PN-ABF-512
ISN 67003

HEALTH CARE FINANCING IN LATIN AMERICA AND THE CARIBBEAN
USAID Contract #LAC-0632-C-00-5137-00

Primary Health Care Services and Agro-Export Farmworkers in Guatemala: Study Design
(revised version)

Prepared by:

John L. Fiedler and Alfredo Solari

Submitted to:

State University of New York at Stony Brook

September, 1987

International Resources Group, Ltd.
100 North Country Road
Setauket, NY 11733 USA

Revised Version
10/9/87

HEALTH CARE FINANCING IN LATIN AMERICA AND THE CARIBBEAN

USAID Contract #LAC-0632-C-00-5137-00

PRIMARY HEALTH CARE SERVICES AND AGRO-EXPORT FARMWORKERS IN GUATEMALA: STUDY DESIGN

Study Design (Revised, Sept. 1987)

By John L. Fiedler and Alfredo Solari

1. Subject of Study

Existing arrangements for the delivery and financing of primary care services to agricultural workers of export crop farms and for their families will be analyzed in terms of costs and results using a case study approach.

2. Background

The agricultural workers of export crops in Guatemala can be divided into two groups: (a) the permanent workers who live with their family on the farm during the entire year and (b) the migrant workers who come to work on these farms, for a period of one to three months, either by themselves or with their families.

Although a more complete review of the relevant literature will be made as part of this study, several previous studies have documented the poor living conditions, low health status and difficulties in accessing primary care services by these two populations. Studies by G. Brown in 1977, of Deman de Andrade and Mazariegos in 1983, and Saenz in 1985 are particularly

relevant.

Several types of arrangements to provide primary care services to the permanent and migrant workers and their families exist in Guatemala:

(a) The Ministry of Health (MOH) provides health care services to Guatemala's rural population through a system of health centers and health posts. The centers are generally located in the county seats of government (cabeceras), whereas the health posts are usually located in predominantly rural areas or villages. The latter, though generally located in closer proximity to the plantations where the population of interest in this study lives, are still difficult to access. Moreover, what is more important, these facilities have traditionally limited their service provision to patients who come to them. The MOH is currently implementing a program intended to encourage the outreach activities of the centers and posts; however, this effort is unlikely to greatly affect the access to or utilization of care: farm owners are likely to continue their traditional policy of severely restricting entry into their plantations.

(b) The Guatemalan Social Security Institute (IGSS) does not have services in the rural areas. Its lowest tier of care consists of the health center. Hence, to the extent that rural workers are covered by IGSS, they have a markedly lower level of access to services. In the regions of the country where export crops are produced, IGSS operates only one of its three health services regimes, the accident prevention and treatment program, including occupational health service. This program covers only

agricultural workers, and does not provide any coverage to their families.

Furthermore, from interviews conducted during the exploratory visit with individual producers and workers it was learned that even these services of IGSS are difficult to access; long distances and the dearth of reliable transportation constitute considerable deterrents to seeking and obtaining care. IGSS has made a decision to introduce its other two programs (mother and child care and general medical attention) in these regions and is presently studying alternative delivery systems to implement its decision.

c) In the private sector there are several types of arrangements that provide health services to the agricultural population in these regions. These arrangements cover primarily the permanent worker population and their families, although some allow for emergency treatment for migrant workers. From a review of available documents and from interviews it appears that the most commonly used or the most important types of such systems are:

i. private physicians and pharmacists working in nearby towns and villages, who serve as the primary health care providers for the population working and living (even temporarily) at the fincas. While some of the physicians are in private practice, others are medical students fulfilling their national health service obligation through MOH primary health care service work. In both cases, the care provided to the agricultural population is primarily curative in nature, and

generally financed through a private arrangement between the physicians and the plantation owners.

ii. Some farms especially the very largest of plantations have a health service of their own. Most commonly, they are staffed by physicians and nurses, and are organized, controlled and financed by the farm owner. Here too, in most cases, the services provided are overwhelmingly curative in nature.

iii. Eighteen plantations have an agreement with a private sector organization (PSO) called Agrosalud. Agrosalud provides centralized administrative, technical and material support to the 18 paramedics who each permanently reside on the finca they service. The paramedics are graduates of the Berhorst Clinic training regimen, where they receive training in both preventive and curative care. The 18 Agrosalud finca health programs are organized jointly with the farm owners who finance the entire operation.

iv. A physician with formal public health training sells a preventive medicine package of services to a limited number of farms.

v. A regional coffee trade association has organized three health facilities, each of which serves a limited number of coffee plantations with physician-provided preventive and curative services. The national association (ANACAFE) has plans to reproduce this approach on a national basis, financed with a portion of the fees paid by its members.

The five different arrangements just noted, are designed to provide care for the permanent agricultural laborers who reside on fincas. Apparently there are no specific programs designed for the migrant agricultural workers and their families. This segment of the population, which has been estimated to consist of nearly one-fifth of the entire Guatemalan population, has the lowest living and health conditions in the country. Delivery of primary care services by private sector organizations to this migrant population would require (1) the expansion of existing ones to provide coverage to this disfavored group, and/or (2) the development of new arrangements which specifically targetting this difficult to reach but high risk group. Both approaches would have to consider the cultural and language barriers to health care utilization characterizing the majority of this population, as well as its special health needs and its relatively limited stay on a particular farm (generally approximately one month).

3. Current Importance of Study

According to MOH, IGSS and National Planning Department (SEGEPLAN) officials, the Government of Guatemala (GOG) assigns high priority to the socioeconomic and specifically the health conditions of the agricultural population in the coastal pacific region. Among other policies aimed at improving the living standards of this population, particulary relevant to this study is the decision to expand MOH and Sickness Insurance programs by

IGSS to the nine Departaments comprising this region.

It is also noteworthy that the USAID/Guatemala plans to develop a project in the next fiscal year to help expand coverage of the population with primary care services, particularly through a Child Survival Approach emphasizing five interventions: oral rehydration therapy, immunizations, treatment of acute respiratory infection, monitoring growth and development and birth spacing. Private organizations will be invited to implement this project together with public sector institutions.

In their efforts to implement these plans, both the GOG and USAID may confront an important issue: the mutual mistrust and sometimes openly antagonistic relationships between farm owners and workers on the one hand, and between private sector and public sector organizations on the other. For farm owners interested in providing increased access to health care to their agricultural workers and their families, private sector organizations may provide the only acceptable approach, and this may prove to be acceptable to MOH and IGSS officials. In short, a PSO alternative may provide the only mutually acceptable approach by which either to expand IGSS programs or effectively to implement the proposed USAID project to this substantial segment of Guatemalans.

The study to be implemented will consist of a description and analysis of existing private arrangements for delivering health services to this population in order to determine their costs and their benefits as well as their capability of expansion and replicability. This objective is considered by USAID/Guatemala a potentially important contribution to achieve

its own objectives and to promote a policy dialogue with and between the MOH and IGSS regarding the financing and organizational aspects of health care delivery to the agricultural population.

4. Specific Study Objectives

a) To develop an inventory of major public and private health resources in each department, and to develop the best possible estimates of the coverage of the permanent and migrant populations by each type of provider (MOH, IGSS, and private) by municipio.

b) To identify and describe in detail existing private sector institutions or arrangements for delivering and financing preventive and ambulatory health care services to agricultural workers of export crops (coffee, cotton and sugar cane) and their families in those municipios in which the greatest proportion of farm land is devoted to agro-export crop production in the six departments of interest (Santa Rosa, Escuintla, Suchitepequez, Retalhuleu, Quetzalienango, and San Marcos). We will also identify and describe arrangements which have already proven to be successful in addressing the unique needs of the target population in other parts of the country.

c) Among those arrangements idenified and described in section (b) above, identify two or three private sector arrangements or institutions that have the highest probability of being expanses and/or replicated within the target region.

d) To undertake case studies of those two or three institutions or arrangements to identify their impact in terms of population coverage, accessibility, utilization, and (to the extent that such data is available) the costs and sources of financing of such services.

e) To identify changes that could be introduced in existing institutions or arrangements -- as indicated in paragraph (b) -- to increase their potential for replicability and/or expansion.

5. Methodology and Work Plan

The study will consist of five steps: (1) design, (2) inception, (3) initial background data collection, (4) additional field research, (5) report writing.

(1) DESIGN: This phase of the project has already been completed with the exploratory visit and the preparation of the present revised draft design.

(2) INCEPTION: This phase of the project consists of John Fiedler and Alfredo Solari visiting Guatemala for one week, during which they will meet with USAID officials to finalize the Design, and recruit and orient the host country counterparts and local-hire U.S. anthropologist in their respective responsibilities in carrying out this study.

(3) INITIAL BACKGROUND DATA COLLECTION: This phase of the project will be three weeks in duration. It will consist of the local counterparts (a) gathering background data on the target population, (b) gathering background data on the agricultural sector in the six departments of interest, (c) identifying and verifying the various private sector arrangements for providing care to the target population, and (d) developing an inventory of health care providers and their respective coverage in the six departments.

(a) TARGET POPULATION PROFILE: The target population consists of the rural agricultural workers and their families in the southwestern region of Guatemala, including both the

permanent workers (colonos) who live on the fincas and the migrant workers (both cuadrilleros and voluntarios). Data to be collected will include the latest available estimates of the size of each group by municipio of work, by farm size, crop type and by the migrants' department of residence, as well as the composition of each group in terms of health status, age, sex, family size, and in the case of migratory workers, whether or not the family accompanies the migrant. Also, the different characteristics of the physical environment of the fincas, the average or most common living conditions on the fincas, including the quantity and quality of available water, sanitation facilities, and housing arrangements will be documented from secondary sources.

b) AGRICULTURAL SECTOR PROFILE: The farms of each municipio in each of the six departments will bedescribed and categorized by crop type, size of holding, and output. In addition, total annual production of coffee, cotton, sugar cane, sorghum, and soya produced in each department of the Republic in each of the past 10 years will be assembled on both a quantity and a value basis. Finally, price and output forecasts by crop type will be obtained from secondary sources for cofee, sugar cane, cotton, sorghum and soya. The objective of this porduction profile is to assess the potential of the region's economic base to support private-sector financing of health care for the target population.

c) HEALTH CARE SUB-SYSTEM'S PROFILES: Information will be collected from secondary sources, and telephone and direct

personal interviews about each public (MOH and IGSS) and private sector organization's inventory of health care resources, including the numbers and types of the most important types of human resources (physicians, graduate nurses, auxiliary nurses, rural promoters, rural health technicians, and environmental health technicians--excluding all those who are hospital-based) in the six departments in question. The inventory of facilities will document the functional status of each facility, including whether or not it is regularly open, and, if so, what is the regular schedule of services. This information will be the basis of a background paper which is to be written by the local counterparts during initial field work, Phase 3, and which will be incorporated into the final report as an appendix.

d) IDENTIFICATION OF PRIVATE SECTOR ARRANGEMENTS FOR THE PROVISION OF HEALTH CARE TO THE TARGET POPULATION: Information from secondary sources, combined with a telephone survey and direct personal interviews of the MOH Area Health Chief, the IGSS Services Department Chief and the local medical association for each of the six departments will be undertaken to identify private sector arrangements for the provision of health care to the target population. We will also indentify and describe arrangements which have already proven to be successful in providing care to this population in other parts of the country.

In the event that there exists no departmental level medical association, the Colegio Medico will be asked to provide a contact person knowledgeable of the health care system within the department in question. The survey will develop an inventory of

existing arrangements, and will verify that inventory from at least one additional source (from one of the other of the three identified sources). Data collected will include a sketch of the nature of the arrangement, including the locations of the arrangements' field activities, the type, size, location of the population covered. In addition, the acceptability of the arrangement by providers, users, financiers; its economic viability; managerial capability; competition of nearby providers, and, if possible, the telephone, address, and names of such arrangements and their contact persons. Finally, the interviewer will inquire which of the identified arrangements are the (approximately) three largest (in terms of coverage), what are the possibilities or plans for expansion of each of the three, if any, and whether or not the respondent believes that each of the three can be expanded in size or if it could be replicated (and why or why not).

e) DESCRIPTION OF THE STATE PHARMACIES PROGRAM: Background information will be obtained on the State Pharmacies program. Data to be collected includes: their number, location, pricing policies, and operational practices, the types and quantities of drugs handled, and the State pharmacies' relationship to specific MOH facilities, and to IGSS, as well as the private sector. Finally the Ministry's plans for further implementation of the program, and particularly its plans as they relate to the six departments of interest will be documented.

(4) ADDITIONAL FIELD WORK: This phase of the work will consist of three major activities:

(a) Preparation and selection of case study sites (one week):

The international health economist and health administrator will meet with local counterparts and be informed of their work and findings, and be given copies of the background papers/appendices on the agricultural sector and health care sub-systems.

Based on Dr. Solari's exploratory trip findings, the project incpetion trip, and the local counterparts' inventory and survey of MOH Area Health Chiefs, IGSS representatives, and medical association representatives, a set of replicability issues and criteria will be developed. Tentatively identified issues include:

- acceptability of alternative health care arrangements
  - i) providers
  - ii) user
  - iii) sponsors/financiers
- economic viability of alternative health care arrangements:
  - i) start-up cost issues
  - ii) long term recurrent cost issues
  - iii) exploring possible new scenarios (e.g., relationships with the state pharmacies).
    with state pharmacies)

- managerial capability
- supply-focused market conditions (numbers and types of providers, distances thereto, monetary and time prices, and capacity utilization)
- the plans and intentions of existing arrangements
- estimated potential coverage of alternate private health care arrangements.

These criteria for selection of case study sites will be completed and used to select from two to five arrangements for more in-depth analysis.

(b) AID/Guatemala Mission-wide briefing, interim assessment and discussion of criteria and selection of case study sites.

(c) Case studies of at least two private sector arrangements (two weeks):

Multiple day site visits by two- to three-person teams of Solari, Fiedler, Sagastume, and Bolanos. Once selected, a market analysis of each site will be conducted. To the extent that such data is available, the cost/expenditure and utilization data of each site will be analyzed. In addition, basic interview guides to be designed by the study team will be developed for the care providers, the finqueros, the colonos, and the migrants. Major issues to be covered in each of the interview guides will be the respondents' views of alternative health care providers of care, the health care system in general, their access to and utilization of medical care, and their satisfaction with health

received.

(c) Data analysis, synthesis, report structuring, development of conclusions and recommendations.

(5) FINAL REPORT WRITING: To be completed by Fiedler after returning to the U.S.

6. Personnel

International Health Economist (IHE): John L. Fiedler, Ph.D. (43 days)

International Health Administrator (IHA): Alfredo Solari, MD, MPH (33 days)

Local Health Economist (LHE): Marina Sagastume (30 full-time days)

Local Health Administrator (LHA): Ramiro Bolanos (30 full-time days)

Local Medical Anthropologist (LMA): Michael Richards (14 full-time days)

INTERNATIONAL HEALTH ECONOMIST: JOHN L. FIEDLER, PH.D.

- Overall responsibility for the study (i.e., Principal Investigator)
- Inception of the study (as described above, with IHA)
- During Field Work:
  - Ensuring that agricultural sector profile background information is complete (with LHE)
  - Ensuring that target population profile background information is complete (with LHA)
  - Responsible for preparing market analysis (with LHE)
  - Participate in development of interviewguides

development (with IMA)
- Participate in field data collection (with all other team members)
- Responsible for developing the structure of the final report, including overallanalysisand synthesis, development of main findings, conclusions and recommendations (withIHA)

. Responsible for writing final report

INTERNATIONAL HEALTH ADMINISTRATOR: ALFREDO SOLARI, MD, MPH

. Inception of the study (as described above, with IHE)
. During the field work:
  - Responsible for the private sector arrangements background information (with LHA)
  - Participate in development of Private Sector Arrangements case study selection criteria (with all other team members)
  - Participate in development of interview guides (with IHE and IMA)
  - Participateinfielddata collection and interviewing (with all other team members)
  - Participate in development of the structure of the final report, including overall analysis, synthesis, development of main findings, conclusions, and recommendations (with IHE)

LOCAL HEALTH ECONOMIST: MARINA SAGASTUME

. Meet with Fiedler and Solari in inception stage visit
. Gather background information on the characteristics of the target population
. Gather background information on the geographically identified component of the agricultural sector
. Gather background information to develop an inventory of local health care providers (with LHA)
. Gather background information on State pharmacies
. Participate in market analysis (with IHE)
. Participate in interview guide development (with all other team members)
. Participate in field data collection
. Participate in initial stages of the development of the structure of the final report, including development of main findings, conclusions and recommendations.

LOCAL HEALTH ADMINISTRATOR: RAMIRO BOLANOS

- Meet with Fiedler and Solari in inception stage visit
- Conduct telephone interview survey for identification and preliminary assessment of private sector arrangements
- Develop an inventory of local health care providers (with LHE)
- Participate in interview guide development (with all other team members
- Participate in field data collection
- Participate in initial stages of the development of the structure of the final report, including development of main findings, conclusions and recommendations.

LOCAL MEDICAL ANTHROPOLIGIST: MICHAEL RICHARDS

- Lead role in development of interview guides for care providers, finqueros, colonos, and migrants to be applied in case studies

- Identify and diagnose the barriers (cultural, language, etc.), if any, tht these arrangements have for extension of care to migrants

- Participate in field data collection (focusing on interviewing and especially the colonos and migrants

7. <u>Activity Planned</u>

	(2)	(3)	(4)	(5)
IHE	7 days (5 +2 travel)		26 days (4-6 day work weeks +2 travel days)	10 days
IHA	7 days (5 +2 travel)		26 days (4-6 day work weeks +2 travel days)	
LHE	5 days P/T	4 weeks (20 days) P/T	5 days P/T	10 days P/T / 5 days P/T
LHA	5 days P/T	20 days P/T	5 days P/T	10 days P/T / 5 days P/T

Totals:

IHE: 43 days
IHA: 33 days
LHE: 30 days (full-time)
LHA: 30 days (full-time)

Note: Activity 1 has already been completed.
Activity numbers correspond to those contained in the Study Design Document's Section 5. Methodology and Work plan.