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# A CLAS act? Community-based organizations, health service decentralization and primary care development in Peru

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## Summary

In 1994 Peru embarked on a programme of health service reform, which combined primary care development and community participation through Local Committees for Health Administration (CLAS). They are responsible for carrying out local health needs assessments and identifying unmet health needs through regular household surveys. These enable them to determine local health provision and tailor services to local requirements. CLAS build on grassroots self-help circles that developed during the economic and political crises of the 1980s, and in which women have been prominent. However, they function under a 3 year contract with the Ministry of Health and within a framework of centrally determined guidelines and regulations. These reforms were implemented in the context of neo-liberal economic policies, which stressed financial deregulation and fiscal and monetary restraint, and were aimed at reducing foreign indebtedness and inflation. We evaluate the achievements of the CLAS and analyse the relationship between health and economic policy in Peru, with the aid of two contrasting models of the role of the state – 'agency' and 'stewardship'. We argue that Peru's experience holds valuable lessons for other countries seeking to foster community involvement. These include the need for community capacity building and partnership between community organizations and state (and other civil) agencies.

**Keywords:** health policy, primary care, community participation, Peru

## Introduction

It has been argued that community based organizations (CBOs) possess the capacity to perform a dual role in the spheres of health policy and health service provision.[1] They are important providers of health-related services in their own right, through the community resources they are capable of mobilizing. At the same time, they can serve as powerful catalysts for change, through their capacity to bring radical perspectives and high levels of personal commitment to bear on formal organizational structures and the policy process.[2] Some theorists have argued that CBOs constitute organizationally and ideologically distinct forms of organization and emphasize their essentially 'alternative' or 'oppositionist' character.[3,4] Others are more pessimistic. They predict increasing bureaucratization, formalization and professionalization, as CBOs experience 'capture' by the structures and processes to which they started out as alternatives.[5]

We describe the development of a network of CBOs – the CLAS (CLAS stands for Comités Locales de Administración de Salud or Local Committees for Health Administration) – in Peru and evaluate their role in and contribution to the Peruvian health care system during the Fujimori administration (1990–2000).

## Background

The Republic of Peru is a middle-income country with a population (2000) of 26 million of whom 73 per cent live in urban areas. Overall life expectancy at birth was 69.5 years (67.1 for men and 72.1 for women).[6] Infant mortality (IMR) was 37.1 per 1000 live births (41.7 for boys and 32.4 for girls) and the under-five mortality rate was 49.1 (53.6 for boys and 44.4 for girls). Maternal mortality (1992–1996) was running at 265 per 100 000 live births –1.5 times higher than the Latin American average.[7] However, although Peru's national health indicators have improved markedly during the 1990s, they conceal continuing and substantial inequalities between its cities and its countryside. For example, life expectancy in 1996 was 76 in urban areas against 60 in rural areas.[8] Lima's IMR was 27, compared with 110 in the Andean province of Huancavelica, and its maternal mortality rate (100 per 100 000 live births) was a quarter of Huancavelica's. These health outcomes reflect inequalities in the distribution of health resources. Lima, with its concentration of national hospitals, accounts for 24 per cent of total public health expenditure,[9] with the top quintile of the population's share of health services being 4.5 times greater than that of the lowest quintile.[7] They also reflect inequalities in the distribution of

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social capital. Among illiterate women the maternal mortality rate is 10 times higher than among well-educated women (448 and 49 per 100 000 live births, respectively).[10] In common with other Latin American countries, Peru's wealthier population is beginning to experience the degenerative diseases associated with affluence and population ageing (such as coronary heart disease, diabetes and cancer). At the same time, poorer Peruvians continue to suffer from the diseases of underdevelopment and poverty (communicable diseases and conditions associated with poor sanitation, lack of nutrition, lack of access to basic health care and the like).[8] Overall 72 per cent of homes (but only 46 per cent of rural homes) are connected to the public water network. Seventy-six per cent of urban homes are connected to the public sewer system, compared with 52 per cent of rural homes.[11]

Peru's health service system is classified as a mixed national health system.[12] Public sector provision is relatively minor and Ministry of Health budgets are relatively small. One-third (or less) of the population is covered by mandatory social health-insurance, and direct out-of-pocket payments are the main source of financing.

The Ministry of Health (MINSA, or *Ministerio de Salud*) is responsible for providing services to the poor and non-insured (who constitute 70 per cent of the population) (see Figure). These services are funded by taxation and user co-payments. The Social Security Institute (ESSALUD) provides the health-care needs of the 23 per cent of the population in formal employment (financed by a 9 per cent payroll tax), and separate systems cover the military and national police. Despite structural reforms in the 1990s aimed at improving service integration, these systems remain poorly integrated and co-ordinated. Expenditure on health amounted to nearly 4.1 per cent of GDP (the equivalent of $90 per capita) in 1997, against a Latin American average estimated to be in the range of 5.5–7.3 per cent.[7]

Since 1993, political reform and the control of terrorism, economic stabilization and the re-incorporation of Peru into the world economic system have allowed an increase in healthcare funding and a programme of health sector reform. The reforms had three objectives:

(1) universal health coverage, which ensured a basic package of services to the whole population, with additional resources targeted on the poorest;
(2) reduction of health inequalities;
(3) health service restructuring, involving decentralization and the promotion of social participation in health.

Progress towards these objectives has been uneven, with Peru continuing to lag behind Latin American averages on most indicators. Certainly, coverage has improved. Between 1990 and 2000 coverage rose from 35 per cent to almost 50 per cent, with the number of beds increasing by 62 per cent and the number of health professionals by 70 per cent. Between 1992 and 1996 primary care facilities increased by 61 per cent.[7] However, although total health spending rose by 50 per cent, it did little more than return to the level that was current in the 1980s. In terms of health inequalities, significant differences remained between rich and poor, and urban and rural populations. The remainder of this paper focuses on evaluating progress towards the third objective – health service decentralization by means of the promotion of community participation in health through the CLAS programme, tied to the promotion of primary care.

## The CLAS programme

The policy background against which the CLAS programme developed is a complex one, consisting of competing (and often contradictory) political pressures and imperatives at local, national and supra-national levels. At local level, the CLAS

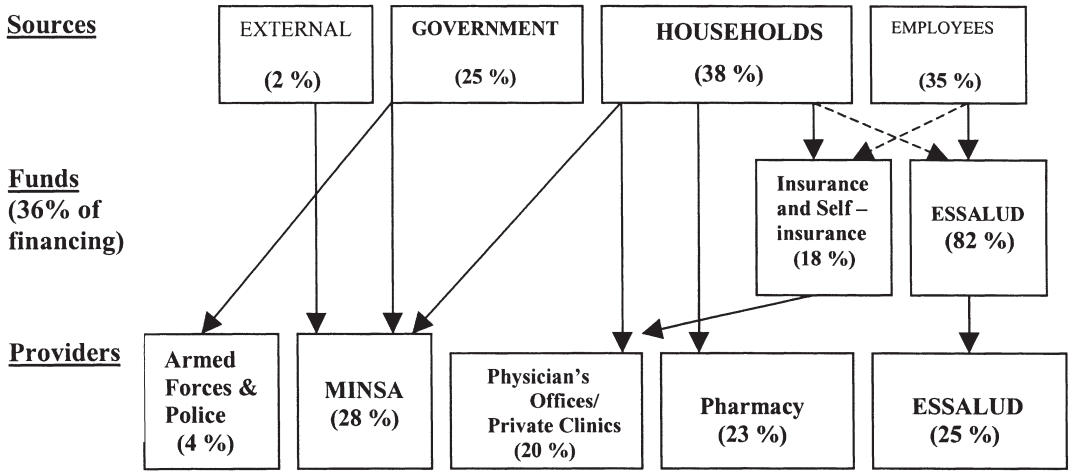


**Figure** Sources and providers of health care in Peru (1998). Arrows with dotted lines indicate minor flows. Sources: Based on MINSA–PAHO (2001). Cuentas nacionales de salud de Perú, 1997–1998. Preliminary. Database. Lima. Cited in PAHO (2001). Health services system profile of Peru. Available at: http://www.americas.health-sector-reform.org/english/perpren.pdt.

programme can be seen as responding to and building on a tradition of local self-help. For instance, during the guerrilla attacks and economic crises of the 1980s, women were active in organizing and sustaining grassroots self-help circles, such as Popular Kitchens (*Comedores Populares*), Glass of Milk (*Vaso de Leche*) and similar neighbourhood initiatives. As ordinary citizens searching for provisions and shelter for their young amidst scarcity, and as leaders of these self-help organizations they acquired invaluable experience for participation in the CLAS programme subsequently. At the same time, citizens' demands for greater accountability and improved services were increasing. Thus, the emergence of the CLAS model can be seen as a 'ground-up' response to these demands.

At national and supra-national levels, however, the political context is more complex and contradictory. The Fujimori government's attempts to respond to basic needs were heavily constrained by its simultaneous pursuit of economic liberalization (state reform, financial deregulation, privatization and the like). This process occurred in a context of fiscal and monetary restraint aimed at reducing foreign indebtedness and controlling domestic hyperinflation (which peaked at 7650 per cent in 1990).[10] In addition, despite lip-service to social participation and the strengthening of local democracy, its attitude towards the growth of local power and any political movements linked to the growth of municipality and province remained highly ambivalent. As a consequence, power became more centralized in Lima than previously, and local governments kept on 'counting on Lima' for everything, from financial resources to leadership. Finally, at supra-national level, in Peru as elsewhere in Latin America, health reform has been heavily influenced by the policies of the World Bank. Although its policies have stressed both equity and efficiency, in reality it has focused on the latter rather than the former. Specifically, it has called for increases in the number of patients paying for their own health care, expansion of the role of the private sector in health care through the development of private health insurance mechanisms, and decentralization of government-provided health care services.[13]

The CLAS programme built on a number of earlier initiatives concerned with developing primary care and fostering community participation. These were the National Fund for Development and Social Compensation (FONCODES) (1991), the Programme for Basic Health for All (PSBPT, or *Programa de Salud Basica para Todos*) and Shared Administration Programme (PAC, or *Programa de Administración Conjunta*) (both 1994). CLAS themselves were set up as pilot projects (in Ayacucho province) that same year. The rationale for the programme was that resource allocation decisions would be improved if they were made jointly by those responsible for allocating budgets and the communities that were to benefit from them. By 1996 the PSBPT budget accounted for 20 per cent of total MINSA expenditure.[7] The growth of the CLAS network is shown in Table 1.

**Table 1** The spread of CLAS-run health facilities, 1994–2000[14]

| Year | Number of CLAS-operated health establishments | Population covered |
|---|---|---|
| 1994 | 133 | 958 473 |
| 1995 | 435 | 3 012 403 |
| 1996 | 611 | 3 200 000 |
| 1997 | 611 | 3 200 000 |
| 1998 | 637 | 4 000 000 |
| 1999 | 985 | 5 000 000 |
| 2000 | 1242 | 6 000 000 |

In 1997, 69 per cent of these health establishments were health posts, and 31 per cent were health centres. (Both health centres and health posts are primary care establishments. However, health centres have a greater number of doctors and other staff, and more equipment and infrastructure than health posts, so can provide a wider range of services.) The 1242 establishments operated by CLAS in 2000 represented 24.5 per cent of the 5060 primary care establishments operated by MINSA and covered just over 22 per cent of the population. The majority were in areas designated as poor (40 per cent) or extremely poor (22 per cent). Roughly 70 per cent were in rural areas and 30 per cent in urban areas.[15]

CLAS operate as non-profit organizations, receiving funding from MINSA on a weighted capitation basis, and with the right to retain the income they generate through the sale of pharmaceuticals and user charges. Each committee consists of seven members: three elected by the community; three community representatives appointed by a head physician of the health centre; and the physician himself/herself. CLAS are responsible for carrying out local health needs assessments and identifying unmet health needs through regular household surveys. These surveys enable them to determine local health provision and tailor services to local requirements. Their administrative and operational decision making takes place under a 3 year contract with MINSA and within a framework of centrally determined guidelines and regulations. Thus, although they are free to make operational decisions such as recruitment of personnel and the pricing of services, they do so always within the limits set by national policy, programmes and priorities. This means that although active community participation is encouraged, it remains subordinate.

Until 1999 CLAS were responsible for a single local health care establishment. In that year a new CLAS model (the so-called aggregate CLAS) was introduced. Each aggregate CLAS is responsible for a network of up to five or six health centres or posts, with a combined budget and within the framework of an integrated locality health programme. The aggregate CLAS aimed at improving administrative efficiency and effectiveness, by simplifying the multi-tiered referral system between CLAS, secondary and tertiary care and reducing training, monitoring and supervision costs. Also, because they operate across a number of communities, they might benefit from a wider base of

support and also enhance financial equality through their capacity to pool and transfer money within the programme. These aggregate CLAS are too recent to have been evaluated, but concern has been voiced that economies of scale may compromise their capacity to remain local.

## Evaluation

Organizationally, CLAS have experienced a number of difficulties, both externally and internally. Externally, relationships with regional MINSA authorities (and other MINSA agencies) have often been problematic. Whereas some authorities have been committed and supportive, others have been indifferent or even obstructive. Where such problems exist, they are attributed to the fact that the regional authorities have lost control over revenues that used to be sent to them since the establishment of CLAS. These relational problems between CLAS and regional authorities have been compounded by the absence of clear central guidelines for the relationship between them. In terms of CLAS' internal organization, four styles of administration have been identified, ranging from community control, to diffuse control, medical–technical control and vertical management. The latter two are characterized by the absence of effective community participation. Other internal difficulties have arisen from the lack of capacity and/or training, particularly in the poorest communities, which are least capable of sustaining the required level of inputs into the CLAS. In general, the level of capacity and support depends on the level of regional commitment to the CLAS. Furthermore, monitoring and supervision of each CLAS by the central office of PAC and/or the regional authority are generally inadequate, because of the lack of financial resources. As a result, their ability to inform policy development and influence health strategies and priorities at the national level may be diminished. It is evident that many CLAS have been under-resourced, inadequately supported and poorly integrated with the national health system. In places, the system remains fragile.

In terms of citizen participation, levels of awareness of how CLAS operated were found to be low (20 per cent), with few service users aware that members were directly elected by the community. However, women's participation and leadership has been noticeably higher than in non-CLAS organizations. CLAS members are typically female and better-educated (90 per cent have completed high school and 57 per cent have at least one year of post-secondary education), and have experience of other public activities and programmes.

Despite these difficulties, CLAS can claim some impressive achievements. User satisfaction has been found to be high, especially in CLAS characterized by community control. Indeed, satisfaction appears to correlate strongly with the level of community participation, together with the level of commitment by the regional authorities. Equally importantly, there is evidence that CLAS are succeeding in reaching the most deprived members of the community. Just 20 per cent of CLAS patients live in homes with brick or cement walls, 80 per cent have only dirt floors and 75 per cent depend on stand pipes or wells for drinking water. Only 13 per cent are connected to the sewage system and only 51 per cent have electricity. It does appear to be the case that local knowledge enables CLAS in rural areas to reach the poorest families, and hence to provide more equitable health care services. Finally, they appear to have been successful in reducing (or limiting the increase in) user-charges: 25.1 per cent of services of CLAS-run establishments were free at the point of use (and this proportion was increasing faster), compared with 17.4 per cent in MINSA-run establishments. It is notable that it is the poorest groups that have expressed the highest levels of satisfaction with services in CLAS establishments.[15]

There is evidence, then, that, at the local level, CLAS have identified unmet health needs, generated and effectively allocated resources to meet those needs, and developed a payment system that protects the poorest. Citizen participation has also been relatively high, with notable gains being made by women.

## Discussion

The Peruvian experience draws attention to a series of issues regarding the role of CBOs in the health sector that are significant for health systems universally. The first of these is the need for community capacity building. Particularly in the poorest (and neediest) communities, the leadership, administrative and technical skills that are needed may not be present, and so will need to be developed. Nor should we underestimate the significance for poor communities of the direct economic costs of the time-commitment required. Each community member of the CLAS works 14 hours a week on average, and 70 per cent of women CLAS members have domestic and childcare responsibilities.[15] Remote communities and communities where there are language barriers face additional problems in terms of isolation, awareness of rights and the dissemination of information and expertise. These may require facilitation of networking and other forms of horizontal contact between CLAS. In addition, the native language should be used as the primary tool of communication and education in written materials to disseminate information about nutrition, sanitation and the like. Creating and sustaining community capacity implies an important developmental role for the state (and other civil institutions such as universities and NGOs). NGOs can function as advocates for and guides to the poorest, addressing social exclusion and working towards remedies for structural imbalances. As important as the internal capacity of the CLAS is the external context in which it operates. It is clear that, where CLAS have been successful, an important contribution has been the support and commitment they have received from regional and local MINSA agencies. The second need, therefore, is to develop partnership between CLAS and the state and other social agencies.

Underlying these issues, however, is a more fundamental debate regarding the role of the state in the health sector. Since

**Table 2** Comparison of agency theory and stewardship theory[16]

| Characteristic | Agency theory | Stewardship theory |
|---|---|---|
| Model of man | Economic man | Self-actualizing man |
| Behaviour | Self-serving | Collective serving |
| Motivation | Lower-order/economic needs | Higher-order needs |
| Situation mechanisms | Control-orientation | Involvement-orientation |
| Approach to governance | Control | Trust/service |
| Time frame | Short-term | Long-term |
| Objectives | Cost control | Quality improvement |
| Values | Individualism | Collectivism |

*The world health report 2000* introduced the concept, there has been considerable discussion of 'stewardship' as a basis of the role of the state in health. Stewardship is defined as 'the effective trusteeship of the nation's health',[16] and as a model of the role of the state and the relationship between the state and the individual, it stands opposed to the more traditional 'agency' model on a variety of dimensions (see Table 2).

It has been suggested that, because stewardship theory is more broadly based than agency theory, it is capable of reconciling operational efficiency with ethical, trust-based representation. More fundamentally, as a framework for decision-making that combines economic efficiency concerns and more normative ethical considerations, it has been seen as a means of (re)legitimizing the broader social contract between the state and citizens. For a country such as Peru, faced with the twin tasks of rebuilding its social and political institutions after a decade of terrorism and restoring its economy, the stewardship model would appear to offer advantages, and the CLAS could conceivably be interpreted as a step in that direction. Our view is that this interpretation would be overly optimistic and overlooks the considerable obstacles that prevent the initiative from developing towards the stewardship model. Certainly, CLAS have given communities that were previously excluded from it, a voice in the health policy process and the delivery of services. They have also improved the micro-efficiency of the health-care system and enhanced equity at local level by targeting resources on individuals and families in greatest need. However, although CLAS have achieved partial mitigation of exclusion and inequality at local level, the fiscal and economic policies being pursued at national level have served to widen the gap between town and country. Overall, infant mortality declined during the 1990s but whereas IMR reduced by 43 per cent in Lima, in Huancavelica it fell by only 33 per cent.[11]

A major difficulty with the stewardship model is that, by treating the state as an autonomous actor and disregarding the context in which it is situated, it overstates its capacity to implement the stewardship approach. Servicing its foreign debts accounts for 20 per cent of Peru's GNP and one-third of its exports.[11] The refusal of foreign debt amnesty by Jubilee 2000 is a reminder of just how tightly Peru is circumscribed.

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