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USER FEES IN HONDURAN HOSPITALS  
AND HEALTH CENTERS  
POLICY AND EXPERIENCE

November 1987

**Resources for  
Child Health  
Project**

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## EXECUTIVE SUMMARY

This research investigates the experience with user fees in the public health system of Honduras. The study examines the policy framework and changes in central government policies and procedures with regard to budgets and fees since the 1950s. It analyzes trends in hospital revenues since 1982, the relative importance of the sources of hospital revenues, the effects on utilization, the relation of fees to the units costs of service, and the effectiveness of mechanisms for assuring access for the medically indigent. Fee revenue and service statistic data for the analysis were obtained from existing Ministry of Health records for 15 of the 20 public health hospitals. Data on current fee structures were gathered from 10 hospitals. More detailed revenue data were collected from a subsample of 6 hospitals.

### Study Rationale

A financial crisis confronts the public health systems of many countries in Latin America. Since the late 1970s, these economies have faced rapid deterioration. Their overriding economic difficulties center around low or negative rates of growth, declining exports, burgeoning debt, mounting fiscal deficits, and increasing inflation. Budgetary pressures have generated austerity measures that have resulted in decreased expenditures in most sectors. Reduced resources for meeting national health goals, in both real and nominal terms, are a pattern familiar across the region.

The health system itself has contributed to the financial crisis through inappropriate allocation of resources, poor management practices, and a commitment to broad and expanded population coverage. Public health systems are costly and fiscally burdensome because they are inefficient and because they subsidize health care delivery for the entire population. Despite the fiscal imperative, many governments have a long standing aversion to charging patients for publicly provided health services. When services are provided free-of-charge, there are no incentives to discourage inappropriate utilization other than by increasing the opportunity costs through long patient waiting time. The recurrent costs of operating a free health care delivery system which is open to all are substantial, while resources are ever more severely constrained.

To combat this serious resource constraint, governments face three strategic options. One is to tolerate a deterioration in the quality, quantity, and coverage of health services. Another is to look for mechanisms to improve efficiency and increase productivity. A third option is to search for new, off-budget sources of revenue. Most countries are likely to use some combination of all three of these options, but the responses of individual countries have not been examined or well-documented.

User fees or charges, which are consumer payments for receipt of public goods or services, are receiving increased attention as a source of off-budget revenues. In addition to their revenue generating potential, user charges provide a tool for establishing incentives for better use of health resources. Empirical data collected from the Honduran public health system provide an opportunity to examine the experience with user fees in public hospitals and health centers and to analyze the potential for user fees as a new source of revenue.

### Policies and Procedures

Fees have been a part of the Honduran public health system since at least the early 1950s. Early implementation of user charges was unsystematic and at the discretion of the individual hospital. Government policies since the 1950s have encouraged experimentation with fees and have led to the present-day approach which permits the use of fees in hospitals and lower level facilities. Since 1983, a policy directive of the director general has encouraged hospital directors to augment their budgets through user fees, and a goal of 30 percent cost-recovery by 1988 was established for all public hospitals.

Hospitals have considerable independence with respect to how they use a fee system. Few national norms exist with respect to what services should incur charges or what those charges should be. Thus each hospital has established its own fee schedule according to its own circumstances. Hospitals must report their earned revenue to the Ministry of Health and the Ministry of Finance, and they must deposit their receipts in the National Treasury. But they retain the exclusive right to expend the funds they generate, subject to certain restrictions.

The most common categories of services for which fees are charged include a one-time charge for hospital admission, outpatient visits, outpatient laboratory and X-ray services. Prices for the same or similar services vary both among hospitals of the same type and between hospitals of distinct types.

### Descriptive Analysis

Revenues earned from fees vary as a percentage of the total hospital operating budget by hospital type. At the national hospital, fees represent 3 percent of the operating budget, whereas at the smaller area hospitals fees are almost 5 percent of their total budgets. If we consider the hospital's nonpersonnel budget as representing its most discretionary resources because personnel salaries are paid directly by the Ministry while other expenditures are managed by the hospital, a comparison of the nonpersonnel budget and fee income indicates the relative importance of fees to the hospital's overall functioning. For 5 of the 8 area hospitals, fee income represents over 16 percent of their nonpersonnel budget.

Nine of the 15 hospitals experienced positive rates of growth in fee income during the 1983-85 period. For three regional and two area hospitals the growth rate was substantially above the 8 percent annual inflation rate. These impressive growth rates were the result of conscious and deliberate efforts by hospital administrators to increase revenues from fees. It must be noted that hospital operating budgets during this period suffered an average 2 percent erosion in nominal terms.

The importance of the sources of revenues varies among hospitals. In general, revenue from inpatient services accounts for slightly more than half of total revenues, and the single most important source of inpatient revenue is usually maternity services. Service areas with low fees and high volumes, such as outpatient and emergency consultations, are usually the next most important source of revenue.

How the revenues generated by fees are spent varies from year to year and by hospital type. The national hospital usually spends half of its fee revenue on miscellaneous supplies and these expenditures represent about 16 percent of the total amount spent in this category. The rest of the hospitals spend half of their revenues for casual labor. They also use revenues for general supplies and materials, and on per diems for supervisory and training visits. Only the national hospital uses fee income for pharmaceutical supplies--10 percent of fee income which represents 3 percent of total pharmaceutical expenditures. The diversity of uses suggests the importance of autonomy in determining how revenue will be used.

User fees are assumed to reduce access to health services and to effect health status adversely. Hospitals use formal and informal mechanisms to exempt those who cannot pay even modest fees and to protect their access to services. However, data to consider directly the assumption of adverse effects in the Honduras setting are not available. Some inferences drawn from one hospital indicate that utilization may be affected for some services in the short run, but the effect is not permanent. Another outcome may be that services shift to an area where charges are not incurred, such as a shift from outpatient X-Ray and laboratory services to inpatient use of these services.

A comparison of fee exemption records and service statistics from a few hospitals permits us to estimate the volume of paying and nonpaying patients. Differences between actual and expected revenues are quite large at the national hospital, and indicate that 25 to 60 percent of inpatients do not pay a fee but are not formally exempted from payment. A similar comparison at an area hospital reveals that approximately 75 percent of discharged patients paid an admission fee. While these calculations are only approximations, they nevertheless indicate that mechanisms which guarantee access for those who cannot pay does not assure payment from everyone else. Higher collection rates at peripheral hospitals may be due to the greater need for discretionary revenues if they are less able than the politically more powerful national hospital to obtain adequate budgetary allocations. Thus, consumers of health services in less urban areas are, in effect, subsidizing urban consumers.

A comparison of the unit cost of service with the fee established for that service is useful for determining the contribution to cost recovery of that service unit, or alternatively, its implied subsidy. The unit costs of service reported quarterly by each hospital are imperfect reflections of actual resource use. Nevertheless, illustrative comparisons reveal that gynecological and obstetric services are the least subsidized while general medicine and pediatric services are the most substantially subsidized.

Large health centers collect a fee for a consultation. Although the fee is very modest, the revenues generated are substantial. Combined revenue for health centers in a region may be greater than the revenues collected from an area or regional hospital. These revenues are used to sustain the regional programs which are oriented to primary health care and child survival.

## Conclusions

The analysis of the Honduran experience reveals the feasibility of user fees as a financial vehicle for mobilizing resources. Revenues from user fees continue to be an increasingly important resource for Honduran hospitals. The 1983 policy directive established an environment which motivated hospitals to increase their fee revenues, and in fact most of them did. The autonomy and independence that hospitals have had in setting fee schedules as well as in collecting and spending fee revenues were critical incentives which contributed to this outcome. The very real budgetary constraints imposed on hospitals undoubtedly have further motivated them to expand revenue opportunities.

In the Honduran setting, user fees contribute to positive resolution of the policy dilemma. The incremental revenues have supported hospitals in their effort to maintain their quantity and quality of services. At the same time, there is widespread agreement that fee exemption procedures have ensured access to services for the most economically disadvantaged. Despite this progress, the Ministry is far from achieving its goal of 30 percent cost recovery. The Ministry needs to examine mechanisms for strengthening hospital fee collection in general, and at the national hospital in particular.

The Ministry of Health and the hospitals themselves have gained much useful knowledge from their experimentation with fees. Standard criteria and guidelines which would apply across the entire system are appropriate at this time to avoid serious inequities, to realize the full financial potential of user fees as a revenue source, and to explore the potential to use fees as incentives for more appropriate use of health resources.

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## THE FINANCIAL CRISIS: A HEALTH POLICY DILEMMA

Public health systems in many developing countries, and particularly those in Latin America, have been built on the premise that health care is a fundamental right and that the state must provide free public services to meet the health needs of the population. Concerns over restricted access to health services by the most vulnerable population groups due to their inability to pay for these services have further reinforced the appeal of free-services. The financial crisis which confronts the health sector in most developing countries today, however, has made it clear that a policy of free services is not affordable over the long term despite its social desirability. The World Health Organization reached this conclusion in its 1987 World Health Assembly.

The financial crisis of the health sector is, in part, the result of the world economic recession of the early 1980s and the economic difficulties it has wrought for most Latin American as well as other Third World economies. During the early 1970s as overall government budgets grew in real terms, health budgets freely expanded in many countries within the Latin American region. However during the 1980s, poor national economic performance, falling prices for primary products, and burgeoning national debt have dictated stagnant or declining government budgets for these countries. Requirements to reduce government spending as part of debt rescheduling arrangements have forced cut backs on expenditures in all sectors, including health. Indeed, between 1972 and 1983, government allocations to health have been reduced to 4.5 percent of total budgets (Griffen, 1987). Poor management and resource allocation practices combined with a commitment to expanded population coverage of the health system have also contributed to the financial crisis. Public

health systems are costly and fiscally burdensome because they are inefficient and because they subsidize health care delivery for the entire population. Furthermore, where services are provided free-of-charge, there are no incentives to discourage inappropriate utilization other than by increased opportunity costs through long patient waiting time. The recurrent costs of operating a free health care delivery system which is open to all are substantial while resources are increasingly constrained.

The seriousness of the resource constraint problem requires that governments either tolerate severe deterioration in the quality and coverage of health services or search for new sources of revenue and mechanisms to curb costs. Despite the fiscal imperative, many governments have a long standing aversion to charging patients for publicly provided health services. Objections to fees are based in part on the argument that they are inequitable because they demand a larger proportion of the income of the poor than they do of the rich. This argument, however, assumes that in the absence of such a charge, health services would be available freely to rich and poor alike. In a developing country, where resources are by definition extremely scarce, the absence of a user charge rarely coincides with the free availability of the associated service. Because "free" health services stimulate demand that often exceeds the supply which the government can provide, services must be rationed in some alternative way. These alternatives may include rationing by waiting time, by who you know, by how close you live, or by how large a bribe you can pay. Those members of society who have free time to wait in line, who know more important people, who live close to the health center, or who can pay a bribe are unlikely to be among the poor. Faced with this dilemma, a number of governments have placed priority on reexamining cost sharing arrangements.

User fees or charges, here defined as consumer payments for receipt of public goods or services, are the least complex of a variety of cost sharing mechanisms and are receiving increased interest as a source for off-budget revenues. In addition to their revenue generating potential, user charges can be used as a tool for establishing incentives for better use of health resources. This function is often much less appreciated by health managers and policy makers. Fees can be used as a set of incentives to consumers to encourage appropriate or discourage inappropriate utilization of services. A number of Latin American countries already utilize user charges as a source of additional revenue for the health sector. Decisions on whether to charge for a given service and how much to charge are technically difficult and politically sensitive. While economic theory suggests that user fees may be most appropriate for financing those health services that are classified as basically private goods, decision-makers lack information to assess the trade offs inherent in the choice among any set of pricing policies.

Among public systems which levy charges for some of their services, the common arrangement is to charge for hospital services. The revenues collected are usually only a fraction of total hospital operating costs. Typically the portion of operating or recurrent costs recovered through user fees ranges between 2 and 17 percent. The vast majority of countries recover costs only at the lower end of the spectrum (Ainsworth, 1984; de Ferranti, 1985). Nevertheless, detailed evidence from Sudan (Bekele and Lewis, 1986), Rwanda (Shepard et al., 1987), Ethiopia (Dunlop and Donaldson, 1987) and the Dominican Republic (Lewis, forthcoming) suggest that fees generate important resources at all levels of the health care system even without a centrally promoted fee system.

Incentives for collecting fees determine the ability of user fee systems to generate revenues for the health system. Fee collection must be endorsed or at least not prohibited by the central government. Fee collection also must be in the interest of the health facility. If it cannot retain and use the revenues, it has no incentive to expend its own scarce resources to raise government revenues. Jamaica, for example, modified the standard practice of remitting all revenues to the central government, permitting hospitals to retain fee revenues as an incentive to raise revenues from patient fees.

The equity concerns associated with user charges for those population groups unable to pay for health care remain an issue. However, evidence suggests that the poor already pay a larger amount for private care than what would be implied by user fees in public facilities (de Ferranti, 1985). Governments ensure access to publically provided care for low income groups by subsidized fee-for-service alternatives for those unable to pay in the Sudan (Bekele and Lewis, 1986), by free preventive services and prenatal care in many countries and by a means test to assess patient ability to pay in a number of Latin American countries. While cumbersome, these systems represent an attempt to limit the population of subsidy recipients. Such targeting addresses equity concerns while conserving scarce resources.

## RESEARCH QUESTIONS AND DATA COLLECTION

Empirical data on the operational experience of individual countries with user fee systems has not been available. The absence of relevant and systematic information has impeded the formulation of appropriate guidelines for establishing user fee policies and the development of effective administrative systems for their operation. Our research analyzes the experience with user fees in public hospitals and health centers in Honduras with the intent of contributing to a body of relevant and systematic information required to determine when user charges are justifiable, when they are not, and how they best can be implemented.

The use of fees in Honduras for publicly provided health services dates back to at least the 1950s. This study examines the policy framework and changes in central government procedures with regard to budgets and fee policies since that time. Particular attention is accorded to the operational experience during the 1982-85 period when the central government altered its policy toward user charges in public hospitals and established incentives for hospitals to generate their own resources.

The Honduran Ministry of Health hospital system is hierarchical with nine small area hospitals of 50 to 70 beds at the periphery, six larger regional hospitals of 100 to 200 beds located one within each health region, and five large national hospitals of 300 to 1000 beds located in the capital. Length of hospital stay averages 4.9 days among area hospitals while their occupancy rates average 58 percent; length of stays for regional and national hospitals are 4.7 and 13.0 days, respectively, while occupancy rates are 73 and 74 percent.

Data on total revenue and service statistics were obtained from existing records at the Ministry of Health for 15 of these 20 public hospitals for the years 1983 through 1985. One area hospital was not included because it opened only in late 1985. Data from four national hospitals were excluded from the study because their average length of stays were greater than 16 days, and they tended to provide long-term chronic or specialty rather than acute care. User fee schedules could be obtained from only 10 of the 15 hospitals. Service statistics were used as a proxy for utilization since this type of information was unavailable.

Management information systems and records are commonly deficient in developing countries and Honduras is no exception. Record-keeping systems for fee revenues in most hospitals were insufficient to determine accurately sources and amounts of revenues generated by individual service units. For this reason in depth reviews of primary hospital records were undertaken in a small sample of hospitals: 1 national hospital, 3 regional hospitals and 2 area hospitals.

From this subsample of six hospitals, we gathered detailed financial and operating data. One regional hospital, Santa Teresa, had complete revenue records for 1982-85 in all service units that imposed charges. Record-keeping for revenues in Hospital Escuela and the two area hospitals, El Progreso and Gabriel Alvarado, were more aggregated. Revenues for inpatient hospitalization, for example were not always well identified. Sources of revenue were only available for 1984-85 for Hospital Escuela and 1983-85 for the area hospitals. For the remaining two regional

hospitals, Leonardo Martinez had breakdowns of revenues for some services for 1983-85, but Atlantida had no disaggregation of total revenues. In these two hospitals, data from receipt books were tabulated to obtain an estimate of revenues from individual service units.

## HISTORY OF THE USE OF FEES IN THE HONDURAN PUBLIC HEALTH SYSTEM

Fees are neither a new nor novel concept for the Honduran public health service system. They have provided a continuous source of revenue since at least the 1950s. Early implementation of user charges was unsystematic and at the discretion of the individual hospital. Government policies since the early 1950s have encouraged experimentation with fees and have led to the present-day approach which permits the use of fees in hospitals and some lower level facilities.

In the early 1950s, before the Ministry of Health was established as an independent institution, hospital budgets were small and most facilities needed to rely on charges for some services to supplement their limited budgets. The most common arrangement was for hospitals to charge substantial fees for private beds. Revenues were retained and administered by each facility. Revenues from fees collected at lower level health centers were administered by a community board of trustees.

When the Ministry of Health was created on December 24, 1954, it designated an allowable number of private beds in each hospital. Furthermore, a decree gave hospitals and health centers the authority to collect "symbolic" fees from nonprivate hospitalized patients and outpatient consultations. Hospitals administered their budgets and their fee-generated revenues with virtually no reporting requirements. There are no records from this era and anecdotal reports from Ministry of Health veterans vary. Some recall that the funds which hospitals generated were large enough to cover a major share of their personnel and supply costs. Others remember that hospital fees covered all but their personnel costs.

By 1965, hospital budgets came under the control of the Ministry of Finance(Hacienda). Although hospitals continued to manage and control their own budgets, the Ministry of Finance performed an auditing function and required that all expenditures and fee-generated revenues be reported. However, few restrictions were imposed regarding the way hospitals could spend their funds. At the same time, a decree established standardized fees for outpatient visits to lower level facilities: health centers (3 Lempiras), subcenters (2 Lempiras), and health posts (1 Lempira). Government budgetary allocations and fee-generated revenues were and continue to be the only sources of revenue for Ministry of Health facilities.

The early 1970s brought organizational changes and consolidation of public health services into a three tiered, hierarchical system. The Ministry of Health imposed some standardization and restrictions on the way hospitals did business. Hospitals were required to report their weekly fee revenues to the Ministry of Finance and deposit them in the national treasury. Each hospital retained the exclusive right to expend the funds it deposited, but expenditures required central approval and only certain categories of expenditures were acceptable. An important restriction on the expenditure of fee-generated revenues was the prohibition of using them for salary payments for professional and technical personnel. As part of the reorganization, health centers and subcenters were replaced by CESAMOS and CESARES. These lower level facilities continued to collect fees for outpatient visits, but community-board control and administration of these funds was replaced by that of the Ministry of Health. Charges for visits to CESARES were eliminated in 1979, but CESAMOS continued to collect fees and remit them to the regional level of the Ministry of Health until mid-1987 when they were required to begin remitting fee revenue directly to the treasury.

Private beds continued to be a source of revenue for many hospitals until 1976. By that time, the abuse of private beds—use without payment—was substantial. Access to private beds relied on connections and relationships and full payment was not necessarily mandatory. Control mechanisms were impossible to enforce. This situation was intolerable to the populist government, and therefore the Ministry of Health prohibited further use of private beds in public hospitals. About this time, the Planning Division of the Ministry of Health began a study of hospital costs with the intention of using the results to develop a fee system based on the costs of providing services in each of the different types of hospitals. When the study was completed, a few hospitals experimented with cost-based fees, but hospitals were not strongly motivated to generate their own revenues at this time because supplements to their operating budgets were easily obtained from the central government.

By the early 1980s the Ministry of Health faced serious problems in meeting its recurrent costs, and the government itself was confronted with economic difficulties. Nevertheless, an ambitious agenda for hospital construction that was presented by an international development agency (Inter-American Development Bank) drew strong government attention and support. Because the Ministry of Health was committed to subsidize preventive health services fully with the necessary and appropriate resources, the Ministry focused renewed interest on fees as a means to sustain hospital operating costs. A policy to renew a private hospital bed system was reviewed but discarded because adequate mechanisms to control abuse could not be

devised. Given the economic environment and the expansion plans, the Ministry of Health encouraged hospitals to collect fees. Hospitals had a strong incentive to comply since the expenditure of these revenues remained under their control within the limitations already described.

In mid-1983, the Director General of the Ministry of Health sent a policy directive to each of the hospital directors stating that requests for supplements to hospital budgets could no longer be accepted. The hospital budget approved at the beginning of the fiscal year would be the hospital's total allocation from the central government. Any need for supplemental funds would be each hospital's own responsibility. Hospital directors were encouraged to augment their budgets through user fees. A subsequent policy directive, instituted in part by the conditions attached to a health sector loan with an international development agency (USAID) established a goal of 30 percent cost-recovery by 1988 in all public hospitals.

## OPERATIONAL PROFILE OF THE USER FEE SYSTEM: HOSPITALS

Hospitals have maintained considerable independence with respect to their use of a fee system. Few national norms exist in terms of what services should incur charges or what those charges should be. The only prevailing norms appear to be system-wide policies not to charge for preventive and maternal-child health visits or for pharmaceuticals. Consequently, each hospital has established its own fee schedule according to its own set of needs and circumstances. Table 1 compares the fees charged for the most common categories of service and reveals some distinct differences among the ten acute care hospitals for which fee schedules were available.

### Inpatient Fees

Most hospitals charge a one-time inpatient admission fee which includes all services related to hospitalization except blood transfusions. Admission fees vary little by type of admission or across hospitals, with the exception of Del Sur whose fees are quite low. Only El Progreso and Puerto Cortes hospitals charge for inpatient services on a daily basis. In practice however, patients at these hospitals who are discharged from a service unit, e.g. surgery or general medicine, tend to pay the same average fee regardless of the length of stay.

The admission charge at the Escuela Hospital is L10 (one Lempira=US\$0.50) plus a pint of blood or the equivalent in cash, L35. Regional hospitals with blood banks also accept blood as partial payment for hospitalization. In all hospitals, patients that require blood transfusions during their hospital stay must either purchase blood or locate an acceptable donor.

### Outpatient Fees

All hospitals charge for outpatient laboratory and x ray services, and there is a rather broad range of fees for these services. Outpatient consultation visits also incur a nominal charge. Many hospitals which did not formerly charge for emergency room visits have instituted fees, as they encountered patients using the emergency entrance to avoid an outpatient fee. A few hospitals have even set a higher fee for emergency visits so as to discourage its inappropriate use. The Leonardo Martinez Hospital, for example, instituted a 24-hour cashier for fee collection. This action eliminated excessive after-hour outpatient visits which formerly did not incur charges.

### Control and Management of Fee Revenues

Hospitals are required to report their fee-generated revenues to the Ministry of Finance, and to deposit daily receipts with the Treasury. Most deposit only weekly or monthly. Hospitals retain control of the use of these revenues subject to certain limitations. Expenditures must be approved by the Ministry of Health and are restricted to about fifteen rather broad expenditure categories. Regular salary expenditures are not permitted, but overtime and casual day labor payments are

allowed. Unexpended revenues revert to the Treasury at the end of December, the close of the fiscal year.

To expend funds, the hospital must receive approval from the Ministry of Health to increase its budget in one of the allowable expenditure categories. This process is a lengthy one since line-item approval is required from the Ministry of Health and approval for a budgetary increase is required from the Ministry of Finance. Consequently, expenditure requests for the fiscal year are accepted only until early November, and hospitals lose between 2 and 10 percent of their annual revenues. This occurs even though hospitals typically withhold deposits of their November and December income until January.

Internal reporting mechanisms for the hospitals are poorly developed and not well standardized. Therefore, sources and amounts of hospital revenues are difficult to verify. Most hospitals use some form of a receipt system for auditing purposes but do not document the source of the revenue very well. The absence of financial management and control mechanisms other than for fraud and inappropriate use inhibit the ability to manage cash flow systematically and maximize revenues. Because hospitals report income earned to the Ministry of Finance and expenditures of these funds to the Ministry of Health, the various accounts of a hospital's total revenues do not agree. Since the Ministry of Health's account for revenues earned is based on expenditures, it is the lowest. The Ministries of Health and Finance have no way of reconciling the differences in their balances.

## Equity Considerations

To protect access to hospital services for the medically indigent, hospitals use formal and informal mechanisms to exempt those who cannot pay even modest fees. Hospital Escuela, the largest hospital, has a staff of 10 social workers whose responsibilities include supervising cashiers and assistants functioning as para-social workers in conducting socioeconomic evaluations of individuals who say they cannot pay the assessed fees. Most regional hospitals have a staff of 1 to 3 social workers who perform the same responsibilities. The criteria that social workers use to determine ability to pay are unique to each hospital. In both the national and regional hospitals, the hospital director has the final decision as to who will be exempt from fees. Few of the area hospitals have a social worker. The hospital director makes all the decisions regarding who will be exempt in these hospitals.

## Administrative Costs of Hospital Fee Systems

The administrative costs of operating a fee system are not large with the major costs being additional salaries for cashiers. Social workers have long been on hospital staffs for reasons other than for fee system exemptions and administrative costs are only the opportunity costs of their time spent on activities related to the fee system. The same is true for hospital administrative personnel who must spend time on fee-related tasks. In a hospital that has a social worker, the director spends a small amount of time on activities related to the fee system. The hospital director without a social work staff spends more time on patient fee exemptions.

## REVENUES FROM FEES IN HOSPITALS

### Trends in Hospital Revenues

Table 2 compares total revenue data for the years 1982-85, based on Ministry of Health figures, for fifteen Honduran hospitals. Hospital Escuela, the large national hospital in Tegucigalpa, earns the largest share of the total hospital revenues due to its large patient volume. However, its share of total revenues declined from 48 to 40 percent between 1982 and 1985. During the same period, the share of revenues attributable to regional and area hospitals increased from 30 to 36 percent and from 22 to 24 percent, respectively.

Revenues as a percentage of the total budget vary somewhat by type of hospital. For the national hospital, revenues were just over 3 percent, and this percentage increased by less than 1 percent between 1982 and 1985. Revenues as a percentage of the total budget for area hospitals are greater, 4.9 percent, and over the 1982-85 period have increased by less than 1 percent. Among regional hospitals in 1982, revenues were a small share of the total budget, 2.8 percent. Between 1983 and 1985 when the new policy on hospital fees was implemented, revenues increased to a 4.7 percent share of the budget.

Table 2 also presents revenues as a percent of the non-personnel budget, and for the area and regional hospitals, these figures are impressive. Revenues represent 12 to 16 percent of the non-personnel budget. Given that personnel salaries are paid

directly by the Ministry, whereas other expenditures are managed at the hospital level, the nonpersonnel budget represents a hospital's most discretionary resources, and can be viewed as a measure of the importance of fee income for a hospital. For 5 of the 8 area hospitals, fee income is over 16 percent of their non-personnel budgets.

Between 1983 and 1985, all but two of the area and regional hospitals experienced declines in their budgets (current prices). Eight of the hospitals were able to more than compensate for that decline by increasing substantially their income from revenues: a minimum increase of 2 percent in the case of Santa Barbara, and 195 percent in the case of Leonardo Martinez. During the same period, the budget for the national hospital increased by 2.7 percent, and revenue collection by over 15 percent.

The impressive increase in revenues at Leonardo Martinez was the result of a conscious and deliberate effort to increase fee revenues. A 24-hour cashier was instituted so that a fee was always required for outpatient consultations. Fees for some services such as maternity and some laboratory tests were increased. Greater attention was focused on identifying and exempting those unable to pay and requiring payment from the rest. The strategy had a high payoff; within one year, revenues increased from less than 2 percent to almost 5 percent of the total budget.

## Sources of Hospital Revenues: Descriptive Analysis

Data from the comprehensive reviews of revenue records at 6 hospitals provide the basis for generalizations about the importance of various sources of revenues. Table 3 presents overall estimations of revenues by service unit for the six hospitals where detailed data were obtained. Revenue from inpatient services accounts for slightly more than half of total revenues in most hospitals, and the single most important source of inpatient revenue is maternity services. Outpatient and emergency consultations, service areas with low fees and high volumes, are usually the next most important source of income.

Charges for blood transfusions associated with hospitalization are an important source of revenue for Hospital Escuela. The fees cover the cost of purchasing blood from the Red Cross when a patient's family is unable to donate the necessary blood. However, the 30 percent of revenues attributed to the blood bank in Table 3 may overly represent charges for blood since some hospital admission charges may be included in this amount.

The relative importance of the sources of revenues varies among hospitals. Since there are no standard criteria for setting fees and hospitals have considerable autonomy in establishing their fee schedules, what they charge for and the level of those charges varies according to the circumstances of the particular hospital, its environmental setting, and the commitment of the hospital director to raise revenues through fees. Atlantida, for example, had no functioning X-ray machine and therefore no X-ray revenue during the period for which data were collected. Gabriel Alvarado relies on dental clinic and health card charges as an important source of

other revenue. Regional and area hospitals collect a relatively larger share of revenue from inpatient adult medicine and surgery than does Hospital Escuela. However, this situation may reflect a less comprehensive collection policy at Hospital Escuela.

## Revenues and Utilization

User fees are assumed to reduce access to health services and to affect health status adversely, but empirical data in support of this assumption generally has not been available. Data which would permit us to consider this assumption directly in the Honduras setting are not available. Because changes in utilization rates are a reflection of a variety of factors, without the appropriate information, it is difficult to sort out the effects on access and health status which result from the changes in hospital fees between 1982 and 1985.

Annual utilization rates for hospital service units are of some usefulness and inferences may be drawn from the utilization statistics for the Leonardo Martinez Hospital. As was already mentioned, the hospital changed its fee schedule in 1983, and by 1985 its overall revenues increased nominally by 195 percent (somewhat less in real terms given inflation rates). If demand for health services is price elastic, we would expect utilization to fall in the face of rising prices. Between 1983 and 1984, the number of maternity discharges declined by 1,000 cases or about 10 percent, but by 1985 the number of cases had returned to 9,226, only 214 fewer than 1983. These declines may reflect random demographic variation. It is also possible that the fee increases for hospital births reduced hospital utilization in the short run, although the affect does not appear to be permanent. More permanent declines in utilization are apparent for outpatient laboratory and X-ray services. However, these declines may reflect a decrease in overutilization, or utilization merely may have shifted to inpatient services where hospital and laboratory services are free of charge.

It is only recently that hospitals have begun to keep records on patients that they exempt from fees. Analysis of the fee exemption data is critical because it addresses the equity issue in the user fee policy. A comparison of these records with overall service statistics can help us estimate the volume of paying and nonpaying patients.

In the case of Hospital Escuela, comprehensive recordkeeping on exempted patients began in July, 1986. The Social Services Department conducts interviews that assess the socioeconomic status of patients' families who state they are unable to pay the required fees. The Department determines whether the patient will be exempted partially or completely from payment. Table 4 compares the numbers of the exempted inpatients with total discharges for the service units where full information is available for July-September, 1986. According to these figures, general surgery has the lowest proportion of nonpaying patients followed by gynecology and pediatrics. Maternity and adult medicine service units reflect the highest proportion of nonpaying patients. These figures indicate that about 20 percent of all hospital discharges have been exempted formally from payment. By implication, 80 percent of hospital discharges would be paying patients.

Assuming an average exemption rate of 20 percent, we estimated expected revenues and compared them with actual revenues. These revealed that many patients who should have paid for services did not. Statistics at Hospital Escuela in 1985 indicate that there were a total of 34,529 discharges. Applying the 20 percent formal exemption rate, the figures below indicate the number of paying and exempt patients and the expected revenues under two different assumptions about what fee (L10 or L35) was paid.

Total Discharged Patients	34,529
Exempt Patients (20%)	6,903
Paying Patients (80%)	27,623

Expected Revenues @ L10 per discharge	L276,230
Expected Revenues @ L35 per discharge	966,623

Although revenues should have been between L276,000 and L966,000. Actual hospital revenues from in-patient fees in 1985 totaled only L174,000 (Table 3), a shortfall indicating that a significant number of patients who presumably should have paid fees did not. The following calculations indicate the revenues which derive from patient discharges and the number of paying patients this implies using the two different assumptions about the fees that patients paid.

Total Revenues	L793,000
Revenue from Inpatient Services (22%)	174,460
Implied Number Paying Patients @ L10 per discharge	17,446
Implied Number Paying Patients @ L35 per discharge	6,978

These figures imply that 25 to 60 percent of inpatients at Hospital Escuela do not pay a fee, but are not formally exempted from payment. Under the conservative assumption that patients only paid a fee of L10, revenues for inpatient services would have been 50 percent greater.

Data from other hospitals are equally limited with regard to this issue, although a few estimations and comparisons reveal a similar pattern. In the case of Santa Teresa, records for exempt patients have been kept only since June, 1986. They indicate formal exemptions for 11 percent of maternity patients and 22 percent for all other inpatients, implying that 89 percent of maternity patients and 78 percent of all other inpatients should pay fees. A comparison of service statistics and

realized revenues for 1986, however, indicates that only approximately 50 to 60 percent of maternity patients and 20 to 26 percent of all other inpatients pay. The 1986 records from Gabriel Alvarado Hospital show that 4 percent of maternity cases and 7 percent of all other inpatients received exemptions from fees. A comparison of total hospital discharges with realized revenues through November, 1986 indicates payment by 75 percent of discharged patients. Finally, Atlantida reports that in 1986, 76 percent of all maternity patients paid the full required fee. If that same percentage of patients had paid in 1985, revenues for maternity would have been 200 percent greater, implying a dramatic increase in collections for 1986 which is substantiated by the projected 88 percent increase in revenue between 1985 and 1986 (Table 2).

While these calculations and comparisons are only approximations, they nevertheless indicate that mechanisms which guarantee access for those who cannot pay does not assure payment from everyone else. Nevertheless, some hospital directors still view fee collection skeptically. Among these four hospitals, the two with the better collection rate from nonexempt patients, i.e., G. Alvarado and Atlantida, have hospital directors who view fees as an important and necessary source of hospital revenue and who actively pursue a fee collection agenda. The hospital administrators of the other two hospitals see fee revenue as essential to the ongoing operation of the hospital.

## Expenditure of Fee Revenues

Table 5 provides an overview of how hospitals spend fee revenue. The percent of total revenues expended in each category is based on an average of 1984-85 expenditures. The diversity of uses suggests the importance of autonomy in determining how revenue will be used. Table 6 indicates the importance of these expenditures for overall spending in these categories for 1984 and 1985, and reveals some yearly variation in expenditures spending patterns.

Hospital Escuela spent nearly half of its fee revenue on miscellaneous supplies, and these expenditures represented 16 percent of the total resources for this category during 1985. Similarly, the 17 percent of revenues spent on nonpersonnel services represented 11 percent of 1985 total resources for this item. While 13 percent of revenues were spent on wages and salaries, these resources represented less than 1 percent of overall expenditures. In contrast, 2 percent of revenues were spent on building maintenance and repair which represented 22 percent of overall expenditures in 1985. Finally, 10 percent of revenues were used for the purchase of medicines and pharmaceuticals, but this total was only 3 percent of the hospitals' pharmaceutical expenditures.

All regional hospitals spent their revenues for casual wage labor and on miscellaneous materials and supplies. On average, regional hospitals spent almost half of their fee revenues on wages for extra, noncivil service personnel and overtime for regular employees, yet these resources represented only 3 percent of their total expenditures in this category. Materials and supplies were the second important category for expenditure of fee revenue, and these expenditures

represented about 13 percent of total resources for general materials and supplies. All but one hospital used fee revenues for per diems which are travel expenditures for supervisory and training visits. While the share of revenues spent is only 3 percent, these expenditures represented over 50 percent of the total resources used for per diems. Expenditures in other categories vary by hospital and may vary from year to year for an individual hospital.

The pattern of expenditures from fee revenues is somewhat similar for area hospitals. One exception is the proportion of revenues that are used for surgical supplies. On average, area hospitals spent 30 percent of their revenues on surgical supplies, and depending on the hospital, expenditures represented between 13 and 50 percent of total expenditures in this category.

#### Comparison of Fees and Unit Costs of Service

A comparison of the unit cost of service with the fee established for that service is useful for determining the contribution to cost recovery of that service unit, or alternatively, its implied subsidy. Honduran hospitals are required to submit quarterly reports on unit costs of service in several categories. All hospitals use a standard method for distributing the monetary resources attached to budgetary line items across all of their service units. One problem with this method is that it may not reflect the actual resource use of any particular unit. The unit cost of a discharge, for example, does not include the ancillary services that were used to produce the discharge. An algorithm that distributes salary costs may not reflect the actual deployment of human resources. Given these problems, interpretations must be made with caution. Nevertheless, an illustrative comparison is useful.

Table 7 provides this comparison based on the reported unit costs from four hospitals for the fourth quarter of 1985. Although unit costs vary by as much as 20 percent from one quarter to another, the table does reveal orders of magnitude. Overall, obstetrics and gynecological services are the least subsidized services receiving an 80 percent subsidy, while general medicine and pediatric services tend to be more substantially subsidized ranging from 90 to 97 percent.

## REVENUES FROM FEES IN CESAMOS

CESAMOS collect L1 per visit and remit these funds to the regional office. The region determines how these revenues are spent. Revenues have to be deposited with the government, but there are no reporting requirements. Data were gathered from the record keeping systems in two regional offices to estimate the magnitude of these resources, and to determine how they are used. Tables 8 and 9 provide estimates for revenues and expenditures from La Ceiba and Comayagua.

Although the fee is very modest, the revenues generated are substantial. Regional offices accumulate more funds than most of the area or regional hospitals. These revenues are used to sustain the region's programs which are oriented to primary health care and child survival.

## CONCLUSIONS

The analysis of the Honduran experience reveals the feasibility of user fees as a financial vehicle for mobilizing economic resources. Revenues from user fees have been, and continue to be an increasingly important resource for Honduran hospitals. The 1983 policy directive established an environment which motivated hospitals to increase their fee revenues, which did in fact, do. The autonomy and independence that hospitals have had in setting fee schedules as well as in collecting and spending fee revenues were critical incentives which contributed to the present successful outcome. The government's de facto policy of benign neglect with regard to implementing fee collection has allowed hospitals to experiment, to remain flexible, and to tailor their fee schedules and their spending to their own needs and constraints. The very real budgetary constraints imposed on hospitals undoubtedly have further motivated them to expand revenue opportunities. In addition, their exclusive right to spend the funds they generated allowed hospitals to determine their own priorities for addressing resource constraints. Autonomy and independence also contributed to keeping the administrative cost of collection relatively low.

In the Honduran setting, user fees appear to be a positive resolution of the policy dilemma. The incremental revenues have enabled hospitals to maintain the quantity and quality of services. At the same time, there is widespread agreement that fee exemption procedures have ensured access to services for the most economically disadvantaged. Despite this progress, the Ministry of Health is far from achieving its goal of 30 percent cost recovery. There are several reasons why this is the case.

Most hospitals fail to collect fees from a significant portion of patients who do not pass through the formal exemption process. While all hospitals exempt certain categories of people by administrative fiat, in some hospitals these categories are quite numerous and in most hospitals social workers report that there is considerable misuse of this blanket exemption. Family members of individuals in exempt categories, for example, are not required to pay a fee. But frequently, very distant family relations are accorded this exemption. Social workers also report that individuals who are able to pay but have the right connections are granted exemptions inappropriately. If these users had paid, fee revenues in most instances would have more than doubled. This missed revenue reveals an inequity in the implementation of the fee policy.

In general, regional and area hospitals have accelerated the growth in fee income more than has the national hospital. This may be due to their greater need for discretionary income because they are less able than the national hospital to obtain budget increases. It also may reflect mechanisms at smaller hospitals which allow fewer individuals to pass through without either paying a fee or receiving an appropriate exemption. Hospital Escuela, where over half of all of the health system fee revenues are generated, is favored for budgetary increases and at the same time has the worst collection record. Patients obtaining services at Hospital Escuela are far less likely to pay a fee than those who obtain services elsewhere in the system. This situation implies that regional and rural populations are subsidizing the health services of the urban, capital population and may be

introducing a serious inequity into the system. If the Ministry expects to achieve its cost recovery goal and at the same time ensure access and equity, it will have to examine mechanisms for strengthening hospital fee collection in general and at Hospital Escuela in particular.

Fees have been used little as incentives in the Honduran setting. A few hospitals have recognized that higher prices for emergency outpatient visits can encourage more appropriate use of the outpatient facilities. However, the use of fees as incentives has remained largely unexplored. There is recognition of preventive and well child care as a merit good, since these services do not carry charges anywhere in the system. There also appears to be an implied acknowledgment within most hospitals that pediatric services are merit goods; pediatric services are more heavily subsidized and pediatric inpatients are far less likely to be charged for admission.

The Ministry of Health and hospitals themselves have gained much useful knowledge from this era of independence and autonomy for experimentation at the facility level with user fees. However, the absence of standard criteria and procedures regarding who must pay, how exemptions are determined, what prices for services are acceptable, and how records are to be kept may thwart further progress. Standard criteria and guidelines which would apply across the entire system are required to avoid serious inequities and to realize the full financial potential of user fees as a revenue source. A Ministry of Health classification of medical procedures, for example, with minimum and maximum fees would give hospital administrators more guidance in setting fees. A common system of record keeping and analysis would provide guidance to both hospitals and the Ministry regarding what actions are more

likely to enhance fee revenue. Although there is validity in continued experimentation at the facility level, the introduction of limited and selected standard criteria based on present knowledge would go far towards increasing revenues and improving equity considerations for the system.

The analysis lends support to the appropriateness of the user fee approach. It offers significant potential for addressing the economic needs of the hospital system in these times of financial crisis. The study also suggests that to realize fully this potential, considerable effort should be devoted to refining the administrative procedures and management systems for user fees. A user fee policy will only be as good as its implementation process.

TABLE 1  
COMPARISON OF HOSPITAL FEES  
(in Lempiras) (a)  
December 1986

	NATIONAL HOSPITAL	REGIONAL HOSPITALS					AREA HOSPITALS			
	Escuela	Santa Teresa	Leonardo Martinez	Del Sur	Atlantida	San Francisco	Gabriel Alvarado	Progreso	Yela	Puerto Cortes
<b>Inpatient Charges</b>										
Normal Delivery	10	20	25	2	35	20	15	25	35	25
Cesarean Delivery	35 or 10+ 1pt blood	20	25	6	35	30	40	90-110	35	100
General Medicine	35 or 10+ 1pt blood	20	25	1	35	10	15	10-20/day	35	3/day
Surgery	35 or 10+ 1pt blood	30	25	1	35	30	15	100-300	35	5/day
Pediatrics	35 or 10+ 1pt blood	10	25	1	35	10	10	8-16/day	35	5/day
Blood Transfusion	25	35-40	25	25	25	40	25	-	25	25
<b>Outpatient Charges</b>										
Outpatient Consultation	1	1	1	1	1	1.5	4	1	NA	NA
Emergency Consultation	3	1	2	1	1	NA	4	3	NA	NA
<b>Laboratory Services</b>										
Basic Exams	1	1-5	1-3	0.5-5	1-5	1.5-10	0.5-2.5	1-3	1-5	1-5
Complex Exams	5-150	1-10	-	1-5	1-15	-	1-3	1-15	-	1-5
<b>X-Rays</b>	5-150	10-30	8-12	5-10	10-20	10	10	7-50	10	15
<b>Other Procedures</b>	5-50	10	10	NA	10	NA	NA	50-500	NA	25-35

(a) One Lempira = US \$0.50

TABLE 2  
OPERATING BUDGETS AND REVENUES FROM FEES FOR ACUTE CARE HOSPITALS  
(in thousands of Lempiras)

	1982			1983			1984				1985			
	Budget	Revenues	Revenues as % total budget	Budget	Revenues	Revenues as % total budget	Budget	Revenues	Revenues as % total budget	Revenues as % non-personnel budget	Budget	Revenues	Revenues as % total budget	Revenues as % non-personnel budget
<b>NATIONAL HOSPITAL</b>														
Hospital Escuela	21,545	606	3.2	21,913	679	3.1	21,504	725	3.4	7.1	21,604	793	3.7	7.9
<b>REGIONAL HOSPITAL</b>														
Santa Teresa	1,499	59	3.9	1,510	73	4.7	1,499	88	5.9	13.2	1,515	101	6.7	15.6
Leonardo Martinez	5,270	96	1.8	5,400	99	1.8	5,206	251	4.8	10.2	5,316	292	5.5	12.3
Hospital del Sur	2,292	94	4.1	2,267	83	3.7	2,257	86	3.8	9.8	2,268	82	3.6	9.5
Hospital del Occidente	2,493	24	1.0	2,561	28	1.1	2,506	39	1.6	3.5	2,510	28	1.1	2.6
Hospital Atlantida	2,308	79	3.3	2,391	90	3.8	2,378	136	5.7	17.4	2,343	107	4.6	12.3
San Francisco	1,422	77	5.4	1,400	59	4.2	1,307	116	8.9	10.7	1,349	103	7.6	10.0
Subtotal	15,364	429	2.8	15,657	433	2.8	15,313	744	4.9	12.1	15,301	713	4.7	11.8
<b>AREA HOSPITALS</b>														
Gabriel Alvarado	1,007	67	6.2	1,120	88	7.1	1,090	79	7.2	14.4	1,110	90	8.1	16.5
Santa Barbara	1,451	30	2.1	1,407	32	2.2	1,447	46	3.2	7	1,455	47	3.2	7.2
Manuel J. Subirana	1,110	32	2.9	1,090	36	3.3	1,005	52	4.0	10.2	1,002	55	5.1	11.1
El Progreso(a)	-	-	-	1,189	87	2.3	1,190	89	7.4	15.6	1,100	80	6.7	16.3
Puerto Cortes(a)	-	-	-	136	-	-	532	-	-	-	935	24	2.4	5.0
Hospital Yela	1,000	104	9.6	1,000	93	8.6	1,072	119	11.1	20.3	1,053	79	7.5	20.5
Salvador Paredes	764	24	3.1	755	23	3.1	756	31	4.1	11.1	760	43	5.7	16.1
Tocoa	406	33	6.8	405	30	7.0	402	40	8.3	19.5	470	33	7.0	17.7
Subtotal	5,906	290	4.0	7,350	309	5.3	7,670	456	6.0	13.7	8,103	451	5.6	16.0
<b>Total</b>	<b>42,095</b>	<b>1,405</b>	<b>3.3</b>	<b>44,920</b>	<b>1,511</b>	<b>3.4</b>	<b>44,567</b>	<b>1,925</b>	<b>4.3</b>		<b>45,000</b>	<b>1,957</b>	<b>4.3</b>	

(a) El Progreso opened its doors in early 1983, Puerto Cortes in late 1983.

**TABLE 3**  
**SOURCES OF REVENUES FOR ACUTE-CARE HOSPITALS**  
 (as a percentage of total revenues)

	National Hospital		Regional Hospitals		Area Hospitals	
	(1)	(2)	(3)	(4)	(5)	(5)
	Escuela	Santa Teresa	Leonardo Martinez	Atlantida	Gabriel Alvarado	El Progreso
<b>Inpatient Services</b>	52%	43%	51%	56%	34%	54%
Maternity	17%	23%	35%	23%	NA	31%
Med./Surg./Ped.	5%	13%	16%	25%	NA	23%
Blood Bank	30%	7%	(b)	8%	Patient Donated	-
<b>Outpatient Services</b>	48%	58%	49%	44%	64%	44%
Outpatient Cons.	18%	22%	21%	19%	27%	8%
Emergency Cons.	7%	(c)	(c)	(c)	8%	7%
Laboratory Exams	2%	22%	5%	9%	4%	14%
X-Ray Services	10%	10%	19%	0%	8%	15%
Other Procedures & Services (a)	9%	4%	4%	14%	17%	NA

1) Based on 1984-1985 Data

2) Based on 1982-1985 Data

3) Based on 1983-1985 Data

4) Estimated from income receipts for March, June, September, December 1985

5) Based on 1983-1985 Data

(a) XIG, XIG, special drugs, dental clinic, health cards

(b) Included in Med./Surg./Ped. Category

(c) Included in outpatient consultations

NA = Data Unavailable

TABLE 4

## COMPARISON OF SERVICE STATISTICS AND EXEMPT PATIENT RECORDS

Hospital Escuela  
July-September, 1986

Service Unit	Total Discharges(a)	Exempt Patients	Percent Nonpaying
Female General Medicine (EMQ A, B, C wards)	591	162	27%
Male General Medicine (EMQ A, B, C wards)	577	198	34
Female Surgery (EMQ A, B, C wards)	290	13	4
Male Surgery (EMQ A, B, C wards)	406	21	5
Female Orthopedics (EMQ)	83	23	28
Male Orthopedics (EMQ)	171	45	26
Normal Childbirth (EMI)	3318	744	22
Gynecology (EMI)	1126	182	12
Pediatric Medicine & Surgery (EMI)	628	97	15
Total	7190	1485	20

(a) These discharges represent over 75 percent of the July-September total discharges.

TABLE 5  
 USE OF REVENUES  
 AVERAGE SHARE BY EXPENDITURE CATEGORY  
 1984-1985

	Casual Labor and Overtime	Per Diems	Building Maintenance & Repair	Non- Personnel Services	Food	Fuel	Medicines and Pharmaceuticals	Surgical Supplies	General Materials & Supplies	Machinery & Equipment
National Hospital Hospital Escuela	13%	0	2%	17%	5%	< 1%	10%	5%	45%	2%
Regional Hospitals										
Santa Teresa	66%	4%	15%	2%	0	5%	3%	1%	17%	0
Leonardo Martinez	36%	2%	0	5%	1%	1%	3%	12%	29%	15%
Hospital del Sur	15%	0	0	1%	0	8%	0	0	67%	5%
Hospital del Occidente	30%	12%	0	0	0	0	47%	0	10%	0
Hospital Atlantida	69%	4%	4%	7%	0	0	0	0	15%	0
San Francisco	37%	3%	0	0	12%	2%	0	23%	27%	2%
WEIGHTED AVERAGE	43%	3%	1%	4%	2%	2%	4%	8%	27%	7%
Area Hospitals										
Gabriel Alvarado	9%	6%	3%	2%	2%	2%	0	13%	43%	20%
Santa Barbara	0	10%	0	1%	23%	0	0	0	65%	0
Manuel J. Subiranan	0	3%	0	0	33%	8%	0	24%	20%	10%
El Progreso	20%	4%	0	0	8%	9%	0	57%	2%	1%
Puerto Cortes	0	16%	0	0	0	79%	0	0	0	0
Tela	26%	2%	0	0	0	3%	0	44%	2%	22%
Salvador Paredes	47%	7%	0	0	0	0	0	27%	22%	0
WEIGHTED AVERAGE	15%	6%	1%	0	9%	6%	0	30%	22%	12%

TABLE 6  
LINE ITEM EXPENDITURE OF FEE INCOME  
AS PERCENT OF TOTAL LINE ITEM REVENUE  
1984-1985

	CASUAL LABOR AND OVERTIME		PER DIEMS		BUILDING REPAIR AND MAINTENANCE		NON- PERSONNEL SERVICES		FOOD		FUEL		MEDICINES AND PHARMA- CEUTICALS		SURGICAL SUPPLIES		GENERAL MATERIALS AND SUPPLIES	
	1984	1985	1984	1985	1984	1985	1984	1985	1984	1985	1984	1985	1984	1985	1984	1985	1984	1985
National Hospital																		
Hospital Escuela	<1	<1	0	0	0	22	13	11	3	1	92	0	1	3	0	4	18	16
Regional Hospitals																		
Santa Teresa	7	7	44	44	22	0	48	0	0	0	22	46	0	2	2	0	9	14
Leonardo Martinez	2	4	38	38	0	0	33	25	0	0	0	5	1	0	5	0	12	12
Del Sur	0	2	0	0	0	0	11	0	0	2	36	40	0	0	0	0	32	25
Occidente	0.1	0.1	0	58	0	0	0	0	0	0	0	0	6	3	0	0	2	1
Atlantida	6	5	41	53	0	50	0	0	13	0	0	0	0	0	0	0	14	0.4
San Francisco	4	4	49	44	0	0	0	0	3	20	49	0	0	0	26	33	36	15
Area Hospitals																		
Gabriel Alvarado	0	2	58	40	0	49	18	0	0	0	14	16	0	0	20	16	27	28
Santa Barbara	0	0	64	58	0	0	0	20	8	7	2	0	0	0	0	0	20	21
H. de J. Subirana	0	0	0	10	0	0	13	0	0	23	8	13	0	0	0	52	45	9
El Progreso	3	2	34	60	0	0	0	0	0	15	17	0	0	0	—	53	10	0
Puerto Cortes	—	0	—	55	—	0	—	0	—	0	—	0	0	7	—	0	—	0
Tela	3	3	44	53	0	0	0	25	0	0	33	18	0	0	37	48	43	2
Salvador Paredes	3	4	24	46	0	0	0	0	0	0	0	0	9	0	12	36	16	7

a) Total Line Item Revenue = Budgeted allocation for line item plus fee income expended on line item.

TABLE 7  
COMPARISON OF UNIT COSTS AND FEES

	GENERAL MEDICINE DISCHARGE			SURGERY DISCHARGE			OB/GYN DISCHARGE			PEDIATRIC DISCHARGE			OUTPATIENT VISIT			EMERGENCY VISIT		
	Unit Cost	Fee	% Cost Recovery	Unit Cost	Fee	% Cost Recovery	Unit Cost	Fee	% Cost Recovery	Unit Cost	Fee	% Cost Recovery	Unit Cost	Fee	% Cost Recovery	Unit Cost	Fee	% Cost Recovery
<b>Regional Hospitals</b>																		
Santa Teresa	397	20	5%	432	30	7%	102	20	20%	341	10	3%	NA			25	1	4%
Leonardo Martinez	513	25	5%	614	25	4%	127	25	20%	471	25	5%	14	1	7%	24	2	8%
Atlantida	795	35	4%	349	35	10%	163	35	21%	341	35	10%	NA			NA		
<b>Area Hospitals</b>																		
Gabriel Alvarado	357	15	4%	459	15	3%	137	15	11%	527	10	2%	12	1	8%	10	1	1%

TABLE 8

REVENUES FROM CESAMOS  
(in Lempiras)

	1984	1985	1986
LA CEIBA	206,518(a)	108,458(b)	151,179(c)
COMAYAGUA	128,146(d)	186,574	129,524(e)

a) Includes 49,995 collected from Hospitals Atlantida, Tocoa, and Tela: tabulations made from regional record books; 22% of revenues derive from CESAMO Olanchito.

b) Jan-June, 1985

c) Jan-Oct., 1986

d) Does not include May

e) Jan-April, June-Sept., 1986

TABLE 9  
EXPENDITURE OF CESAMO FEE REVENUES  
1986  
(in Lempiras)

	LA CEIBA(a)		COMAYAGUA(b)	
	Total	%	Total	%
Salaries and Wages				
Permanent (111)	27,363	20%	13,299	22
Other (112,115,116)	9,239	7	1,504	3
Per Diems (230)	25,162	18	18,612	31
Building Maintenance (280)	3,458	3	3,623	6
Vehicle & Equipment Repair (200)	26,113	19	NONE	—
Fuel (361)	59	<1	NONE	—
Surgical Supplies (397)	NONE	—	812	1
	(398-99)	NONE	15,374	26
Machinery & Equip.(400)	11,375	8	400	<1
Loans to Personnel (100)	6,233	5	NONE	—
Other	NONE	—	5,372	9

a) Tabulations from Region record-books for 19 CESAMOS: Jan-Aug, 1986  
b) Tabulations from Region record-books: Jan-Mar, 1986

TABLA 1A  
COMPARACION DE PRECIOS  
(en Lempiras)  
DIC. 1986

	HOSPITAL									
	NACIONAL	HOSPITALES REGIONALES					HOSPITALES DE ARRA			
	Escuela	Santa Teresa	Leonardo Martinez	Del Sur	Atlantida	San Francisco	Gabriel Alvarado	Progreso	Tela	Puerto Cortes
<b>Maternidad</b>										
Normal	10	20	25	2	35	20	15	25	35	25
Cesarea	10 + sangre	20	20	6	35	30	40	90-110	35	100
<b>Hospitalizacion</b>										
Medicina Interna	10 + sangre	20	25	1	35	10	15	10-20/DIA	35	5/DIA
Cirugia	10 + sangre	30	25	1	35	30	15	100-300	35	5/DIA + 25-100
Pediatrica	10 + sangre	10	25	1	35	10	10	8-16/DIA	35	5/DIA
Sangre	25	35-40	25	25	25	40	25	Donado	25	25
Consulta Externa	1	1	1	1	1	1.5	1	1	2	-
Emergencias	3	1	2	1	1	-	1	3	-	-
<b>Servicios de Laboratorio</b>										
Neatologia	1	1	1	1.5	1	-	1-2	1	1	1-4
Heces	1	1	1	.75	1	1.5	.50	1	1	1
Orina	1	1	1	.75	1	1.5	.50	1	1	1
Colesterol	-	4	-	5	5	1.5	-	3	1	-
Tipo Rh	-	3	-	5	3	1.5	2	3	1	1
Acido Urico	-	4	-	5	3	1.5	-	3	1	3
Glucosa	-	3	-	5	-	1.5	-	3	5	-
Gravindex	-	5	3	5	5	10	2.5	3	-	5
Neatosoarios	-	1	-	.50	gratis	-	-	1	1	-
Cultivos y Antibioqr.	-	10	3	-	15	-	1.5	10	-	-
Otros	5-150	1-10	-	1-5	1-15	-	1.3	1-15	-	1-5
<b>Rayos X</b>										
Abdomen	5	10	12	5-10	15	10	10	12	10	15
Cabeo	11	15	8	5-10	15	10	10	10	10	15
Torax	5	10	10	5-10	15	10	10	12	10	15
Brazo	6	10	12	5-10	10	10	10	7	10	15
Otros	5-150	10-30	-	-	10-20	-	-	7-50	-	-
<b>Procedimientos</b>										
RIG	50	-	10	-	-	-	-	-	-	-
RIG	15	10	10	-	-	-	-	35	-	-
Yeso	5-35	-	-	-	10	-	-	50-500	5	25-35
Tarjeta de Salud	-	-	3	3	3	3	-	-	-	-
Odontologia	1-2	-	-	1	2	1.50	3	-	-	2

TABLA 2A  
PRESUPUESTO E INGRESO POR HOSPITAL 1982-1986  
(en miles de Leopiras)

	1982			1983			1984				1985			
	PPTO.	Ingreso	Ingreso x PPTO total	PPTO.	Ingreso	Ingreso x PPTO total	PPTO.	Ingreso	Ingreso x PPTO total	Ingreso x PPTO No Personal	PPTO.	Ingreso	Ingreso x PPTO total	Ingreso x PPTO No Personal
<b>HOSPITAL NACIONAL</b>														
Hospital Escuela	21,545	686	3.2	21,913	689	3.1	21,584	725	3.4	7.1	21,604	793	3.7	7.9
<b>HOSPITALES REGIONALES</b>														
Santa Teresa	1,499	59	3.9	1,510	73	4.7	1,499	80	5.9	13.2	1,515	101	6.7	15.6
Leonardo Marrines	5,270	98	1.8	5,400	99	1.8	5,286	251	4.8	10.2	5,316	292	5.5	12.3
Hospital del Sur	2,292	94	4.1	2,267	83	3.7	2,257	86	3.8	9.8	2,268	82	3.6	9.5
Hospital del Occidente	2,493	24	1.0	2,561	28	1.1	2,506	39	1.6	3.5	2,510	28	1.1	2.6
Hospital Atlántida	2,308	79	3.3	2,391	98	3.8	2,378	136	6.9	17.4	2,343	107	4.6	12.3
San Francisco	1,422	77	5.4	1,400	59	4.2	1,307	116	8.3	10.7	1,349	103	7.6	10.8
Subtotal	15,364	429	2.8	15,657	433	2.8	15,313	744	4.9	12.1	15,301	713	4.7	11.8
<b>HOSPITALES DE AREA</b>														
Gabriel Alvarado	1,007	67	6.2	1,128	80	7.1	1,098	79	7.2	14.4	1,110	98	8.1	16.5
Santa Barbara	1,451	39	2.1	1,487	32	2.2	1,447	46	3.2	7.8	1,455	47	3.2	7.2
Raquel J. Subirana	1,110	32	2.9	1,098	36	3.3	1,085	52	4.8	10.2	1,082	55	5.1	11.1
El Progreso	-	-	-	1,189	87	2.3	1,198	89	7.4	15.6	1,188	88	6.7	16.3
Puerto Cortes	-	-	-	136	-	-	532	-	-	-	985	24	2.4	5.0
Hospital Tela	1,080	104	9.6	1,080	93	8.6	1,072	119	11.1	28.3	1,053	79	7.5	20.5
Salvador Paredes	764	24	3.1	755	23	3.1	756	31	4.1	11.1	760	43	5.7	16.1
Toca	486	33	6.8	485	38	7.8	482	48	8.3	19.5	478	33	7.8	17.7
Subtotal	5,986	298	4.8	7,358	389	5.3	7,678	456	6.8	13.7	8,183	451	5.6	16.8
<b>Total</b>	<b>42,895</b>	<b>1,485</b>	<b>3.3</b>	<b>44,928</b>	<b>1,511</b>	<b>3.4</b>	<b>44,567</b>	<b>1,925</b>	<b>4.3</b>		<b>45,888</b>	<b>1,957</b>	<b>4.3</b>	

TABLE 2B  
CAMBIOS DE INGRESOS Y PRESUPUESTOS 1983/85-86

	1983			1985				1986		% Aumento 83-85		% Aumento 85-86	
	PPTO.	Ingreso	Ingreso % PPTO total	PPTO.	Ingreso	Ingreso % PPTO total	Ingreso % PPTO no personal	PPTO.	INGRESO	PPTO.	INGRESO	PPTO.	INGRESO (4)
Hospital Nacional Hospital Escuela	21,913	689	3.1	21,604	793	3.7	7.9	26,287	668 (1)	-1.4	15.1	21.7	1.1
Hospitales Regionales													
Santa Teresa	1,540	73	4.7	1,515	101	6.7	15.6	2,553	98 (2)	-1.6	38.4	68.5	5.9
Leonardo Martinez	5,408	99	1.8	5,316	292	5.5	12.3	6,302	339 (3)	-1.7	194.9	18.5	16.1
Hospital del Sur	2,267	83	3.7	2,268	82	3.6	9.5	2,547	118 (3)	0	-1.2	12.3	43.9
Hospital del Occidente	2,561	28	1.1	2,510	28	1.1	2.6	2,760	34 (3)	-2.0	-3.4	10	21.4
Hospital Atlantida	2,391	90	3.8	2,343	107	4.6	12.3	2,570	168 (1)	-2.0	18.9	9.7	88.4
San Francisco	1,400	59	4.2	1,349	103	7.6	18.8	1,497	126 (3)	-3.6	74.6	11	22.3
<b>SUBTOTAL</b>	<b>15,657</b>	<b>433</b>	<b>2.8</b>	<b>15,301</b>	<b>713</b>	<b>4.7</b>	<b>11.8</b>	<b>18,229</b>	<b>883</b>				
Hospitales de Area													
Gabriel Alvarado	1,128	80	7.1	1,110	90	8.1	16.5	1,475	108 (2)	-1.6	12.5	32.9	30.9
Santa Barbara	1,487	32	2.2	1,455	47	3.2	7.2	1,600	47 (3)	-2.2	2.2	10	0
Manuel J. Subiranan	1,090	36	3.3	1,082	55	5.1	11.1	1,285	62 (3)	-.7	52.8	11.4	12.7
El Progreso	1,189	87	2.3	1,188	80	6.7	16.3	1,312	73 (2)	-.1	-8.0	10.4	-1.3
Puerto Cortes	136			985	24	2.4	5.0	1,086	88 (3)	624.3	NA	10.3	266.7
Hospital Tela	1,080	93	8.6	1,053	79	7.5	20.5	1,185	46 (3)	-2.5	-15.1	12.5	-71.7
Salvador Paredes	755	23	3.1	760	43	5.7	16.1	854	42 (3)	0.7	87.0	12.4	-2.4
Tocoa	485	38	7.8	470	33	7.0	17.7	532	34 (3)	-3.1	-13.2	13.2	3
<b>SUBTOTAL</b>	<b>7,350</b>	<b>389</b>	<b>5.3</b>	<b>8,103</b>	<b>451</b>	<b>5.6</b>	<b>16.8</b>	<b>9,249</b>	<b>462</b>				

(1) Cifras actuales hasta Octubre, 1986.

(2) Cifras actuales hasta Noviembre, 1986.

(3) Cifras proyectadas para el año por MSP a comparación 83-85

(4) Basado en los ingresos del '86 proyectados hasta el fin del año.

**TABLA 3A**  
**FUENTES DE INGRESOS PARA HOSPITALS**  
 (por porcentaje de contribucion de acuerdo a ingreso total)

	Hospital Nacional	Hospitales Regionales			Hospitales de Area	
	Escuela	Santa Teresa	Leonardo Martinez	Atlantida	Gabriel Alvarado	El Progreso
Hospitalizacion	52%	43%	51%	56%	34%	54%
Maternidad	17%	23%	35%	23%	81%	31%
Med./Cirugia/Ped.	5%	13%	16%	25%	51%	23%
Banco de Sangre	30%	7%	b)	8%	Donado por Paciente	-
Servicios de Consulta Externa	46%	58%	49%	44%	64%	44%
Consulta Externa	18%	22%	21%	19%	27%	8%
Consulta de Emergencia	7%	c)	c)	c)	8%	7%
Exámenes de Laboratorio	2%		5%	9%	4%	14%
Rayos X	10%	10%	19%	0%	8%	15%
Otros Procedimientos & Servicios (a)	9%	4%	4%	14%	17%	51%

1) Basado en los datos de 1984-1985

2) Basado en los datos de 1982-1985

3) Basado en los datos de 1983-1985

4) Estimado de acuerdo a los recibos de marzo, junio, septiembre y diciembre 1985

5) Basado en los datos de 1983-1986

(a) Electrocardiograma, electroencefalograma, medicamentos especiales, clinica dental, tarjetas de salud

(b) Incluida en la categoria de Med./Cirugia/Ped.

(c) Incluida en consulta externa

SI = Sin Informacion

TABLE 28  
ESTRUCTURA DEL INGRESO  
PORCENTAJE DEL INGRESO TOTAL POR FUENTE

HOSPITAL ESCUELA	PATRIAL HOSPITAL		
	1984	1985	1986*
Hospitalización	22.05	22.4	22.13
Maternidad	16.52	17.01	NA
Cirugía	2.21	2.12	NA
Medicina	1.69	1.61	NA
Pediatría	1.63	1.66	NA
Sangre	29.68	29.51	29.52
Consulta Externa	10.56	11.51	10.23
Pediatría	10.16	9.59	NA
General	7.01	7.50	NA
Otro	0.59	0.34	NA
Rayos X	10.26	10.96	9.22
Emergencia	7.23	7.11	7.02
Procedimientos	6.13	6.39	5.55
Laboratorio	2.35	2.86	3.06
Otro(1)	3.57	3.12	6.07
Seguro Social	0.17	0.16	NA

\* Valores hasta Octubre

(1) Electroencefalograma  
Electro Cardiograma  
Endoscopia  
Citología  
Densitometría  
Insulina

TABLE 29  
ESTRUCTURA DEL INGRESO  
PORCENTAJE DEL INGRESO TOTAL POR FUENTE

SANTA TERESA	HOSPITALES REGIONALES				
	1982	1983	1984	1985**	1986
Hospitalización	39.1	35.1	33.4	42.6	41.6
Maternidad	24.0	19.5	20.0	26.0	25.0
Cirugía G.	6.1	7.5	6.4	0.2	9.4
Medicina G.	1.9	1.5	1.4	1.0	1.6
Cirugía G.	1.0	2.2	1.0	2.1	1.0
Medicina G.	1.6	1.4	1.3	1.6	1.2
Pediatría	3.6	3.0	2.5	2.1	1.0
Laboratorio	23.9	21.6	19.0	19.3	15.3
Emergencia/Consulta Externa	21.2	25.2	26.6	16.3	15.3
Rayos X	9.0	5.5	10.4	10.7	15.2
Bancos de Sangre	-	-	7.0	7.7	10.3
Otro	5.0	5.6	2.4	3.4	2.7
LUISIANO MARTÍNEZ					
Hospitalización (a)	NA	49.6	52.7	51.0	
Maternidad	NA	32.7	33.6	39.7	
Cirugía G.	NA	-	-	1.6	
Medicina G.	NA	-	-	6.2	
Cirugía G.	NA	-	-	1.3	
Medicina G.	NA	-	-	1.9	
Pediatría	NA	-	-	0.3	
Trauma/Ortoped	NA	-	-	0.7	
Rayos X	NA	22.0	21.0	15.4	
Consulta Externa	NA	15.0	20.0	20.4	
Laboratorio	NA	7.9	6.1	3.0	
Fisioterapia/Cirugía-Plástica/IIIC	NA	1.9(1)	1.1(2)	1.6(3)	
Otro	NA	3.6	0.5	0.3	
ATLANTIDA (b)					
Hospitalización	NA	NA	NA	40.0	
Maternidad	NA	NA	NA	23.1	
Cirugía G.				3.4	
Medicina G.				5.7	
Cirugía G.				6.2	
Medicina G.				3.6	
Ginecología				6.0	
Pediatría				2.3	
Ortopedia				0.1	
Consulta Externa				19.1	
Tarjetas de Salud (Escuela y Barrio)				9.5	
Laboratorio				0.7	
Sangre				7.5	
Clinica Dental				3.7	
Cirugía Menor y Tese				3.0	

(a) Estimaciones basadas en recibos del talonario de los meses sep.-dic. 1985  
(b) Estimaciones de ingreso basadas en recibos del talonario de los meses marzo-junio, septiembre, diciembre 1985. Durante este periodo el equipo de rayos x no funcionaba

(1) solo fisio terapia  
(2) fisioterapia y cirugía plástica

TABLE 30  
ESTRUCTURA DEL INGRESO  
PORCENTAJE DEL INGRESO TOTAL POR FUENTE

CARIBBE ALVARADO	HOSPITALES DE AREA			
	1984*	1985	1986	1986
Hospitalización	37.0	32.2	34.1	34.4
Consulta Externa	27.0	30.3	23.2	27.5
Tarjetas de Salud	15.7	12.0	12.2	16.0
Rayos X	6.0	10.4	10.1	5.1
Consulta Emergencia	0.6	0.5	9.4	7.3
Laboratorio	1.3	1.0	6.0	6.3
Otros	1.9	2.0	0.0	2.2
EL PROGRESO				
Hospitalización	23.0	23.1	23.1	23.2
Obstetricia	30.6	30.0	30.0	30.0
Medicina	6.6	6.6	6.6	6.6
Cirugía	10.0	11.0	11.0	10.9
Pediatría	3.1	2.2	2.2	2.4
Ortopedia	3.3	3.3	3.3	3.3
Rayos X	15.2	15.3	15.3	15.3
Laboratorio	14.4	14.5	11.5	14.5
Consulta Externa-Especialidad	0.5	0.6	0.6	0.6
Consulta Externa-Emergencia	1.5	7.7	7.7	7.6

\* Cifras basadas en datos de solo seis meses

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TABLA 5 A  
GASTO DE LOS INGRESOS PROPIOS  
(ingreso en miles de Leapiras)

	JORNALS Y SUELDOS a)		VIATICOS b)		MANTENIMIENTO Y REPARACION DE EDI. c)		SERVICIOS NO PERSONALES d)		ALIMENTOS e)		COMBUSTIBLES Y LUBRICANTES f)		MEDICINAS g)		SUNISTROS DE CIRUGIA h)		OTROS SUNISTROS i)		MAQUINARIA Y EQUIPO j)																			
	1984	1985	1984	1985	1984	1985	1984	1985	1984	1985	1984	1985	1984	1985	1984	1985	1984	1985	1984	1985																		
	ING X	ING X	ING X	ING X	ING X	ING X	ING X	ING X	ING X	ING X	ING X	ING X	ING X	ING X	ING X	ING X	ING X	ING X	ING X	ING X																		
HOSPITAL NACIONAL	95	13	94	12	0	0	0	0	28	4	143	19	124	15	53	7	19	2	3	0.4	-	-	51	7	115	14	-	-	74	9	365	50	312	39	11	1	28	3
HOSPITALES REGIONALES																																						
Santa Teresa	61	69	65	61	4	5	4	4	1	1	0	-	3	3	0	-	0	-	2	2	7	7	0	-	5	5	2	2	0	-	12	14	20	20	0	-	0	-
Leo Martinez	81	32	113	39	3	1	5	2	0	-	0	-	15	6	10	3	0	-	0	-	3	1	14	6	0	-	42	26	26	9	101	40	50	17	6	2	85	29
Del Sur	4	5	24	29	0	-	0	-	2	2	0	-	0	-	0	-	0	-	6	7	7	9	0	-	0	-	0	-	0	-	5	13	2	7	0	-	0	-
Occidente	11	22	9	32	0	-	7	25	0	-	0	-	0	-	0	-	0	-	0	-	0	-	23	50	10	35	0	-	0	-	35	21	10	9	0	-	0	-
Atlantida	101	62	83	77	3	2	5	5	0	-	0	-	0	-	0	-	0	-	0	-	0	-	0	-	0	-	0	-	0	-	52	41	12	11	3	3	0	-
Saa Francisco	29	25	50	49	3	3	3	3	0	-	0	-	3	3	0	-	3	3	4	3	0	-	0	-	0	-	22	10	30	29	52	41	12	11	3	3	0	-
HOSPITALES DE AREA																																						
Gabriel Alvarado	4	5	11	12	7	9	3	3	0	-	5	6	3	4	0	-	0	-	3	3	0	-	0	-	0	-	12	15	10	11	35	41	37	41	15	10	19	21
Santa Barbara	0	-	0	-	5	11	4	9	0	-	0	-	0	-	1	2	12	25	12	25	10	21	0	-	0	-	0	-	0	-	29	63	32	68	0	-	0	-
Hauuel Subirana	0	-	0	-	3	6	0	-	0	-	0	-	0	-	0	-	17	33	17	33	18	33	0	-	9	16	0	-	0	-	13	25	8	15	11	21	0	-
El Progreso	10	20	16	20	2	2	5	6	0	-	0	-	0	-	0	-	0	-	0	-	0	-	0	-	0	-	0	-	0	-	0	-	0	-	0	-	0	-
Paerto Cortes	0	-	0	-	6	-	4	16	0	-	0	-	0	-	0	-	0	-	0	-	0	-	0	-	0	-	0	-	0	-	0	-	0	-	0	-	0	-
Tela	19	16	29	37	5	4	0	-	0	-	1	1	0	-	0	-	0	-	0	-	0	-	0	-	0	-	0	-	0	-	0	-	0	-	0	-	0	-
Salvador Paredes	15	48	20	46	2	6	3	7	0	-	0	-	0	-	0	-	0	-	0	-	0	-	0	-	0	-	0	-	0	-	0	-	0	-	0	-	0	-

a) codigos 111-129  
b) codigo 230  
c) codigo 200  
d) codigo 200  
e) codigo 310

f) codigo 361  
g) codigo 365  
h) codigo 397  
i) codigo 300  
j) codigo 4,129