CAN COMMUNITY INVOLVEMENT BE A KEY COMPONENT OF DECENTRALIZED HEALTH SERVICES IN PERU?

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I. Introduction

The presentation is organized into five parts. First, general comments are made about community participation or involvement. Secondly, a description is given of the Shared Administration Program in Peru, which is unique in the world, and little known outside of Peru and the Latin American region so far, and holds promise as a model for local health planning and social control of primary health services by organized communities under a legal framework. Thirdly, there is a discussion of how this program is a decentralized model of health services delivery and how this does or could fit into the decentralization process in the county. Fourth, data will be shown on how CLAS influences equity of access to health for the poor, and at the end will be discussion of lessons learned and future challenges yet to be resolved in Peru.

II. Defining community participation or involvement

Community participation is a complex idea. During the twenty-five years since Alma Ata, there has been a rich debate on its definition and how it can serve to improve empowerment, equity, poverty reduction, and other problems of development. Social participation can serve critical roles in the surveillance and control of health services, in promotion of health behaviors and lifestyles of individuals, and as facilitator of intersectoral community development. These roles depend on the public sector to promote and facilitate capacity-building, especially among women and the poorest members of the community.

Is participation a means to an end, or goal in itself? Lack of clarity in the definition or purpose of community participation has been a problem in Peru, where some mid-level MOH officials have written off as ineffective the Program I'm describing today saying that this is supposed to be a program for community participation, and they don't see the community participating right away.

How do you define community? Apart from the various orientations as to what exactly constitutes participation, one must also consider the distinct types of communities in which power relations can vary significantly with respect to their influence on the particular forms of participation within the community. In Peru there are at least three major types of communities classified by level of complexity or diversity: low, medium, and high. A Peruvian sociologist showed that the simple and pyramidal socio-political structure of an indigenous community implies a type and potentiality of participation that is very distinct from more complex communities with various social groups and greater social and economic independence of community members. In each of these, social participation has its own dimensions of logic, necessity, and form.

III. Why is it necessary to have social participation in health?

Social participation increases efficiency of public spending on health if local people identify their needs and spending is oriented to meet those needs, and not others could be mistakenly identified by central planners. The watch-dog role of citizens over use of public resources can ensure more transparency and reduce malversion of funds, also thereby improving efficiency. Citizens can exert social control over the quality of care through the pressure placed on health care providers at the point of service delivery to make sure they come to work on time and that they treat patients well. Also, citizens tend to spend discretionary funds (fees-for-services) on equipment, health facility maintenance, and even hiring additional health personnel or medical specialists to provide better quality of care. Better equity can be achieved through various forms. Local health and development programs can also have better sustainability if the community is involved from the beginning. Social participation is particularly important in decentralization processes whereby administrative functions are being delegated to lower levels of the health system where management skills may be weak and the centralized control functions have been loosened. The community is the party most interested in surveillance to ensure transparency and proper local governance.

IV. Alma Ata and Selective PHC

While the concept of community participation in health was formally initiated with the Alma Ata Document, the counterproposal for selective primary health care was implemented worldwide in the form of vertical child survival programs. As we all know, the vertical programs left community participation out of the equation, as well as several major thematic areas that continue to plague the poor more than ever, especially maternal and neonatal health and chronic child malnutrition. More recent attempts to integrate vertical programs through IMCI (Integrated Management of Childhood Illness) have been successful on the clinical side but are still having difficulty on the community side. Peru was not immune to any of these tendencies over the years. However, Peru is a country with a long tradition of community organizing (mainly with help of NGOs and the religious organizations) for the purpose of survival given the vacuum of public or governmental support to meet basic needs of the people. In 1994, a daring pilot program was started by the Ministry of Health that in many respects recalled the spirit and strategy of Alma Ata.

V. Shared Administration Program

Peru is among the few countries in the world that has a governmental health program with legalized, regulated, and institutionalized community participation. The Shared Administration Program was made into law in 1994, giving community entities responsibility and decision-making power over the management of public resources for the administration of the health services in the primary level of care. These are called CLAS Associations, which stands for Local Health Administration Committee. They are private non-profit entities that are legally registered in the Public Registry.

Each CLAS has six members who are elected from the community. A seventh member is the health center or post chief physician who is called the CLAS manager. Each CLAS opens a commercial bank account, receives transferences of funds from the public sector and deposits these along with fees-for-services, and makes expenditures

with checks signed by the CLAS treasurer who is an elected community member, and the health facility physician.

The effectiveness of CLAS is due to its legal formality: participation revolves around a series of legal dispositions and a contract signed between the CLAS Association and the Regional Health Department. The contract between civil society and the state is based on a local health plan for which the CLAS Association is obligated to supervise its administration and completion, and the government (by way of the health sector) is financially accountable for implementation of the plan (within budgetary limitations).

At present about 35% of the 6700 health centers and posts in Peru are incorporated as CLAS. This program is the first manifestation of health reform in Peru, with decentralization of financing and decisions on several lines of action with co-management by the organized community. It is noteworthy that the Shared Administration Program and CLAS have never been funded by external donors. This is a program indigenous to the country of Peru.

VI. How CLAS operates

CLAS is one of three cogs that works together with the community and with the Regional Health Office (DISA). The **Legal** framework of CLAS guides all its actions and ensures adherence to correct financial management. **Financing** of CLAS comes from many of the same sources that finance traditionally-administered health facilities, including salaries for government-employed health personnel, goods and services, and costs for vertical health programs which continue to be administered through the Regional Health Office. An additional amount is deposited monthly in the CLAS bank account and is administered directly by the CLAS. This is mainly for payment of health personnel who are contracted under private law. Health facility income from fees-for-services is spent based on decisions made by CLAS members. This income is normally used for hiring additional personnel or making improvements in the health facility such as purchasing computers, medical equipment and furniture, painting, improving security, and sometimes building additions on to the health facility. The **Local Health Plan** represents a major change from the previous vertical planning process. Community information is gathered through local health surveys, so an accurate population count can be made of newborns, children, pregnant women, elderly, etc. and more realistic coverage goals can be made. The CLAS represents active **Participation of the Community** in health service management and delivery.

The community part of the equation includes **Community leaders**, **Base organizations**, **Development committees**, and **Health promoters**. All of these interface with the CLAS on health-related issues.

The Regional Health Office (DISA) is an essential cog in the wheel that needs to provide **Technical assistance** and **Monitoring** for the successful functioning of a CLAS. All of these pieces are tied together under a normative and supervisory framework of the Ministry of Health.

VII.-VIII. Forms of community participation in CLAS

These include:
Administration of resources transferred from the State
Decisions on the use of fees-for-services
Contracting and control of personnel
Quality control of health care
Supervision and control of activities within health facility
Evaluation of management
Health facility maintenance and security
Community diagnosis: help with local health census
Planning: review and approval of Local Health Plan
Monitoring implementation of Local Health Plan
Support promotional activities
Communicate directly with people to convince them to attend health facility
Mobilization of additional resources

IX. Decentralization process and CLAS

Peru is one of the most highly centralized countries in Latin America. Decentralization has been discussed for many years, but the institutional environment of Peru has made it a very political and partisan issue. After years of discussion there is still no clear plan or legislation on decentralization, although the current government is holding regional elections this month anyway despite the persisting indefinition. Much trepidation exists at what the near future will bring as a result of these elections. One decision that has been taken is that there will be a progressive decentralization of functions, and that the health and education sectors will be among the last sectors to be fully decentralized – likely to the municipal level.

The CLAS model of decentralization is based on direct links from a central government agency to the community. There are currently few links with municipalities – those that exist are in the form of occasional resources provided to CLAS, though these are few and mainly in kind such as gasoline for health facility vehicles or ambulances or other types of support for community health campaigns.

As the first real manifestation of health reform in Peru, CLAS has served as the basis for design of the second major step in health reform, which is the Maternal-Child Insurance, now called the Integrated Health Insurance. The pilots of this insurance scheme were conducted in areas where all health facilities were incorporated into CLAS, since CLAS provided the financing mechanism for direct transfer of reimbursements to health facilities, where the money would be used directly for repurchasing medicines and supplies, providing incentives to personnel, and other uses. As the insurance scheme has expanded to a large part of the country by now, the reimbursements must be passed through the regional health offices, which prefer to do the purchasing themselves of medicines and supplies that they in turn send to traditionally-administered health facilities that cannot receive cash reimbursements. Unfortunately in some cases the regional health office chooses to treat CLAS and non-CLAS facilities the same way and are not directly reimbursing CLAS, which deprives CLAS of much needed income that would otherwise be obtained from fees-for-service.

X. Decision-space framework to assess decentralization in CLAS

A useful framework was developed by Tom Bossert from Harvard School of Public Health that allows one to compare and contrast different country experiences in decentralization. One can assess the level of decision-making power that is delegated to lower levels of the health system for each of a series of specific management functions that are commonly present in health systems. The range of choice in decision-making for each management function is rated as narrow, medium, or wide.

CLAS have a **wide range of decision-making** on:

- **Sources of revenue** – as a private non-profit entity, CLAS can receive donations from any public or private donor.
- **Income from fees** – CLAS makes decisions on all income from fees, on fee-setting, and on exoneration of fees based on ability to pay.
- **Contracts with private providers** – CLAS contract with private laboratory services, for example.
- **Contracts** – CLAS signs contracts with professional and technical health personnel and other such as guards and cleaning personnel, using private law contracts. These are essentially different from public sector contracts in that private law provides for sick pay, vacation time, and social security benefits for the employee.
- **Targetting** – CLAS can identify the neediest populations and target services to them as part of the Local Health Plan.
- **Community participation –** CLAS are legally authorized to make contracts and agreements with any type of community organization.

CLAS have a **narrow decision-space** on functions related to:

- **Required programs and norms,** and..
- **Vertical programs: supplies and logistics** – these are still directed from the central level.
- **Civil service** – health personnel who are government functionaries still work in CLAS facilities if they choose to stay.
- **Health offices** – Regional Health Offices work on strict public sector norms.

CLAS have **moderate range of choice** on matters related to:

- **Allocation of expenditures –** decisions are made by CLAS on use of discretionary funds and reimbursements from the Integrated Health Insurance program.
- **Insurance plans** – the new Integrated Health Insurance program for mothers and children ages 0 to 17 is a centrally-administered program, but CLAS can also create local pre-paid insurance schemes for specific conditions or with local businesses and factories if there is a demand for them.
- **Local accountability**

In total, functions that have a wide decision-space for CLAS predominate (6 of them) while fewer functions are in the other categories of decision-making choice. I must mention, however, that as we speak there are elements in the Ministry of Health that are preparing new legal resolutions to remove some decentralized functions from CLAS and re-centralize them at the DISA level.

XI. Balance of power in CLAS

It is widely recognized that public participation and access to information creates power and possible disputes over power. Although, it has been suggested that "conflict can be an essential and creative factor for the good" (Chambers, 1998), and that "power struggles are crucial for the long-term viability of participatory strategies" (Morgan, 2001). Evaluations of CLAS have noted that the internal balance of power between the CLAS manager, health personnel, and community members of CLAS varies widely from CLAS to CLAS, and that this can be a function of the amount of time since the CLAS was founded in a particular health facility, or a function of the dedication, interest, and character of the CLAS manager or any one of the other actors.

There are various types of power balancing that are present in different CLAS. There is the autocratic **"vertical management**" model, well-known and self-explanatory; the **"diffuse control**" model whereby friction between the Manager and CLAS may be present with each of those two creating alliances with different groups of health personnel; the "**medical-technical control**" whereby the health staff is allied and dominates the CLAS who are considered weak and perhaps unnecessary link; and finally the more ideal "**community-control**" model, where a balanced alliance exists between the manager and CLAS.

XII. Maturation process of a CLAS

We have seen that every CLAS goes through a maturation process over time from its inception, with this process taking a minimum of one or more years. This process is facilitated by capacity-building among CLAS members, that in its ideal form is horizontal training through observation of other CLAS and by intra and interregional meetings of CLAS to exchange experiences. Time and experience are the best allies of CLAS. They are not built overnight.

XIII. Methods used by CLAS to ensure equity

The litmus test of a health service delivery model is the results it obtains in providing better services, especially in regard to increasing coverage and improving equity of access. We have shown elsewhere that coverage is increased through CLAS. To achieve better equity, CLAS is able to implement a number of mechanisms.

- Equity of access is improved when the Local Health Plan is oriented to neediest populations that are identified in the community health census.
- Community leaders and other community members identify indigents and high risk community members by
- Use of sliding fee scales to reduce economic barriers for the poorest.
- Local social marketing is used, especially word-of-mouth, to stimulate demand, letting people know about what services are available and how the quality is.

XIV. Impact on equity of user-fees

Data from a 1997 Living Standards Survey that assessed health utilization and expenditures shows the proportions of clients with full or partial exonerations from user-fees. Comparing patients in the lowest income quintile who attended CLAS versus non-CLAS health centers or posts, one can note that in urban areas, CLAS charged lower or no fees for 66% of the poorest patients, while non-CLAS did this for 32% of their poorest patients. In rural areas in the lowest income quintile, 90% of CLAS attendees had partial or complete exoneration from fees, while 70% of non-CLAS attendees had partial or full exoneration.

XV. Equity of access to medicines

An evaluation of 700 patients attending CLAS and 1500 patients attending traditional non-CLAS primary health facilities showed that more of those who attended a CLAS were able to obtain the needed medicines. This difference occurred in adults and especially among the elderly. Children and youths are more likely to have equal access to medicines in CLAS and non-CLAS facilities due to the presence of vertical child health programs and the school-age child health insurance programs that provide free medicines to those groups.

XVI-XVII. Lessons learned from CLAS

- Decentralization of financial administration and/or control is an important incentive for participation of civil society
- Capacity-building in communities is essential for participation in CLAS
- Participation in CLAS is not just a goal in itself, it is part of the process.
- Participation of women in CLAS confers more dynamism to management of the health facility.
- Existence of committed, trained, and capable leaders, such as the Regional Director and CLAS manager, strengthens social participation.
- A professional or other change agent as link between the community and the government is nearly always required for adequate development of programs and activities.

XVIII. Challenges for CLAS

1. Defining CLAS role in promotion of personal health behaviors
   - CLAS need to ensure the delivery of education and information on health, nutrition and sanitation. Local Health Plan should include goals for changing mother's knowledge, beliefs, attitudes, and practices.
   - The role of CLAS in community health should also be to promote links with community health agents (promoters) and support to the community from NGOs, universities, municipalities, and other public and private institutions.

2. Strengthening processes for better democracy of CLAS
   - ✠ Provide adequate orientation to communities for the initial formation of CLAS.
   - ✠ Ensure the selection of normally excluded groups: women, poor, other linguistic groups. Quotas work.
   - ✠ Reduce the number of health facilities incorporated into one aggregate CLAS.

3. Strengthening processes for local planning and evaluation
   - ✠ Capacity-building among health personnel and community for conducting a local health census, problem diagnosis, priority setting, and planning for Local Health Plan.
   - ✠ Establish indicators for gender, equity, participation, and empowerment.
   - ✠ Information systems for monitoring and evaluation of health and development.

4. Strengthen regional-level MOH support to CLAS
   - ✠ Need clearer and stronger policy mandate from the central to regional health departments (DISA) to support CLAS.
   - ✠ More institution- and capacity-building in DISAs is necessary to provide sustained technical assistance, training, monitoring, and supervision to CLAS.
   - ✠ Need to improve information systems for monitoring and evaluation of financial and administrative systems under private, as well as public, law.

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