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Peru: Reforming Health Care for the Poor

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Introduction

Peru's famously high levels of infant mortality are concentrated among the poor –two thirds of infant deaths occur in the 40% poorest households. In recent years, health outcomes have began to improve –infant mortality and child malnutrition, for instance, have fallen by a third after 1992. This partly results from the overall improvement in incomes and living conditions that followed the economic collapse of the late 1980s and early 1990s caused by hyperinflation and terrorism. It also results from the rapid recovery of the health sector from that collapse –public and private spending in health rose by over 50% in the three years after 1994. The improvement in health status also coincides with the introduction of a number of reforms in the health system aimed at improving health care for the poor. The paper will discuss these reforms.

Three areas of reform will be discussed in turn. The initial reforms, initiated in 1994 where in **health provision**. These were soon complemented with the introduction of **community participation** in primary care and an initial separation of financing from provision. More recently, in an effort to expand access to services by the poor, reforms have been implemented in **health financing**. This paper will review these reforms, comment on their success at improving health care for the poor and suggest some conclusions and policy implications. The objective of this paper is to disseminate information about institutional innovations that are being tried to improve services for the poor. To understand the reforms, it is important to link them with the political economy of their context.

Reforming Health Provision

Public health provision suffered enormously during the years of economic collapse and terrorism. By 1992, many health centers had closed down and those which remained open had no supplies and a poor quality of service. At the same time, many health professionals were out of work. As economic growth was reestablished, and the proceeds from privatization eased the fiscal constraint, the government assigned new funds to rehabilitate the health sector. In an effort to reach the population that had been exposed to terrorism in the poor areas of the highlands, it sought for new ways of providing services. It also sought to target the new programs according to regional poverty levels. The new programs and the effectiveness of targeting are discussed in this section. The expansion of public health provision has not been problem-free and the section concludes with a discussion of a major concern among policy makers in Peru: the low productivity of providers.

THE NEW PROGRAMS

An important feature of the rehabilitation of the health sector was the emphasis on new programs of primary care (collectively known as *Salud Básica*). MINSA service providers can be divided into three categories, each of which receives government financing through different channels: National Hospitals, Regional Hospitals, and primary health clinics (PHC). The overall budget for the Ministry doubled in real terms during 1994-97. Most of

that increase was assigned to the newly created targeted programs, which received a budget of around US$150 million in 1998. The new programs finance: (i) salaries of health workers in primary care centers; (ii) programs against communicable disease and (iii) food supplementation programs in the poorest highland areas (a $35 million per year program run independently from Salud Básica).

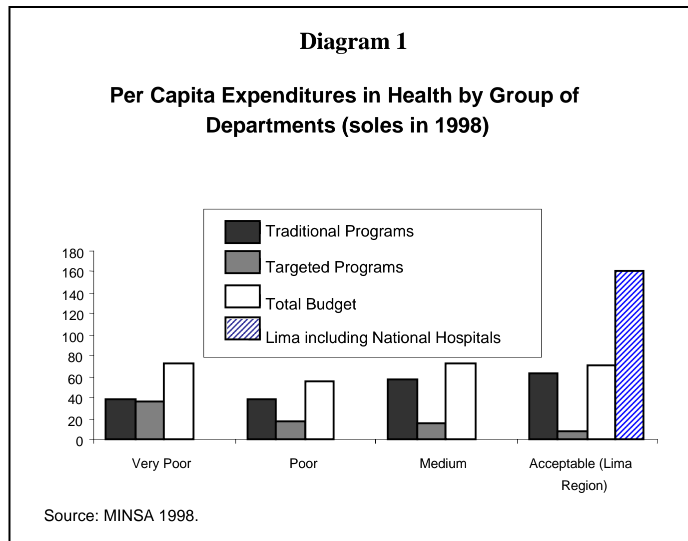
The brick and mortar for primary care has expanded greatly. FONCODES (Peru's social investment fund) alone built or rehabilitated over 1200 clinics –other agencies also contributed to this expansion increasing the number of clinics by 51% in four years. The new programs then became crucial to staff these clinics by financing salaries for 12 thousand health workers. The glut in the labor market for health workers was taken advantage by creating a system of renewable temporary contracts which avoid the rigidity of civil service contracts. The new programs also became crucial to determine the priority areas and the system of work in the primary clinics. The emphasis went to immunization, controlling cholera, malaria and tuberculosis, and family planning.

The increased funding for primary care was achieved by the creation of new programs using fresh funds. The traditional programs were not closed or reoriented. The use of fresh cash to fund the targeted programs postponed any conflict with the powerful organized groups in the traditional services. Today, faced with a tight fiscal position the new programs are being cut to a greater extent than the traditional programs.

TARGETING IN THE MINISTRY OF HEALTH (MINSA)

There has been much debate concerning the accuracy of the targeting by the new programs. Are they effectively directed to the poor? This section analyzes the regional distribution of the main MINSA-based programs according to departmental levels of poverty.[1] Departments were classified by MINSA following the poverty map used by the public sector in Peru into four groups: "very poor, poor, medium and acceptable". More sophisticated poverty maps have recently been developed by the government and private institutions, including measurement of intra-departmental poverty levels, but are still not widely used. The Department-based map continues in use by most public institutions and retains an intuitive appeal for public opinion that more sophisticated maps continue to lack.

[1] The data base was prepared by OGP (*Oficina General de Planificación*) for this study. It does not include health investments managed by other ministries.



The degree to which expenditures are directed to the poor or rich Departments varies according to the channel of expenditures. Diagram 1 shows the per capita distribution of expenditures across the four groups of departments separating the traditional programs (mainly clinical services in regional hospitals) from the targeted program expenditures. Three clear patterns emerge. First, the traditional programs are regressive. Per capita allocations assigned through these programs are higher in the richer departments. Per capita allocations in Lima (before including the budget of the National Hospitals which are mostly in Lima) are 66% higher than in the poorest departments.

By contrast, the targeted programs are fairly well targeted geographically. Per capita transfers to the poorest group of departments are 5 times larger than they are for Lima. The targeted programs account for almost half the public health spending in the poorest departments and for smaller proportions in the rest of the country. Although there are some transfers for Lima, these represent only a small fraction of the total. In per capita terms, transfers to the poorer departments double the national average and transfers to Lima are less than half the national average.

In the aggregate, in 1998 the pro-poor bias of the targeted programs could only compensate partially for the pro-rich bias of the traditional programs. Leaving aside the budget of the National Hospitals, per capita expenditures budgeted for 1998 were similar for the "very poor", "medium" and Lima Departments. Given the highly regressive starting point in the distribution of public expenditures, it has been difficult for the government to progress towards this neutral pattern of expenditure. While the amount of targeting incorporated into the targeted programs constitutes an important achievement, there remain significant problems and regional inequities:

- First and foremost, the targeted programs are *vulnerable to fiscal and political changes*. The "neutrality" achieved in the original 1998 budget was lost during execution of the budget. At mid-year there was a fiscal contraction in response to the effects of the Asian crisis. MINSA responded with significant cuts to the targeted programs which proved to be easier to cut than expenditures financed by the regional budget;
- The department-based poverty map is not enough for geographic targeting of health interventions. A more precise methodology is needed for designing and monitoring

program targeting. In addition to the general poverty map indicators, MINSA needs indicators of burden of disease to guide its investments;

÷ The achievement of equalizing expenditures across regions is dwarfed by a remaining inequity favoring Lima. The National Hospitals, most of which are in Lima, account for 24% of the total public health budget. This budget is in addition to that of the Lima region. While the last few decades have seen an improved access to the specialized hospitals in Lima by non-Lima residents made possible by cheaper and faster transportation, and communications, these facilities continue to benefit the population of Lima to a greater extent than the population of the rest of the country;

÷ Finally, MINSA equalizes per capita spending for the population as a whole, but 26% of the population are covered by Essalud (the government's health insurance for formal sector workers). If the above calculation is done estimating MINSA per capita expenditures for the uninsured population (i.e., excluding the population affiliated to Essalud), a strong bias reappears in favor of the two richer groups of departments which contain only 44% of the uninsured population, but receive two thirds of MINSA's budget).

While the main form of targeting is geographic, the targeted programs are also benefiting the poor by focussing expenditures on fighting communicable diseases Funding for tuberculosis and malaria programs has grown by a multiple of 10 from 1992-3 to 1998. This type of investment tends to be very pro-poor. MINSA estimates show that communicable diseases are the cause of 45% of deaths among the poorest 20% of the population and only 22% among the richest 20%. Demographic and Health Survey (DHS) estimates show that mortality rates are almost three times higher among the former compared with the latter. Taken together, this suggests that an accelerated decline in mortality from communicable disease distributed evenly across all social classes would benefit the poorest 20% almost 10 times as much as it would the richest 20%.[2]

PRODUCTIVITY IN PRIMARY HEALTH CLINICS

The efforts to increase the number of primary facilities have been successful, but they now create new challenges. Productivity in primary health clinics remains at very low levels and unit costs are very high. On average, health workers in MINSA (including clinical technicians) produce in the range of 288 to 738 consultations in a year, or roughly between 1 and 2 per day. The 1,020 health centers, usually employing 3-5 health professionals produce on average around 16 consultations per day. The 4,700 health posts on average produce around 3 consultations per day. These low averages disguise a high degree of dispersion. The majority of facilities are concentrated at extremely low productivity levels. 73% of MINSA health centers have 7 or less daily consultations per health professional. 70% of health posts have less than 3 consultations per health professional. As a point of comparison, a primary care physician in private practice in Lima or in a busy hospital can see around 40 patients in an afternoon. Low productivity translates into high unit costs: ambulatory consultations in primary clinics (56 soles) are

[2] Estimates based on MINSA 1998 and INEI 1997. Mortality rates by income level are from Davidson 1999.

more costly than ambulatory consultations in public hospitals (31 soles).[3] Productivity is slightly higher in urban areas, but even there the average is only 6 consultations/day per professional. When comparing groups of departments, productivity is slightly higher in Metropolitan Lima (7/day).

While there is no dispute about the existence of low levels of productivity in most health clinics, the figures quoted above exaggerate the problem because of three weaknesses in the data available: the 1996 Infrastructure Census (CISRESA 1996). First, this data base combines data on human resources for 1996 with production data for 1995 from the health information system. Using 1996 production data for *Salud Básica* facilities (which constituted a subset of the total) productivity increases by about 50% —higher, but still extremely low. Second, many of these facilities were recently rehabilitated and may have been in the process of initiating activities in 1995-96. Third, these productivity measures include only the production of clinical intramural contacts. Many facilities also produce preventive activities and extramural activities. *Salud Básica* has tried to measure these activities and estimates that *Salud Básica* staff produce almost 2 preventive activities per day and an average of almost one extramural consultation per day. While the definitions for non clinical activities are vague and the data are likely to underestimate the effort assigned to these activities, their inclusion does not change the basic picture of low levels of productivity.

The Government is planning to increase utilization by introducing public insurance schemes (described below) to increase demand by overcoming the economic barriers to access. It also plans to improve the quality of the service by improving incentives and management using a combination of institutional innovations. One that is particularly promising is to enhance the participation of civil society in public service management. These reforms were pioneered by the creation of community-managed publicly financed health committees (CLAS) –these are discussed in the next section.

Transferring Primary Care to the Community

The CLAS (*Comités Locales de Administración de Salud*) are private, non-profit, community-administered institutions created by community members around a health center or post. Their functions are to work with health providers to develop a local health plan, define the budget to implement the plan, and monitor expenditures and the provision of health services to the community. The objective of CLAS is to improve the quality and coverage of ambulatory services at the primary health level through greater participation by the community in planning, administration, management, and supervision of public resources. In December 1997, three years after the program's initiation, there were 548 CLAS formed in 26 of the 32 health regions or subregions.[4] These CLAS administered 611 health establishments, about 10 percent of those in the country, attending about 75% of the 2.65 million inhabitants in their area of jurisdiction, according to 1997 service data. A recent study comparing CLAS and non-CLAS

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[3] This comparison excludes asset depreciation, which is substantially higher in hospitals.

[4] No permits for the formation of new CLAS were issued in 1998, at the time of writing this report government officials informed the Bank that new permits would be issued shortly.

establishments found that the CLAS have higher rates of community participation and have been quicker at introducing improvements to the service (Table 1).

Table 1

Improvements in Service Delivery in Community-Managed Publicly Financed Health Committee and Non-Community-Managed Publicly Financed Health Committee facilities

INDICATORS OF COMMUNITY PARTICIPATION IN CLAS AND NON-CLAS HEALTH SERVICES %	HEALTH CENTERS		HEALTH POSTS	
	CLAS	Non-CLAS	CLAS	Non-CLAS
	(n=5)	(n=15)	(n=14)	(n=32)
The community organization meets regularly	100	67	86	72
Meetings are led by a community member	100	60	93	88
Women participate in the community organization	100	80	93	88
Women participate in training and decision-making	100	67	86	72
Disadvantaged groups are adequately represented	60	33	29	41
Needs of socially and economically disadvantaged groups are addressed in the local health plan	100	87	86	66
The community approves paid health personnel	60	7	43	22
The community evaluates personnel or the local health Program	40	13	57	28
Indicators of Improvements in Services %:				
Needed services are newly available	80	47	86	53
Clinic hours, waiting time is improved	100	73	86	75
A health promoter program was implemented	80	60	71	50
More extramural activities and home visits	100	80	86	91
Community projects have been successful	80	33	57	50

Note: Proportion of health facilities that satisfy selected indicators of community participation, based on subjective rating by health personnel in each facility, by type of health facility.
Source: Data collected by J. Salcedo from 66 low-income urban health facilities, Region of Arequipa – Peru for the Programa de Fortalecimiento de Servicios de Salud; data analysis by L. Altobelli (1998).

The CLAS is constituted by six members of the community plus the director of the health facility who serves as manager of the CLAS. Under Peruvian law, these entities are allowed to receive public funds to produce services specified by a three year contract. Under the contract, management of the facilities is officially transferred by MINSA to the CLAS. MINSA finances the CLAS through transfers and through direct payment of some of the staff.[5] This arrangement has a number of important advantages:

÷ *Improved planning of health activities*. All CLAS prepare annual Local Health Plans (LHP), which are based on a diagnosis of the actual population size, socio-demographic characteristics, health status, and major causes of morbidity and mortality. The LHP sets targets, activities and the required budgets to implement those activities. It is approved by the Board of the CLAS and is the basis of the performance contract signed with regional health authorities. CLAS undertake an annual local census as part of the community diagnosis to prepare the LHP;
÷ *Improved incentives to raise productivity and improved accountability*. The contract between CLAS and MINSA is designed to finance outputs rather than inputs. The CLAS is held accountable for reaching the targets agreed on in the LHP and presenting audited financial and technical reports related to the management of funds;

[5] Two groups of staff exist; those who already had a civil service contract when the CLAS was formed are paid directly by MINSA; the majority are hired and paid by the CLAS.

÷ *Flexibility in the management of budgets*. CLAS are not subject to the slow procedures of public sector budget management and procurement regulations. Most health centers cannot manage public funds (these are managed by the health regions), CLAS by contrast can do so with great agility;
÷ *Flexibility in the hiring of staff*. CLAS hire staff under private sector legislation. The use of short-term contracts and bonuses provide them with a strong incentive framework;
÷ *Improved quality of care*. The CLAS members are empowered to demand better treatment of clients and oversee the purchase of necessary equipment and supplies to improve health care provision.

The CLAS system has been received with great sympathy by communities, but has encountered significant resistance within the public sector since 1997. MINSA has refused to issue any new permits for the creation of new CLAS, despite the existence of numerous requests. This resistance is mainly based on concern by Regional health officials with the loss of direct control over health facilities and staff. Health professionals who work for the CLAS are often supportive, but would like to enjoy greater stability and higher benefits. Public sector unions which represent the shrinking fraction of staff with civil service contracts, view the system as a threat.

The initial years of experience with CLAS revealed a number of weaknesses, many of which are now being addressed.

÷ CLAS worked better in the less-poor urban communities, where users can afford higher co-payments and require less exceptions from payment and where a higher formal education facilitates the development of management skills in the community. Co-payments supplementing government transfers are utilized to contract more health personnel, update physical facilities, and purchase equipment and supplies. The presence of community members with skills in management and accounting is another factor that contributes to the success of CLAS. These factors, which are generally not present in rural and very low-income areas, should now be taken into consideration when planning support for CLAS. Plans to provide higher transfers and management training to CLAS members in poor undeveloped areas should also be developed;
÷ There had been no systematic evaluations of the CLAS program to investigate its impact on coverage, quality and opportunity of services, and community satisfaction. Several small studies have now been carried out and a new major study on CLAS is in the final stages of completion, with preliminary results showing improved client satisfaction and increased utilization of CLAS facilities as compared to non-CLAS facilities;
÷ There was no mechanism established to monitor progress on the health targets of the management contracts. Supervision was mainly focused on financial and legal procedures. Now, a more streamlined method for estimating budgets on the basis of the LHP has been issued and could also facilitate evaluation of results, potentially strengthening the LHP as a management instrument. Health regions have mainly focused on controlling the CLAS. There are now plans to develop capacity in the

regions to provide technical support for the implementation of the LHP. This will be done sometimes directly by the regions, and at others by recruiting specialized services of NGOs;

- While there are no known instances of open corruption, there have been cases where audits have identified the use of incorrect financial procedures. More training and orientation of CLAS members is expected to correct those problems.

Reforming the financing of services

THE ECONOMIC BARRIER

The cost of medical attention is a deterrent for the poor. Labor costs, which are paid by the Treasury, tend to be moderately to strongly subsidized by MINSA establishments. By contrast, most drugs and medical inputs, which are financed by the establishment out of revenues from user charges, are charged to the user at full cost plus a mark-up. Consequently, tariffs for services in public establishments are generally affordable. Drugs and medical inputs on the other hand constitute 71% of direct health expenditures. Among the poorest 20%, these items represent 81% of direct expenditures (table 3). The poor make proportionately less use of inpatient services than they do for outpatient services. This again is likely to be partly an effect of the cost of inputs and transport. When all costs are included, the full cost of a normal birth delivery at a public hospital can reach $100, the full cost of a cesarean or a hernia operation can reach $400, whereby the cost of the tariff for the service may be no more than 10% of these totals.

Table 2

Out-of-pocket Health Expenditures by Quintile

	Total	Q1	Q2	Q3	Q4	Q5
Health Expenditures (soles per capita)	90	21	45	74	93	216
Of which (% distribution):	100	100	100	100	100	100
Outpatient Services	16	16	14	15	15	18
Inpatient Services	3	1	2	4	3	3
Diagnostic Analysis	10	3	7	10	8	12
Drugs and Inputs	71	80	77	71	74	67

Source: ENNIV 1997-Cuánto S.A.

Most MINSA facilities make an attempt to address the economic barriers to health care for the poor by reducing tariffs. Total exemptions from payment are rare —less than a fifth of the poor are exempt from payment for outpatient services and only a fourth of the poor are exempt from payment for inpatient services. However, many more among the poor (50%-66%) benefit from low or reduced payments in what is often regarded as a morally and financially more acceptable mechanism. Hospitals tend to be less generous than primary care clinics.[6]

The existing system of exceptions has several defects. First, there is no fund to subsidize drugs and inputs at the provider level. Most drugs dispensed are purchased by the

[6] Hospitals keep their revenues, while primary clinics share them with the regional office –this may explain the greater generosity found in clinics.

provider and sold to the user at cost with a mark-up.[7] All revenues from the pharmacy are maintained in a separate account used only to restock inventories. Years of scarcity and high inflation rates have led to the development of a culture that places great store by protecting the integrity of these "rotating funds". Hence all exceptions are discouraged. Exceptions are also discouraged to protect a simple rule that provides transparency and accountability: only one person has the key to the pharmacy and all drugs dispensed have a cash entry counterpart. Any loss to the rotating fund is the responsibility of the person in charge of the pharmacy.

Second, exceptions for the poor have to be financed by local generosity, as there is no instrument to have subsidies "follow the poor". There is no national or regional or even municipal pool to subsidize establishments that receive large proportions of the poor. Each establishment finances the lost revenues from its own resources, even if some establishments serve a very poor constituency while others serve a richer population.[8] Many providers seem to set aside 10-20% of their revenues from tariffs for the poor. In the establishments serving a large proportion of the poor, this is not enough to cover all those that would need the subsidy. While most establishments may assign a fraction of funds to reduce co-payments by the poor, this is a voluntary decision taken mainly by the management of the facility. There is no obligation to do this. There is a growing concern that some of the more entrepreneurial establishments discourage use by the poor and may assign much less from their revenues for this purpose. This is believed to include some of the best National Hospitals and Institutes, which are moving to serve more of the middle class.

Third, there are no standard criteria or methodology to identify the poor. Each establishment develops its own system and applies it erratically most of the time. This, compounded by the greater influence and contacts of the middle class, partly explains why much of this subsidy gets diverted to the non poor: around half of the exemptions and reduced rates are captured by the richer 60% of households (Francke 1994).

THE PUBLIC INSURANCE SCHEMES

The government is beginning to confront the economic barrier with the introduction of schemes designed to provide universal access by vulnerable demographic groups to key services. The *Seguro Escolar* (insurance for schoolchildren) was created in 1997. It is now considering the creation of a *Seguro Materno Infantil* following the new international evidence on the benefits of such schemes; for example the hugely successful Bolivian scheme increased institutional coverage of births by 32% in only 18 months (see Box 1). Both schemes eliminate co-payments by patients at the point of use of the service and cover prescription drugs. A predefined package of services is provided to any member of an easily identifiable demographic group, and the government reimburses providers for these services. The *Seguro Escolar* is free of charge to beneficiaries. The

[7] The National Categoric Programs (described in Chapter 3) finance a few drugs (e.g. for malaria and tuberculosis); these are purchased by each region and distributed free of charge to the provider, who passes them on at no charge to the user.

[8] In theory, subregional offices pool all revenues from health centers and health posts and distribute them back according to need. In practice, this happens in few places, and even in those places, the funds pooled are redistributed mainly in proportion to revenue-collected and not to "need" (after taxing away a large slice for administrative expenses).

Government is considering a small subsidized insurance premium (possibly free of charge in the poorest regions) for the SMI. The Government is also considering the creation of a scheme to target benefits to all individuals identified as poor.

Box 1. Bolivia's Public Mother and Child Insurance

The Seguro Nacional de Maternidad y Niñez was created in 1996 as a complement to the decentralization of health services that had taken place a few months before. The decentralization transferred the responsibilities for all social services to regions and municipalities, and assigned them a global budget to cover these responsibilities. For health, the management of public clinics and hospitals was assigned to municipalities. Initially the health services were underfinanced, as municipalities assigned the budget to other more politically visible activities outside the health sector. The Seguro was created, after a process of consensus building and cajoling, to earmark part (3.2%) of the global budget targeted to municipalities to financing key services in health.

During its experience with hyperinflation in the 1980s, Bolivia allowed its public health providers to substantially increase tariffs from users of health services. The Seguro eliminated these tariffs and created a system of reimbursements for key services offered to mothers and children. Its principal objective was to increase coverage of services for mothers and children to reduce infant and maternal mortality. Funding for the Seguro is transferred by the treasury to municipal special accounts created especially for that purpose. Facilities present invoices for eligible services provided. These invoices are approved by a body that includes community representation. Once they are approved, the municipality makes a reimbursement from the special account. Important lessons emerge from the Bolivian experience:

÷ Comparing 1995 and 1997, a sample of public and private establishments showed an aggregate increase in coverage of 32% for institutional births, 45% for new ante-natal visits, and 70% for all antenatal visits.
÷ The package was provided free of cost at all levels of attention and at the establishments of the Ministry of Health and the Social Insurance (which are regarded as better quality). Services of the private sector were not reimbursed. This produced a number of significant shifts in demand: users switched from private to public producers (the increase in institutional births in public facilities was almost 50%, while births in private facilities fell by a third); from primary clinics to hospitals (two thirds of the increase was in third-level facilities); and initially from the Ministry to the social security facilities – until the latter began to refuse to provide services for the Seguro.
÷ Insurance covers only part of the inputs and provides no reimbursement for labor or other costs and payments are often made in kind, instead of cash. This has generated bottlenecks as providers find no incentive to meet the increase in demand, and the in-kind payments create rigidities and delays.

The government is preparing to launch a second generation of the Seguro (the Seguro Básico) aiming to confront the problems mentioned above and to increase coverage of key interventions. The new scheme would also attempt to create incentives for preventive and extramural activities.

The Seguro Escolar and the Seguro Materno Infantil. The *Seguro Escolar*, with a budget of about US$30 million for 1998 is designed to cover health services and drugs for all children aged 3-17 who attend public schools (around 6 million). During 1998, the scheme covered 4 million consultations. Although there is no systematic study to establish how much of this is a net increase in coverage, many hospitals are reporting higher attendance by children. Also, lower level facilities are reporting lower attendance as some users have switched into hospitals. The scheme suffers from logistic problems which need to be addressed to avoid the development of bottlenecks. Facilities complain that reimbursements are slow, and that they have been forced to cover many expenses from their own revenues. These problems arise from lack of clarity about what

interventions are covered by the *Seguro Escolar,* and from the use of cumbersome and slow barter mechanisms for reimbursements —facilities are paid in inputs, instead of in cash**.** The main problem is that only the cost of inputs is reimbursed, whereas the revenues from tariffs, that existed before the *Seguro* was established, also covered other costs, including benefits for the staff (such as food baskets). This problem could become a true disincentive for the provision of services.

The proposed *Seguro Materno Infantil* (SMI) would cover a package of basic services for mothers and for children under 3 years of age (those between 3 and 17 are covered by the *Seguro Escolar*). The Seguro will cover outpatient consultations, inpatient stays, surgery, drugs and emergencies for a carefully chosen group of cost-effective interventions. The SMI would reimburse the facilities for services and inputs that would be provided without cost to the user. A pilot scheme is being implemented in two regions to test logistics and procedures, and to experiment with new payment mechanisms. The Government plans to introduce the SMI as a separate scheme. Once it has taken hold, it would establish a single public insurance consolidating it with the *Seguro Escolar* and possibly incorporating the option of using private providers.

A data base of poor households? While the *Seguros* would go a long way to surmount the economic barrier for mothers, infants and schoolchildren, it would not solve the problem of access to other hospital services by the poor. MINSA has been considering the creation of a system that would allow it to pay subsidies for catastrophic events only for the poor. A number of steps have already been taken to develop such a system, including the design and pilot testing of questionnaires and the statistical analysis of variables that could be used in an index to identify the poor. Two options under examination include an ambitious proposal to create a national or regional data base of the poor; and a modest proposal to use questionnaires, statistics and algorithms to improve and systematize the ways in which health facilities decide whom to exempt.

While the modest proposal is clearly workable, the Colombian experience (which inspired the ambitious proposal) suggests that the creation of a data base should not be undertaken in the short run: (i) To effectively reach the poor, the system needs to go beyond the facility and undertake a quasi-census approach —this would be costly and demanding; (ii) Several studies show that a large fraction of the poor in Peru move in and out of poverty every year; this implies that the data base would need to be updated periodically, adding substantially to the administrative costs; (iii) The experience of Colombia and other countries is that there is a great risk of political manipulation of the information. Once people understand how the classification is arrived at, many give false information to obtain the subsidy. Developing safeguards to limit this behavior adds to administrative costs; (iv) The population moves rapidly; in Colombia, after three years a third of the poor have moved; (v) Finally, qualified people are needed at the facility level to manage the data base; in Colombia it has been very hard to train and retain these people. Finally, despite the investment, there is no evidence to show that the system has substantially improved targeting in Colombia.

CONCLUSIONS AND POLICY IMPLICATIONS

The most important action in relation to the targeted programs is to take measures to *reduce their vulnerability to fiscal or political crises*. The cut in fiscal spending in 1998 was mainly concentrated in the targeted programs. While the rest of the system is permanent and politically powerful, the targeted programs have ad hoc arrangements such as short term contracts and could easily be dismantled or modified.

Targeting can be strengthened by introducing internal improvements to the programs that are already targeted and by making external reforms to target the rest of the provision of care. Internally, there is scope to increase the accuracy of the targeting both across and within regions: (i) The accuracy of the methodology to target across regions is blunted by the existence of other objectives in guiding the allocation of funds, such as occupation of frontier areas, and these other objectives should be funded separately to avoid loss of transparency on the methods of targeting; (ii) Most regions have poor and less poor areas within them. As there exist many forces that tend to pull resources towards the better-off areas, a periodic audit of the specific location of the programs within regions should be implemented; and (iii) Improved poverty maps using more powerful analytic techniques and taking advantage of modern software could be incorporated to the planning tools in use by the programs. This should be done with care to minimize the loss of the transparency and simplicity that characterized the old poverty maps.

The main benefits of improved targeting would derive from external reforms to incorporate more programs into the targeting framework and unify that framework. All programs should be planned as part of a wider of public expenditure effort, rather than individually. As transfers are used to compensate for regional shortfalls in financing, MINSA should make an effort to identify regional expenditures from all public sector programs, including those of high relevance to health that are managed by other agencies. Much could be achieved by going beyond the special programs and improving the distribution of the "core budget" – which is currently mainly assigned to hospitals. This would require improving the geographic distribution of these resources and improving the use of hospital facilities by the poor.

To reform the provision of primary health care, it is essential to continue working with the CLAS and to carefully review the plans for *Redes*. The CLAS continue to be under attack by some public officials, but enjoy recognition by the communities. Specific recommendations at this point are:

- Establish mechanisms to monitor progress on the local health plans of CLAS;
- Develop units (possibly covering several regions) to provide technical assistance to the CLAS in the areas of organization, local health planning and evaluation, provision of services, community extension, multisectoral integrated community development, and other areas.
- Undertake permanent systematic evaluation of the CLAS program to monitor its impact on coverage, quality and opportunity of services, and community

participation. The monitoring should include comparisons with other primary health clinics and should serve to make continual improvements in the system;

÷ Provide incentives and resources to allow some CLAS to expand their local health plans to include the management of environmental risks;

÷ Improve the institutional dialogue of MINSA and the CLAS. Strengthen the office that coordinates the CLAS so that proper support can be provided to CLAS at the local level. Replace the adversarial system of audits of CLAS, conducted by opponents to the system, with a more supportive system that will include the provision of technical assistance in the area of financial management.

The direct and indirect costs of services have created an economic barrier for the poor. To confront this barrier, MINSA should pursue its work in the *Seguro Escolar* and the *Seguro Materno-Infantil*. The *Seguro Escolar* should be improved and simplified. First, reviewing the tariff levels and the tariff structures used for reimbursements to bring them in line with the full cost of services. Second, improving the logistics used for reimbursements by simplifying the paperwork and by reimbursing in cash. Even if this implies a loss in price gains associated with larger purchases, the loss would be balanced by a more timely availability of cash. Third, reviewing the impact of the scheme on the willingness of providers to work.

The *Seguro Materno Infantil* should become a priority. The plan should reimburse co-payments for services and the costs of drugs and medical inputs. Reimbursement rates should be set at levels sufficiently high to make key inpatient activities currently of difficult access for the poor (especially births and maternal complications) attractive for the providers. Reimbursements should also be designed in a way to create incentives for prevention, extramural activities and referrals. Incentives to the users should take into account indirect costs, such as transport and childcare. Lessons should be learned from experience acquired with the *Seguro Escolar* concerning reimbursement procedures. Bureaucratic procedures that could stifle the system should be avoided.

In the short run, the government has decided to implement the two schemes independently and to limit the choice of providers to MINSA facilities. In the medium term, and once the basic procedures have been tested in this logistically easier context, the two schemes should incorporate more developed features in two areas. A wider array of services could be covered if the non-poor contribute through the payment of insurance premiums. Second, competition and improved quality could be obtained by extending the choice of providers to include other public and private providers.

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