emphasis as a vertical program throughout the 1990s, but not until 1999-2000 was maternal health seriously addressed. Good progress was made over two decades on iodine deficiency prevention. Other micronutrients such as iron and vitamin A were recognized as important, but no financing was available for them until the past two years.

As of 2001, MOH funding still prioritized family planning ($9.7 million) and immunizations ($9 m.), followed by AIDS ($5.3 m.), maternal-perinatal health ($4.8 m.), malaria ($4.6 m.), and tuberculosis ($4 m.). Other vertical health programs such as zoonosis, diarrheal and respiratory disease control, child growth and development, micronutrients, and others have budgets of less than $2 m. each per year. Each of 23 vertical programs is managed by separate offices in the central MOH, each with its own system of norms, supervision, monitoring, evaluation, information and logistics, training, IEC, and community participation activities. Reporting systems are particularly cumbersome for service delivery personnel since each vertical program has its own series of specific indicators and reporting forms. At the regional level, each program has its own coordinator, who carries out training, supervision, reporting, and other functions specific to each program. This system has recently changed in some regions where programs have been combined into child health and women's health areas.

2.2 Overview of Health Sector Financing

A number of diagnostic studies have been carried out since 1995 on health sector financing in Peru with the goal of contributing to a better rationalization of the policy and planning processes (Consorcio ESAN, 1997; World Bank, 1999). The current report does not pretend to provide an in-depth analysis of public health sector financing in Peru, but to point out that the main characteristics identified are: 1) regressivity in resource allocation, with more funds assigned per capita in more affluent departments of the country, 2) fragmentation of the planning, budgeting, and execution processes, leading to operational and cost-inefficiencies, and 3) underfinancing of the health sector, with health expenditures representing only 3.6% of the PBI, and $156 per capita expenditure on health, about half the Latin American average.

Health sector financing reform efforts have been proposed and tested over the past decade. Those that have successfully achieved legislative reform are related to improvements in the ESSALUD insurance system that covers employed persons. Public health services MOH have still not been successful in effecting comprehensive reform measures, though several innovations have effectively targeted the poor with basic health and nutrition services, and there has been a recent introduction of insurance schemes for school children and maternal-child health as steps to reduce cost barriers for specific population groups. One of the most successful innovations to date has been the Shared Administration Program that involves organized community participation in the decentralized management of public sector resources. Many advances have been made by these new programs in coverage and financing levels. At the same time, the side effect has been further fragmentation of the financing, management, and delivery of health care for the poor.

Targeted program for financing and operating basic health services

In the 1993 GOP Lineamientos de la Politica Social, a policy was laid out to achieve greater equity, with emphasis on permanent activities in health and sanitation, nutrition, education and culture, and justice. As of 1994, the GOP launched the *Programa de Focalización de Gasto Social Básico*, later called the *Programa de Mejora del Gasto Social Basico*, with the objective to improve the quality of expenditure, targeted to poverty populations, in four priority sectors: nutrition, health, education, and justice. Nutrition spending evolved into a series of poorly monitored food assistance programs spread out among five governmental entities (PROMUDEH, Ministry of Education, Ministry of the Presidencia, MOH/INS, and municipalities). The Ministry of Health and FONCODES received financing under this program as of 1994. In the health sector, this became the *Programa de Salud Basica Para Todos* (PSBPT) that provided a basic package of services in primary care facilities, financing health personnel contracts, basic equipment, training, and control activities in zones of greatest poverty. FONCODES financed the expansion of infrastructure. A special pilot project was launched in 1994 to involve active community participation in the management and control of primary health care services through private, community-based Local Health Administration Committees (CLAS) that signed a management contract with regional health authorities to plan, implement, and evaluate a Local Health Plan, financed by the state.

Beginning with approximately 2,000 primary care facilities in 1994, by 2001 6,378 primary care facilities have been built or reactivated (1,072 health centers and 5,306 health posts). PSBPT directly contracts (as non-personal services) approximately 14,000 health workers, including both professionals and non-professionals. PSBPT currently manages approximately 15% of the budget administered through the central level MOH, through a separate financial management system that has proven very efficient as compared to normal public sector administrations. It also has a streamlined information system and its own supervision, monitoring, and evaluation system that function on national and regional levels. Due the efficiency of its financial management system,

the budget for supplies for all national health programs was transferred in 1998 from DGSP to PSBPT management.

Public insurance schemes: school health and maternal-child health

The School Health Insurance Program (*Seguro Escolar Gratuito* – SEG) was initiated in 1997 under a mandate from ex-President Alberto Fujimori to provide full health care coverage to the 6 million children between the ages of 3 and 17 (inclusively) who attend public schools in Peru. Ambulatory, surgical, emergency, and dental care, including hospitalization, laboratory tests, image diagnostics, medicines, supplies, and special procedures are provided free of charge on a year-round basis, 7 days a week, 24 hours a day in Ministry of Health facilities. This program was feasible due to the already existing infrastructure and personnel available through PSBPT and FONCODES/INFES. Health facilities are reimbursed for each child attended, and medicines and supplies earmarked for SEG are provided to each facility through regional purchasing and distribution systems. From August 1997 to June 2000, 15,391,870 specific health services for school children were financed by SEG. For the year 2000, 8.6 million services were provided under SEG at a cost of S/ 70,159,412 nuevos soles (US dollar $20 million), 22% of these through MOH hospitals, 45% through health centers, and 33% by health posts. SEG does not include services provided to children under age five through the national health programs: diarrheal disease control, ARI, tuberculosis, malaria, AIDS, STDs, etc.

Box 1 - Policy Making Process for the School Health Insurance

Within the context of high level multi-sectoral discussions in mid-1996 on proposed poverty alleviation programs, the Ministry of Education was the first to argue for a school health insurance program to address the problem of undernourished and sick children attending pubic schools, and to provide an incentive for improved school attendance. During his yearly independence day speech on July 28, 1997, President Fujimori made a surprise announcement of his establishment of the School Health Insurance Program (SEG). Within days, the Ministry of Health had taken over the initiative and set out to design the operational aspects of the program with assured funding levels from the Ministry of Economy and Finances. A special administrative unit was created for SEG, directly responsible to the Vice Minister of Health, and working through a vertical management system with eight macro-regional SEG offices and local offices in each regional health office.

The Maternal-Infant Health Insurance (*Seguro Materno-Infantil* – SMI) was created in response to the high rates of maternal and perinatal morbidity and mortality, the low coverage of prenatal care, and even lower institutional attendance of births. Reasons for such low coverage, aside from cost barriers, include cultural, social, and physical access barriers, and perceived poor quality of care and resolutive capacity of the health care system. The new insurance scheme, which resolves primarily the cost barrier, was begun in two pilot areas (Tacna and San Martin) in November of 1998. In 1999 and 2000, five additional departments in the sierra were incorporated (Huancavelica, Ayacucho, Cajamarca I, II, and III, Apurimac I and II, and Puno), and eight more were included in 2000 (Amazonas, Cusco, Huanuco, Junin, Lambayeque, Ancash, Piura, and La Libertad). Eight more departments are expected to be included by mid-2001, and the final six departments, including Lima and Callao, will be incorporated in 2002.[1] Beneficiaries will eventually be the 68% of all pregnant women and children under the age of 4 who are not covered by other insurance programs. As of November 2000, 298,647 affiliates were inscribed, and 1 million services had been provided free of charge. Services demanded most frequently are for prenatal care and child. For the year

[1] According to Resolucion Ministerial No. 448-99-SA/DM creating the Seguro Materno-Infantil on September 15, 1999.

2000, a total of S/ 15,527,861 nuevos soles (US dollars $4.4 million) were reimbursed to the 18 departments. This represented 50% of the budgeted amount due to restrictions from MEF. It is expected that enrollment will continue to increase as SMI marketing activities are implemented, more departments are incorporated, and additional financing becomes available through new loans from BIRF and IDB[2].

Sources of financing: fragmentation of the public system

Diverse sources of public health sector financing create administrative inefficiencies, duplications, and confusion in the programming, budgeting, and reporting processes required especially of the regional health offices. Fiscal year 2001 budget information related to planning and administration of health sector activities for the GOP is listed Table .2 Health services are financed through a complex system with at least three major channels through the MOH: the Office of General Administration, PAAG (Administration of Management Agreements Program), and PARSALUD (Health Reform Support Project). A fourth channel is the Ministry of the Presidency through Transitory Regional Administration Councils (CTARs). Also, five decentralized public organisms (INS, ENSP, INMT, INAPMAS, and SEPS) received direct financing independent of the MOH. Health infrastructure is funded through the Ministry of the Presidency (through CTARs, FONCODES, and INFES). Food assistance is channeled through the INS, Ministry of the Presidency – CTARs, PROMUDEH, and municipalities.

DISAs have very little programming authority in relation to their total budget. DISAs receive mostly pre-programmed funds, including earmarked "entrusted funds" for national health programs and financing of PSBPT contracts and permanent staff salaries. DISAs have discretion over a relatively small amount budget received from the CTAR for goods and services, and the cash deposited by health facilities from fees charged for health services. In some or many regions, these discretionary funds are put to uses that are neither programmed nor reported nor supervised. The quality of health services depends to a large extent on the efficiency and transparency of use of these few discretional funds.

[2] Both IBRF and IDB projects are expected to be approved during 2001, to be administered through PARSALUD, a new executing unit in central level MOH.

Table 2
GOP Budget for Health – Fiscal Year 2001

Amounts in millions of US dollars

Source	Planning Unit	Executing Unit	Activities/ Projects	Amount in budget 2001	Investment	Personnel	Goods and Services
MEF	MOH/ VM/OGP (Total Pliego MOH= $485.2 m)	OGA	Pensions	42.6 m.		x	
			Central level adm. DIGEMID admin. DIGESA admin. 4 DISAs (Lima) Epidemiology	207.5 m. (includes 133.9 m. RDR, credit & donations)		x	x
			Donor project counterpart funds (USAID, CE, GTZ, KFW, France, OPS)	36.5 m. (-20.2 m.)**	x		
		OGA (Includes regions)	Family planning	9.7 m.			x
			School child health insurance	25.7 m.			x
		7 specialized hospitals (Lima)		60.9 m.		x	x
		5 national hospitals (Lima)				x	x
		15 hospitals (Lima)				x	x
		PAAG (Entrusted to regions)	PSBPT	27.9 m.		x	x
			PAC/CLAS	19.4 m.		x	
			Nat'l Health Programs - vertical	38.3 m.	x		x
C.E.			PASA	(5 m.)	x		x
MEF		PARSALUD	Maternal-infant Insurance	11.6 m.			x
			Investment	0.1 m.	x		
BIRF			PSNB	0.7 m.	x		x
			Investment	(27 m.)*	x		x
IDB			Investment	(28 m.)*	x		x
MEF	INS	Instituto Nacional de Salud	School Breakfast	59.4 m.	x		
			PACFO and other food programs	28.8 m.		x	x
			Public health laboratory network, research, administration, etc	10.3 m.	x	x	x
	USAID		Proyecto Vigia	2.3 m.	x		
	ENSP	Escuela Nacional de Salud Publica		.59 m.		x	x
	INMT	Instituto Nacional de Medicina Tradicional		.95 m.		x	x
	INAP-MAS	Instituto Nacional de Proteccion del Medio Ambiente para la Salud		.19 m.		x	x
	SEPS	Superintendencia de Entidades Prestadores de Salud		2.7 m.		x	x x
MEF	MIPRE (Total for CTARs in health= $97.12 m)	Entrusted to CTARs in 23 Departments outside of Lima/Callao	Control of health	1.47 m.		x	x
			IEC in health	.85 m.		x	x
			Public health laboratory network	.07 m. (6 CTAR)		x	x
			Health prevention	7.28 m.		x	x
			Health surveillance	3.14 m.		x	x

			Diagnostic and treatment support services	7.86 m.		x	x
			Control of non-communicable diseases	.31 m. (10 CTAR)		x	x
			School child health insurance	.47 m. (9 CTAR)		x	x
			Maternal-infant health insurance	.39 m. (6 CTAR)		x	x
			Food assistance -high risk	4.25 m.		x	x
			Health care under agreements/contracts	.27 m. (5 CTAR)		x	x
			Basic health care	34.93 m.		x	x
			Specialized health care	32.23 m.		x	x
			Support to families and the disabled	1.50 m.		x	x
			Construction of facilities	1.76 m.	x		x
			Rehabilitation of facilities	.14 m. (4 CTAR)	x		x
			Equipment of health facilities	.13 m. (3 CTAR)	x		x
			Formulation of norms and rules	.02 (2 CTAR)		x	x
			Support for Integrated Health	.04 (1 CTAR)		x	x
	MIPRE	FONCODES	Construction of health and education facilities	(30.2 m)	x		
		INFES	Construction of health facilities	.75 m.	x		
	MEF	Municipal governments	Vaso de Leche (food assistance)	125 m.	x		

** Amount has been deleted from the 2001 budget

* Pending signing of agreements in FY 2001

Budget allocation decisions by MEF to CTARs for health are based on such considerations as: the proportion of each political region in the General Budget, the weight of the health sector in each political region, information available about immediate health needs in each (such as the presence of epidemics or natural disasters), adherence to monthly reporting on expenditures, and personal contacts between regional functionaries and the MEF functionary. Stronger and more successful DISAs are able to obtain greater CTAR funding.

Table 3 summarizes the formation in Table 2, listing the proportional distribution of the health budget for administration and delivery of services (total US $576 million), and for other health-related activities (including food assistance) financed through decentralized public organisms, other ministries, and municipalities.

Table 3
Summary of MOH-CTAR Budget for
Health Services Administration and Delivery

PLIEGO	Executing Unit	Subtotal US$ million	Total US$ million	% of total MINSA-CTAR
HEALTH SERVICES ADMINISTRATION AND DELIVERY				
MINSA			$485.2 m.	**83.3%**
	OGA	382.9		65.8
	PAAG	90.6		15.6
	PARSALUD	12.4		2.6
Ministry of Presidency	CTAR – Health		$90.8	**16.7%**
	Hospitals	32.2		5.5
	Health centers/posts	34.9		6.0
	Other	23.7		5.2
TOTAL MINSA-CTAR			**$576.0**	**100.0%**
OTHER HEALTH-RELATED ACTIVITIES				
RESEARCH & DEVELOPMENT			$17.0	
Health Sector Decentralized Public Organisms	INS-ENSP-INMT-INAPMAS-SEPS	$17.0		
HEALTH INFRASTRUCTURE			$4.0	
Ministry of Presidency	CTAR	2.0		
Ministry of Presidency	FONCODES	~1.25 (est.)		
	INFES	.75		
FOOD ASSISTANCE			$300.0	
Instituto Nacional de Salud	School breakfast, PACFO, PANFAR,other	88.2		
Ministry of Presidency-CTAR	Food assistance	4.3		
PROMUDEH	Various food programs	82.5		
Municipalities	Vaso de Leche	125		
TOTAL OTHER SOURCES			**$321.0**	

On Table 4, data is presented showing the per capita expenditure on health in each Department (assuming a distribution in the total population) based on the 2001 national budget for the Republic of Peru. One notes that departments that are better off economically and in health status indicators such as infant mortality rate and child nutritional status, such as Tacna and Moquegua, are those with the highest per capita budget in health. Metropolitan Lima, which has the highest economic and health status indicators, and a high proportion of population already covered by ESSALUD, Armed Forces/Police or private health insurance, has five times as much expenditure per capita (US$50.57) as compared to the regions outside of Lima/Callao (US$10.09). Thirty percent of the total health budget (including both CTAR and MOH budgets) is sent to regions outside of Lima/Callao where 67.9% of the total population lives. The conclusion is that health budget allocation decisions in the public sub-sector of health are not made on the basis of need, and in fact are regressive.

Table 4
Health Budget for 2001 by Region of Peru :
Per Capita Expenditure on Health

REGION	(a) **CTAR Budget for Health** (US$)	(b) **MOH Budget++** (US$)	(c) **TOTAL** (US$) (a+b)	(d) **% of Budget from MOH** (b/c)	(e) **% of Total Health Budget** (c/C)	(f) **Total Popu-lation 2000***	(g) **Infant Mort-ality Rate** **	(h) **Per capita US$ for Health** (c/f)
Lambayeque	140,000.00	2,556,434.86	2,696,434.86	95%	0.5%	1093051	34	2.47
Junin	40,571.43	4,073,764.57	4,114,336.00	99%	0.7%	1190488	57	3.46
Madre de Dios	1,510,234.57	1,481,160.00	2,991,394.57	50%	0.5%	843832	40	3.55
Piura	5,251,896.29	6,719,206.00	11,971,102.29	56%	2.1%	1545771	56	7.74
Cajamarca	4,301,351.71	7,070,133.14	11,371,484.86	62%	2.0%	1411942	58	8.05
La Libertad	7,875,924.00	4,160,315.43	12,036,239.43	35%	2.1%	1465970	43	8.21
Ancash	7,082,266.86	3,573,360.86	10,655,627.71	34%	1.8%	1067282	41	9.98
Cuzco	6,507,151.43	5,072,935.43	11,580,086.86	44%	2.0%	1158142	78	10.00
San Martin	4,274,023.43	3,225,508.57	7,499,532.00	43%	1.3%	743668	47	10.08
Huanuco	4,098,854.86	3,941,915.43	8,040,770.29	49%	1.4%	776727	59	10.35
Puno	9,403,932.00	4,272,814.86	13,676,746.86	31%	2.3%	1199398	82	11.40
Loreto	4,876,905.14	5,485,614.86	10,362,520.00	53%	1.8%	880471	50	11.77
Huancavelica	2,430,716.86	2,741,373.71	5,172,090.57	53%	0.9%	431088	109	12.00
Amazonas	1,713,300.86	3,233,131.14	4,946,432.00	65%	0.8%	406060	51	12.18
Arequipa	9,824,810.00	3,781,840.86	13,606,650.86	28%	2.3%	1072958	50	12.68
Tumbes	1,459,126.86	1,024,812.29	2,483,939.14	41%	0.4%	193840	47	12.81
Ica	6,841,873.14	2,084,822.00	8,926,695.14	23%	1.5%	649332	39	13.75
Apurimac	3,157,252.00	3,037,129.43	6,194,381.43	49%	1.1%	426904	73	14.51
Ucayali	3,704,394.86	2,454,779.14	6,159,174.00	40%	1.1%	424410	64	14.51
Ayacucho	4,254,832.86	3,585,754.57	7,840,587.43	46%	1.3%	527480	69	14.86
Pasco	1,493,634.29	2,312,554.57	3,806,188.86	61%	0.7%	247872	67	15.36
Moquegua	2,299,780.86	932,478.00	3,232,258.86	29%	0.6%	147374	52	21.93
Tacna	4,417,018.86	1,927,148.00	6,344,166.86	30%	1.1%	277188	26	22.89
SUBTOTAL	96,959,853.14	78,748,987.71	175,708,840.86	45%	30.2%	17421799		10.09
Lima		377,573,548.86	377,573,548.86	100%	64.9%	7466190	26	50.57
Callao		28,847,662.29	28,847,662.29	100%	5.0%	773701	26	37.29
TOTAL US	**$ 136,125,877.71**	**$509,544,648.86**	**$ 645,670,526.57**	**83%**	**100%**	**25661690**		**US$25.16**

* Source: National Institute of Statistics and Information.
**Source: INEI, National Demographic and Health Survey (ENDES III), 1996. (No. of deaths per 1000 live births)
+Source: Presupuesto Nacional del Peru 2001.
++Does not include health-related Decentralized Public Institutions (INS-ENSP-INMT-INAPMAS-SEPS), FONCODES/INFES infrastructure or most food assistance programs.

2.3 Results in Health Sector Performance and Health Status

With major credit going to PSBPT, SEG, SMI, and the FONCODES and INFES health infrastructure programs, the health sector has been able to increase health care coverage from 6 million persons attended in 1995 to 13 million in 1999. With data from the Peru DHS survey, it is possible to track the progress on key indicators of coverage and health status achieved over the past decade.

Table 5
Key Health Status Indicators

Indicator		ENDES II 1991/92	ENDES III 1996	ENDES IV 2000
Infant-child health and nutrition				
Infant mortality	Total	55	43	33
(# deaths < age 1 per 1,000 live births)	Metropolitan Lima		23	17
	Other urban areas		44	36
	Rural areas	80	71	60
Chronic malnutrition	Total	37	26	25
(% < 5 yrs with height/age < -2 sd)	Metropolitan Lima	10	10	7
	Urban coast	15	12	10
	Urban jungle	29	26	22
	Urban sierra	35	25	21
	Rural coast	33	24	24
	Rural jungle	42	38	35
	Rural sierra	54	44	45
Global malnutrition	Total	11	8	7
(% < 5 yrs with weight/age < -2 sd)	Metropolitan Lima	3	1	< 1
	Rural Sierra	18	14	12
Exclusive breastfeeding (% of infants < 4 months of age)		40	61	73
Prevalence of diarrheal disease (% children <5 years)			18	15
Prevalence of acute respiratory illness (% children <5 years)			20	20
Maternal health				
Maternal mortality (# deaths per 100,000 live births)		263	265	--
Prenatal care	Total	70	72	71
(% with at least one visit)	Metropolitan Lima	95	89	96
	Other urban areas	78	80	85
	Rural areas	45	51	45
Institutional delivery	Total	48	51	54
(% of all births)	Metropolitan Lima	92	91	94
	Other urban areas	62	66	76
	Rural areas	18	18	25
Prevalence of use of modern contraception (% women 15-49)		31	41	50
Total fertility rate in women 15-49 years of age		4.0	3.5	2.9

Sources: INEI, Encuesta Nacional de Demografia y Salud, 1992, 1997, and 2001.

It is clear that much progress has been achieved in reducing deaths in children under age one, likely due to a reduction in post-neonatal (30 days to one year of age) deaths from infectious diseases, while neonatal deaths associated with perinatal conditions have not declined. Nutritional status improved significantly overall by about 30% between 1991 and 1996 on indicators of both chronic and global malnutrition, but did not improved in the past five years despite over $300 million per year investment in food assistance programs. Tremendous gaps persist in infant mortality and nutritional status between children in Lima and those living in other parts of the country. Health

services variables are an important part of the gap, but the most significantly associated factor is maternal education, followed by household income level (Mercer, 1987). Significant improvements occurred in exclusive breastfeeding rates, which can be attributed to intensive training and promotion efforts over that decade. Only a slight associated decline has occurred in diarrheal disease prevalence, and acute respiratory illness has not changed. While prevalence in infections may not have changed much, improvements in early home treatment, and increased health service utilization for diarrheal and respiratory diseases as a result of intensive vertical program efforts may be responsible for much of the decline in the rate of infant deaths.

Coverage of prenatal care remains relatively low and unchanged in a decade. Extreme gaps persist in institutional birth attendance between Lima and rural areas. Even though the latter has increased significantly by 30%, it still remains at a level that is unable to show an impact on maternal mortality. Cultural and social factors plus practical considerations of distance, time, work load, child care, and cost weigh heavily in a woman's decision to use health services for herself. More importantly, perceived poor quality of care and poor resolutive capacity of health services are among the main reasons for not seeking health facilities for care during child birth, according to recent studies in rural areas. Improvements in both quality and availability of services will determine future increases in birth attendance coverage for rural populations. For peri-urban populations, increases in quality will be most important, being defined here as improvements in provider-patient relationships and resolutive capacity.

Modern contraceptive use has improved significantly over the decade, which has had an important effect on reducing the total fertility rate (the average number of children born to a woman in her lifetime). Family planning has been a highly prioritized vertical program for many years, with strong financial and political backing of President Fujimori. Peru is still unable to measure other key health indicators such as the proportion of low birth weight newborns that itself is a sensitive indicator of maternal health and nutrition status and is a major predictor of perinatal and infant mortality.

The overall balance suggests that the investments and expansion of human resources in the health sector are producing positive results in the health of the population associated with vertical child health and family planning programs. Better results should not be expected, since the Peruvian economy has continued to suffer throughout the decade despite the promising mid-decade surge in economic growth of the country. The maternal-infant insurance scheme is so new that its impact cannot be measured, and the school health insurance program addresses a population that is not included in key health indicators. Additionally, the main impact of the school health insurance program may be seen more in the education sector on indicators of school attendance and performance, though data is not yet available to identify any changes in those indicators since mid-1997.

2.4 Possible Reasons For Lack of Progress on Key Health Indicators

Despite increased funding in the health sector and the development of new forms of financing of health services with insurance schemes (though only recently), these have been relatively small adjustments in the way health is delivered. Reasons for continuing poor results in health status indicators are likely to include:

Human resources development for the health sector is unregulated and lacking in adequate incentives for improved results.
MOH has no office for regulation or control of human resources. Multiple hiring systems co-exist. Government staff are low-paid but have life-time guaranteed employment, lacking incentives for

advancement or improvement. PSBPT contract personnel are paid at a higher rate for working in isolated zones, but are short-term with no social benefits. There is a daily productivity requirement for number of patients attended, which is intended to provide an incentive to do extramural work in areas where there is low intramural demand. The production requirements are the same for urban and rural areas, promoting the over-reporting of production data in low-demand rural areas (see Annex 1). There is no accreditation of educational programs for the health professions nor personnel certification, resulting in professionals poorly-prepared to work in non-hospital settings or to provide services appropriate to the epidemiologic and cultural/social profile of the country.

At the management level, a critical issue and contradiction in improving health sector management at all levels has been the freeze on salaries in the public sector, that prevents the offering of adequate salaries for sufficiently well-qualified personnel. Personnel contracts under private law as used under the Shared Administration Program - CLAS is the only example of provision of incentives for performance based on social control by the community organization that contracts them.

Poor organization and quality of services, including poor referral systems.
MOH is still in the process of restructuring the central level, and has yet to redefine the structure and functions of the regional health units, UTES, hospitals, and peripheral health facilities. Manuals of Organization and Functions (MOF) are required of each facility, but most have not updated theirs for many years. Operations are conducted under tight budgetary restrictions in response to specific production goals demanded by MOH national health programs Several pilot projects (i.e. PFSS, PSNB, and APRISABAC) have designed new models for health care networks, referral systems, and methodologies to improve quality of services, and have provided technical assistance to DISAs and health services personnel to develop new management and technical skills to support the changes in health facilities. These strengthened DISAs are still a small minority.

Poor access to secondary and tertiary level services for obstetrical emergencies.
Improvements in pregnancy-related morbidity and mortality of women and newborns is the major challenge to the health sector now that deaths due to infectious diseases of early childhood are coming under control. Maternal-perinatal health had no funding priority until late 2000 when an initiative called “Plan de Contingencia para la Reduccion de Mortalidad Materna” was launched as a major short-term campaign in all regions of the country with emphasis on those with highest maternal mortality rates. The campaign was effective in generating local planning processes and actions to improve resolutive capacity for obstetrical emergencies with central technical assistance to DISAs, interestingly coinciding with the political conjuncture of the first "vladi-video" and President Fujimori’s resignation from office, which provided MOH with political capital to launch such an expensive new initiative.

Improvements in resolutive capacity of primary care health facilities for obstetrical and other emergencies still requires substantial investment and solutions to difficult problems such as adequate blood-banking and surgical capabilities for operative obstetrics. Appropriate training of human resources to handle emergencies is also a major requirement now. Most importantly, improvements in quality of care and provider-client relationships are required to change the negative perceptions currently held by women toward health providers that prevent them from seeking care.

Little focus on behavioral change for prevention, or on community health.
Sustainable improvements in health and nutrition indicators will be more possible when MOH prioritizes prevention and organized systems of community health. IEC (information, education, and communication) strategies for behavioral change in health, nutrition, and sanitation have been

developed through projects such as PSNB, but have not been systematically financed and implemented by the health sector. A policy on community health for better outreach from health facilities and links with community organizations and community health agents is still lacking, resulting in reduced access of the neediest populations to information and services. Standardizing the expectations for work in communities, including educational/promotional content, direct services, information reporting requirements, and others, would assist health facilities in their local health planning.

For example, the large investment in SEG is not measured in the most commonly used health status and coverage indicators, which mainly refer to the population of women of fertile age and children under age five (or under age three). Nor does the SEG program provide data to demonstrate improvements in health status or practices of its target population. A major gap in the program is the lack of an educational component to improve health and nutrition knowledge and preventive behaviors among children and parents. Therefore, sustainable improvements in health or nutritional status could not be expected. Rather, the program serves more as an income transfer to families through subsidizing health care costs for the 85% of children nationally who attend public schools. It is regressive since it is non-targeted and covers non-poor families as well as poor and extremely poor families. The poorest of poor children, who are not enrolled in school, are not eligible for the benefits.

While SMI insurance scheme is still at an initial stage of operations in the poorest departments, projections to include the entire country suggest the potential to develop into another regressive financing scheme unless effective methods are developed to identify priority beneficiaries and market the services to the poor, and to charge co-payments to those who are able to pay.

Fragmentation of policy-making and regulatory functions

The problem of fragmentation has been especially acute for interventions in maternal and child health (due to the vertical programs), nutrition, and environmental health and sanitation, none of which has had a clear structure for policy or planning. There was no organized focus on nutrition and maternal-perinatal health since these do not fit into the vertical program framework, requiring an integrated and preventive life-cycle approach. This explains why the major problems still facing the health sector are maternal mortality and chronic malnutrition in children.

Box 2 -- Fragmentation of Food and Nutrition Programs

Within the MOH, nutrition has been fragmented among many different health programs. Central level DGSP vertical programs that include some aspect of nutrition are child growth and development, micronutrients, diarrheal disease control, school and adolescent health, and maternal-perinatal health. Since each has functioned independently, there has been no coordination of the nutrition components among them. The result has been lack of consistency and partiality in the delivery of nutrition messages to health facility clients. On a mass media level, integrated nutrition messages have only recently been promoted through limited-scope donor-funded projects working in selected regions. Recently, a nutrition division has been created in the DGSP, creating an expectation that most of this fragmentation will end.

Considering the role of other ministries in food assistance, competing food programs with combined budgets of over $300 million per year managed through FONCODES in MIPRE[3] and PRONAA[4] in PROMUDEH[5] and directly with Municipalities have created a highly inefficient

[3] Ministry of the Presidency
[4] *Programa Nacional de Asistencia Alimentaria*

system in terms of duplicative administrations and logistic systems, as well as duplications in beneficiaries, with families frequently receiving food from two or more programs simultaneously. These programs are seriously lacking of nutrition education components, reducing sustainability of impact. Neither are they monitored or evaluated on nutritional outcomes. In the past months, two large school feeding programs, one from FONCODES and the other from PROMUDEH, have been created

The Ministry of Health under the current transitional government is taking some extraordinary measures to begin to correct the fragmentation. In January of 2001, a Multisectoral Committee on Food and Nutrition was created by Supreme Decree No. , giving leadership to the MOH to coordinate all activities related to nutrition and food assistance among six Ministries (Health, Women and Human Development, Education, Agriculture, Fisheries, Presidency). Other actions taken have been the transfer of the FONCODES school breakfast program to the MOH/INS; and most recently the creation of a Technical Directorate of Nutrition within the DGSP.

Fragmentation of maternal and child health services have had repercussions on administrative efficiency (see page 4 of this report under Vertical Programs), and on the limited outcomes of health services delivery efforts due to a predominantly curative or service-delivery focus of each program, rather than an integrated educational/promotional approach to preventive health and nutrition.

In March 2001, a Ministerial Resolution was signed reorganizing the DGSP to three executive directorates: Integrated Health Care (Maternal and Child, Adolescent and Adult, Communicable Diseases, and Nutrition); Health Services (Basic Services, Specialized Services (hospitals) and Certification/Accreditation); and Health Services Management (Integrated Management, Capacity Development (training), and Promotion). Also, the main Office of General Administration of the MOH just had a change of its top leadership after more than 20 years with the same director. As of this writing, daily progress is being made in establishing new relationships among DGSP, PSBPT, OGP, and OGA. So dynamic is the situation that it is difficult to predict how far the changes will go before the nearly elected government takes office.

What is the evidence or feasibility that these changes at the central MOH will succeed in integrating and improving the delivery of health services? One could look at a few of the other changes that will be required at different levels. Many of these involve strengthening the DISA, which currently suffers from ambiguous accountability arrangements and performance problems.
(1) The programming and budgeting system will need to be revised. A mini-case study, below, on the SPP presents an assessment of the process, suggesting that the revision will be difficult due to the needs for MEF to change its budgeting system for the health sector, for PSBPT to relinquish programming of vertical health programs, and for changes in the system of transfers of entrusted vertical program funds to the DISAs, among other factors.
(2) DGSP personnel at the central MOH will need to assume a new role of governance, norms, and control, suggesting a high level of technical capability to determine best practices, organize and analyze epidemiologic data, identify information needs and ensuring implementation of necessary research and evaluation. Salary incentives will be necessary to attract appropriate personnel, and financing and funding mechanisms will be necessary for proper research and evaluation, preferably in coordination with the General Office of Epidemiology (OGE).
(3) OGE will need to expand its focus to include maternal-child health, nutrition, chronic diseases, and accidents from one predominantly oriented to infectious and communicable diseases.
(4) DISA level health program coordinators will either loose their jobs, or take on a broader integrated supervisory function, requiring retraining.

[5] Ministry of Women and Human Development (*Promocion de la Mujer y Desarrollo Humano*)

(5) DISAs will have to take on a new role of programming and budgeting their own activities based on local population size and needs. DISAs will need to develop skills (i.e. receive training and technical assistance) in local health diagnosis and planning, and will have to work with local health facilities to get the job done, much as CLAS are doing now on their own without much help from DISAs.
(6) DISA logistic systems will have to begin programming and budgeting their acquisitions, a task not undertaken by most DISA logistic offices. This need will to be reduced as more health facilities become CLAS and do their own local purchasing.

Box 3 - Mini-Case Study of the Programming and Budgeting System (SPP)

SPP was designed in 1997 to insert order into the fragmented budgeting process by creating a unique consolidated budget from all sources, based on a locally-designed health program that would consider local health situation analysis (epidemiology) and local prioritization of health needs. P2000 worked with OGP to develop the SPP. All 34 DISAs are now trained in the system and are using the SPP to begin programming for 2002, though it is still done in parallel to the old system, since OGP must still submit the old type of budget to MEF. This is due to the fact that a new programming system has never been discussed, much less a consensus reached, between MOH, MEF, and MIPRE (for the CTARs). Inexplicably, dialogue among the projects in MOH and MEF was discouraged by the MOH Office of Financing, Investments and External Cooperation (OFICE) which had direct responsibility for P2000, PSNB, and PFSS from 1994 to 2000.

Problems for SPP within MOH were due to the parallel budget systems of OGP and PSBPT, and the lack of a governing body within MOH that coordinates budgets from all sources. The OGP is technically responsible only for approving annual programming and budgets for 35 Budget Executing Units (UEs) in Lima/Callao, one of which is PSBPT. Each UE is independent in programming its budget, and receives funds directly from MEF, to which each reports directly. Ideally, the OGP should be the governing and normative body for all planning and budgeting in the health sector for the entire country, and should negotiate the needs of MOH with MEF. P2000 technical assistance to the OGP to develop the SPP and train all DISAs in its use was blocked within the MOH until a negotiated agreement was reached between USAID and OFICE. The OGP at first was reticent to receive technical assistance on the SPP due to tense relationships between all MOH offices and all donor projects, but eventually saw the usefulness of the system. PAAG was hesitant to join in on the SPP, perhaps because such a move would necessarily alter its own streamlined administrative and information system. Furthermore, the OGP has not been able to promote the SPP in higher spheres of the MOH, which would be required for a mandate to PAAG and for direct negotiation with MEF on changing the programming system. Within the current initiative of DGSP to restructure and streamline their division into a regulatory body for integrated health, primary level and hospital services, health promotion, training, quality of care, and health system management[6], the vertical structure of national health programs is now slated to disappear. Necessarily, the newly integrated approach to primary health care delivery requires a new "Functional Programmatic Structure", on which OGP programming and the MEF health sector budget is based. This new structure has been proposed by DGSP to OGP, which is reluctant to accept it since the SPP with its fully-developed software system would need to be replaced and all DISA personnel retrained.

[6] Resolucion Ministerial No. SA/DM. March, 2001.

3. Current Strategy For Decentralization of Health

3.1 Characteristics of the Program for Shared Administration and Local Health Administration Committees (CLAS)

Key assumptions and benefits of a public-private model.
The Shared Administration Program was established by law in April of 1994 to improve the quality of expenditure of public resources. It was designed on the notion that transferring public resources to the private sector for management would contribute to greater transparency, efficiency, and effectiveness of scarce resources in the provision of public health services. At that time, there was an implicit framework of a national decentralization policy and a positive experience in the education sector on which to justify the strategy. The characteristics that define this management model are:
(a) Decentralization of management through local decision-making capability and the horizontal relationship between the community and health facility.
(b) Community participation in the administration of all resources of the facility or group of facilities.
(c) Management of public resources under private law.
(d) Joint local health planning.

Tradition of community participation in the health sector.
Community participation has always existed in Peru, with many communities developing strong organizational traditions as a survival mechanism through many years of government indifference or incapacity to meet their needs. With the initiation of CLAS, a new form of participation was created to legally allow the community to share in the administration of public resources and exert effective social control over the quality of services.

CLAS management of public resources.
Application of private law to use of public resources increases the transparency and fluidity of expenditures and reporting. The community participates in the allocation, prioritization, and monitoring of use of public resources. Public administration operates within rigid line items in a vertical programming system. CLAS are able to use resources in a flexible manner to meet local needs, increasing the efficacy of resource use. Accounting systems used by CLAS are under private, not public, law. Resource management by CLAS Associations includes not only finances, but also participation in the management of human and material resources.

Joint local health planning.
The assignment of the planning function as a joint responsibility of health services and community is a unique experience in Latin American health reform efforts. The main assumption, and most would agree, is that the direct beneficiaries of services are best able to identify and prioritize their own problems in health and development. Another assumption is that health personnel working with communities have the knowledge and skills to guide the community health diagnosis and planning process, and mesh these with national health policy and norms. Despite the risks involved, the joint planning process improves chances that the health plan will be more appropriate to the true size and needs of the population under jurisdiction, and that those with least access to services will be incorporated into the plan, therefore contributing to improved efficacy and equity.

Human resources management under private law and social control over quality of services.
An important benefit of direct participation of civil society in CLAS is their direct control over the hiring and firing of contracted health personnel, who are subject to community control of their daily attendance at work, promptness, and provider-client relationships. Since CLAS members

technically have no jurisdiction over government employees, the frequent existence of a dual personnel system, of both privately-contracted CLAS employees and permanent government employees ("nombrados") in the same facility can create tension due to differences in productivity and other incentives.[7]

Financing for CLAS.
The government finances CLAS Associations in the following items: salaries of personnel contracted by CLAS based on the number and type of personnel required to implement the Local Health Plan, extension of daily working hours (from 6 to 12) for public health employees that work in CLAS facilities, social benefits (unemployment insurance, bi-annual bonuses, social security insurance, etc.) according to private labor law D.L. 728 for workers contracted by CLAS, goods and services accounting for up to 10% of the amount for salaries (used for basic services such as electricity, water, and telephone, plus gasoline, travel expenses for CLAS members, and other small expenses), and training (an amount transferred once per year to CLAS to organize events and management training). In comparative perspective, personnel contracted by CLAS and PSBPT receive higher remuneration than permanent MOH employees (*nombrados*). For physicians, nombrados receive gross pay of S/ 1800 nuevos soles per month for salary minus a percentage (about 12%) for social benefits under public law. CLAS and PSBPT physicians both receive a base net salary of S/ 1600 nuevos soles per month, but CLAS receive an additional 30% for social benefits under private law. In gross pay, CLAS contractors receive S/ 2080 per month, or 15.6% more than nombrados. PSBPT receive a higher cash payment than *nombrados*, but are under short-term contracts that provide no benefits and are technically unrecognized by law.

Basic rules for financial operations of CLAS.
- Resources are obtained from the Public Treasury disaggregated as: transfers from the central MOH, self-generated fees-for-service (including the reimbursements for School Health Insurance and the Maternal-Infant Insurance), donations, and contributions from community activities.
- All transfers are deposited in a commercial checking account that is administered by the CLAS manager and treasurer. All fees-for-services are retained and utilized by CLAS to finance the Local Health Plan.
- Payments are made by check for the following: salaries, recurrent and capital costs, contracted services, and withholdings for social benefits of personnel.
- All goods acquired by CLAS are donated to the DISA at the end of the year and are incorporated as government-owned property. CLAS continue to maintain the equipment with their own resources under the terms of their Shared Administration Contract, as well as on their own initiative to maintain good quality services for their community.
- CLAS present to the DISA a monthly sworn financial statement and progress report on implementation of the Local Health Plan.
- CLAS may change budget line items with the knowledge and consent of the DISA.

3.2 Conditions for Optimal Functioning of the CLAS Model

The main goals for optimizing the functioning of CLAS are to generate strong community participation and management capability, that are conditions found to develop over time through a maturation process. Program experience has shown three critical phases in the development of

[7] The Colegio Medico del Peru, the main professional organization of physicians, looks favorably on the CLAS model, but is currently promoting legislation to transfer the status of all contracted public-sector physicians to that of permanent government employees, with the rational that this will improve quality of care through prolonged provider-client relationships, less attrition of trained personnel, and greater institutional identification.

CLAS: initial conformation of the CLAS, initial generation of local capacities, and continued technical assistance and training.

Initial conformation of CLAS.
Several issues are of importance: (a) The territorial extension of a CLAS should not be very great in order to permit the proper social control and direct participation in the administration, and to provide better conditions for the proper management of a manageable number of health facilities and personnel. (b) Information must be disseminated in the community and health facility on the conceptual framework, regulations and norms, operational aspects, characteristics of the management model, and the roles and responsibilities of all the different actors in CLAS. (c) From the beginning, all potential actors should participate in the conformation process, including community members, local leaders, local health agents, institutions from other sectors, health personnel, and the DISA. (d) Representation of all communities within a jurisdiction should be ensured, again suggesting a smaller jurisdiction. If there are many communities, each may have an opportunity for representation through the required every two year rotation of the CLAS General Assembly.

Generation of local capacities.
Once constituted and inscribed in the Public Registry as a private non-private civil association, the elected and appointed CLAS members need to be provided information to progressively be involved in the administration of the health facility. (a) They must first receive **the Basic Course**, including information on: norms of the Shared Administration Program, basic rules governing civil associations (statues, rules, functions, requirements, annual plans), how to prepare and implement a community health census and local health plan, how to manage a rotating fund and other facets of the PACFARM[8] program. (b) **A community census and diagnosis** should be done by the CLAS manager[9] with technical assistance from the regional office of INEI and the DISA Office of Statistics and Information, in order for them to validate the data collection process. Costs for this activity should be solicited by the DISA from the national PAC Office. In practice, resources are rarely transferred to CLAS for this activity, causing difficulties with its implementation. (c) The Board of Directors of CLAS should prepare **an institutional annual work plan**, propose rules required by the statutes, open basic registers (of associates, for recording sessions of the General Assembly and of the Board of Directors), and sign a contract for administration of the pharmacy. (d) The DISA should provide technical assistance for the formulation of **a Local Health Plan and operational budget**. For this there should be a direct link with the DISA planning office, but current practice depends on the voluntary will of the DISA and other competing priorities of the DISA Integrated Management Committee.[10]

Continued technical assistance and training.
This should be a fundamental role of the DISA as a decentralized management function. DISAs require (but continue to lack) a clear orientation from the central MOH as to the level of priority of the Shared Administration Program. DISAs vary in their level of knowledge of the CLAS model and in their commitment to its promotion and support. The Shared Administration contract signed between the DISA and CLAS should specify not only the obligations of CLAS to oversee the

[8] PACFARM is the Shared Administration Program for Pharmacy, which functions in every public health facility on a nationwide basis with required purchasing through the MOH DIGEMID (Direccion General de Medicamentos, Insumos y Drogas).
[9] The CLAS manager is the chief physician (usually) of the health facility that serves as the legal home of the CLAS.
[10] All DISAs now have a *Comite Integrado de Gestion* (CIG), though their technical capabilities vary from DISA to DISA.

implementation of the Local Health Plan, but should also specify the obligations of the DISA to provide continual technical support to the CLAS.

3.3 Assessment of the Current Situation for the Shared Administration Program

CLAS actually cost the government somewhat more than a non-CLAS primary care facility due to the private-sector nature of personal contracts. The additional personnel benefits are an important incentive that, combined with the community participation, results in improved use of public resources through improved productivity, wider population coverage, and more equitable delivery of services. The issue of improved equity is possibly the greatest benefit, as improvements in health indicators of the whole country will occur to the degree that health improves for the most disadvantaged sectors of the population. The following table summarizes the incentives available in the CLAS model as compared to non-CLAS. Table 6 makes clear the importance of decisions in the DISA regarding financial stability of CLAS.

Table 6
Types of Incentives for CLAS and non-CLAS

AREA	CLAS	Non-CLAS
Personnel salaries and management	+: Net take-home pay is higher than *nombrados**, and gross pay is 15.6% higher due to more social benefits. +: CLAS hires and fires personnel. +: Contracts are longer-term for better continuity of care with population.	+/--: PSBPT take-home pay is higher than *nombrados*, but gross pay is lower since short-term contracts include no social benefits. --: PSBPT are short-term. Lack of continuity of care for population.
Use of FFS	+: Decisions on use made by CLAS for 100% of the amount.	--: All FFS are deposited in an account managed by the DISA.
Operational costs (rent and utilities)	+: Paid by DISA as 10% of the amount transferred for CLAS personnel contracts. --: Amount is low when more *nombrados* work in facility. Balance paid from FFS.	+: Paid by DISA from budget and partially from deposited FFS.
Investments (maintenance, equip-ment, infrastructure)	+: Decided by CLAS using FFS.	--: Little implementation. Funds from donor-projects when available.
National Health Programs	--: Some DISAs send few supplies to cover program needs. Balance purchased by CLAS from FFS.	DISAs send supplies to cover all program needs according to goals.
Benefits for DISA	+: Better results to report. --: DISA does not control FFS directly (though some DISAs do indirectly by manipulating other amounts transferred to CLAS)	DISA keeps up to 80% of income collected in health facilities – used for DISA *nombrados* and expenses. Varies by DISA.

**Nombrados* = permanent government employees.
** FFS = fee-for-service.

A budget cut from MEF in mid-2000, in the amount of the bi-annual bonuses paid to CLAS contract personnel, produced a series of financial problems for the Shared Administration Program. While the MOH has adjusted budgets to eventually pay the bonuses, there was a rupture in legal obligations of the public sector to honor current private-sector labor laws. The end result has been the reduction of the amount provided to CLAS for goods and services, as well as a series of legal and policy implications, and problems for service provision, community participation, and the

health team. This budget cut showed that the Shared Administration Program is not a "protected" program, and is as vulnerable to budget unpredictability as much as, if not more than the rest of the public sector. From a legal stance, there could be legal action by contractors toward their employer (CLAS) claiming their rights to benefits, and by CLAS Associations toward DISAs for non-compliance with the Shared Administration contract. From a policy stance, this represents a regression in human resources policy, and distorts the CLAS service-delivery model for primary care. If this situation continues, CLAS could have to reduce their levels of exonerations to indigent patients in order to cover operating costs, causing declines in equity, and prioritization of curative services (that could be charged for) over preventive and promotional services that are free to patients. While non-CLAS facilities are also supposed to provide preventive and promotional services, PSBPT personnel have more incentives to provide curative services to complete their production quotas. For the team of health providers, the CLAS budget cut represents a rupture in organizational culture due to possible conflicts between the contracted workers and CLAS.

Continued reduction in the budget will remove an important incentive for CLAS, which will no longer have minimum resources to improve services and quality of care through investments in infrastructure, furnishings, equipment, and maintenance. All of their self-earned income will have to go to paying for basic operational costs which were previously covered by transfers from the DISA under the Shared Administration contract. In a non-CLAS, self-earned income is automatically sent to the DISA which decides on how the money is to be used. It is uncommon for non-CLAS to obtain resources for maintenance or replacement of equipment or infrastructure.

Table 7
Effect of Budget Cuts to CLAS in October 2000 -
Illustration from North Lima

	Year 2000		Year 2001
	July-Sept.	**Oct.-Dec.**	**Jan.-Mar.**
Transferred from MOH for salaries	S/ 49,203	49,203	49,203
Transferred from MOH for goods/services	S/ 2,316	0	0
FFS income (nuevos soles)	S/ 19,044	23,094	22,950
FFS income as a % of the total	37.0%	46.9%	46.6%
N° general medical consultations	1,951	2,114	1,782
N° specialized medical consultations	196	295	273
N° promotion-preventive activities (PPA)	**6,013**	**4,375**	**1,615**
N° exonerations	**230**	**142**	**184**
% change in general consultations	-	+8.4%	-15.7%
% change in PPA	-	-27.3%	-63.1%
% change in exonerations	-	-38.3%	+29.6%
Income from laboratory (nuevos soles)	S/ 1,548	1,646	1,974
Cost of each consultation (nuevos soles)	S/ 3	S/ 4	S/ 4

*FFS = fee-for-service.
Source: CLAS Confraternidad, Health Center Juan Pablo II, North Lima.

Table 7 illustrates the effects on a CLAS Association in North Lima due to an across-the-board budget cut in goods and services in October 2000. Although the CLAS appears to be financially stable in an urban environment of a non-extreme level of poverty, the facility lives on the edge of financial viability. As a result of the budget cut, and to meet its financial needs, this CLAS was forced to increase income by raising the fees for consultation and laboratory tests, in turn affecting the demand for services (both general and specialty consultations). Preventive-promotional activities, that do not generate income, were reduced by 27%. Exonerations were reduced

drastically in the short-term with a partial recovery by the first quarter of 2001, which was compensated by a continued reduction in the number of preventive-promotional activities. The ability of CLAS to make local decisions provides the ability to ride out financial crises. However, the consequences can be detrimental especially for the preventive-promotional role of CLAS, and in the medium and long-term on service delivery.

The lesson learned from this recent experience is to confirm past warnings that the Shared Administration Program should not be relied on as a means of creating economic sustainability (or independence) of public health facilities, to thus reduce the need for government expenditures in health care (Altobelli, 1998a). In order for co-managed facilities to function, there is a need for commitment on the part of the government in maintaining at least minimum funding levels, without which the contract between the government and the community cannot be fulfilled. The "profit margin" of a CLAS is usually so small, and investment needs are usually so great, that the entry of a CLAS into a system of cross-subsidies as a subsidizer would require a long start-up period of years to reach equilibrium with demand for services.

CLAS as a model for urban areas.
More clients can afford to pay fee-for-services; fewer families require exonerations. A higher level of formal education provides a pool of community members with management skills resulting in improved management and accounting. Many of these are retired school teachers or other professionals. 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. Eventually, a CLAS-run health center or post attracts clients who previously used public hospital out-patient clinics or commercial pharmacies, as shown in analysis of national survey data (Altobelli, 1998b).

CLAS development of more advanced health services, such as specialized clinical and laboratory services.
These are frequently highly desired by the community, since the public sector does not provide these types of services except in hospitals, and patients are forced to pay commercial prices anyway by a private provider if the public sector physician orders a lab test. When CLAS provides these services, they are providing an additional service to the community, improving the quality of care, allowing patients to obtain needed tests conveniently and at reasonable cost. One could question whether this type of CLAS development would result in less attention to community health promotion and prevention. Experience has been that as a result of satisfying community demand for good quality curative care, CLAS have gained credibility and leadership to more effectively work in the community. Also, with more clients visiting the facility, more are reached directly with promotional and preventive services.

CLAS as a model for non-poor urban areas.
Given that CLAS has proven to be a good model for poor periurban areas that have strong community organization and social capital, the question is how well will CLAS work in less-poor urban areas where people are better off, more independent, and social capital is not strong. Nearly all communities, even in denser and more developed urban areas, have social organizations such as school parent-teacher associations, Lions Club, associations of commerce and business, citizens committees on different issues, and others. Assuming that a population is present that is otherwise uninsured and needing of government health services, such a health center run by CLAS could eventually build itself up to well serve health needs in its jurisdiction, improving the preventive and promotional role that it should play in the community. If the community is composed largely of insured persons, then the MOH should possible consider closing the facility and assigning the few uninsured to a different public facility.

CLAS as a model for rural areas. Rural CLAS face a different set of circumstances. The population is generally poorer and less educated than the periurban population. Greater indigence reduces capacity to self-generate income from charging fees-for-services. Government subsidy is needed for investments to develop quality services. Community members of CLAS need more technical assistance and training to fully perform their assigned functions. Once empowered, rural CLAS can play an important role in community development, soliciting and coordinating resources from other sectors for multisectoral development.

Needs for strengthening DISA capabilities to support CLAS

Many of the problems experienced with the CLAS model have as the main sources the manner in which the DISA manages the CLAS. DISA management decisions determine to a large degree the financial soundness of each CLAS. When DISA support the CLAS model and are concerned with improving service delivery, the CLAS financing model works well. Despite norms and regulations, DISAs are able to manipulate financial accounts to their own benefit to the disadvantage of the CLAS model. For example, some DISAs have claimed CLAS to be "non-public sector" entities that have self-generated income from patient fees, and as a result would not send CLAS their assigned budget for goods and services to cover utility bills and other operating costs. Some DISAs are accustomed to keeping up to 80% of FSS deposited by non-CLAS for distribution among "*nombrados"* in the DISA. For these and other reasons, any decentralization strategy will need to implement major changes in the functions of the DISA and strengthening of administrative control over the DISA by the central level. A proposed solution is to remove control of FFS from the DISA and give it to an independent financial operating unit at the regional or network management level. This action would require that the DISA be reorganized to accommodate fewer financial management functions and to take on a larger role in strategic planning and technical assistance, supervision, monitoring and evaluation of their management agreements or contracts and/or Shared Administration contracts with hospitals, centers, and posts, and perhaps in the future, with district municipalities. DISAs also need to be properly financed to carry out the latter functions.

3.4 Results From CLAS

Coverage and rate of growth.

Since inception in 1994, the Shared Administration Program has grown from coverage of 7% of the population under MOH services to now well over one third of that population, as shown on Table 8. The program grew between 1994 and 1996, at which time there was a freeze on new funding through 1998. In January of 1999, a renewed program expansion began under the mode of aggregate CLAS, which grouped together a number of health facilities under the administration of one CLAS. The aggregation process was responsible for the decline in overall number of CLAS and increased number of health facilities under CLAS management between 1999 and 2000.

Table 8
Expansion of CLAS Management Model 1994-2001

	1994*	1995	1996**	1997	1998	1999	2000	2001
Total n° health centers/posts								(Goal)
MOH	3784	5529	5790				6200	
National	4162		6717			6667****		
N° inhabitants in jurisdiction of all centers/ posts***	13,878,000	14,119,000	14,368,000			15,139,000	15,397,000	
N° of CLAS	133	435	548	548	548	529	482	686
N° of centers/ posts under CLAS model	133	435	611	611	637	985	1242	1820
N° inhabitants in jurisdiction of CLAS	958,473	3,012,403	3,200,000	3,200,000	4,000,000	5,000,000		
% of population in jurisdiction of CLAS	6.9%	21.3%	22.3%			33%		

Source: PAAG, based on Shared Administration Program data.
* Data from CISRESSA 1992.
** Data from CISRESSA 1996.
*** Estimated population is 60% of the projection by the National Institute of Statistics (INEI).
**** Information provided by the MOH Office of Statistics and Information (OEI).

Evidence of access and equity.
A national evaluation of CLAS in 1998-99 provides data on which to assess access, equity, and quality in relation to other non-CLAS health facilities. It was conducted on a sample of eight DISAs from seven distinct geographic regions of Peru, and within those a random sample of 61 CLAS and 122 non-CLAS. A random sample of 2,088 (749 CLAS and 1,271 non-CLAS) clients were given exit interviews.

Results in Table 9 show that economic barriers to health care are lower in facilities under the CLAS model of management. Medicines are more accessible to patients in CLAS especially in rural areas. Patients under age five and 6 to 20 years of age have equal access to medicines in all health facilities through national health programs that target children under age five (i.e. provision of free medicines for diarrheal and respiratory diseases) and through the School Health Insurance Program. Adults and the elderly are significantly more likely to be able to purchase medicines in CLAS facilities. CLAS are able to apply a more rational and fair policy of exonerations than non-CLAS. All clients, rich and poor, in urban and periurban areas are given approximately the same level of exoneration. In rural areas, CLAS give more exonerations to the poor (72.5% in CLAS versus 66.4% in non-CLAS), while non-CLAS give more exonerations to the non-poor (80.4% in non-CLAS versus 56.8% in CLAS).

Table 9
Economic Access and Equity in
CLAS versus non-CLAS Primary Health Facilities

		CLAS (%)	Non-CLAS (%)
% OF PATIENTS UNABLE TO PURCHASE MEDICINES			
Location of Facility	Urban	5.0	11.3
	Periurban	10.4	13.7
	Rural	12.3	18.6
Type of Facility	Health center	10.5	14.5
	Health post	11.8	17.1
Age of Patient in Years	< 5	16.1	16.6
	6-20	3.8	4.3
	21-49	14.7	24.1
	> 50	10.0	30.0
% OF PATIENTS EXONERATED FROM FEE-FOR-SERVICE			
Urban and Periurban socioeconomic strata	Higher strata (A and B)	63.9	60.3
	Lower strata (C and D)	60.3	66.1
Rural socioeconomic strata	Higher strata (A and B)	56.8	80.4
	Lower strata (C and D)	72.5	66.4
N =		**749**	**1,271**

Adapted from source: Vicuña M et al (1999) Lima, Peru: Ministry of Health-PAAG-SBPT-AC.

A national population survey provided another source of information on CLAS when sampling clusters were matched with districts and population centers with CLAS facilities. Table 10 shows the results of patient consultations in health centers or posts by quintile of per capita expenditure. CLAS provided significantly more full and partial exoneration (S/ 2 nuevos soles or less) than non-CLAS for all quintiles combined, and especially for the lowest quintile.

Table 10
Equity in Consultation Fees
In MOH Primary Care Facilities by Quintile of Per Capita Expenditure

	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
URBAN AREAS OUTSIDE OF LIMA/CALLAO												
Free of charge	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 – 5.0	54.6	33.3	50.0	23.4	62.8	27.8	74.9	27.0	70.0	29.7	61.6	27.6
S/. 5.1 +	13.8	0	13.5	43.3	7.1	2.4	4.0	19.0	6.8	0	8.8	11.6
TOTAL	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
RURAL AREAS												
Free of charge	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	100	35.0	46.2
S/. 2.1 – 5.0	29.7	12.2	37.3	24.2	61.3	35.3	42.9	61.6	60	0	37.0	24.8
S/. 5.1 +	1.3	0	6.3	4.2	0	9.5	4.9	0	0	0	2.5	2.3
TOTAL	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

Source: Altobelli L. (1998) UNICEF. Lima, Peru. (Data from ENNIV 97, Cuánto, S.A.)

4. Assessment of Options for Decentralization of Health

Other countries in the Latin American region that have implemented health reform in recent years, such as Chile, Colombia, and Bolivia, have done so with a major overhaul of their entire systems. It is important to recognize that health reform does not necessarily require such drastic changes, and above all, that reforms in health systems should result in greater, and not less, equity and efficiency in the delivery of health services. Health reform has been defined as a process of "sustained, purposeful and fundamental change" – "sustained" in the sense that that the effort will endure, and not be a one-shot effort of non-implemented legislation; "purposeful" in the sense of being evidence-based, planned, and rational; and "fundamental" in the sense of addressing the major processes and outcomes of health care systems (Berman, 1995). These major processes and outcomes have been usefully described as "control knobs" that can be established, set or adjusted as the major foci of a health reform process, and include the control knobs of financing, payment, organization, regulation, and consumer behavior (Hsiao, 2000).

It is useful to characterize health reform by distinguishing the more strategic and fundamental programs of system change from those that are more limited, partial, or incremental. The former have been referred to as "big R" reforms and the latter as "little R" reforms; the former involving at least two or more control knobs in programs that affect a substantial part of the health care system, and the "little R" reforms addressing only one control knob with a more limited scope of change (Berman and Bossert, 2000). For example, a new or expanded system of national health insurance could qualify as a "big R" reform, since important changes would be required in financing, regulation, and possibly organization of health care delivery. A "little R" reform could be the granting of autonomy to hospitals, or the implantation of the Shared Administration Program on a small pilot-project scale. Berman and Bossert (2000) suggest that while a "big R" reform may involve the implementation of many "little R" activities, it is the broad systemic package that makes a "big R" implementation more than the sum of its "little R" parts. What is important is that the components of the reform are clearly articulated so that major actors responsible for implementing the change can: specify goals and objectives, acknowledge the relationship of their activities to achieving the goals of reform, and the purposeful linkage among different components of system change (Berman and Bossert, 2000).

Decentralization of health can be a "big R" reform if it involves complete reassignment of responsibilities in financing, payment, organization, and regulation; or it can be a "smaller R" reform if it involves decentralization of specific functions in an incremental process.

Proposals for decentralization within health reform should be assessed as to whether the decentralization process would fulfill the central objectives of health reform (Bossert, 1997). These objectives are generally considered to be those of improving equity (including universal coverage, access and solidarity), efficiency, quality and financial soundness (Berman, 1995). Most of these are the objectives of the Peruvian MOH, "efficiency, quality, and equity", as delineated in the document *Peru: Lineamientos de la Politica de Salud 1995-2000.*

Bossert provides some useful recommendations for approaches to analyze the potential effectiveness of different decentralization models in health. The most relevant is the principal-agent model, with assessment of decision space and innovation. This approach assumes that a central agency (the principal) will decentralize functions to a more peripheral agency (the agent). The true degree of decentralization is determined by the degree of decision space (or amount of decision-making authority) that is given to the agent. Decision space will determine the amount of innovation that is practiced by the agent to enhance efficacy, efficiency, quality, equity, and financial soundness of the local health services.

Due to the paucity of studies and evaluations of national and regional hospital services and financing, the current discussion does not involve that level. Rather, it is recommended that a series of major studies be undertaken on pubic hospital financing and functioning to determine what laws and regulations are needed for potential autonomy of hospitals under management agreements with DISAs that will ensure a minimum proportion of exonerations to poor patients.

4.1 Option of Decentralization of Health Services to CLAS and Health Promotion to Municipalities

CLAS and decentralization of decision space.
Can the Shared Administration Program be characterized within the framework of state decentralization in Peru? The CLAS model represents a new form of decentralized health financing that is uncommon to most Latin American experiences in health decentralization: public resources are transferred to the private sector (a private non-profit association) in communities, and most planning and spending decisions are made at the community level. A Shared Administration contract between the DISA and CLAS is based on commitments on the part of CLAS to ensure completion of an annual Local Health Plan (LHP) and on the part of the DISA to finance the plan.

Table 11
Map of Decision Space For CLAS

Functions	Range of Choice		
	Narrow	Moderate	Wide
Finance			
Sources of revenue			***
Allocation of expenditures		***	
Income from fees			***
Service Organization			
Hospital autonomy	Not applicable		
Insurance plans	Defined by MOH		
Payment mechanisms	Defined by MOH		
Contracts with private providers			***
Required programs and norms		***	
Vertical program, supplies and logistics	***		
Human Resources			
Salaries		Expansion of hours	Could determine increases
Contracts			***
Civil service	Hiring/firing restrictions		
Access rules			
Targeting			***
Governance rules			
Local accountability			***
Facility boards	Defined by MOH		
Health offices	Defined by MOH		
Community participa-tion			***
Total Decision Space	**7**	**3**	**7**

Using the decision space framework of Bossert (1997), there is a high level of decision transferred to CLAS, with local decisions on health planning (prioritization of services according to health needs of the population), financial management (tariffs, exonerations, investments), human resources management (personnel mix, hiring and firing of personnel, quality control), and other operational aspects of the health facility, within the scope of MOH guidelines and procedures. The decision space for CLAS is illustrated in Table 11, showing a relatively high number of functions in which there is moderate or wide range of choice within a CLAS.

Strengthening the delivery of preventive and curative services in the community.
A proposal presented here provides an outline of a means by which to strengthen the delivery of health services and promotion, building on the model of CLAS and incorporating the participation of district municipalities in health actions to promote behavioral change, improve environmental conditions, further increase health care coverage, and thus achieve a better impact on health outcomes. This option involves strengthening capacities in DISAs, municipalities, and health services that could be viewed as an interim step to a future devolution of greater fiscal responsibilities from the health sector to the municipal level. The proposal differentiates: (1) patient care (individual health) by 'privatization' of health services through transfers to private entities, CLAS Associations, on the basis of "shared management contracts", and (2) preventive-promotional public services (collective health) through devolution of collective health functions from the public sub-sector of health to local governments, municipalities, at the district level through a management agreement (*acuerdo de gestion)*.

The idea has existed that health facilities should concentrate on individual health (i.e. curative care), while collective health should be left to national and regional levels. The proposal here is to bring the responsibility for collective health down to the municipal level. This model takes advantage of many of the current legal responsibilities of the municipality in health that are ineffectively implemented because: (1) they do not fit into an overall strategic objective (i.e. improving health status, improving health behaviors, reducing deaths due to accidents, reducing environmentally caused illnesses, etc.), (2) their importance is not perceived, (3) other incentives exist for not enforcing control functions over local industry or commerce (i.e. kickbacks for ignoring pollution regulations) or other types of non-compliance, or (4) there is a simple lack of funds (non-funded mandates).

Current role of municipalities in health and nutrition.
The largest role currently played by municipalities in the field of health and nutrition is implementation of the Vaso de Leche program, with transfers of approximately $125 million per year from MEF to local municipalities. The latter are responsible for purchasing and distributing food supplies to voluntary committees in every community. One of the greatest benefits of the program has been the organization of women's groups, called *Comités de Vaso de Leche*, that serve many objectives.[11] *Vaso de Leche* committees provide a superb opportunity for reaching mothers with educational messages in their monthly meetings to receive rations. The nutritional content of *Vaso de Leche* rations are not regulated or standardized, and are unevaluated. Many municipalities purchase a "non-milk milk product" and cereal(s) that is distributed on a periodic basis to each local committee, prepared daily in a central community location (sometimes out-of-doors over an open fire) from where beneficiaries pick up the rations due them. Rations are given to pregnant women and all children up to age 13. The only reporting system in place on this program is the amount of money transferred to each municipality. No information exists on the number of beneficiaries,

[11] For example, in the presidential election of 2000, the government utilized the *Vaso de Leche* network to coerce massive attendance of women at political rallies.

number of rations, or other qualitative data. Box 4 lists the legal responsibilities of municipal governments.

Box 4 - Municipal Functions in Population, Health, and Environmental Sanitation

The functions of municipalities in matters of population, health, and environmental sanitation in accordance with Article 66 of the Ley Orgánica de Municipalidades Ley No. 23853 (1984) are the following:

1. Regulate and control activities related to environmental sanitation.
2. Disseminate programs of environmental education.
3. Regulate and control the cleanliness and hygiene of commercial and industrial facilities, housing, schools, swimming pools, beaches, and other public places.
4. Initiate campaigns for forestation and reforestation.
5. Install and maintain public toilets and baths.
6. Promote and organize actions for preventive medicine, first aid, and medical posts.
7. Construct and equip medical posts, medicine kits, and first aid stands.
8. Implement local programs of health prevention and education
9. Implement rural sanitation campaigns and control of epidemics.
10. Establish control mechanisms for noise control of traffic and public transport.
11. Organize civil registries (births and deaths), maintaining relevant statistics according to legislation on the matter.
12. Implement public waste-removal service, locating areas for garbage accumulation and/or industrial waste removal.
13. Control animal health.

Despite the legal role given to municipalities in health, the amount of emphasis placed on health activities depends to a large degree on the discretion of the district mayor, as well as municipal capacity to collect fees and taxes to cover costs. Visits to several municipalities for this study revealed a variety of roles played by them in health, as shown in the mini-case study from Chiclayo (see Box 5). As another example, the highly urbanized municipality of Los Olivos in North Lima has a mayor who, as a physician, is very interested in health. He has approached the issue by building the shell of a four-story multiple service maternity hospital from municipal income, expecting to make it self-sustainable from charging patient fees which he hoped to keep as low as $1 per visit. The mayor wished to obtain the hospital finishings and equipment from an international donation, still to be identified, and did not yet have a financial plan for personnel or logistics management or administration. This investment of municipal funds in high-cost curative care is exactly the opposite of the priorities of the municipal role in health, according to the provisions of the *Ley Organica de Municipalidades*.

Box 5 – Mini-Case Study of the Municipal Role in Health, Chiclayo, Lambayeque

The district of Jose Leonardo Ortiz is the second largest in Peru, covering a population of 342,000 inhabitants in periurban Chiclayo, many of whom are migrants. The district has 3 urbanizations and 58 *pueblos jovenes*, with 54 neighborhood committees, 24 mothers clubs, and 116 Vaso de Leche committees. Municipal agents, who represent the municipality in each *pueblo joven*, should notify the municipality of any local problems in her/his jurisdiction, including health problems such as epidemics. The office of *Participacion Vecinal* within the municipality works on a number of issues with largest MOH health center in the district. For example, during the El Nino phenomenon, health personnel trained municipal agents to teach community groups about hygiene. The municipality also oversees marketplace hygiene; for instance, helping to control an outbreak of dengue that was transmitted through food produce shipped in from an endemic area in

northern Peru. Technical assistance is received from NGOs, such as the German-funded *Programa Integral de Seguridad Alimentaria* (PISA) which trains municipalities and health centers how to educate community leaders (municipal agents, coordinators of *Vaso de Leche* committees, and leaders of mothers' clubs), providing training manuals and materials. PISA is also assisting the municipality with a new project to develop micro-enterprises for garbage collection in poor periurban areas, based on a study by the same group showing that two workers can remove trash for 1000 families at the cost of .57 US cents per month. After one year, the micro-enterprises will be turned over to the municipality for administration. Municipal planning personnel claim that planning is done on the basis of requests from citizens or institutions. They administer in a reactive, not proactive, manner and lack resources for implementation. They seek a greater role in health through organizing with community-based organizations and supervising, but do not want to manage financing, except to cover their operational expenses to carry out activities. At the same time, they expressed the idea of charging a per capita fee to use towards health activities.

Role of district municipalities with CLAS.

In order to better understand the variety of relationships that exist between municipalities and CLAS, a survey of DISAs and a follow-up telephone survey of CLAS was conducted by PAAG-SBPT-AC of the Ministry of Health at the request of the author. A general impression of the ways in which district municipalities collaborate with MOH health facilities managed by CLAS Associations is found in Table 12. Of 482 CLAS Associations, 237 or 49% of them benefited from one or more types of collaboration with the district municipality. The most frequent type of assistance provided to CLAS by municipalities is related to the implementation of health prevention campaigns in the community, suggesting that municipalities do take seriously their role in health prevention and promotion. The second most frequent type of support to CLAS is for infrastructure improvements and donation of land. DISAs in which a high proportion of CLAS received support from municipalities were: Tacna, San Martin, Puno, La Libertad, Piura I, Piura II, Huancavelica, and Ayacucho. Considering the varying levels of DISA support provided to CLAS in the different health departments of the country, one could surmise that the frequency of municipal support to CLAS is associated in some way with the level of DISA support to CLAS, being higher than average in most the DISAs just mentioned.

Table 12
Types of Assistance Provided to CLAS by District Municipalities

Type of Assistance	N° of CLAS
Vehicle support for community health prevention campaigns	115
Maintenance, amplification or remodeling of infrastructure for health services	69
Gasoline contributed for community health prevention campaigns	36
Food/snacks for health personnel during community health prevention campaigns	18
Donation of land for construction of the health facility	15
Support for activities in water and sanitation	14
Salary payment for clinical health personnel	13
Loan of physical facility for meetings	13
Municipal personnel serve in leadership posts in CLAS	8
Salary payment for administrative personnel	7
Support for vehicle maintenance costs for health center vehicles	3
Participation in community meetings	1
Support in provision of medicines	1
Support for purchase of cleaning materials	1

Prepared through collaboration of PAAG-SBPT-AC of the Ministry of Health, Peru.

Proposed involvement of municipalities in decentralized health promotion

A municipal health promotion plan would be the basis for a management contract between the DISA and district municipality. The plan could follow a general template with specific monitoring and evaluation indicators for a "Health Community – Healthy People", though with specific activities would be designed by the municipality. The municipality would receive funds from the DISA on the basis of the plan. The contract would be renewable annually based on completion of the municipal health promotion plan. The DISA would award prize incentives for municipalities that achieve specified benchmarks on their indicators of "Healthy Community – Health People". Incentives would include provision of technical assistance from the DISA. Actions needed for implementation of this strategy at each level include:

a. Role of the Central MOH

- Enhance and clarify the leadership role played by the central MOH to set priorities and define functions by level of government for the health sector with an orientation to strengthening the efficacy, equity, and quality of health services and a sectoral commitment to preventive health promotion.
- Improve streamlining of the programming and budgeting system to rely more on local programming and budgeting, and not on top-down estimates of needs based on national programs and estimated populations.
- Conduct a functional analysis to define DISA functions and responsibilities in relation to municipalities and CLAS, and provide them with technical assistance to reorganize the DISA to carry out these functions.
- Create management contracts between the central and regional levels of the MOH, requiring health status results and improvements in organizational structure of the DISA, providing training, technical assistance, increased funding from the central level as incentives for action and change.
- Provide funding for DISAs to be able to carry out supervisory and other control and technical assistance functions in relation to municipalities and CLAS (i.e. vehicles, gasoline, maintenance, per diem).
- Develop a medium-term plan for streamlining the fragmented financing system for health budgets to account for the increasing incorporation of health facilities as CLAS Associations.
- Standardize operating procedures (basic guaranteed plan, protocols, supplies, technical capacity of human resources, quality of care, network management, etc.);
- Direct global health policy (priorities, health norms and standards);
- Oversee implementation of health policy and services, oriented to results;
- Coordinate with other sectors at the highest level; and
- Promote technological development and capacity building.

b. Role of DISA

- (Possibly) Remove the financing function from DISAs, passing it to an independent financing entity that is audited by the DISA and (preferably elected) regional government.
- Provide funding for DISAs to be able to carry out supervisory and other control and technical assistance functions in relation to municipalities and CLAS (i.e. vehicles, gasoline, maintenance, per diem).
- Strengthen the DISA governing and control/auditory role through Shared Administration contracts with CLAS, and "Healthy Community – Healthy People" Partnership contracts with municipalities, as well as management agreements with public hospitals.
- Provide technical assistance to health facilities and CLAS Associations on how to - organize effective health services, conduct community health assessments, do strategic and operational

planning, ensure quality of care, evaluate process and outcome indicators, facilitate community participation, manage legal aspects of private contracting and financial management, etc.
- Prepare and sign Shared Administration contracts with CLAS Associations.
- Supervise and coordinate health services production, ensuring completion of goals on quality standards and health outcomes as specified in the Shared Administration contracts.
- Oversee the use of financial and material resources for health services delivery and take corrective action when necessary.
- Provide technical assistance and training to district municipalities on health promotion planning, financing, organization, implementation, monitoring and evaluation.
- Sign "Healthy Community – Healthy People" management contracts with each municipality, etc.

c. Role of Municipalities

- Prepare Local Development Plans to achieve and maintain status of "Healthy Communities – Healthy People" for individual communities within the district, indicating multiple sources of financing for various activities. A healthy sense of competition to attain this status should develop between communities through incentive awards provided by the DISA, and announcements in the mass media.
- "Healthy Community – Healthy People" Partnership contracts with DISAs will provide municipalities with some financing to conduct activities in health promotion. Other funds will be raised by the municipality from other sources, i.e. taxes, other sectors.
- Municipalities will receive encouragement and technical assistance, if required, to form *Mesas de Concertación* or "Local Health Councils" with local public and private institutions, NGOs, universities, community leaders, and others, to participate in the planning, monitoring, and implementation of the "Healthy Communities – Healthy People" initiative.
- Assist the chief physician to coordinate the election of community representatives to the CLAS Association.
- Conduct and continually update a health and economic census of the population in its jurisdiction and identify those qualifying for state subsidy.
- Prepare and implement a Local Development Plan to carry out functions under Article 66 of the Organic Law of Municipalities No. 23853.
- Sign "Healthy Community – Healthy People" management contracts with the DISA.
- Work with CLAS to organize and supervise community health promotion activities, etc..

d. Role of health personnel in health centers and posts

- Continually assess the health status and perceived health needs of its population.
- Do operational planning for health activities, coordination and use of health resources.
- Organize health services for the most effective, opportune and economic delivery of the Guaranteed Plan.
- Report on health activities and results to the central and regional MOH.
- Coordinate health promotion activities with municipalities, as per the Local Development Plan, etc.

e. Role of CLAS Associations

- Assist with assessment of the health status and perceived health needs of its population.
- Assist with strategic and operational planning for health activities.
- Ensure that health services are organized for the most effective, opportune and economic delivery of the Guaranteed Plan.

- Approve the hiring and fire health facility director and personnel using technical criteria.
- Receive, assess and transmit community complaints and opinions to the health service.
- Supervise the performance of and resource use by health facilities in their jurisdiction.
- Coordinate the participation of community members in solution of health problems.
- Approve the yearly report on health activities.
- Hold title to the health facility.

Key assumptions for health care contracts between DISAs and CLAS

- Creation of a *Regional Technical Units for Decentralization* to guide the process.
- Maintenance of laws and regulations regarding Shared Administration Program.
- Per capita financing to reduce inequities, emphasis on curative care, and over-utilization.
- Macro-allocation of funds among DISAs by the MOH done on equity considerations.
- Continuation of multiple sources of financing through DISA as filter and sole financier for non-CLAS providers until switch over to CLAS.

Key assumptions for health promotion contracts between DISA and municipality

- Creation of a *Regional Technical Units for Decentralization* to guide the process.
- Formation of a *Municipal Health Promotion Office* in each municipality with defined structure and functions, approved by the MOH. Associations of Municipalities could be formed if too small individually to establish a municipal health promotion office.
- Preparation by each municipality of a *Local Development Plan for Health, Population, and Environmental Sanitation* to carry out the functions assigned to them in Article 66 of the Organic Law of Municipalities No. 23853.
- Management contracts signed between regional health offices and district municipalities to carry out *Local Development Plan* in exchange for technical assistance and capacity building for municipalities on technical issues of health promotion and administration, including development of management tools for monitoring and evaluation.
- Existence of GOP decentralization policies that provide municipalities with ways to obtain additional funding to carry out mandates (no more non-funded mandates).
- Incentives applied to encourage the adoption (rewarding advances) and sustainability (awarding additional responsibilities, prizes, penalties) in this decentralization process.
- Creation of a *Central MOH Technical Unit for Decentralization* to manage and trouble-shoot the change process, providing on-going analysis and adjustment of the decentralization process.
- Penalties for specific causes.

Assessment of the strengths, opportunities, weaknesses, and threats

Strengths: The model maintains current legislation, and does not require legislative modifications or additions. Municipalities are strengthened through technical assistance and some financing from the health sector to complete the tasks that they are already assigned in the Ley Organica de Municipalidades. The municipalities would implement community health programs using standard protocols and procedures provided by the Ministry of Health. Use of decision space - Decision space is used in CLAS in a creative way as needs demand, i.e. contracting specialists (dentists, pediatricians, etc.) to attend patients on a part-time basis, doing social marketing in the community by forming a CLAS soccer team, or generating external donor support for expanding the health facility infrastructure. Expansion of CLAS and administration of health promotion through municipalities would decrease reliance on the frequently unreliable DISA administration.

Opportunities: This model would contribute to achieving the goals of intersectoral coordination, via the incorporation of health and sanitation into the general theme of development. Intersectoral planning at a local level (regions, valleys, provinces, districts, or population centers) would be based on "management agreements" with built-in incentives for assumption of responsibilities.

Weaknesses: Underfinancing of municipalities is a chronic problem. If not resolved by transfers from the health sector, or by legislation that allows municipalities to raise funds from other sources, the municipal role in health promotion and sanitation would be severely limited. This model relies on a DISA prepared to take on a new role of technical assistance provision, supervision, monitoring and evaluation of CLAS and municipalities.

Threats: If municipalities do not fulfill their role in health promotion, the transference of these responsibilities to municipalities by the Ministry of Health could result in an absence of health education and promotion activities that may not be reabsorbed automatically as a function of the health sector, thus jeopardizing the population.

4.2 The 1999 and 2000 Proposals For Health Decentralization To Municipalities

The two formal proposals on decentralization of the health sector were submitted to the Peruvian Congress for debate in 1999 and 2000. Both proposals contemplated the active incorporation of provincial and/or district municipalities in the financial management of all public health centers and posts, including the management of Shared Administration contracts with CLAS Associations.[12] Management of hospitals was proposed in 1999 to be implemented under management contracts between the hospital and the regional health department or between the hospital and an integrated ESSALUD that would have administrative control over all second, third and fourth level hospitals.

The proposal for regulation of the 1999 proposed decentralization law (Alfageme et al, 1999) is presented here as an example of what potential role a municipal government could have in health decentralization, in order to examine more closely the strengths and weaknesses of that model.

Proposed Regulation of 1999 Proposed Law on Decentralization of Health

a. Role of Central MOH and DISAs

- Assignment of per capita financing to reduce: inequities, emphasis on curative care, and over-utilization,
- Macro-allocation of funds by the MOH done on equity considerations,
- Multiple sources of financing continue, with regional health offices serving as filter and sole financier for municipalities and providers,
- Standardization of operating procedures (basic guaranteed plan, protocols, supplies, technical capacity of human resources, quality of care, etc.),
- Direction of global health policy (priorities, health norms and standards),
- Supervision of health policy and services implementation, oriented to results,
- Coordination with other sectors at the highest level,
- Promotion of technological development and capacity building,
- Creation of *regional technical units for decentralization* to guide the process, and

[12] As discussed in a previous section of this report, CLAS are currently run under Shared Administration contracts with DISAs (regional health departments), without the mediation of municipalities.

- Signing of management contracts between regional health offices and district municipalities based on financing of results.

b. Role of municipality

- Formation of Municipal Health Office in each municipality with defined structure and functions, approved by the MOH. Associations of Municipalities could be formed if too small individually to establish a municipal health office,
- Elaboration of a Local Development Plan by each municipality,
- Signing of service delivery contracts between the district municipality and each CLAS Associations,
- Implementation of a process for generating capacities in municipalities on technical issues of health and health administration, including development of management tools for monitoring and evaluation,
- Gradual transformation of labor regimens to indefinite length contracts with remuneration tied to results and quality performance,
- A Guaranteed Plan of services offered with both individual and collective health provisions,
- Current legislation carefully reviewed and revised to ensure coherence,
- Incentives applied to encourage the adoption (rewarding advances), sustainability (awarding additional responsibilities, prizes, penalties), and personal involvement (career advancement in primary care, salary raises, improved technical level) in this decentralization process,
- Creation of a team to manage and trouble-shoot the change process, providing on-going analysis and adjustment of the decentralization process,
- Penalties for specific causes,
- Continually assess the health status and perceived health needs of its population,
- Lead strategic and operational planning for health activities, coordination and use of health resources,
- Organize health services for the most effective, opportune and economic delivery of the Guaranteed Plan,
- Coordinate the election of community representatives to the CLAS Association, and designate from among those elected, the president of CLAS,
- Prepare and sign Health Service Delivery Contracts with CLAS,
- Conduct and continually update a census of the population in its jurisdiction and identify those qualifying for state subsidy,
- Hire and fire health facility directors using technical criteria,
- Supervise and coordinate health services production, ensuring completion of production goals and quality standards as specified in the Health Service Delivery Contracts,
- Oversee the use of financial and material resources for health services delivery and take corrective action when necessary, and
- Report on health activities and results to the central and regional MOH.

c. Role of CLAS Associations

- Receive, assess and transmit community complaints and opinions to the health service,
- Supervise the performance of and resource use by health facilities in their jurisdiction,
- Coordinate the participation of community members in solution of health problems,
- Approve the yearly report on health activities, and
- Have title to the health facility.

Assessment of the Proposed Law and Proposed Regulation for Decentralization of Health

Decision Space

As shown in Table 13, the decision space that is allowed to municipalities under the 1999 and 2000 health decentralization law proposals is small. Municipalities would have a wide range of choice only in the areas of targeting and community participation. A moderate range of choice would be had for required programs and norms, since there would be some local planning involved in which local priorities could be set. All other management functions are defined by either the central level or by CLAS, leaving municipalities with a very small decision space.

Table 13
Map of Decision Space for a Municipality Under
The Proposed Regulation of the 1999 Proposed Health Decentralization Law

Functions	Range of Choice		
	Narrow	Moderate	Wide
Finance			
Sources of revenue	Defined by GOP		
Allocation of expenditures	Defined by MOH		
Income from fees	Defined by CLAS		
Service Organization			
Hospital autonomy	Not applicable		
Insurance plans	Defined by MOH		
Payment mechanisms	Defined by MOH		
Contracts with private providers	Defined by MOH		
Required programs and norms		***	
Vertical program, supplies and logistics	***		
Human Resources			
Salaries	Defined by MOH		
Contracts	Defined by MOH		
Civil service	Hiring/firing restrictions		
Access rules			
Targeting			***
Governance rules			
Local accountability	Defined by MOH		
Facility boards	Defined by MOH		
Health offices	Defined by MOH		
Community participation			***
Total Decision Space	**13**	**1**	**2**

Assessment of strengths, opportunities, weaknesses, and threats

Strengths and Opportunities. The strength of the 1999 proposed law is its reliance on CLAS as the organizational and management structure in charge of delivering services at the local level.

Weaknesses. The main debility of the 1999 proposed law is the poor track record of municipalities in management functions. It is sufficient evidence to visit any district in the country to observe the

poor state of implementation or maintenance of nearly any public facility or service under the responsibility of municipalities. Provision of management training and incentives for reducing corruption are long-term strategies. A further weakness is the interposition of an intermediary between the CLAS and the regional health office, where one does not currently exist, and which has not been identified as a need for improved management of CLAS Associations. The regional health department, a here-to-fore technical body that plays a role in formation and capacity generation for CLAS Associations, would lose any technical control of health facilities, having to focus attention on generating capacities in municipal health units

Threats. Municipal selection of CLAS President could easily fall into political clientelism, personal favors, and the like. This threatens the principal-agent relationship that should exist between the municipality and CLAS, that should be one of supervision and control.

5. Conclusions

5.1 Regarding Needs for Health Sector Organization and Performance

A tremendous amount of "little R" reform work and "knob adjustment" still needs to be done by the MOH to establish health sector policies on reforms to support decentralization, including such issues as:

- Prioritization of reaching the poor,
- Prioritization of health education for behavioral change, water and environmental sanitation, control of emerging and reemerging diseases, and other issues that require multisectoral interventions,
- Strategic planning and consistent leadership guidance from the highest levels of the Ministry of Health,
- Streamlining of financing and budgeting processes,
- Epidemiological surveillance and integrated information systems for tracking needs, planning, and measuring progress in meeting the needs,
- Hospital financing and management policies to ensure improved access of the poor to hospital services,
- Strengthening and expansion of the CLAS model to provide higher quality and more efficient delivery of primary care by the public sector,
- Institutionalization of targeted programs (such as PSBPT and food assistance programs) to reduce their vulnerability to fiscal or political crises,
- Reorganization of the functional structure of the regional level (DISA) to better reflect its role in governance and internal control of the system, rather than in implementation or financing, and continual training of DISA personnel to fulfill their role,
- Establish human resource policies for the health sector that promote continuity and quality of care through provision of incentives, and management training of health management personnel at all levels.

Most of these elements are included in recent plans of the Ministry of Health for implementation under a new program to support health reform, jointly-supported by the World Bank and IDB.

5.2 Regarding Decentralization of Primary Health Care Services in the Health Sector

CLAS is the major strategy to be piloted that has shown promise for the improvement of effectiveness, efficiency, equity, and quality of health services. As a "little R" reform, the Shared

Administration Program is gathering force as it expands to greater numbers of primary health facilities. Combined with other "little R" reforms such as the Maternal-Infant Insurance Program, CLAS is positioned to be the center-piece of a "big R" reform. The issue is not how to design a decentralization model different from the one already functioning through CLAS, but how to strengthen the CLAS model itself, including strengthening of its support system from higher levels of the sector, especially the DISA, and coordination with other government sectors, including municipal governments. In particular, the aspects of community participation and equity will be the most critical components of CLAS to strengthen in order to better reach the poor. The community empowerment that is facilitated by CLAS is especially important to develop in poor areas where social capital is weak. Strengthening of community organization, and therefore empowerment, is not only in the purview of the health sector. Rather, it should be a shared multisectoral goal. CLAS can serve as the kernal of community development through local generation of projects, given that CLAS Associations are private non-profit entities that can receive grants and donations from any source, in addition to transferences of public resources. Other social programs such as FONCODES should work more closely with CLAS in the future, since the permanence of the CLAS Association provides a sustainable framework for development activities.

5.3 Regarding Decentralization of Health Promotion Activities to Municipalities

Due to the recognized administrative weakness of most district municipalities, but given a potential political will to include them in decentralization of the public sector, the current recommendation is to incorporate municipalities in health actions in iterative stages to build capacity over time, treating decentralization to municipalities initially as a "little R" reform. An abrupt transfer or "dumping" of administrative responsibilities on municipalities for all aspects of health facility financing, management and service delivery, due to the complexity of the task, has a high risk of reducing the effectiveness, efficiency, equity, and quality of health services delivery in the short and medium term. The proposed alternative is to revalidate the municipal responsibilities in population, health, and environmental sanitation, as described in Article 66 of the Ley Organica de Municipalities, which imply an important role in health promotion. The work of municipalities and municipal agents with communities and community-based organizations, especially groups of women, through such on-going activities as Vaso de Leche and Mothers' Clubs, provides them with immediate channels for health promotion. Their current role in environmental protection in regards to installation of water and sewage systems, sanitation, garbage disposal, air and industrial pollution control, and traffic control, taken one step further, would result in community education campaigns in health prevention. It is assumed that the "management agreements" between the health sector (DISAs) and municipalities would appropriately specify objectives, monitoring and evaluation systems, technical content and priorities, and incentives for the attainment of "Health Community – Health People" designation.

"Big R" reforms involving decentralization of health would best occur when there is an adequate financing system, as well as appropriate preparation and placement of human resources in DISAs, networks, municipalities, hospitals, and primary health facilities who are prepared to implement the reforms. One could argue that no reforms should take place unless there is a high probability that health coverage and impact will be improved as a result.

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