

COUNTRY CASE DESCRIPTIONS: AID EXPERIENCE IN HEALTH CARE FINANCING

* BOLIVIA

* EASTERN CARIBBEAN

* GUATEMALA

Prepared as part of the Overview of Health Care Financing
in Latin America and the Caribbean 1982-1988 for
AID/LAC/DR/HN

Resources for Child Health Project

August 1989

REACH



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BOLIVIA - EASTERN CARIBBEAN - GUATEMALA

by

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August 1989

FOREWORD

The Resources for Child Health (REACH) Project was initiated by the U.S. Agency for International Development (A.I.D) to provide technical assistance to developing countries in the areas of immunization and health care financing (HCF). The overall goal of A.I.D. assistance in the health sector is to improve health status in developing countries through support of cost-effective interventions directed at the most needy populations -- poor mothers and children. A.I.D. health assistance is seen primarily as an investment in building developing countries' capacity to achieve and sustain improvements in health status. These gains are reflected by reductions in infant, child, and maternal mortality and morbidity.

Sustaining improvements in health status requires, in addition to direct program support, assistance for strengthening the national capacity to generate and manage resources more effectively. The provision of such support is the basis for A.I.D. involvement in health care financing, and its implementation, carried out by the Health Care Financing Group of John Snow, Inc., is a central focus of the REACH Project. The goal of this assistance is to increase the effective level of resources available for health in developing countries. To achieve this goal A.I.D. implements where appropriate, activities to increase the level and focus the direction of government commitment to health, mobilize increased revenues from users of health services and other nongovernmental sources, and improve the efficiency with which available resources are utilized in both the public and the private sectors.

As part of this endeavor, REACH has conducted several major studies of HCF in Africa, Asia, and Latin America which examine the costs of health services, patterns of utilization, the potential for generating additional resources, and management efficiency in the health sector.

The difficult economic conditions faced by the LAC region during this decade have made evident the need to review the health financing policies, and have given rise to an extensive policy dialogue among financing organizations, donors and host countries. These Country Case Descriptions examine experiences of USAID in the field of HCF. The analysis is done within the context of the characteristics of the Health Care Financing problems in each country as well as in the LAC Region, with the objective of drawing lessons that can be used to improve strategy development and policy dialogue with host countries.

The REACH Project invites comments on all of our publications and welcomes the opportunity to continue our collaboration with interested colleagues through the widest possible dissemination and discussion of REACH materials.

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The REACH Project
August 1989

INTRODUCTION

In response to a LAC/DR/HN request, the Resources for Child Health (REACH) Project undertook an overview of health care financing (HCF) activities in the Latin American and Caribbean (LAC) region. The scope of work calls for three main components: 1) a compilation of health care financing initiatives in the region; 2) preparation of case studies of USAID health financing experiences in three countries; and 3) development of a set of general guidelines which can be used by health officers to identify opportunities for HCF activities. The study is not an evaluation of HCF activities. Rather its objective is to review, within the context of the HCF characteristics in the region, initiatives undertaken by USAID in this field and draw lessons that can be used in the future to improve strategy development and policy dialogue in the Missions.

This document presents a preliminary draft for the country case study component of the overview. Countries were selected with LAC/DR/HN and USAID missions concurrence. The criteria followed for country selection were as follows:

1. Geographical coverage. In order to cover each sub-region in the LAC region, cases were developed for countries in South America, Central America and the Caribbean.
2. Potential to derive lessons. The ultimate goal of this overview is to support the development of simple guidelines to be used by USAID Missions in identifying and undertaking HCF activities. For that reason, countries were selected whose HCF experience could most readily be applied to other settings notwithstanding the limits arising from each country's peculiarities.
3. Development of HCF activities. The economic situation and HCF policies in the particular countries to be selected provided the basis for describing and studying the USAID experience in HCF. Therefore, countries with some experience with HCF activities were selected to provide a better defined framework for analyzing USAID experience.
4. USAID participation in HCF activities. Countries selected should have experienced not only several HCF activities but, ideally, some level of USAID involvement. Additional lessons could be learned from the positive aspects of active USAID participation in HCF activities in the country.

The economic crisis suffered by the region during the first part of this decade confirmed the need to re-examine the financing of the provision of health services within a broader context than the health sector alone. In fact, the fall in the level of economic activity in Latin American

countries has had a direct impact on reducing the amount of public sector resources devoted to health. Without exception, the budgets for the Ministries of Health in the region experienced reductions that diminished their ability to support the provision of health care services.

The economic crisis resulted in reductions in the Gross Domestic Product (GDP) and personal income and increased the rate of unemployment. These factors increased the size of the population eligible for public health services. At the same time, the adjustment and stabilization programs implemented in response to the economic crisis required severe reductions in public expenditure. Thus, the actions taken to solve the macroeconomic problem were inevitably accompanied by a further deterioration in the level of resources devoted to the social sectors, reducing their ability to respond to their target populations' growing needs.

Given these circumstances, it is important to consider USAID experience in the field of HCF in a broader context that includes the macroeconomic situation of the country, the HCF strategy followed by the respective government, and the role played by other donors.

A team of three HCF specialists visited Bolivia in South America, Guatemala in Central America, and the Regional Development Office in the Caribbean (RDO/C). It was felt that analyzing a regional office experience could be helpful to focus other regional initiatives that may be considered in the future.

The team was formed by Gerald Rosenthal, Ph. D., Associate Director for HCF at the REACH Project; Matilde Pinto de la Piedra, Health Economist at the REACH Project; and Alfredo Solari, MD and specialist in HCF in Latin America. Countries were distributed in such a way that each team member had the opportunity to visit two countries, each of them with a different partner. Bolivia was visited by Ms. Pinto de la Piedra, and Dr. Solari; the Eastern Caribbean was visited by Dr. Rosenthal, and Dr. Solari; and Guatemala was visited by Ms. Pinto de la Piedra, and Dr. Rosenthal.

This draft contains the main findings of the team for each of the countries. Given the focus of the case description and the range of initiatives which were reviewed, the potential to conduct comparative analyses of specific initiatives is limited. For example, a review that focused specifically on initiatives in the areas of user fees would include a comparative analysis of the proportion of recurrent costs being met by fees in different countries or the mechanisms being used to set fee levels. The lessons learned from this kind of comparison would necessarily be more focused^[1]. The reviews presented in this document consider only the

[1] see Overholt, Catherine. User Fees in Public Facilities: A Comparison of Experience in the Dominican Republic, Honduras and Jamaica, REACH Project, Draft Report May 1989.

broader issues of how financing priorities are identified and the impact of the activities and interventions which result from this process on improving the financing of the provision of health services within the country. Specific lessons learned from each case are presented in detail in the corresponding sections.

The visits to the field confirmed the notion that there is no single "pre-packaged" strategy that can be applied to a particular country. A HCF strategy that is sound in one environment may not be appropriate in another. Resource mobilization efforts such as cost recovery programs which may be well suited in a particular environment like Santa Cruz in Bolivia, may have little potential in the Guatemalan highlands or even in the rural areas of Bolivia. Priorities for USAID activities in the field of HCF needs to be closely related to the epidemiological, economic and public expenditure profiles of the country. A population health status characterized by a low infant mortality rate and an epidemiological profile that requires expensive care, as in the RDO/C countries, gives a different dimension to the issues of improving efficiency and resource allocation. While, in Guatemala and Bolivia, the improvement of health status requires increased coverage of primary health care and a financing strategy that supports the reallocation of resources toward these activities, in the RDO/C countries the improvement of health status may depend on strategies that operate through the provision of hospital care.

While specific primary health care policies and projects need to be addressed to particular population groups, HCF strategies need to be directed to the health sector as a whole. The lessons learned from these base studies form the basis for the development of a set of guidelines aimed to facilitate the identification of priority areas, the design of an appropriate strategy and the development of Missions' activities within a strategy framework.

BOLIVIA: COUNTRY CASE DESCRIPTION

ACRONYMS

CCH	Community and Child Health Project (USAID)
CDSS	Country Development Strategy Statement (USAID)
EPI	Expanded Program on Immunization
IBSS	Instituto Boliviano de Seguridad Social
GDP	Gross Domestic Product
GOB	Government of Bolivia
HCF	Health Care Financing
HHR	Health and Human Resources Dept., USAID/B
HPN	Health, Population and Nutrition
IDB	Inter-American Development Bank
LAC	Latin American and Caribbean
MOH	Ministry of Health
NEP	New Economic Program
NGO	Non-Governmental Organization
ORT	Oral Rehydration Therapy
PAHO	Pan American Health Organization
PP	Project Paper
PVO	Private Voluntary Organization
REACH	Resources for Child Health Project
SEF	Social Emergency Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
USAID/B	USAID/Bolivia Mission
WHO	World Health Organization

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I. INTRODUCTION

In response to a LAC/DR/HN request, the Resources for Child Health (REACH) Project undertook an overview of health care financing (HCF) activities in the Latin American and Caribbean (LAC) region. The scope of work calls for three main components: 1) a compilation of health care financing initiatives in the region; 2) preparation of detailed case studies of USAID health financing experiences in three countries; and 3) development of a set of general guidelines which can be used by health officers to identify opportunities for HCF activities. The study is not an evaluation of HCF activities. Rather its objective is to review, within the context of the HCF characteristics in the region, initiatives undertaken by USAID in this field and draw lessons that can be used in the future to improve the strategy development and policy dialogue. The following case study describes the USAID experience in health care financing activities in Bolivia.

In response to a deep economic and social crisis suffered since the late 1970's, Bolivia has undergone radical transformations since mid-1985. These changes have made it necessary to relate the financing of health services to the overall economic, social and developmental issues faced by the country.

II. HEALTH CARE FINANCING BACKGROUND

1. Economic, Social and Political Context

The Republic of Bolivia is a landlocked country, located in the heart of South America, with an estimated population of 6.8 million people as of 1987 and a per capita income of US\$ 600 in 1986, which makes it the poorest country in South America. The only country in all of Latin America and the Caribbean which presents poorer economic indicators is Haiti⁽¹⁾.

Bolivia has seen its social and economic development seriously hampered by a combination of political, geographic, ethnic and cultural factors, particularly before the early 1950's. The 1952 revolution sought to end the most irritating distortions caused by the highly skewed distribution of wealth and income. This revolution initiated a period of social and economic progress that lasted for more than twenty-five years. Due to high prices of minerals (tin and silver) and oil as well as to heavy borrowing, the yearly rate of GDP growth between 1970 and 1978 was 5.4%. However, by 1979 the economic situation began to deteriorate rapidly. Extreme political instability, an abrupt cutback in foreign lending,

⁽¹⁾ The World Bank. World Development Report 1988, New York, Oxford University Press.

reversed the growth curve. From zero growth in 1979, Bolivia registered negative rates of yearly growth from 1980 to 1986. A rapid increase in the size and service of its foreign debt; falling investments, savings, exports and consumption; a series of natural disasters causing a sharp drop in agricultural production; public sector deficit which grew to 24% of the GDP by 1984; and an inflation rate that reached the equivalent of 25,000% per year in mid-1985 were the main contributors to an explosive economic crisis.

Wealth and income have always been unequally distributed in Bolivia. Despite the land redistribution and the social progress achieved after the 1952 revolution, income distribution remained highly skewed. Even before the economic crisis of the 1980's, the vast majority of Bolivians were living at or below the poverty line. Official statistics for 1975 classified 80% of the population as poor, living on incomes below the level required to satisfy 70% of their basic needs for goods and services. The economic crisis of the 1980's has worsened this situation. In 1986, per capita income for the poorest 40% of the population was 26% lower in real terms than that reported in 1981. As a result, while chronic poverty continues to prevail in the rural sector and in marginal urban communities, a new situation of acute deprivation has arisen for former wage earners in the now depressed mining and manufacturing sector.

A new democratically elected government took office in August 1985. After an agreement was reached by the two largest political parties, drastic changes in economic policy were introduced by the end of the same month through a program called New Economic Policy (NEP). It initiated an economic stabilization program and a series of far-reaching structural reforms. Since 1986 inflation has been dramatically reduced, the exchange rate has stabilized, foreign lending and investment have resumed and the long process of economic recovery has begun.

While the government has been highly successful in stabilizing the economy, its record has not been as positive in terms of economic growth. While positive rates of growth have been obtained for the last two years, these have been quite moderate, around 2.5%, and certainly lower than the rate of increase in population (2.7%). The absolute level of economic activity as measured by the GDP in 1988 remains 8.4% lower than that observed in 1980. Furthermore, the economic stabilization program has imposed a high social cost upon the people of Bolivia. For example, real wages fell by 45.6% in 1985 and by 39.2% in 1986. The rate of open unemployment rose from 15% in 1984 to 20% in 1986 (the first year of the NEP)². Combined with under-employment this number rises to a recent estimate of about 50%. These indicators and other considerations led the

[²] Inter-American Development Bank. Economic and Social Progress in Latin America, 1987 Report.

USAID/B Mission to conclude that ". . . the real income of the lower income groups must have deteriorated significantly since 1980".³⁾ In per capita terms, the situation is even less promising, since the GPD per capita suffered a deterioration of 26.3% from 1980 to 1988⁴⁾. In effect, the main tasks that presently confront the Bolivian authorities are the reactivation of the economy and the attenuation of the social impact of its economic policies.

While there are indications that the government has succeeded in setting the basis for arresting and reversing the decline in economic activity, a number of factors inhibit the rate of recovery. These include the burden of the external debt, the composition of and weak markets for Bolivian exports, and continuing uncertainties in the private sector concerning the policies that future governments might adopt.

The economic recession and its management until 1985, as well as the stabilization and structural adjustment program contained in the NEP have had a profound impact on Bolivian society. Urban unemployment has increased from 5.8% in 1980 to 20% in 1986, with marked social dislocation, particularly in the mining communities. By 1983, total consumption per person had fallen to US\$ 446 -- below the level prevailing in 1970. Domestic investment has sharply declined and public services including health have been constrained by a tight budget. The net social effect is that Bolivia is now facing increased poverty and worsening social distress. Even as the economic recovery program takes root, it is expected that GDP per capita in 1990 will still be lower than the 1970 level.

In November 1986, the World Bank sponsored the creation of a Social Emergency Fund (SEF) aimed to ameliorate the negative impact not only of the economic recession, but of the adjustment and stabilization program. The SEF was conceived as a transitory mechanism (1987-1989) to provide financing for investment projects with high impact in the target population during the construction as well as during the operational phase, thus eligible projects are those labor intensive during the construction stage and aimed to provide health, nutrition, education and sanitation services.

General elections were held in May 1989, and a peaceful transition to a new government took place in August as determined by the Constitution. These signs of political stability are a landmark on the Bolivian political scene. The major political parties are expected not only to maintain their agreement on which the NEP is largely based, but to expand it into new

[³⁾ USAID/Bolivia. Bolivia - Country Development Strategy Statement. 1989-1993.

[⁴⁾ Economic Commission for Latin America and the Caribbean. Balance Preliminar de la Economía Latinoamericana, Santiago de Chile, December 1988.

social policies. Specific programs to ease the burden on the poor of Bolivia are among the highest priorities in three major parties (MNR, ADN, and MIR).

2. Health Status and Health Services Organization

A. Health Status

The health status of the Bolivian population is highly related to poverty and to demographic characteristics.

Demographic characteristics exacerbate the situation. The country has experienced an increase in the natural rate of population growth during the last four decades. Because the crude birth rate has remained almost constant (from 47.1 to 44.0) while the crude death rate declined (from 24.0 to 15.8) between 1950 and 1985, the natural rate of growth has increased during this period from 2.3% to 2.7%. Furthermore, with an official pro-natalist policy, it is unlikely that this rate will decrease in the near future. The high fertility rate results in a very young population. In 1950, 42% of the population was under 15 years of age. That proportion increased to 44% by 1985. This demographic profile is responsible for two important situations:

- a) the prominence of maternal and child health problems in the health status of the Bolivian population, and
- b) a high dependency ratio (89.4 in 1985), which means that a high share of public and private resources must be devoted to the needs of the young, at the same time that a relatively lower share of the population is in economically productive age groups which can pay for those needs.

Mortality and morbidity statistics reflect the effects of both the poverty and demographic characteristics just mentioned. Of primary concern in Bolivia are the very high rates of infant, child (age 1-4), and maternal mortality. Current estimates of infant mortality range from 169 to 200 deaths under one year per 1000 live births; tabulations from the 1976 Census showed infant mortality rates above the national average in the Altiplano (191) and Valles (210) regions, as well as among Aymara (238) and Kechua (277) populations. As in other countries, the high degree of association between infant mortality rates and maternal literacy is evidenced in Bolivia. Diarrhea is widespread and responsible for a high proportion of infant deaths. Another contributing factor is the low level of prenatal care available to mothers: only 50% of mothers in urban areas and less than 5% in rural areas have access to prenatal care.

The child mortality rate experienced a decline between 1965 and 1986 from 37 per 1000 children aged 1-4 years to 23 per 1000, mainly as a result of a reduction in deaths from gastrointestinal and respiratory diseases. Maternal mortality, however, continues to be a very serious health problem. It is currently estimated at 48 maternal deaths per 10,000 live births, ten times higher than that of Chile, Costa Rica, and Cuba⁵¹. Although maternal mortality is very high, it does not reveal the whole picture of health related problems that Bolivian mothers currently suffer. Abortion, though illegal, might be the most prevalent means of birth control. It is estimated that up to 60% of bed occupancy of maternity wards in hospitals of the Ministry of Health (MOH) and of the Instituto Boliviano de Seguridad Social (IBSS) is attributable to complications of induced abortions.

B. Health Services Organization

There is only scattered information about the organization and financing of health services in Bolivia, due to a lack of comprehensive descriptions and numerical data. Health care services are delivered by four organizations or groups of providers:

1) Public Sector. The MOH has a network of facilities ranging from national hospitals to small health posts. It has a central office in La Paz and delegated offices -- Unidades Sanitarias or Health Units -- in the capital of each Department. It is organized with vertical programs for malaria, tuberculosis, immunizations, oral rehydration, and so forth. Although the MOH is the principal institution in health care delivery, its coverage is limited to, at best, 40% of the population. More realistic estimates put the actual coverage provided by MOH services in the range of 25%-30% of the population. The deficiencies within the MOH relate to the lack of administrative support systems, lack of maintenance of facilities and equipment, poor logistical services, inappropriate personnel mix, poor coordination among operative units, and the absence of standard policies regarding cost sharing or cost recuperation mechanisms.

2) Social Security System. The social security system covers two kinds of contingencies: sickness (health care delivery) and income maintenance (disability and pensions). While health services are provided to every beneficiary through one organization named Caja Nacional de Salud, long term benefits are provided through 16 organizations that include the Caja Petrolera for petroleum workers, the Caja Ferroviaria for railroad workers, and other organizations. Until 1987, contributions by employers and employees were made to a single fund. The proportion of this fund spent on health care for sickness and maternity benefits increased, threatening the capability of the IBSS to fulfil its obligations to its income maintenance programs. Furthermore, the total level of contributions -- the proportion of the payroll that was taxed, was becoming prohibitively expensive both

[⁵¹] The countries with the best health status in the LAC region.

for employers and workers. These and other structural issues were addressed in the 1987 reform of the social security system. Total contributions were lowered from 27% to 21%. The most important reform was that monies were separated into two independent funds: one for sickness and maternity, supported by a 10% contribution by the employer, and another for income maintenance, supported by 5% contributions from both employers and employees and a 1% contribution from the government. Both funds, sickness and pensions, are slated to be administered completely separately in the future. Social security coverage nationwide is provided to almost 18% of the economically active population and their dependents, concentrating in industrialized (mining or former mining) areas such as Oruro, Potosi, La Paz and to some extent Santa Cruz. Its total coverage is about 24% of the total population. Public sector organizations, including both the MOH and IBSS (which have some overlap of clientele), provide health care coverage to about 50% of the population.

3) Private Sector. Private modern medical practitioners and hospitals provide coverage to a very restricted segment of the Bolivian population, estimated at only 5 to 7%. With a widespread distribution of private pharmacies means that the proportion of people covered by the private sector, in terms of drug procurement, is much larger than the above figures.

4) Non-Governmental Organizations. The limited coverage provided by private for-profit and public organizations has permitted the establishment and acceptance of a large number of non-governmental organizations (NGO's) and private voluntary organizations (PVO's), both national and foreign. These organizations mainly work in primary health care and provide services to 15-20% of the urban and rural populations. Although their activities have not been coordinated in the past, an effort is being made by the GOB, particularly the MOH, and international donors to promote coordination. Associations of NGO's working in the health field have been formed at the departmental level, and a national federation has been created for this purpose. With financial support from PAHO/WHO, the Foreign Affairs Office at the MOH began to make an inventory and general assessment of projects run by NGO's. When the REACH team visited Bolivia, the MOH was also in the process of elaborating a standard letter of agreement between NGO's and the GOB. In a number of the agreements already signed there is a commitment from the GOB to continue the operation of the project once the NGO's support is over. It is not clear though what public financing mechanism is to be used if support is to be continued.

Thirty percent or more of the population still lack any type of health care other than traditional healers and herbalists. Inaccessibility due to financial or geographical factors does exist in a country as poor and sparsely populated as Bolivia. However, cultural factors also play an important role. Among native groups, the persistence of ancestral beliefs, illiteracy, and other cultural attributes have contributed to a widespread reluctance to accept western medicine, lack of confidence in physicians,

and weariness of official health programs. As cultural beliefs are an important factor in explaining access to and utilization of health services, they need to be carefully taken into account in the design of health programs as well as in the development of a HCF strategy. Even if this segment of the population could afford to pay for health services, health education and acculturation would be needed for them to realize that modern health services can improve their health status and that it is "worthwhile" to demand and pay for these services.

3. Health Care Financing Characteristics

There is a paucity of data on the volume and distribution of national health expenditures in Bolivia, precluding any precise estimates. Indeed, baseline data and projections of costs and revenues are to assist in the development of a HCF strategy. It is widely accepted that the total level of funding per capita is very low and that a high proportion of resources are received from patients based on an undefined user fee schedule, as well as from payroll taxes of the social security system.

Moreover, there is a perception that health services financing has changed during the economic and social crisis of the late 1970's and early 1980's. In effect, as funds from general revenues and social security taxes became more scarce, financial resources had to be raised from international donors and from users to help maintain the level of services.

The sources of funds vary according to the institution delivering the services. Up to 30% of the budget of the MOH is financed by donations from multilateral or bilateral agencies. The remaining 70% is financed from general revenues (85%) and from user charges (15%). Most recent available data show that the MOH's share of the total (capital and investment) Central Government Budget in 1986, 1987 and 1988 was, respectively, 3.37%, 1.24% and 2.24%. Since it is predicted that the economy will continue to grow very slowly (2 to 4% per year), there is no reason to expect that the MOH's share of central government funds will increase appreciably. Thus, MOH facilities will have to rely even more heavily on non-government funding in order to maintain and expand their operations.

In terms of equity, the level of cost recovery from users of hospital services in urban areas could certainly be improved without affecting the population's access to services. Such a system would charge the population that is able to pay for secondary care but is receiving it free at present, with an appropriate mechanism to provide for the indigent. This would make it possible to reallocate some resources to finance the needed expansion of primary care services to the population still not covered. User fees do not affect only revenues; they also affect utilization, and therefore touch upon issues of cost of service delivery and allocation of resources. Indeed, in considering a HCF strategy, as distinct from a HCF project, cost recovery is but one possible component. In any event, the potential of

cost recovery on a large scale in Bolivia cannot be estimated without substantial data collection on the cost side as well as analysis on ability to pay.

Another important aspect of MOH finances relates to the components of expenditure. Over the five year period from 1982 to 1986, there has been almost no investment. An average of 94% of the MOH's total expenditures were allocated to recurrent costs. Over the same period, an average of 80% of recurrent expenditures were devoted to wages and salaries of MOH personnel, while supplies and equipment maintenance accounted for most of the remaining 20%. Despite this heavy concentration of expenditures on personnel, salary levels within the ministry are extremely low. Even though some improvements have been achieved during the last year, salary levels remain a permanent source of conflict among public sector providers.

Health services provided by the IBSS are entirely financed from payroll contributions, as explained earlier. There are no user charges and no external contributions to cover either investment or operating costs. Similarly, private health services are financed entirely by users through their payment of fees. The social security agencies have their own network of facilities, and a limited type and number of services are financed for social security beneficiaries in the private sector. The financing of private physicians and hospitals is entirely from patients paying on a user fees basis, mainly through fee for services with a small proportion of prepayment schemes.

Information is scarce on the financing of private/NGO health services, particularly with regard to levels of cost recovery. Because they are free to establish their own rates and criteria for service charges and there are at least 300 NGO's providing health related services, a wide diversity of cost recovery policies and charges can be assumed. One study done in 1985 of 12 major NGO's showed that most of them have multiple sources of funds, among which direct donations and user charges were both important and common.

4. USAID/B Policy Dialogue

The team reviewed documents and conducted personal interviews in order to become aware of the health care financing issues which are subjects of policy dialogue between USAID/B and the GOB. Since most of this dialogue is conducted on an informal basis by USAID/B staff, it is difficult to assess in its entirety. Thus the description that follows may be incomplete and to some extent too limited.

The dialogue on health policies is almost entirely restricted to personnel of the MOH, with the exception of population and family planning issues, which are also discussed with authorities of the social security institutions. There are some very informal exchanges of information with

other GOB agencies, particularly the Ministry of Planning and the Social Emergency Fund (SEF), but these are conducted without a clear aim or guiding policy.

In addition to health care financing issues, two other areas are stressed in the dialogue with the MOH: child survival and family planning. This reflects the high priority given by the USAID Mission to these two topics.

Within the area of health care financing, two major subjects have been emphasized in discussions with MOH authorities during the last six years (1982-1988):

- a) reallocating the MOH's budget towards stronger support for primary health care activities and away from secondary and tertiary care services;
- b) promoting recovery of operating costs through user charges, particularly for curative services.

In addition to these two major areas of concern, the dialogue with the government has covered, particularly in the recent period (1987-1988), four other areas:

- c) emphasizing stronger community participation, not only in the financing but also in the management of primary health care services delivery;
- d) supporting the careful and detailed preparation of projects and programs during the identification and appraisal phase in order to increase the effectiveness and efficiency of services once started;
- e) restraining the tendency of the GOB, particularly of the MOH and the Ministry of Foreign Affairs, to exercise excessive control over NGO's, especially in financial aspects;
- f) fostering more efficient operation of the MOH through the promotion of operations research and the development of an operative plan to improve efficiency.

Areas (c) through (f) have been pursued with less emphasis than the two major areas and for a shorter period of time. Although USAID/B has made progress in these four areas a pre-condition to its support for MOH projects, USAID staff noted that these pre-conditions are not strongly enforced by the mission. Moreover, conditionality of projects, useful as it is, does not constitute a successful policy dialogue which results in the GOB making the policy decisions that are believed to be relevant and necessary. In the team's view, the policy dialogue conducted by the

USAID/B Mission could be improved in two closely related areas. These are the content and the process, in terms of participants and procedure, of policy dialogue.

A. Content of Policy

During this decade, Bolivia has experienced dramatic social and economic changes which need to be taken into account properly when designing a HCF strategy and policies. A long term approach based on the actual evolution of resources devoted to the health sector during the last five or six years and the expected macroeconomic trend for the next five to ten years provides the framework within which a comprehensive and stable policy to finance the provision of health services at every level should be designed.

The HCF strategy needs to be clear and coherent, with priorities set in the agenda for policy dialogue. It must be effective in helping the MOH to assign a real priority to the provision of primary health care. The issue of community participation needs to be properly addressed and delimited. If the community is involved from the project identification phase, its participation will be more fruitful in helping to increase both health care coverage and the financial contribution from the population. The latter can take the form of monetary resources as well as provision of labor during the investment or operational phase of the projects (e.g. labor to build health facilities or voluntary community health workers). A design for cost recovery should propose specific services for which patients can be charged and guidance on which population groups should pay for services and which should receive free care. In sum, USAID/B can play an active role in providing technical assistance that supplies essential information to help shape a HCF strategy.

B. Dialogue Participants

The recent experience of recession, adjustment, and stabilization in Bolivia, with a recovery program which did not directly address social sector issues, showed that the residual adjustment that these sectors had to face was highly negative. Even though the Social Emergency Fund (SEF) has been able to cushion part of the deterioration in the standard of living among the most vulnerable groups in the population by funding 1500 community level projects, the negative impact on the quality of health services as well as the population's access to health care services could have been lessened had the health care financing policy been an integral part of the economic program.

The USAID/B Health Office is already working closely with the Social Emergency Fund to identify projects suitable for SEF funding. As a matter of fact, a number of PROSALUD health centers developed with USAID support will be funded by the SEF within a year^[6].

At the macroeconomic level, the first two goals of the mission are, in order of priority, the achievement of: 1) basic structural reforms leading to rapid and sustained economic growth, and 2) shared benefits of growth^[7]. The strategy presented in the Country Development Strategy Statement recognizes that some of the country's social problems are critical and require immediate attention even if that means diverting resources from the primary goal of economic growth. This position highlights the need to expand the dialogue on HCF issues to a wider audience. In particular, the attention of economic policy makers must be drawn in order to ensure that the country develops a coherent HCF strategy within the framework of the overall economic restrictions. For this purpose more channels could be established with the Ministry of Planning and Coordination.

Unlike most countries, donors in Bolivia have established a coordination strategy and -with the GOB agreement- have assigned responsibility to coordinate each economic area and sector to a particular donor. Among them, public expenditure and public sector technical assistance are coordinated by the World Bank, Agriculture sector activities have been assigned to the Switzerland Technical Cooperation, the Inter-American Development Bank is in charge of the infrastructure sector and USAID/Bolivia is the donors' coordinator for health sector activities. Thus, the Mission is in a privileged position to exercise a leading role in the ongoing policy dialogue in the area of health care financing. This is particularly important since consequential policy dialogue is taking place in the area of health care financing due to the existence of important investment projects funded by the Inter-American Development Bank (IDB) and the World Bank that call for changes in the HCF strategy.

As head of the donors organization for health sector activities, USAID/Bolivia can play an active role in the design of a HCF strategy. This includes both the provision of a common framework of analysis to donors so that appropriate HCF interventions can be identified and proposed to the GOB as well as undertaking activities aimed to provide the needed technical assistance to the GOB and nourish the policy dialogue.

[6] PROSALUD is an USAID/B supported project aimed to provide primary health care services on a self-financing basis to low income population.

[7] USAID/Bolivia. Country Development Strategy Statement 1989-1993.

III. HEALTH CARE FINANCING ACTIVITIES

1. Past Health Projects and Background

Towards the late 1970's USAID/B financed a large primary health care project aimed at the provision of basic health services to the urban and rural poor in the district of Montero in the Department of Santa Cruz. An explicit objective of this project was to strengthen the Health Units of Santa Cruz, promoting the decentralization of services and decision making and the recovery of operating costs through user charges, especially for prescription drugs. The project tried to improve the health status of the population through the delivery of an integrated package of health services together with potable water and sanitation systems. Montero was a large, important project that received mixed evaluations -- positive and negative -- but was later perceived by USAID as unsuccessful. Apparently the reason for this perception lies in the extreme autonomy of the project vis-à-vis the Health Unit of Santa Cruz and the small, if any, effect that the entire project had on the organization and performance of the Health Unit once it finished.

Due to a military coup and to political instability, no new projects were started and existing ones were allowed to terminate between 1980 and 1982. Once the democratic process was reinitiated in 1982, development of new projects commenced. Among the portfolio of initiatives that were considered and developed in the five-year period 1983-1987, there are three that deserve special consideration.

a) In 1982 USAID and three multipurpose cooperatives began developing a self-financing primary health care services initiative which later became PROSALUD. At the time it was conceived, it was based on three principles: it would be undertaken by existing private organizations, namely, the agricultural cooperatives; it would aim at financing their operating costs; and it would provide primary health care services up to the first level of care. The final objective of the project was to improve the health status and, thus, the productivity of agricultural workers. Although the project was approved in August 1983, it did not begin until January 1985, when key decisions to redefine it were made by USAID/B. The institutional base was changed from existing cooperatives to a newly created organization -- named PROSALUD -- which evolved from the original concept of having a central Management Support Unit. With it, the entire target population and marketing approach also changed from cooperative members and their families to low income periurban and, to a lesser extent, rural people not previously organized into groups. Since PROSALUD has been successful in achieving relatively high levels of self-financing and is perceived by USAID/B officials as their most important project in health care financing, it will be analyzed in greater detail in the next section (Key Elements of USAID Activities).

b) In 1983 another project was started that had important implications for health care financing. Its aim was to support the development, implementation and operation of water and sanitation systems in 200 small rural communities. The project was institutionally based in the MOH but had a strong community participation component. The project was very successful not only in achieving its physical targets but especially in developing strong community organizations. Through these organizations, the communities have been able to sustain to the present almost the entire costs of operating and maintaining these water and sanitation systems. This is quite remarkable given the economic uncertainties that characterized the period of 1983-1988. The implications that this approach might have for the development and operation of self-financing primary health care systems have not yet been fully explored and realized.

c) During the same period of time, another project was undertaken with the MOH in response to natural disasters, such as extreme drought and extensive floods. A component of this project was the development of revolving drug funds in at least four Departments of the Altiplano. Because it began during a period of uncontrolled inflation and competed with other MOH initiatives -- in which drugs were provided free of charge -- the project failed. It was difficult to set realistic prices that would have maintained the real value of the funds. Thus, the funds were depleted after a short period and, at present, only one is still functioning.

2. Present Portfolio of USAID Health Projects

At present, the Health and Human Resources (HHR) Department of USAID/B is managing eleven projects, of which seven relate to health care financing. The following table lists these seven projects and provides some information about each.

Table 1

Selected Projects Currently Managed by HHR

a. Name of Project	Purpose of Project
b. Grantee	
c. Amount	
d. Period	
1. a. Self Financing Primary Health Care b. MSH-PROSALUD c. US\$ 2.10 million d. 8/83-8/90	Provide primary care services on a self-financing basis to low income population.

- | | |
|---|--|
| <p>2. a. Child Survival-ORT & Growth Monit.
 b. CRS-Caritas
 c. US\$ 1.24 million
 d. 9/85-9/89</p> | <p>Training women in oral rehydration and growth monitoring; Mothers' clubs.</p> |
| <p>3. a. Child Survival-Rural Sanitation
 b. CARE
 c. US\$ 4.50 million
 d. 8/86-8/90</p> | <p>Developing primary care services, water and sanitation systems and training communities in maintaining these services.</p> |
| <p>4. a. National Oral Rehydration
 b. MOH
 c. US\$ 0.45 million
 d. 4/87-12/89</p> | <p>Provide the MOH with 3.2 million ORS packets for the National Oral Rehydration Program.</p> |
| <p>5. a. Child Survival PVO Network
 b. PVO Network
 c. US\$ 1.67 million
 d. 1/88-1/91 Coordinate</p> | <p>Coordinate policies and activities of ten major PVO's (nine of them American) in Child Survival.</p> |
| <p>6. a. T.A. to PVO's PL-480 Title II
 b. Planning Assistance
 c. US\$ 1.30 million
 d. 6/88-6/91</p> | <p>Provide T.A. to three U.S. PVO's in planning to improve their use of PL-480 resources.</p> |
| <p>7. a. Community and Child Health
 b. MOH
 c. US\$ 16.50 million
 d. 7/88-7/93</p> | <p>Improve health status of urban and rural poor by strengthening MOH delivery of Child Survival interventions, institutional development and community participation.</p> |

The other four projects currently being managed by HHR are less related to the subject of health care financing. These are: Management Training, Handicraft Export Development, AIDS Prevention and Control and Radio (health) Education.

As can be seen in the chart, the projects developed and implemented during 1987 and 1988 concentrate on child survival as the main programmatic objective and on resource mobilization and improved efficiency as the most important health financing targets. Projects 5 and 6 above provide assistance to the MOH aimed at achieving these objectives. The latter, the Community and Child Health Project, because of its size and duration, is especially important. Because of its complexity and its importance, and because it concerns both efficiency and resource mobilization, it will be analyzed in greater detail in the next sections.

3. Initiatives by Non-USAID Agencies

USAID officers stressed the Mission's policy and efforts to coordinate its activities with other bilateral and multilateral agencies, particularly with the World Bank, PAHO, UNICEF and IDB. However, these agencies have not been able to reach a common approach to issues of health care financing in Bolivia, neither among themselves nor with the government. Even within one agency (the World Bank), there are different approaches to financial issues such as resource mobilization.

One of the most active agencies in the health field is PAHO/WHO which provides technical assistance to the MOH in programmatic areas, such as planning, social mobilization, environmental sanitation, maternal health, expanded program on immunization (EPI), oral rehydration therapy (ORT), communicable diseases and health service delivery. UNICEF also has a very active program in maternal and child health, supporting MOH programs in breastfeeding, EPI, ORT, growth monitoring, community development, social communications, female literacy and reproductive education.

The World Bank is active in several areas. First, it provided the initial loan to launch the Social Emergency Fund. The SEF has become a highly visible and effective organization aimed at alleviating the social effects of the high unemployment caused by the NEP. This was to be achieved by lending for small and mid-size infrastructure projects, including the construction of health posts in urban and rural areas. The Fund has been budgeted at US\$ 130 million for its two years of existence and has disbursed US\$ 55 million. Thus far, the SEF has had short-term objectives, received direction directly from the Presidency, and has worked outside the structure and rules of the bureaucracy.

A second project that is being developed by the World Bank is called Economic Management Strengthening Operation, with the overall objective of improving the performance of public sector organizations. It is organized into five components:

- a) Economic Management Strengthening at Regional Level, which works in the areas of health, education and roads.
- b) Management Strengthening of Public Sector Investment.
- c) Strengthening the Management and Operations of the National Statistical Institute.
- d) Strengthening the Internal Revenue Service.
- e) Creation and development of a Civil Service Corporation.

For each of the three programmatic areas, the project is performing an institutional and a financial/fiscal analysis of government agencies involved at the national, regional and local levels. The project is still in its diagnostic stage and is now preparing alternative proposals. Implementation will not start before the change in government, that is, before the second half of 1989. It is likely that the delivery of health services will become more of a decentralized or regional responsibility, undertaken by the Development Corporations. Each region would decide how to organize the service delivery in terms of private/public sector organizations and how to finance both investment and operative costs. Under this proposal, the MOH at the central level would have only a normative role.

A third World Bank project, being planned by a team from the Ministry of Health, is the Primary Health Project to be implemented through three (regional) Health Units. It is an entirely public sector project. In effect, its technical staff describes this project as a project financed by the World Bank, "but of and through the MOH." It includes an important component for institutional strengthening. It is designed to reverse the progressive deterioration of the MOH and its Health Units due to the lack of resources for delivering services for the past 5-7 years. This deterioration, according to the project planners, has left a leadership gap which has been filled at least partially by NGO's "over which the MOH has little or no control." The project will emphasize the role of the traditional public sector services financed by general revenues, "reversing the proportion presently observed of paying vs. non-paying users in MOH facilities." At present it is estimated that only 28% of hospital patients receive care completely free of charge. According to MOH officers working in this project, the goal would be to reverse this proportion and have only 28% of users actually paying for secondary and tertiary care. The reasoning is that public hospitals are still expected to provide free care.

The issue of long-term financial sustainability, which has so often been responsible for the failure of these activities once external financing is removed, has not yet been addressed. From a revenue mobilization perspective, this project, with its traditional public sector financing and health services delivery supported by a multilateral agency, represents one extreme in the spectrum of financing health services in Bolivia just as PROSALUD, with its self-financing goal, represents exactly the opposite extreme.

The inability of donors and the government to come to a consensus regarding sources of financing and responsibility for organizing and operating health services has contributed to the lack of a coherent policy for financing the delivery of health services during a period of high economic and social difficulty.

IV. KEY ELEMENTS OF USAID HCF ACTIVITIES

The project paper (PP) for the Community and Child Health Project (CCH) sheds some light on how the key elements of USAID/B health care financing activities interact. Annexes C and H of the PP, containing the Economic and Financial Analysis, describe the serious challenges that the Bolivian cultural, political, institutional and economic realities present for a large primary care project.

The CCH project will be implemented by the MOH in conjunction with the Health Units of three Departments, La Paz, Cochabamba and Santa Cruz. Its goal is to improve, during the next five years, the health status of the rural and periurban population, particularly children under the age of five and pregnant and lactating women. The purpose is to reduce infant, child and maternal mortality.

The project will work within the framework of the MOH's national health service program, and it will have three components: 1) National Immunization Program Support (US\$ 3.3 million to help implement the EPI Action Plan for 1987-1991); 2) National Diarrheal Disease Control Program Commodity Support (US\$ 1.5 million to provide ORT packets required by the national program from 1989 to 1993); and 3) District Integrated Child Survival Program (US\$ 17.2 million to deliver child survival interventions in eleven project districts located in the three departments mentioned above). The total cost of the project is \$22 million of which \$16.5 million will be USAID's contribution. The GOB's contribution, cash and in-kind, will be \$5.5 million. As the PP states "USAID ongoing policy dialogue will stress ways for the GOB to meet its recurrent costs responsibilities during and after the Project's life. A prioritization of GOB resources for child survival needs to be an inherent component of USAID/GOB dialogue." As will be seen from the analysis of the two Annexes of the same PP, this will not be an easy task for the GOB.

Annex C presents the CCH Project as a response to the health consequences that the economic crisis has had on the poorest segment of the population, specifically on women and children. "It appears very likely that the health of the Bolivian population has been damaged by economic development during the past decade and that prospects for the near future are for only slight improvement...."

Two issues are discussed in detail in the PP: the most cost-effective way of delivering services and the financing of recurrent costs during and after the project.

The project paper argues that activities must be implemented through the public health system since it is the only organization with national coverage and it is large enough to ensure economies of scale. The creation of a "more efficient private system clearly would entail charging for the service, eventually on a full cost basis, which many of the poor can not

afford." This is clearly a very weak argument since more efficient organizations could be subsidized by the central government and USAID to deliver services to the target population.

Clearly, this alternative was not fully analyzed, since the PP argues later that "several of the preventive health measures to be undertaken by the project are not amenable to 'cost recovery', i.e. charges based on a 'benefit received' basis. Examples include improved sanitary and potable water services. As a result, they could not be undertaken by PROSALUD, a PVO or a private organization that can not count on tax revenues..." This statement is not quite accurate, as USAID/B has had successful experiences in cost recovery, both in water and sanitation systems as well as in the delivery of health services. These experiences are noted in the conclusion of the Financial Analysis in Annex H, in the section, "Sustainability of the Project," of the same PP.

Sustainability is defined by the Mission as "the capacity of Bolivia to support the proposed health project financially after the period of AID funding." First, Bolivian support capability in the form of governmental resources is assessed. Given the country's poverty and the poor prospects for economic growth above the rate of population increase, the conclusion is reached that "there are few grounds for optimism in expecting the MOH to come forward with appreciable new funds from the government in order to bear much of the burden of the new recurrent costs required to continue the full project in 1994 and beyond."

Alternative sources of funding are identified and assessed as follows. Regional Development Corporations and the Social Security Institutions are discounted because their resources are fully committed, and the former is intended for investment purposes and the latter for a different target population.

Community contributions in-kind, through the provision of labor and other inputs, are assessed as representing a good source of long-term support for certain health interventions, especially for water supply and sanitation. However, these contributions are valued at only two percent of total project costs.

Other private sources of funds, such as charitable contributions through missions, PVOs, private raffles or other types of gambling are discarded because they are already fully committed. Thus, the discussion turns to cost recovery from users: "After consideration of these private sources of support -- funding only in-kind contributions to offer (limited) promise -- what else can be said? Clearly the only major remaining possibility is 'cost recovery' through the payment of direct fees by patients to providers or through prepayment mechanisms".

After recognizing that there is little promising experience with prepayment, the paper addresses fully the issue of direct fees. "Direct payments, or fees, have been tried and are worthy of further examination. Local delivery units of the MOH charge fees for certain services. They are fully utilized for on-going programs at the Ministry and, thus, represent no new financing source. Given the limited ability of rural Bolivians to pay for additional services, further cost recovery through fees offers little promise for the proposed project. However, three other notable examples of fee-supported activities in Bolivia should be cited: a proposed fee-based rural sanitation-child survival project of CARE; the use of revolving funds with fees for medicines in four departments, and PROSALUD's experiment with self-financing of basic health services in the Departamento of Santa Cruz".

The PP summarizes the limited options and difficulties in financing, on a long-term basis, the recurrent costs of delivering primary care services without improving the efficiency of organizations needed to carry out this task. Although Bolivia might be an extreme case, because of the magnitude of its poverty and the depth of its economic crisis, it nevertheless illustrates and represents the difficulties surrounding health care financing in developing countries. The PP concludes: "An inevitable result of proposing a large, Ministry-based Project to serve very needy rural populations through multiple interventions is high cost. As shown in this PP, substantial expenditures supported by AID and GOB are required for the Project period. If the activities are to continue after that, appreciable recurrent costs must be borne somehow. Among the conclusions in this analysis are: the doubtful capacity of the government to meet many of those recurrent costs, if economic and other conditions do not change in unexpectedly favorable ways; and the limited prospect for financial sustainability through alternative means. Some help can be found in community in-kind contributions, drug purchases (with new revolving funds), and perhaps modest fees for certain services. It is quite unlikely, however, that these and the Government's general revenue sources will add up to sustainability of a large part of the total recurrent burden. Thus, still other sources -- probably external to Bolivia -- must be considered for the post-project period."

V. LESSONS LEARNED

The experience of visiting Bolivia, interviewing the main actors involved in the development of the health sector, and having the opportunity to visit the field enabled the team to gain a comprehensive view of the main problems to be addressed in the development of health care financing initiatives, design of a HCF strategy, and implementation of a policy dialogue regarding these matters. The visit to Bolivia shed light on the country situation, technical assistance, and procedural issues that should be considered not only by USAID/B but also by other Missions in the region. A summary of lessons learned follows.

1. Designing a HCF Strategy

The GOB does not have an explicit strategy for expanding and financing primary health care services. The investment component of primary health posts has been partially funded out of external resources, that is, construction costs of these projects has been financed through the SEF. The lack of an overall financing strategy for health services has resulted in various government agencies taking different and even opposing financing approaches. This reflects the GOB's absolute priority of economic stability and growth, without including in the recovery agenda an explicit strategy to cushion the social effects of the adjustment policies. At this point, there is consensus within the GOB that social welfare matters should somehow be addressed in future economic planning, and the government has initiated this process.

USAID/B has shared the Government's approach during this period and will maintain it in the next five years (1989-1993). In fact, supporting economic growth is a primary goal listed in the current Country Development Strategy Statement (CDSS). A secondary priority is to improve the distribution of the benefits of growth. Health activities are key to achieving this latter goal. The CDSS also states that the social situation is so critical that it may require prompt attention, even if this means diverting resources from the principal objective of growth. The USAID Mission can be extremely helpful to the GOB in providing technical assistance for designing those schemes. The concurrence and active participation of the Economic Affairs Office at the Mission is required in this area. This office has a deep knowledge of the economic situation and is in a better position to have a dialogue with economic policy makers.

2. User Fee Policy

In terms of health care financing, the policy of the GOB prior to mid-1985 might have been to charge some fees to patients for some services -- namely hospital services, medicines, and laboratory procedures -- but the emphasis was on providing primary care services free of charge. After the implementation of the NEP, the network of primary care centers of the MOH became grossly underfunded. Because the resources per center in the public sector decreased so drastically, the quality and quantity of services delivered deteriorated and the services had to rely increasingly on resources from patients (payments in exchange for services received) to cover operating costs, particularly supplies. Since the NEP was adopted in 1985, health care financing scheme has been implicitly accepted by which external sources (donations from multilateral and bilateral agencies and users fees) have substituted for a dwindling government health budget to finance operating expenditures of health services.

The current user fee policy is not clearly stated. The only component over which there is consensus is that maternal and child care is to be provided free of charge. Revenue generation mechanisms in the hospital system are not homogeneous across the country and there is no complete assessment at the central level. It is known that the user fee system at the secondary level of care is crucial to improving the equity of resource allocation between primary and secondary care. It is important that technical assistance be provided to health sector planners during the appraisal and implementation phase of a user fee scheme.

3. Need to Design a Comprehensive Cost Recovery Scheme

USAID has a four point policy statement about financing the operating costs of health services^[8]. As it was seen previously, particularly in the analysis of the CCH project, USAID tries with mixed success to apply these criteria to its own projects. It has also shared these policy positions with other donor agencies and with the MOH, although it has not been able to impose them. Furthermore, these four policy criteria do not constitute a complete strategy for financing health care services, since there are essential aspects that are not fully addressed. The most important of these seems to be the need to identify efficient delivery systems and multiple though realistic source of funds. Of particular relevance is the fact that different degrees of cost recovery, even for a basic service package, and the need for government subsidies for the lowest echelons of the income scale have not been properly addressed within the USAID Mission, by other donor agencies, or by the GOB. Alternative ways of establishing these subsidies and channeling them to private sector organizations for a more efficient result should be explored and their implementation, where appropriate, should be strongly endorsed.)

4. Conditions for Project Replicability

The most specific health care financing project developed by USAID/B in the area of resource mobilization has been PROSALUD. The project deserves high marks for reaching high levels of cost-recovery while serving a low income population. However, it should be carefully evaluated in the way it has attained its two other equally important goals besides self-financing: provision of a balanced mix of primary care services (particularly those for which users are less willing to pay), and extending coverage to reach people that otherwise would not have had access to health care.

[8] See letters (c) through (f) in the Policy Dialogue Section.

Notwithstanding these two issues, the self-financing primary care model, working in the private sector with more flexible rules than in the bureaucracy, is seen by Mission officials and by PROSALUD staff as highly successful and replicable. However, it is the team's opinion that the cultural and economic conditions within which this model can be successfully replicated are not yet fully addressed. There is a trade-off between the two objectives given to the project. It was confirmed in the field that a health facility that must be self-financed cannot be very active in providing care to the population that either cannot pay or does not go to the health center for cultural reasons. A number of factors must be assessed in order to determine whether projects of this type can be implemented successfully only in urban areas without extreme poverty. This would help USAID and other donors to choose the most effective locations for future initiatives of this kind.

5. Organization of Health Services

It is widely accepted within USAID/B, as well as other agencies and even some GOB institutions, that the MOH at the central and regional levels has a weak organization. It is organized along vertical programmatic lines, with little or no coordination across programs. Furthermore, it is stated that the MOH lacks essential information about the cost and performance indicators of its own services. Despite the recognition of these facts, USAID/B has not promoted projects to strengthen institutionally the MOH at the central level, nor has it provided technical assistance that would allow the Ministry to fill the information gap. An important component of USAID assistance should be in the area of policy formulation, including health care financing. Moreover, the Mission can, undertake or sponsor some of the studies that are needed to monitor the performance of health care delivery organizations and, thus, be prepared for a more useful policy dialogue with the GOB on health care organization and financing.

6. Identification of the HCF Component

Many senior USAID/B officers do not identify the financing components or implications in their own health projects that have another primary objective (e.g. child survival or technical assistance to PVO's). This is probably due to the fact that the Mission is implementing a project (PROSALUD) that specifically addresses health care financing through resource mobilization. However, all the projects currently managed by the HHR Division analyzed by this team specifically address how operating costs are to be covered during the life of the project. Furthermore, they also address the issue of financial sustainability after the project's completion.

This observation is not unique to the Bolivian experience. Rather, it reflects the way in which the approach to HCF matters has evolved within USAID. A few years ago, user fees and private for-profit sector participation were seen as the relevant elements of HCF⁹¹. Thus field officers have tended to identify only these two kind of activities as being related to the financing of the provision of health services. Additional training in this area would help health officers and other Mission staff to have a more comprehensive view on the subject, where a HCF strategy is conceived as one that includes elements aimed to promote resource mobilization, improve resource allocation, foster efficiency of production and facilitate equity in access to health services.

⁹¹see "Report for the LAC Health Officers' Workshop, Annapolis, November 16 to 20, 1986".

APPENDIX I: PERSONS AND PLACES VISITED

- Mr. Robert Kramer, Deputy Director, USAID/B
- Mr. Clark Joel, Chief of Economics Affairs, USAID/B
- Mr. John Clutier, Development Officer, USAID/B
- Mr. Paul Hartenberger, Chief of HPN, USAID/B
- Mr. Rafael Indaburu, Health Officer, USAID/B
- Mr. Oscar Antezana, Assistant to the Chief Economist, USAID/B
- Dr. Alberto Suárez, Deputy Minister of Health
- Mr. Fernando Mendoza, World Bank Representative in Bolivia
- Lic. Fernando Camacho, Office of Foreign Affairs, MOH
- Ing. Carolina García, Health Officer, Social Emergency Fund
- Mr. David Hess, Chief of Party, The World Bank, Decentralization Project
- Ing. Guillermo Pacheco, The World Bank, Decentralization Project
- Dr. Javier Luna-Orozco, The World Bank, Decentralization Project
- Arq. Jorge Urquidi, The World Bank, Decentralization Project
- Mrs. Carlota Ramírez, Ministry of Planning and Economic Coordination
- Dr. Rosario Andree, Planning Office, Ministry of Health/World Bank Project
- Dr. Gonzalo Fernández, Ministry of Health/World Bank Project
- Dr. Luis Santa Cruz, Director Medical Services, PROSALUD
- Lic. Antonio Arrazola, Administrative Director, PROSALUD
- Lic. Marta Mérida, Training and Marketing unit, PROSALUD
- Dr. Nora Siles de Justiniano, Chief of Planning Unit, Unidad Sanitaria Santa Cruz
- Dr. Temístocles Sánchez, Acting PAHO Representative in Bolivia
- Mr. Luiz Da Silva, Inter-American Development Bank Office in Bolivia
- Dr. Ramiro Portocarrero, Director, PROSALUD Center, Villa Pillín

EASTERN CARIBBEAN: CASE DESCRIPTION

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ACRONYMS

CDB	Caribbean Development Bank
EC	Eastern Caribbean
ECDS	Eastern Caribbean Drug Service
EDI	Economic Development Institute at the World Bank
GDP	Gross Domestic Product
HCF	Health Care Financing
IMF	International Monetary Fund
IBRD	International Bank for Reconstruction and Development (World Bank)
LAC	Latin America/Caribbean Bureau, USAID
MBS	Medical Benefits Scheme (Antigua)
MOH	Ministry of Health
OECS	Organization of Eastern Caribbean States
PAHO	Pan American Health Organization
PS	Permanent Secretary
RDO/C	Regional Development Office/Caribbean, USAID
REACH	Resources for Child Health Project
USAID	United States Agency for International Development

I. INTRODUCTION

In response to a LAC/DR/HN request, the Resources for Child Health (REACH) Project undertook an overview of health care financing (HCF) activities in the Latin American and Caribbean (LAC) region. The scope of work calls for three main components: 1) a compilation of health care financing initiatives in the region; 2) preparation of detailed case studies of USAID health financing experiences in three countries; and 3) development of a set of general guidelines which can be used by health officers to identify opportunities for HCF activities. The study is not an evaluation of HCF activities. Rather its objective is to review, within the context of the HCF characteristics in the region, initiatives undertaken by USAID in this field and draw lessons that can be used in the future to improve strategy development and policy dialogue.

The following case study describes the USAID experience in health care financing activities in the Eastern Caribbean region. Unlike the other two places visited by the health care financing (HCF) team (Bolivia and Guatemala), the Eastern Caribbean region is an area made of several countries, of which seven were included in the study. Their inclusion was dictated by the support they receive from USAID. The countries are: St. Vincent and the Grenadines, St. Lucia, St. Kitts and Nevis, Dominica, Grenada, Antigua, and Barbuda and Montserrat. Except for the last, which is a British possession, all these countries are independent and each has its own government. They all obtained their independence from Great Britain within the last twenty years.

Given this political background, the seven islands share many social, economic and political characteristics derived from their common British colonial heritage. The similarities in the organization and financing of health services with a predominance of the public sector, is a good example of their common past. However, the seven islands also have differences ranging from geography, to economic development and types of production, as well as to ways health services are organized and financed.

Therefore, while in the other places visited - Bolivia and Guatemala - the USAID Mission confronts one society, one country and one government, in this area it must deal with seven, considering not only their commonalities - that push towards "regional" approaches - but also their individualities, which call for "country specific" approaches.

II. HEALTH CARE FINANCING BACKGROUND

Since the commonalities among these countries prevail over their differences, this section will focus with the group of countries as a whole. However, when a country differs significantly from the overall trend, it will be identified.

1. Economic, Social and Political Context

Overall these countries have small and relatively stable economies, subject to the impact of natural disasters upon infrastructure and agriculture as well as to the effects of changes in market prices for agricultural products. Unlike the majority of Latin American countries, the Eastern Caribbean (EC) countries included in the study have performed well during the last decade, suffering mildly and recovering rapidly from the negative effects of the recession in the developed countries during the early 1980's. (See Table 1.) In effect, inflation has been low (no higher than 7% per year); growth on a per capita basis has been moderate to strong (between 3 and 6% per year) as a result of good economic performance, low or declining fertility rates and emigration to external labor markets; financial deficits by central governments either did not exist or, when they did, were addressed by austerity programs and/or two reforms leading to generalized fiscal solvency; and finally, favorable trade balances have allowed them to avoid an excessive external debt burden.

TABLE 1

Background and Macroeconomic Data on the Eastern Caribbean Countries

Country	Area (Km ²)	Mid-Yr Pop (83) (000's)	GDP per capita (83) (US \$)	GDP Annual Growth Rate (80-86)	Annual Rt Inflation (80-86)
Antigua	440	78.1	1493	6.0	7.0
Dominica	750	81.3	966	3.8	5.3
Grenada	345	108.8	1065	2.9	5.7
Montserrat	102	11.7	2513	2.9	7.1
St. Kitts & Nevis	269	44.6	980	4.4	4.9
St. Lucia	616	126.6	1096	4.1	4.2
St. Vincent	388	113.9	794	4.9	6.8

Source: Leroy Taylor: "Economic Adjustments and Health Care Financing in the Caribbean"; Institute of Social Economic Research, U.W.I. Nova, 1988.

There are exceptions to this general picture. Grenada has had a large fiscal deficit financed by grants and by payments from the sale of a public sector phone company. It has also had difficulties with its balance of trade and has not been able to reach an agreement with the IMF and the IBRD. St. Vincent is the poorest country in the region, with lower prospects of economic growth. Because of its dependence on agriculture and the fluctuation of agricultural prices and output, St. Vincent had significant trade imbalances in 1987 and 1988. Dominica is the island with the greatest development limitations due to weather, topography, cost of

production, and other constraints. Hard hit by floods and two hurricanes in 1979 and 1980, Dominica's public sector led an economic recovery in the 1980's at the expense of larger and increasing fiscal deficits. These were addressed through a structural adjustment program resulting in a reduction of fiscal and trade deficits. Still, the external debt is the major threat pending over Dominica's economy. The government of St. Kitts and Nevis was also very successful in promoting economic growth but ran into difficulties with its fiscal balance as well as with its balance of trade. Although both improved in 1987 and 1988, St. Kitts has to balance its financial and external trade performances.

Another important set of economic characteristics that are common to most of these countries are: the large size of the public sector - government expenditures represent between 20 and 35% of the GDP; a relatively even distribution of income without the inequalities that are so common in developing countries, particularly in Latin America; and high unemployment. This occurs despite high rates of economic growth experienced during the past ten years and the existence of areas of labor shortage compounded by the continuous drain on qualified human resources - particularly nurses - due to the cultural and geographic proximity of better markets like the US or the UK.

High literacy rates and a relatively even distribution of income are probably the result of the performance of public sector institutions, particularly in the area of education, inherited from colonial times. Although the governments have some (sometimes significant) presence in the production sector of the economy, their roles are larger and more visible in social areas like education, health and social security. Public sector institutions devoted to the delivery of social services are almost entirely tax financed and included in the mainstream of central government administration.

A. Forms of Government

As explained before, with the exception of Montserrat, the RDO/C countries are independent with parliamentary systems of government. Each has a strong civil service topped in every Ministry by a Permanent Secretary (PS), a career bureaucrat (not a politician) who gives continuity to the activities of the Ministry. The political side is represented by the Minister, who must be a member of Parliament. Another important characteristic derived from the parliamentary system and the way the bureaucracy is organized is the non-medical leadership of the Ministries of Health. The highest executive position reserved for MDs in the MOH is that of Chief Medical Officer (CMO), who reports directly to the PS. Since the position is filled on a contractual basis and because of reasons already referred to above, the MOH is less permeated and influenced by the medical profession. This is particularly evident when the MOH's of these countries are compared with those of Latin American countries with presidential systems.

B. Role of Politics

Party politics are very active and the democratic institutions in these islands go back to colonial times and are very stable. Given the small size of each country, political considerations penetrate every aspect of the life of society. This is certainly true of the health sector, where issues such as replacing or refurbishing the hospital or paying higher wages to health personnel are immediately (and probably mainly) analyzed in their political context. One interesting by-product of the relationship between size and political activity is the number of portfolios that a Minister must handle. In our visit to St. Lucia, the team learned that the Minister of Health was also responsible for Labor, Housing, Information and Broadcasting.

2. Health Status and Health Services Organization

A. Health Status

The EC countries have been very successful over the past ten years in improving the health status of their maternal and child population. It is not uncommon for these countries to go one or two years without a maternal death. Infant mortality and child mortality have declined to levels that are not frequently observed in countries with similar levels of development (expressed as GDP per capita). Table 2 shows the remarkable reduction in infant mortality rates between 1980 and 1984, in every country except Dominica. Due to the low number of observations, the rates fluctuate significantly. And, although St. Kitts and Nevis experienced a positive improvement during this five-year period, the rates are still high when compared to the other countries, and the improvement is not as dramatic as it was in the others. (See, for instance, Montserrat or St. Vincent.)

TABLE 2

Infant Mortality Rates from 1980-84 Selected Eastern Caribbean Countries

	1980	1981	1982	1983	1984
Antigua	34.7	13.6	12.2	11.1	11.6
Dominica	12.9	10.2	11.5	13.9	23.9
Grenada	23.7	31.8	13.4	21.2	13.8
Montserrat	40.2	21.6	7.7	30.1	12.3
St. Kitts & Nevis	53.0	45.7	42.8	41.2	--
St. Lucia	25.0	25.0	23.0	27.0	17.0
St. Vincent	60.1	46.7	40.5	37.0	26.4

Sources: Health Situation Analysis 1985-86 for each EC country (by several authors), sponsored and funded by PAHO.

The Crude Death Rate also shows improvements over the same period of 1980-84. In addition, partial data available for later years show some further gains. For most of these selected EC countries the prevailing rate is between 5 and 7 deaths per 1000 people as shown in Table 3. There are two exceptions to this overall picture. First, St. Kitts and Nevis has a rate of ten per 1000. This may be related, at least partially, to the high and slowly declining infant mortality rate. Second, Montserrat has also a higher than average death rate. Although it started the period with a high infant mortality, it brought this rate down. The comparability of these rates is limited by the fact that they are not age adjusted and there may be differences in the age and sex distribution in each country depending on different rates of fertility and emigration. Overall, the mortality statistics show a situation that is good by developing country standards and improving.

TABLE 3

Crude Death Rates from 1980-84 for Selected Eastern Caribbean Countries

	1980	1981	1982	1983	1984
Antigua	5.1	4.9	5.1	5.2	4.6
Dominica	5.2	4.5	5.3	4.5	5.5
Grenada	---	---	---	---	6.34
Montserrat	8.9	10.1	9.9	10.6	8.8
St. Kitts & Nevis	---	---	10.93	10.32	---
St. Lucia	7.0	6.7	6.6	6.0	5.5
St. Vincent	6.89	7.35	7.03	7.28	6.51

Source: Leroy Taylor: "Economic Adjustments and Health Care Financing in the Caribbean;" Institute of Social and Economic Research, U.W.I., Nova, 1988.

A relatively good health status is confirmed by the nature of the leading causes of death. Heart and cardiovascular diseases, including hypertension, malignant neoplasms and cerebrovascular diseases are the three leading causes of death in the region, though not necessarily in the same order in each country. With the exception of St. Kitts, infant mortality is concentrated in the neonatal period.

The health status of the population in the selected EC countries creates some peculiar and more pressing problems for financing health care services. First, maternal and child health has been successfully addressed and does not constitute, at present, a priority problem. Of course, improvements can be made, but these will come from upgrading the technologies used around delivery rather than from traditional child survival interventions. Second, the Caribbean population is "aging." Life expectancies at birth (in the area of 70 for males and 75 for females),

together with emigration from the region of young and adult population, contribute to what is believed to be a rapidly changing age-structure of the population. The leading causes of death are consistent with this interpretation. Third, probably the most dramatic change in the scope of health problems is the appearance and increasing prevalence of AIDS. This is said to be favored by the prevailing culture regarding the widespread practice of having multiple sexual partners.

B. Health Services Organization

The morbidity profile resulting from three factors mentioned above (low prevalence of MCH problems, aging population, and increasing prevalence of AIDS) leads to a situation of higher health care expenditure per capita than would be needed in other developing countries, at least on the curative side. The insufficiency of recurrent health expenditures, the need for additional capital expenditures to upgrade facilities and equipment as well as the pressure to incorporate higher technology are the more readily visible results of the changing health situation.

The health services system has four major characteristics that again differentiate these elected EC countries from others, of the same or even higher level of development in the LAC region. These are:

- 1) Universal access: the absence of financial, geographical and sociocultural barriers ensures that, except for isolated cases due to geographical location, the entire population has access to the services that are available. This universality of access, reflecting a society that has a higher degree of integration than is usual in developing countries, is reinforced in hospital care where the entire population has access to the same physical facility and thus to similar technology.
- 2) Predominance of public sector institutions: with the exception of some ambulatory care and drugs that are not included in the MOH formulary, the organization, administration and financing of personal health care services is performed by government organizations, usually directly under the control of the Ministries of Health. Moreover, with the exception of some national financing schemes organized as payroll-based social security systems and run by autonomous public corporations, the network of health facilities and services is administered directly by the Ministry of Health and financed by the central government out of general revenue.
- 3) Hospital based system: the network of facilities of the MOH includes a group of ambulatory care centers, usually widely distributed and thus easily accessible; some specialized hospitals for mental patients; a few small village hospitals/health centers; and a relatively large acute care hospital that has an out-patient clinic, an emergency department, in-patient facilities (with accommodation in wards and private rooms), intensive care and/or recovery room, etc. The hospital is perceived by the population (and by many providers) as the focal point of the system. Since these systems were developed under British oversight they continue to

reflect the central hospital - district facility - community nurse model of service provision. This induces the population to "by-pass" the health centers and seek care directly in the hospital, even for conditions that can be appropriately managed in the periphery.

4) Small scale of operations: in most of the selected EC countries, because of their size, there is only one acute general hospital. Thus, the Radiology and Laboratory Departments of the hospital are the only diagnostic capabilities of the country. This has important implications in terms of costs and particularly in terms of incorporating technology. In effect, to the extent that a technological improvement requires a large market (say several hundred thousand people), the technology cannot be incorporated without incurring high costs due to excessive use relative to the population, below capacity utilization, or both. In some instances, particularly in Antigua, this problem is dramatically emphasized by the number of patients (and the proportion of expenditure) being sent abroad - both within and outside the Eastern Caribbean region - for treatment. This in turn justifies or provides a rationale for incorporating equipment that clearly requires a larger market for a cost-efficient operation. For example, a CAT Scanner was acquired and put into operation in the Holberton Hospital, though it would be difficult to justify the purchase of this piece of equipment on a cost-savings basis. Although some intraregional exchange of resources and patients takes place the health delivery systems are still aiming at technological self-sufficiency by each country. An exception to this approach is the joint procurement of pharmaceuticals by six countries in the region.

Besides these four major characteristics - universal access; predominance of public sector; hospital-based system; and small scale of operations/lack of regional approach - there are other aspects of the system which are important to consider.

First, the traditional public health measures and the first level of care are effectively available through the network of primary health care centers. These centers are conveniently located, making for easy access in most health districts. However they suffer from a chronic shortage of personnel, particularly community nurses, who are attracted by higher wages in developed countries.

Second, the acute general hospitals were built in the colonial period - most of them are 100 years old or more - and are inadequately maintained particularly because of the obsolescence of the physical plant which, as a result, is highly inadequate for modern hospital care.

Third, it is interesting to note that the hospitals are predominantly run by a trained hospital administrator, frequently an expatriate, a matron and a chief maintenance person. Whereas the nurses, nurse's aids and administrative personnel work for the hospital as employees, the physicians, even on salary, enjoy a different relationship. They may be on salary, they may have a time requirement (which usually is not strictly followed) and they relate to the administration either by a Chief of Medical Staff or by a Medical Director. In theory, physicians working for

the hospital are government employees and as such "might be allowed to practice privately in their own offices." In reality, physicians attach higher priority to their private practice, although without neglecting their responsibilities toward the hospital - which is usually the only place where they can provide in-patient care. Because of this approach, there are some patients that could receive ambulatory care by a physician in the hospital's outpatient department who end up being treated in the private office under a fee for service arrangement. This may be a realistic approach to attract well-qualified physicians that would not otherwise have agreed to work in the hospitals. It also indicates the willingness of some patients to pay for services that would have been provided free of charge in the hospital, provided that they are delivered without the inconveniences of the hospital setting.

3. Health Care Financing Characteristics

A. Revenues

As already mentioned, health services are mostly financed from tax revenue. Even in those countries where there is a social security tax for income maintenance and health services benefits, the funds are usually channeled through the consolidated government's revenue. Moreover, revenues collected from patients by the public sector health services facilities are also channeled through the treasury. Thus, the budgets of the health delivery facilities come from the government and result from the resource allocation process.

Little is known about how the resources collected for health services by the social security funds are managed. In general they are said to be incorporated into the consolidated tax revenues. However, this is not always the case. In Antigua for instance the Medical Benefits Scheme (MBS) collects a fee equal to 5% of all wages, half from employers and half from employees. The fund is administered by an autonomous public corporation that pays the MOH for services provided to its beneficiaries. These include two categories of people: first, everybody under 16 years of age and over 60; and second, every person that suffers from one of eight specified diseases, e.g., diabetes or hypertension. Payments to the MOH by the MBS are forwarded to the Treasury and do not modify the budget of the Ministry.

Further, little has been documented about user fees charged by public sector health services. With the exception of St. Vincent, all of the governments have some level of user fees on the books, with revenues going to the general treasury, thus, providing little incentive to collect from those who are required to pay. In most instances, a large majority of the populations in the OECS countries are exempt from paying fees which also serves as a disincentive for pursuing collection by health workers. In the case of St. Lucia, for example, the number of groups of people exempted from paying fees at time of consumption leaves only 7 to 10% that are required to pay. The need then becomes not so much introducing fees, but rather obtaining from governments their commitment to this financing

scheme; developing equitable, realistic and acceptable protocols and procedures for a coherent national policy; and devising a public campaign to reduce political fallout.¹

Besides the lack of incentives for collection, user fees run counter to the prevailing culture, which is accustomed to universal access to health services free of charge. Imposing user fees carries a large political cost that few political parties are willing to suffer. Furthermore, the obsolescence and poor maintenance of hospital facilities increase the reluctance of the population to pay. Finally, in considering user fees, the issue of equity must continue to be considered. In effect, despite economic growth and a more equitable distribution of income, there are segments of the population that cannot afford to pay. Raising financial barriers to access by imposing user fees to all users seems to run against a deep and widely shared social value.

Another source of funds is commercial health insurance, though this is very limited in scope due to the reluctance to implement user fees and the prevailing method of financing services through taxes. However, little is known about the relationship between payments to private providers (physicians, pharmacies, dentists) and health insurance coverage. It seems that the most common method of paying private providers is through out-of-pocket payments at time of consumption. Obviously this constitutes an additional source of funding for the health services system. However, in the absence of comprehensive studies about health care expenditures, it is impossible to estimate the relative importance of this source in relation to others, particularly to government expenditure.

Finally, external donors are an additional source of funds, particularly oriented towards capital investment (e.g. building of health centers or water systems, refurbishing or remodelling hospitals) and towards supporting recurrent expenditures of preventive public health programs.

Within the public sector services, employees are on salary, including physicians. In some countries, however, physicians receive a fee for some procedures in addition to their salaries from the government, usually surgical procedures, performed on paying patients. The effect of this incentive system on utilization (whether procedures for which physicians receive fees are performed more often than would be expected) has not been studied. However, given the small number of paying patients, the effect of the incentive on use may be almost negligible. Moreover, if physicians are willing to increase their incomes, they can induce the patient population to seek ambulatory care in their private offices - where they are allowed to charge freely - instead of the ambulatory facilities of the public sector services system.

B. Expenditures

As Table 4 shows, government recurrent expenditures for health in the region are a high proportion of total government expenditure, usually ranging between 12% and 16%. Capital expenditures represent a smaller proportion of governments' total investment expenditures and fluctuate more widely, depending on the nature of investments being undertaken in the health services system. Although not shown in Table 4, recurrent expenditures are more stable and, although they show a trend toward increasing in recent years, they have stabilized around 15%.

TABLE 4

**Total and Health Government Expenditure for
Selected Eastern Caribbean Countries, 1986**

Country	Total Gov't Expenditures as % of GDP	<u>Government Expenditure in Health</u>		
		as % of total gov't recurrent expenditures	as % of total gov't capital expenditures	as % of total gov't expenditures
Antigua	17.8	13.3	0.7	6.2
Dominica	28.4	15.3	4.2	11.0
Grenada	35.4	N/A	N/A	N/A
Montserrat	22.0	15.9	0.9	13.3
St. Kitts & Nevis	25.4	11.6	N/A	---
St. Lucia	29.6	12.6	15.8	14.0
St. Vincent	36.8	13.8	0.3	8.4

Source: Leroy Taylor: "Economic Adjustments and Health Care Financing in the Caribbean"; Institute of Social and Economic Research, U.W.I., Nova, 1988.

As shown in Table 4, a high percentage of the government recurrent expenditures are devoted to health services. These figures are of great significance since total government expenditures are high in relation to the size of the economy. This fact, recognized by several officials of the countries, has led donor agencies and local observers to believe that government financial resources for health services will not increase further. No new additional public funds are likely to be devoted to the

health delivery system. It is not clear for the REACH team that this position applies as well to capital investment projects. It was clearly stated for recurrent expenditures.

However, there are a number of reasons that put an upward pressure on the cost of health services. In particular, an aging population, the relative affluence resulting from sustained economic growth, a stable and growing middle class, and exposure through mass media to new medical technologies seem to be the most important factors. These needs and expectations of the population are frequently channeled through the political system. For instance, the expenditure by the public sector for medical treatment abroad is high and requests for treatment in the US, Canada or England are usually decided at the Cabinet level. There is a common expectation among the population regarding the need to first, improve the quality and amenities of care; second, upgrade the medical technological capabilities readily available on each island; and third, increase the salaries of health personnel in order to attract competent staff, and particularly to avoid the drain on nurses.

All these factors put an upward pressure on the level of resources needed to finance the health care system. Since new recurrent funds are and will continue to be needed, and since additional funds are unlikely to come from the government, the EC countries are left with a relatively limited range of options to cover this cost. First, improved efficiency of operations would result in fresh funds becoming available to cover some of the additional costs. Second, alternative sources of funding could be tapped. In particular, two likely sources are (1) funds from the imposition of user fees as facilities are improved and new technologies incorporated and (2) reorganization and expansion of the social security tax to cover a wider range of beneficiaries and benefits.

The financing of health services in the EC countries has reached a point at which changes must to be introduced if universal accessibility and high quality are to be maintained. It provides a unique opportunity for exploring new financing strategies in developing countries.

4. USAID Policy Dialogue

The primary concern of AID's Regional Development Office in the Caribbean (RDO/C) for the past as well as for the next five years has been the health of these countries' economies. Particular attention has been given to: economic growth; the development of a suitable environment for private sector investment; sound fiscal policy with the aim of achieving and maintaining fiscal solvency and, finally, maintaining favorable trade balances. These are the areas of primary concern for the RDO/C which are expressed in a variety of projects, initiatives and policy dialogue.

A second important consideration derives from the fact that these countries have been very successful in dealing with the basic maternal and child health problems, as was shown in Table 2. The traditional public health district approach, high literacy, relatively even distribution of

income, safe water supply and sanitation as well as favorable climate, have all contributed to these positive results. Child Survival interventions, a top priority elsewhere in the developing world, are of secondary importance in the Eastern Caribbean.

Thus, recent USAID policy dialogue in health with the countries has centered primarily on two areas: programs to prevent the spread of AIDS and issues of financing health care services. The policy dialogue on health care financing issues is particularly important in this region for two reasons: first, it is an essential element of a sound fiscal policy package given the size of the public sector health services delivery system (fiscal policy, in turn, is a top priority in the list of economic concerns of the RDO/C) and second, as explained before, the development of the health services system has reached a stage at which changes in infrastructure and in health care financing mechanisms are overdue.

In terms of health care financing, the policy dialogue has focused on the areas of cost recovery (primarily through user fees) and cost containment and other efficiency measures. Few changes have been achieved or put into operation. However, from discussions with country officials it was clear to this team that health financing issues are at the top of the agenda of the Ministries of Health and, to a lesser extent, Planning and Finance. Although changes have not been implemented, there are a number of proposals being discussed, and the need for further studies and analysis of the issues is quickly presented to outsiders by public officials.

The policy dialogue capability of the RDO/C is limited by the fact that it is a regional entity located in Barbados and thus not able to maintain a day-to-day, regular exchange of ideas with interested parties in each country. Although communications are good and travel by air is not difficult, seven countries, each with its own peculiarities, is a large number if one wishes to maintain a fluent and updated dialogue with each. Nevertheless, in the countries we visited, AID policies and cooperation in the health field, particularly with regard to health financing issues, was readily recognized, reflecting an active policy dialogue process.

III. HEALTH CARE FINANCING ACTIVITIES

Reflecting the importance of HCF for the countries themselves and also for bilateral and multilateral agencies, the team found numerous activities related to this area. All of them have been identified and briefly described in another REACH document^{1 1)}, and thus it is not worth repeating them here. Nonetheless, there are some initiatives that deserve special mention.

^{1 1)} Pinto de la Piedra, Matilde. Annotated Compilation of Health Care Financing Activities in the Latin American and Caribbean Region 1982-1988, REACH Project, Arlington, VA, October 1989

First, it seems important to recognize the pioneering effect of the Regional Workshop on Health Care Financing, sponsored by AID in early 1985. Its central purpose was to bring together Ministers of Health and their Permanent Secretaries and Health Advisors from the Organization of Eastern Caribbean States (OECS) to discuss health care financing issues. As a result of the workshop, assistance was requested in a number of areas by each country. Four years later, in early 1989, a new Regional Seminar was held in Barbados on Health Economics and Financing, sponsored by PAHO, EDI and CDB. Two interesting features of this Seminar are worth noticing: first, the type of participants from each country was different. The 1989 Seminar included senior officers of the Ministries of Planning and Finance as well as from the Ministry of Health. Second, the Seminar used case studies based, to a large extent, on actual experiences presented by each country. This experience demonstrated the extensive activity that had taken place between the two events. Health care financing is a pressing issue in the OECD countries, and the experience of both seminars, as well as the activities between them, reflect this reality.

1. Country-Specific Activities

Activities undertaken with the support of AID and other agencies can be classified into two groups: first, there have been several studies on specific problems of individual countries. The most common example is the number of studies done (and currently underway) on hospital costs and potential sources of revenue. The reasons for undertaking this type of study are the need to compute unit service costs in order to be able to establish reasonable user fees for hospital services and the need to have cost information that may enable hospital authorities to identify areas of inefficiency and take corrective action. A further step in this direction, not yet being considered by most people involved, is the development and implementation of a standardized hospital information system to be incorporated by all countries in the region. This would provide hospital administrators and Ministerial authorities with comparative information which is essential to assess the performance of each facility. In turn, this approach would have a beneficial effect in the management of some hospital facilities in the region that are not well-developed and lack the data needed to monitor their performance.

The hospital cost studies that have been done were well received by MOH officers interviewed by the evaluation team. Their usefulness was appreciated and the effects upon some areas of hospital performance was recognized. Moreover, the team was pressed to sponsor additional studies that would take the level of analysis one step further: to enable the hospitals to compute unit service costs segregated by type of service (specialty, outpatient, inpatient and emergency).

Although hospital cost studies are clearly justified on the basis of their importance in the MOH's budget, there are two other neglected areas that deserve attention. None of the seven studies address the financial size of the private health sector. Neither are there studies of total national health expenditures (public and private). Such studies, if

performed, could show the size of health expenditures, both public and private, relative to GDP in order to determine whether it is likely that any additional resources might be devoted to health or if some provable upper limit on health expenditures has been reached.

Cost-effectiveness studies of health centers (particularly those that have a small number of hospital beds) and the acute care general hospital facilities should also be considered. The preference of patients for private ambulatory care by physicians cast some doubt on the effectiveness of health centers as they are currently conceived and managed. It would be useful to undertake some studies of this type to identify areas where efficiency could be improved.

2. Regional Activities

A. Purchasing

The second type of initiatives that USAID and other agencies have sponsored are regional and included almost all the countries in the region. Among them, the most successful has been the implementation, under USAID auspices and managed by OECS, of a joint tendering system for pharmaceuticals, known as the Eastern Caribbean Drug Service (ECDS). The project includes all the countries being studied, with the exception of Antigua and Barbuda. Governments still procure and distribute individually although procurements are channeled through the ECDS and the Drug Service recurrent costs are financed by a 15% administrative levy on individual purchase order. The system does not purchase items in bulk. This has been a highly successful project which has enabled a more cost-efficient and timely provision of pharmaceuticals. Obviously this is an area where economies of scale provide good opportunities to increase the efficiency of operations.

B. Training

Another area of regional concern is the training of health care managers, particularly hospital and health center administrators. There has been some effort by USAID and by other agencies, notably by PAHO, in training. This is particularly needed because of the importance of HCF issues being faced by all these countries, but also because key positions held by expatriates since the end of colonial rule are rapidly being turned over to local individuals that have not had the opportunity for formal training and/or experience. This need is particularly pressing in the areas of medical facilities and technology planning, financial management and hospital administration at all levels with special emphasis in maintenance. People of the EC countries are characterized by a highly professional public sector, reflecting the British tradition of trained committed civil service. Thus, the attitude and environment are appropriate for developing an effective and efficient bureaucracy. The need identified here is for appropriate training in management and planning skills which are sorely needed and which can only be answered on a regional scale.

IV. KEY ELEMENTS OF USAID HCF ACTIVITIES

Some methodological approaches taken by USAID's RDO/C Mission have already been identified in this report; e.g., policy dialogue, seminar of 1985, coordination with the economic approach of the Mission. However, there are a few additional methodological aspects that will be covered in this section.

First, USAID is well regarded by health authorities in the region because, among other factors, of its ability to quickly respond to requests. Besides having a responsive staff that works in an area where problems are manageable, at least by developing country standards, USAID's speed of response in the area of HCF has been made possible by its ability to call on centrally supported projects.

Second, there is already coordination among the multilateral, bilateral and national agencies involved in the development process. This is achieved by the Caribbean Group for Cooperation in Economic Development, chaired by the World Bank, through annual meetings to coordinate donors, and regional and national government planning. However, in the area of HCF this coordination process should be tightened up to avoid decisions that, having been pushed by a single agency, endanger the effectiveness of wider goals being pursued by several agencies in the same country.

Finally, on the methodological side, the RDO/C Mission appears to be successful in advancing the HCF agenda. These may be due to two reasons:

- a) the relevance and timeliness of the health financing issues for all the countries being supported by AID in the region, due to factors already explained in this report, and
- b) AID's approach, in which the governments and USAID officers successfully seized an initial learning opportunity, represented by the Seminar of 1985, and followed up by country studies in specific issues as well as by a highly visible regional project (drug procurement and revolving drug fund).

V. LESSONS LEARNED

Several areas of importance emerge from the above analysis of the health services and health financing system in this region. Their analysis follows.

1. Improving Efficiency

The most promising source of additional funds for financing needed improvements in the system appears to be improvements in the efficient operation of the delivery system. Within this category, support

should be given to projects aimed at developing and implementing health services management information systems and management training. In addition, this portfolio should include studies aimed at reviewing the policy implications of the predominant form of the delivery system. Most countries are, in one way or another, addressing the issue of whether the delivery of health services by public sector facilities, directly administered by the MOH, results in the most efficient operation. Some countries are examining the incentives that this approach presents for both consumers and health personnel. Furthermore, some countries are considering alternative ways of organizing the delivery of services, such as establishing an autonomous semi-public corporation, as well as alternative or supplementary mechanisms of financing services. Issues of productivity, accountability, improved planning, programming and budgeting are being addressed, opening opportunities for USAID support aimed at improving the efficiency of a delivery system that is obsolete, which has become an increasing burden on the public purse and which is not upgrading itself and delivering the technologies and amenities that people demand. Efficiency improvement initiatives should include a gradual expansion of the regional drug procurement program. The inclusion of supplies is a logical next step, but other avenues could be explored. Repair and maintenance of medical equipment could be done more cost-effectively if joint procurement of medical and hospital equipment is undertaken. Moreover, the scale of operations calls for planning on a regional basis, if medical technologies that require large markets are to be introduced successfully.

2. Potential Resource Mobilization Activities

Given the already large share of government expenditures that go to the health sector in these countries, it is unlikely that additional public funds will be devoted to health. As a result, resource mobilization becomes key to meeting the rising costs of health care, incorporating higher technology into the system, and maintaining and upgrading the existing facilities. Two areas seem to hold the greatest promise on the issue of resource mobilization: the revision of health-related social security funds and the introduction of user fees. Both require additional information and analysis before they can be implemented successfully. Moreover, they should be considered in the context of the reorganization of the entire delivery system referred to above. However, political considerations make the introduction of user fees difficult in countries where the population is accustomed to nearly free universal health care. Moreover, until improvements to obsolescent physical plant take place, it is unlikely that the population would be willing to pay more for public sector health services.

3. Regional Approach

From the methodological point of view, the importance of analytical support and training on a regional basis needs to be emphasized. The countries have differences in some aspects of health care organization

and financing. However, their commonalities and their small scale call for regional approaches. Moreover, there are valuable, well-trained local human resources in the region serving just one country. The exchange of experiences and the provision of technical cooperation using these well-trained local resources could benefit the entire region. USAID has recognized this and, through seminars and regional activities, has helped to promote this approach. USAID should use these resources more extensively to further promote regional responses, which, in some areas of medical technology, are the only reasonable response.

4. Exploring Regional Health Insurance

An initiative that holds good potential but might be more distant for political reasons, is the introduction of region-wide health insurance schemes. This approach would be able to overcome the constraints that these small markets put on the development of health insurance. Because of market size considerations as well as equity and historical reasons, a regional, public sector, universal coverage, health insurance system appears to be more feasible than the development of competitive commercial health insurance.

APPENDIX I: PERSONS AND PLACES VISITED

Ms. Gail Goodridge, Senior Health Advisor RDO/C
Mr. Roy Grohs, Chief, Program Development Office RDO/C
Ms. Carol Becker, Acting Chief, Health, Population, and Education RDO/C
Mr. Larry Armstrong, Deputy Director RDO/C
Mr. John Wooten, Project Development Officer RDO/C
Mr. Halmoud Dyer, Director, Caribbean Regional Coordination PAHO
Mr. José Dekovic, Management Advisor, CRC PAHO
Mr. Beleke Zeleke, Deputy Director, CRC, and Health Services Advisor PAHO
Mr. Philip Musgrove, Health Policies Development, PAHO
Mr. Cornelius Lubin, Permanent Secretary, Ministry of Health St. Lucia
Mr. Michael Cooke, Administrator, Victoria Hospital St. Lucia
Mr. Llewellyn Gill, Chief Accountant, MOH St. Lucia
Mr. James St. Catherine, Chief Medical Officer St. Lucia
Mr. Henson Barnes, Permanent Secretary, Ministry of Health Antigua
Ms. Marilyn Simon, Assistant Secretary, Holberton Hospital Antigua
Mr. Louston Warner, Superintendent, Medical Benefits Scheme Antigua
Ms. Louise Williams, Administrator, Central Medical and Drug Supply Antigua
Mr. Marius St. Rose, Vice President, Caribbean Development Bank
Mr. DeLisle Worrel, Director of Research, Central Bank of Barbados
Mr. David Dunlop, EDI

GUATEMALA: COUNTRY CASE DESCRIPTION

ACRONYMS

GDP	Gross Domestic Product
GOG	Government of Guatemala
HCF	Health Care Financing
IDB	Inter-American Development Bank
IGSS	Guatemalan Institute of Social Security
ILO	International Labor Organization
LAC	Latin America and Caribbean Region
MOH	Ministry of Health
PAHO	Pan American Health Organization
PREALC	Latin American Office of the International Labor Organization
REACH	Resources for Child Health Project
SIECA	Secretariat for Economic Integration in Central America
SIF	Social Investment Fund
TRS	Rural Health Technician
USAID	United States Agency for International Development
USAID/G	USAID/Guatemala Mission

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I. INTRODUCTION

In response to a LAC/DR/HN request, the Resources for Child Health (REACH) Project undertook an overview of health care financing (HCF) activities in the Latin American and Caribbean (LAC) region. The scope of work calls for three main components: 1) a compilation of health care financing initiatives in the region; 2) preparation of detailed case studies of USAID health financing experiences in three countries; and 3) development of a set of general guidelines which can be used by health officers to identify opportunities for HCF activities. The study is not an evaluation of HCF activities. Rather its objective is to review, within the context of the HCF characteristics in the region, initiatives undertaken by USAID in this field and draw lessons that can be used in the future to improve the strategy development and policy dialogue.

The following case study describes the USAID experience in health care financing activities in Guatemala. While each country is different and experiences are not totally transferable Guatemala provides an important example of a setting in which the work of AID and other donors is of critical importance for the organization and delivery of health services and health care financing initiatives to contribute to the goal of improved health status.

Guatemala has one of the most unbalanced socioeconomic situations in Latin America. One third of its people are in absolute poverty. A similar proportion are illiterate and lack adequate housing. Less than half of the population have access to safe water. Conditions have been worsening in recent years under the impact of declining family incomes. This summarizes all too well the context within which health activities generally and health care financing activities more specifically need to be developed and implemented.

II. HEALTH CARE FINANCING BACKGROUND

1. Economic, Social, and Political Context

After a sustained period of economic growth in the 1960's and 1970's averaging almost 6% per year, the Guatemalan economy has suffered deteriorating economic conditions since 1980. This downturn reflected weaknesses in the region's political circumstances as well as a significant worsening of the terms of trade and the failure of the Central American Common Market. While much of the region faced the same problems, by 1983-84, most of the Central American region had begun a renewed period of growth. In Guatemala, however, the recovery process did not start until 1986.

In the period between 1981 and 1988, real per capita income declined 19.5%^(1) reflecting both a decrease in total GDP and one of the highest annual population growth rates in Latin America (2.9% in 1986). The number of persons in extreme poverty (unable to purchase a minimal food basket) had risen from 2.7 million to 3.5 million or from 39% to 42% of the population by 1987. Of that 3.5 million people, about 30% had a deficit of more than 40% of the food basket cost^(2).

In Guatemala, the economic programming process has been closely linked to the political process. The democratically elected government that took office in 1986 was committed to a political agenda of support for economic development to back up the democratization process. This meant that the GOG committed itself to make the reforms needed to secure economic progress. This effort was part of a transition from a situation of immediate crisis to one of developing opportunities. Within the long term objective of "economic democratization", two short-term economic programs have been implemented in the recent years and a third is to be undertaken during 1989. The first one, initiated in 1986, was the "Short-term Program of Economic and Social Streamlining". The objective of this program was to overcome the crisis of 1981-85 through the stabilizator and ordering of the economy. As a result of this program, the negative trend in the growth rate was reversed and, in 1986 a positive rate of economic growth was obtained for the first time in six years. The second phase, the short - term "Program of National Reorganization" was implemented in 1987-88. This program concentrated on introducing reforms to facilitate economic progress and a better distribution of the benefits of growth. The program was successful in achieving positive economic growth rates of 3.1% and 3.5% respectively in 1987 and 1988.

The current program for 1989 and 1990 is the "Program of Democratic Consolidation"^(3). Its main objective is to improve equity in the distribution of benefits of growth. Thus, the program gives a high priority to social sectors development and, consequently, to the provision of social services. Decentralization and regionalization are seen as the main instruments to obtain these objectives. And to reflect this focus, the fiscal budget for 1989 is presented by regions for the first time. While each of the measures included in this program influences the financing of health care, the fiscal policy components have the greatest effects and set an implicit framework for the development of a HCF strategy. In this area, the priority in expenditure will be investment as opposed to recurrent expenditure, and efforts to increase operating revenues will be emphasized.

(1) Economic Commission for Latin America and the Caribbean. Balance Preliminar de la Economía Latinoamericana, Santiago de Chile, December 1988.

(2) SEGEPLAN, Encuesta Nacional de Ingresos y Gastos Familiares, 1979-81, Guatemala 1983

(3) Ministerio de Finanzas Públicas de Guatemala. Consolidación Democrática y el Presupuesto 1989, October 1988

The impact of the weak economic performance of the 1980's is made more critical by the extremely skewed income distribution. In 1980, the top quartile of the population received over 60% of the income while the lowest quartile received less than 7% and the lowest half received only 19%. Surveys made in 1947-48 and 1970 demonstrate essentially the same income distribution. In actual monetary terms, only 3% of the employed population in 1986-87 earned more than \$240 per month while over 55% earned \$48 or less per month^{1 4)}. At least 20% of the labor force was unemployed, with another 20%, mostly in rural areas, estimated by the Ministry of Labor to be seriously underemployed. While between 60,000 and 70,000 new workers enter the labor force each year, there has been no substantial increase in jobs since 1980.

The picture is made clearer when the importance of agriculture in the Guatemalan economy is considered. The sector represents two-thirds of all exports and accounts for over 25% of GDP. Additionally, agriculture provides employment for over one-half of the labor force.

The structure of the sector is highly dualistic with approximately 54% of the farms, with four-fifths of the rural population, of 1.4 hectares or less. This size is inadequate to produce sufficient food or income for the typical rural family of 5 or more people. At the other extreme, 3% of the farms covered 66% of the arable land area. Exacerbating this distribution is the fact that the large farms are found on the south coast which has only 15% of the population but 30% of the good soils in Guatemala while the altiplano which has 46% of the population has only 19% of the country's fertile soil (capable of high to moderate yields). The largest percentage of agricultural workers, estimated at 9 out of 10, are engaged in subsistence farming on plots of ground too small to provide subsistence and, as well, are employed as migrant labor, working seasonally on large farms away from their usual residence at wages considerably under the official minimum wage of Q3, approximately \$1.20. In 1980, the percent of families in extreme poverty in rural areas was more than double that in central urban areas.

The difference in circumstances reflected not just the economics noted above but, to a large extent, more basic social and demographic conditions. Approximately one half of the over eight million Guatemalans are Indians (referred to in Guatemala as "Mayans") who, as a group, have been politically, socially, economically and linguistically isolated from the rest of Guatemala. They represent a large proportion of the rural population and live predominantly in the western highlands in one of 18,000 communities of less than 1,000 persons. They work primarily in subsistence farming and as itinerant laborers, migrating to the large farms in the south to harvest export crops.

^{1 4)} SEGEPLAN, Plan de Desarrollo Nacional 1984-86 - Plan Global de Distribución del Ingreso.

While most of the rest of the population tends to live in more urban areas, speak Spanish, and work in market-oriented agriculture, commerce, industry, and services, the Mayan population speaks local or regional dialects of one of four main language groups (Mam, Ixil, Quiche, and Cakchiquel), makes up most of the rural population (which is around 60% of the total population), and works at the least rewarding and most isolated forms of employment. The income inequities between urban and rural dwellers reflect as well a long-standing history of neglect and mistreatment to which the Mayans have responded by focusing on activities within their own society and distrusting outside influences.

The problems noted above are also reflected in other aspects of the society. The overall literacy rate was less than 50%, one of the lowest in Latin America. For non-Indians, the rate was over 65%, while among the indigenous Indian population, 33% of males and only 15% of females were literate. Over two-fifths of the labor force has no formal schooling while another 25% of the population has completed 1-3 years. Only 15% of the 13-18 year age group is enrolled in secondary school. To some extent, the low literacy rates reflect the poor state of the education system as well as the economic and social context.

While two-thirds of all children 7 to 14 years of age live in rural areas, two-thirds of them do not attend school. In the highlands, fewer than 50% of the children 7-14 are enrolled. Half of all children in the first grade repeat it, and generally high repetition rates result in the need to provide an average of 8 years of schooling for every child that completes six years of school. As in other areas, the problems are worse in rural areas where language difficulties compound the inadequacy of the school system.

The problems of underdevelopment, poverty, and illiteracy are compounded by the fact that Guatemala devotes the smallest proportion of GDP to its public sector of any country of Latin America. Tax revenues fell to a low of less than 8% of GDP in 1983-85 and rose somewhat to 8.7% in 1986, still one of the lowest tax efforts in the world. While the reasons for this are both complex and historic, they reflect the extreme maldistribution of income and wealth that characterizes the Guatemalan economy. As a result, relatively few public resources are available to deal with the extensive deficiencies in investment and services in the social sector of the economy.

The deterioration suffered by the Guatemalan economy during this decade has come to worsen a social situation that was already very poor, as just described. Public expenditure in social areas was reduced in real terms in such a way that available resources had to be devoted mainly to finance operation costs with almost no expenditure in new capital investment or even capital maintenance. Even though the impact of this lack of investment may not be noticed immediately, it will be seen after a time lag, when the deterioration of infrastructure will make it impossible for the social sectors to maintain the level of service provision.

The GOG recognized this under-spending in social areas, and is actively working towards the implementation of a program that can solve this gap. The GOG borrowed the expression of "social debt" coined by PREALC, the Latin American Office of the International Labor Organization⁵, and has developed a program of expenditure in social sectors to pay for this debt. It is interesting to note that while the PREALC estimation is related to the absolute deterioration of social sectors during the recession period, the Guatemalan measure of social debt is relative rather than absolute and takes into account the economic recession in the standards of comparison. In fact, the latter measure is defined as the difference between the average investment per capita in social sector by Latin American countries during the decade and the actual level of Guatemalan investment in those sectors during the same period of time.

While the team was visiting the country, the GOG was preparing a proposal to fund a Social Investment Fund (SIF). The project was to be presented to the World Bank Advisory Committee to request funding from the international community. The proposal had two bases: first, the fact that in Guatemala not only has there been a reduction of social expenditure like in every Latin American country, but the Guatemalan deterioration has been worse than that experienced by other countries, as measured by the concept of social debt; second, although the public budget for 1989 and 1990 gives a high priority to investment in ministries in the social areas, domestic resources are not sufficient to cover the gap.⁶

The rationale for the SIF recognizes that the fundamental constraint to to improving social services is a lack of resources. Misallocation and inefficiency are also major problems in the health sector, however, and the MOH is considered one of the weakest in Central America. For the purposes of this country case description, this is a very relevant observation since it frames the setting for health care financing initiatives that can be undertaken by the GOG as well as the activities that USAID/G can sponsor in the form of studies and pilot/demonstrations projects.

2. Health Status and Health Services Organization

A. Health Status

As suggested by the above discussion, the health status in Guatemala is poor, particularly compared to other countries with similar levels of per capita income. Estimates of the infant mortality rate (IMR) vary widely but even the lowest estimate of 61 deaths per 1,000 live births for

⁵ PREALC. Ajuste y Deuda Social. Un Enfoque Estructural, Santiago de Chile, 1987

⁶ The budget for 1989 allocates 10.9% of GOG expenditure to the health sector, while the investment component of the MOH budget is 27%.

1986 is high^{1 7)}. The USAID Mission uses the the rate of 73.4 reported in the 1987 Demographic Health Survey, while other "official" estimates range from 82 to 110 per 1,000. These aggregate indicators mask the realities for much of the population. For all mortality measures, the poor rural states in the central highlands, Tontonicapan, Chimaltenango, Escuintla, and Quetzaltenango, have rates approximately double the national averages. The MOH goals for 1990 are to eradicate polio and reduce the IMR to 50 per 1,000 live births, though these targets are certainly unattainable given the current rates. The Mission estimates that the IMR will be lowered to 69.4 per 1,000 by 1991.

Child mortality (5 years and under) is a high 15 per 1000 in the age group. Although children in that age group comprise only 18% of the population, they accounted for 44% of all the deaths in 1983. Over 70% of these children live in rural areas. Over 50% of all children's deaths are linked to intestinal and respiratory diseases which reflect the poor housing and sanitary conditions. In rural areas, fewer than 25% of the population has access to potable water. Excreta disposal systems (latrines, etc.) which could reduce the high risk of disease are not widespread.

While Guatemala has made some public investment in improved water and sewerage systems, there is little expectation that these developments will result in significant overall improvement in health status since, between 1981 and 1986, over three-quarters of those investments have been concentrated in Guatemala city and other urban areas. For Guatemala city alone, these expenditures amounted to US \$8.1 per capita as compared to US \$1.3 for the rural areas where the deficiencies in water and sewerage have their greatest impact on mortality and morbidity.

The health risks noted above are worsened by the high incidence of malnutrition, which affects over half of children 5 years and under and large numbers of pregnant women. Maternal mortality is estimated at 1.2 per 1000 live births. The high rate of maternal mortality reflects as well the fact that only 20% of births are attended by physicians with another 22% attended by formally trained midwives. Most of the remaining 58% are attended by "empirical" midwives untrained in modern delivery practices. Of all deliveries, only 20% occur in hospitals or clinics, with the remainder being delivered at home under conditions which are often poor and unsanitary. The pattern of inadequate delivery of prenatal and obstetrical care is repeated for all other components of health care, particularly primary health care.

B. Health Services Organization

1) Ministry of Health. The primary source of health care services for Guatemalans is the Ministry of Health, which operates 35 hospitals and services in 24 health areas which cover, in principle, all of the country.

^{1 7)} The World Bank. World Development Report 1988, New York: Oxford University Press

The MOH has responsibility for providing care for all Guatemalans who are not covered by the Guatemala Institute of Social Security or who are too poor to pay for services in the private market. This population is estimated at two-thirds to three-fourths of the total population of eight million, yet only one-third to one-half of these people actually have access to MOH services. Others use services of the Guatemala Institute of Social Security (IGSS), private providers, or, in many cases, go without services. The Ministry of Health estimates that around 35% of population has no effective access to health services.

As with all other Guatemalan statistics, the rural population reflects the poorest extremes. Overall, less than 30% of the population has access to maternal and child health care. For many rural areas, such care is totally nonexistent. In 1984, the MOH had established 690 health posts to serve a rural population of approximately 4.8 million. This represents an average service population of around 7,000 persons but, in fact, almost 15% were not operational because of lack of staff and supplies. More than half of all of the rural health posts lacked a Rural Health Technician (TRS) implying that many of the health posts that were "operational" in the sense of being open lacked staff trained to provide basic primary health care services.

Additionally, some 200 posts and health centers are in premises not owned by the MOH. Many of these are without equipment, running water, or electricity. Almost one-half of the health posts are over 10 years old and poorly maintained, making the problem of inadequate facilities of increasing importance and immediacy. The 209 health centers which are to provide services in municipal capitals and larger villages also suffer from lack of staff and supplies. As a result, in 1983, the per capita use of ambulatory consultations in urban areas (1.0 per year) was ten times that in rural areas (0.1 per year). In some rural areas, utilization rates are considerably lower.

The geographic maldistribution of services, with its adverse implications for health status, is reinforced by the inefficient distribution and use of resources within the health care system. While primary health services are the most appropriate response to the most pressing health care needs, they represent a relatively small proportion of overall health expenditures. For the MOH, curative care receives the bulk of attention and resources. In the last few years, primary care has received less than one-fourth of operating expenditures and less than one-fifth of capital expenditures in the budgets of the MOH.

The emphasis on curative care is as well an emphasis on urban health services, particularly focused on the capital city. The extreme nature of this maldistribution is reflected in the budgets of the MOH as well as the distribution of its personnel. Three-quarters of all MOH curative care expenditures are at two Guatemala City hospitals, Roosevelt and San Juan de Dios which, together, represent almost one-third of the 7,419 hospital beds in the system. Additionally, over 45% of all MOH physicians and 40% of auxiliaries work in the Department of Guatemala.

This focus on urban curative care has also influenced the makeup of human resources in the MOH toward physicians and other specialized personnel and away from auxiliaries, community health workers, health promoters, and Rural Health Technicians more appropriate for rural primary health care. As a result, in 1983, there were almost twice as many physicians in the MOH as there were nurses. Of the total MOH field staff, 68% were employed in hospitals, while only 7% were in health posts. The remaining 25% served in health centers. This outcome reinforces the urban curative care focus by creating a labor force with little flexibility, unable to respond to a change in emphasis or priorities.

The inefficient distribution of health care resources within the MOH is reinforced by the process of allocating resources for capital investment. Each of the 35 hospitals and 24 health areas can make requests for investments. While there is an elaborate system of formal review, many of the hospital directors from bigger institutions make requests directly to the Minister, where political and other considerations often supercede more specific relative economic assessments. In such cases, more rapid and positive responses are likely. Additionally, when investment funds are granted, hospitals can initiate work directly without further review and approvals. For the health areas, even approved investments are subject to continued revision and additional approvals and must be implemented through the MOH, a process which adds considerably to the time required and, presumably, to the costs of implementation.

This process creates three circumstances which foster the maldistribution of investments toward urban curative care. First, since hospital directors and senior medical staff can more clearly link investment needs to specific areas directly of interest to decisionmakers, hospitals are more likely to have investments approved than health areas which have more general investment needs. Second, because of the political aspects of the investment request process, bigger and more important hospitals (i.e. in Guatemala City) are more likely to have investments addressed more rapidly and approved. Third, when health areas' proposed investments are initially approved, their implementation is subject to longer delays. There is always the possibility of finishing a fiscal year without final commitment for expenditure, thereby making it necessary to initiate the request all over again. The above process also tends to emphasize investments for new projects rather than for the repair and replacement of existing resources, and for the initiation of new specialized services since such projects have more political "appeal".

2) Social Security. While the discussion above has emphasized the MOH as a prime source of health services, other providers play important roles in the provision of care. The Guatemala Institute of Social Security (IGSS) provides health services as well as retirement benefits to individuals employed in the public and private sector, representing approximately 12% of the population. For many areas of the country, IGSS services are limited to care provided to covered employees for work-related accidents only. At the other extreme, in the Department of Guatemala a wider range of services are provided including care for dependents, maternal and child health services and all care for children under 5 years of age. Recently,

agreements have been made with the Inter-American Development Bank to analyze the feasibility of expanding the population covered by these extended services to 15.3% of the population and serve 6 additional departments^(8).

The IGSS provides health services through a system similar to the MOH. At the basic level, services are provided at health posts staffed by auxiliaries and health centers staffed by a physician and one or two nurses or auxiliaries. Most of the IGSS resources, however, are based in hospitals. As is the case with the MOH, IGSS resources are concentrated in urban settings. Of the Institute's 22 hospitals, 4 are located in Guatemala city. These 4 hospitals account for 54% of all the beds in the system and are the work location for 81% of all IGSS-employed physicians.

Overall, the distribution of IGSS facilities is similar to that of the MOH, although more concentrated. However, facilities of both are often underutilized, and the problems noted with deteriorating facilities and absence of water and electricity in the MOH also apply to IGSS facilities, particularly in rural areas. Some efforts have been initiated to share facilities within the public sector, but typically little use is made of existing, and often underutilized, MOH facilities to deliver care to IGSS beneficiaries. Moreover, IGSS services are rarely provided to MOH beneficiaries even where MOH services are not available and IGSS services are underutilized. This absence of coordination leads to excess facility development and a generally more inefficient use of resources for both major providers. It also serves to limit the ability of IGSS to expand the benefit package beyond accident coverage outside of urban settings.

3) Private Sector. Health services are also available from private sources through private hospitals and clinics, traditional healers, midwives, and "injectionistas." In urban areas, with higher employment levels and a cash economy, private providers are probably a major source of care. In rural areas, private services would most likely take the form of plantation or employer contract care or PVO-sponsored medical care, which have a lower dependence on user generated revenues. Overall, the MOH estimates that approximately 25% of population is covered by private sector health services, including for-profit organizations and NGO's.

3. Health Care Financing Characteristics

Expenditures on health in Guatemala are low in both absolute and relative terms. As a percentage of Gross Domestic Product (GDP), health expenditures declined from 3.0% in 1980 to 2.2% in 1985. This low level of relative expenditure reflects the poor and declining economic circumstances of the past decade and the small proportion of resources flowing to the public sector. The majority of these funds come from public sources, through general taxation in the case of the MOH and from earmarked wage

^(8) Instituto Guatemalteco de Seguridad Social, Informe Anual de Labores 1987.

taxes in the case of IGSS. Capital investments are supported from operating revenues, donor contributions, and loans. Donors also provide support for specific areas of program activity, such as immunization and other child survival services.

For the MOH, most revenues are derived from general tax revenues. Both the actual and relative amounts have declined during the 1980's. During this period, operating and capital actual expenditures have been lower than those budgeted due to shortages of funds and an inability to implement budgeted investments. The MOH charges a modest fee for outpatient care, Q 0.25⁽⁹⁾, that has remained unchanged since the 1970's. Efforts at collection have not been a priority, and it is estimated that no more than 2% of revenues have been derived from this source.

The social security health care program run by the IGSS is financed through earmarked taxes. Workers pay 3% of their salaries, employers pay an amount equal to 7% of the wage bill and the government contributes an amount equal to 3% of salaries of all workers within the system (public and private sector). Although the income maintenance program has different rates of contribution, funds of both programs are administered jointly and neither the direction nor the amount of cross-subsidization among the two programs is clear. While some year-to-year fluctuations occur, IGSS expenditures have remained essentially even over the decade, amounting to approximately one-quarter of all health expenditures. No fees are charged for services provided to eligible beneficiaries.

Private sector arrangements for financing include fee-for-service, employer contracted services, prepaid health insurance, and health maintenance organizations. The latter two arrangements are found primarily in Guatemala City and a few other urban areas. Private sector services have been increasing in both absolute and relative terms over the decade, in part as a response to the deterioration of public programs and in part as a response to increasing demand for services in the urban areas.

The increasing reliance on private services reinforces the maldistribution of access between urban and rural areas noted earlier. The urban Guatemalan economy is a cash economy with ample resources to support private health activities. The National Survey of Family Income and Expenditures indicated that for the 1979-81 period, the 15% of Guatemalans living in the Guatemala City area earned 40% of the income and incurred over 50% of the country's total medical care expenditures. On the other hand, the rural economy, particularly in the central highlands, is a noncash economy with fewer opportunities to generate sufficient revenues to support needed services. During the same period, 1979-81, persons living in rural areas, who make up 64% of the total population, incurred less than 31% of all medical expenditures. As a result, most rural private services are provided by traditional practitioners and PVO's and church-based organizations which are subsidized from outside the direct market for

(9) In January 1989, when the field trip took place, the exchange rate was
Q 2.7 = US\$ 1

services. In general, families in Guatemala City spent 6 times as much on medical care as rural families. While more recent data are not available, the deteriorating economic situation has probably increased the urban-rural differences since the survey was made.

4. USAID/G Policy Dialogue

The U.S. government has had a long history of working with the health sector in Guatemala. A primary focus of this effort has been the strengthening of the MOH and its ability to organize and manage services. While the U.S. played a major role in the design and support for the Roosevelt hospital in the 1950's, since the mid 1960's its emphasis has been on improving services for the most vulnerable populations.

The policy dialogue focused initially on rural health services. During the latter half of the 1960's, AID supported the development of mobile rural health units to provide services in rural communities. Part of this effort supported the construction of numerous health posts which ultimately became service delivery sites for the MOH. In the 1980's, AID supported the development and training of Rural Health Technicians, mid-level health workers for rural communities. Over 400 were trained during this period and, while lack of infrastructure has often limited their effectiveness, they continue to represent a significant and critical resource for improving rural health services.

More recently, the policy dialogue and AID support has focused on Child Survival programs, beginning with immunization and later adding oral rehydration and other Child Survival components. In Guatemala, this commitment has recently concentrated on general strengthening of the MOH through support for improved management and logistics systems, training, and direct support of Child Survival services in departments with limited resources and high health needs. The priority area is the western highlands but the deficiencies in planning and management capability require general attention in the policy dialogue process. An ongoing effort is being made to strengthen the capacity of the MOH to address these issues.

The effectiveness of policy dialogue is complicated by a number of factors. The generally inadequate scale of the public sector and, particularly the public health sector, has made it difficult to develop long run plans and to implement strategies directed at seriously addressing the tremendous health needs of the country. The deteriorating physical plant and the widespread need for training and improved management systems has prevented the establishment of realistic priorities for utilizing the limited resources. Efforts to confront this issue directly are confounded by the precarious stability of the government and its political dependency on sectors of society which support the low tax effort that characterizes the country.

Declining revenues of the past decade have resulted in less maintenance of equipment and infrastructure and reduced expenditure on pharmaceuticals and medical supplies. As a result, the proportion of the MOH budget being spent on professional medical personnel has been increasing. Most of these personnel work in urban curative care settings and do not necessarily support changing priorities.

A major constraint to the effectiveness of the policy dialogue is the high rate of personnel turnover in the government, particularly in the MOH. The relatively short tenure of senior officials makes it difficult to establish long run strategies or to gain continued consensus for development.

III. HEALTH CARE FINANCING INITIATIVES

1. Overview of Major USAID Initiatives

Although up to now USAID/G has not played an active role in the design of a health care financing strategy in Guatemala, the Mission has been concerned about this issue and has made a number of efforts to identify suitable areas of intervention.

As stated above, the public sector in Guatemala faces not only budgetary restrictions, but also inadequacies in the public sector's capacity to manage resources due to managerial and administrative weaknesses. These problems are also present in the Ministry of Health, and thus the Mission faces a public sector counterpart with little capacity to absorb additional resources. Furthermore, due to the procedure the MOH must follow in order to spend its budget, at the end of each fiscal year usually less than 100% of capital budget actually has been spent.

USAID/G is aware that these problems limit the ability of the public sector and the MOH to act as an effective counterpart in the implementation of new health projects. Thus, the Mission has worked to identify the context within which project activities can continue once AID participation is over as well as private sector partnership alternatives.

AID has carried out two efforts aimed at identifying appropriate areas for HCF interventions in Guatemala. The first was part of a series of historical case studies of sustainability funded by CDIE/PPC⁽¹⁰⁾. It evaluated the sustainability of U.S. government funded health projects in Guatemala from the initiation of U.S involvement in 1942 until 1986-87. The final report was released in 1988 and included a complete economic analysis that made it possible to identify what kind of projects are more likely to be sustained at different stages in the economic cycle. Contextual factors and project characteristics were analyzed in order to sort out the elements that contribute best to project takeoff and to

[10] Bossert, Thomas et. al. Sustainability of U.S. Supported Health Programs in Guatemala, CDIE/PPC, January 1988

continuation of the project once outside funding has ceased. The conclusions and recommendations of this study are relevant for HCF initiatives. Regarding contextual factors, it was confirmed that national commitment is an important condition for sustainability. Projects were more likely to be sustained if they pursued goals which were also priorities for the national government and significant groups in the health sector. The characteristics of the implementing institutions were also highly correlated--that is, projects were more likely to be sustained if run by organizations with good skill levels and internal organization. Finally, it was found that ethnic differences between Ladino and Indian communities limited the sustainability of some projects.

The sustainability study made a set of recommendations relevant to the design of health projects and to the implementation of HCF initiatives. These recommendations are grouped into four areas:

- a. National priorities. National priorities and national involvement must carefully be considered in the design of the project in order to increase the probability of success.
- b. Strengthen implementing organization. The study suggested enhancing the administrative effectiveness and capacity of the implementing agencies before integrating project activities into those institutions.
- c. Financial design. It was recommended that the financing design of the project be done in such a way as to encourage absorption of recurrent costs during the life of the project.
- d. Project design. A sound design is a basic condition for a project that effectively allows the beneficiary population to obtain the expected benefits of the project and thus achieves the project goals.

The second analytical initiative took place during the last quarter of 1987, while USAID/G was designing a new project called "Improved Family Health". This was an exploratory mission from the HCF/LAC (SUNY) Project in response to a Mission request to identify private agencies that could fill the coverage gap left by private sector institutions in delivering primary care services, particularly those in the area of child survival. The exploratory report documented the private sector participation in the provision of health services for agricultural workers and indicated areas of exploration for further action in the areas of pricing and coordination with the social security system. Finally, the HCF/LAC Project conducted a study to assess the feasibility of extending primary health services through the private sector to agro-export workers and their families in the South Coast region of Guatemala^[11].

[11] Gretchen, Gwyne (ed.). Private Sector Health Care Alternatives for Agricultural Workers on the South Coast of Guatemala, HCF/LAC Research Report No. 7, August 1988

2. Initiatives by Non-USAID Agencies

International organizations have played an important role in the financing of health services in Guatemala, particularly in investment. Although their participation has contributed to increasing the resources available to fund the provision of health services in Guatemala, as in other countries there is no consensus on the net impact, in terms of resource allocation, of receiving this financial aid. Inexpensive investment loans are usually pointed out as the cause for misallocation of resources in the health sector. Investment in hospitals have been carried out without a realistic assessment of recurrent costs. As a result, once these facilities begin providing services, a portion of the recurrent costs are covered by funds that otherwise would have been devoted to the provision of primary care. Other recurrent costs are simply not financed, and facilities are not able to deliver the level of services that they could provide if used at full capacity. Thus, funding investment projects without an appropriate evaluation may result in inefficiencies and misallocations of resources within the health sector.

During the development of this country case description, several health care financing initiatives undertaken by international organizations were identified. While some provide additional resources to fund health services, others could potentially have a greater effect in the design of a long term HCF strategy. The organizations involved were the World Bank, the Inter-American Development Bank, the Pan American Health Organization, and PREALC (the Latin American Office of the International Labor Organization).

A. The World Bank

The main World Bank initiative in Guatemala in the social sector in recent years is the design of a Social Investment Fund (SIF). With GOG participation, World Bank staff and consultants prepared a proposal to be presented at the Consultive Committee in the first quarter of 1989. It is important to highlight the circumstances under which the decision to prepare such a project was taken. The only previous experience with a social fund in the region is the Social Emergency Fund (SEF) in Bolivia. While both projects were designed to respond to the needs of vulnerable groups in the population, the emphasis was different in each case. The target in Bolivia was to ameliorate the negative effects of a very restrictive program of adjustment and stabilization on the population's standard of living. The target population could be identified easily, and basically corresponded to the unemployed from the mining sector. The emphasis was not on improving the already poor conditions of living of an important segment of population; rather, the goal was to compensate the group that had been hardest hit by the social impact of the New Economic Program. In Guatemala, on the other hand, the SIF was a response to an absolute need for additional funds that could not be supplied by the GOG to the social sector.

The World Bank is carrying out policy dialogue with the GOG as a condition to the implementation of this fund, and there is some room for improving the effectiveness and efficiency of funds devoted to the health sector. However, the absolute lack of national funds for the basic health needs of the population is recognized as a serious constraint.

B. The Inter-American Development Bank

IDB has taken two types of initiatives in the Guatemalan health sector. The first is the lending of funds for the implementation of investment programs, the traditional IDB role. The second is an area in which the IDB is becoming more actively involved in recent years: strengthening institutional capability in the provision of health services.

In the investment area, the IDB provided a loan to finance a complete program of health posts, health centers and hospitals. The program includes 4 hospitals, 25 health centers, and 100 rural health posts. The loan was approved in February 1981, and facilities were scheduled to begin operating by mid-1989. In part, the investment program was designed to replace old facilities which are currently in operation. Thus for those facilities, there are available funds budgeted to cover recurrent expenses. However most of the facilities built are meant to increase the total capacity of the public sector, which will mean that additional funds will be required for them to start operating. This issue was raised during the team's visit to the country and it was not clear whether the MOH would be able to provide the required funds. Again, this is a matter in which the financial organization cannot take all the responsibility, since the design and soundness of the project were analyzed during the evaluation of the investment project.

In the area of institutional organization, the IDB provided a non-reimbursable fund of \$300,000 in 1988 for a baseline study to assess the feasibility of increasing social security coverage throughout the country. The goal is to increase coverage from 12% to 15.3% of population. This initiative is being carried out with the IGSS in collaboration with the ILO. Although the program was in its initial phase during the development of this case description, it is an initiative that can have a great impact on the financing of health services through the social security system in Guatemala. In particular, the background studies that will be developed for this initiative will shed light on a number of issues related to the present provision of health services by the IGSS.

C. Pan American Health Organization

The Pan American Health Organization has participated actively in the organization of health services delivery in Guatemala. In addition to a number of actions related to the provision of preventive care through sanitation and malaria prevention programs, two initiatives are relevant to the financing of health care: (1) the creation of regional revolving funds for medicines and vaccines, and (2) the attempt to strengthen health services organization through the SILOS model ("Sistemas Locales de

Salud"). The latter scheme focuses on decentralizing health services and thereby increasing participation in the decision-making process at the local level.

The experience with the revolving funds has had some success, and has shed light on a number of administrative issues that are relevant for designing regional initiatives. Differences in countries' legislation on taxes, per diem payments for national officials, and differences in national lists of basic drugs created problems during the initial phase of the project and reduced the speed with which project activities could be started.

IV. KEY ELEMENTS OF USAID HEALTH CARE FINANCING ACTIVITIES

Within the framework of the child survival countries, USAID/G has decided to target its health activities in the region with the highest concentration of population with the worst level of health status, while integrating family planning and maternal and child health services. Thus, health activities are to be focused in the western highlands. The implications of these priorities are discussed in section V. In the team's view, the regional priorities set for health activities do not coincide with the areas where health care financing activities should begin. Thus the first issue that needs to be worked out is the priorities for areas of intervention. Otherwise, HCF activities will not be effective in providing support for improving the health status of target population. On the other hand, the GOG has an implicit strategy for financing the provision of social services. Within that agenda, a number of initiatives can be taken in order to help the country shape a final HCF strategy within national priorities.

V. LESSONS LEARNED

The experience of visiting Guatemala, interviewing the main actors involved in the health sector, and visiting rural areas allowed the team to obtain a clear picture of the HCF situation and perspectives in the country. While the Guatemalan characteristics are in some respects different than those seen in other countries in the LAC region, a number of observations can be generalized in an effort to identify relevant elements to be included in the design of a HCF strategy and policy dialogue. As mentioned above, the fact that the GOG was preparing a proposal for a Social Investment Fund to be presented at the Consultative Committee of the World Bank highlighted a number of issues about an implicit HCF strategy in the country that need to be properly addressed by the USAID Mission. These issues are outlined below:

1. Geographical Priorities

Because Guatemala is a Child Survival Country, USAID/G has targetted its health action to the western highlands. In this area live the poorest population and very low health indicators point to low infant health status. Thus, initiatives to support the provision of health services in Guatemala will have the highest social return when focused on this part of the country. On the other hand, HCF initiatives to support the achievement of health goals would be most suitable in the areas of resource allocation and resource mobilization. An initial activity could take the form of reallocation of funds from the urban to rural area and from secondary to primary care, while a second activity could explore the feasibility of a scheme to generate additional revenue from higher income groups. Initiatives in these two areas would allow the country to release resources from population groups in less need and transfer them to the groups with the lowest health status and poorest ability to pay for basic health services.

Under these circumstances it is clear that the geographical area chosen as a target for Child Survival activities is not the same as that in which HCF initiatives should be concentrated. Further, while the western highland area should receive first priority in the allocation of additional funds, it is not the geographical area where the process of releasing of resources or generation of additional revenues should start. From an equity point of view, a user fee system should be considered for the provision of hospital care in the urban area, and a sliding scale system could be considered in order to protect groups which are not able to pay. A system such as this would allow the MOH to release resources from the secondary level and to devote them to the provision of health services in the western highlands. This result will not automatically follow and the redirection of resources needs to be the focus of specific complementary initiatives.

The Guatemalan case clearly illustrates the argument that in order to achieve a given set of goals in improving a population's health status it may be necessary to draw one set of regional priorities for actions in the provision of health services and a different set for initiatives in the field of health care financing. This is an argument that will be present in every country where differences in health status and income level are significant across regional areas.

2. Sector Priority

The review of the health care financing situation in Guatemala shows once more that this issue cannot be solved within the limits of the health sector. The macroeconomic characteristics, as reflected by the small size of the public sector and the poor performance of the economy, are such that no relevant improvement can be made with isolated efforts from the MOH. The GOG has taken some steps that acknowledge this reality. The first initiative is the creation of the "Instituto de Fomento Municipal". Through this mechanism, the municipalities have received additional

resources that have been partially devoted to the financing of health projects. At the same time, the creation of this organization has helped expedite investment by municipalities. The second initiative is the proposed Social Investment Fund which is an effort to compensate for the deterioration of social sectors during the present decade. Even though the GOG has not developed an explicit HCF strategy, these two efforts illustrate the need to have a framework wider than the health sector.

This observation is not unique to Guatemala. During the development of this study, the team has reinforced its belief that HCF issues should not be restricted only to health officers. At the country level, this means drawing the attention of economic policy makers to HCF issues. At the USAID Mission this means drawing the attention of economic affairs and program officers, as well as the directors, who are in a better position to have a fruitful policy dialogue with the appropriate policy makers.

3. Designing a HCF Strategy

Even though the GOG has made some movements towards improving the level of resources devoted to the provision of health services, a final HCF strategy is still to be worked out. USAID/G can help this process by taking some initiatives that assist in the design of some components of the strategy and permit the assesment of their feasibility. One of the alternatives presently under consideration is the implementation of a user fee schedule. This mechanism can be successfully used to help reallocate financial resources towards the provision of primary care and increasing population coverage, though the potential of user fees is quite limited in the highland area which is the target geographic area for Mission health activities.

Another element that is also outside of the geographical target area of USAID, but that has an important impact on the provision of primary care, is related to the organization of health services. This last element entails the coordination of public organizations involved in the provision of health services. In fact, important public funds are presently devoted to financing a social security system that provides non-comprehensive health care to its beneficiaries and a different composition of services in different parts of the country. Since health services are provided by the social security system in geographical areas where the MOH is also providing services, it would be useful to explore the feasibility of a joint effort by the two organizations that would allow them to take advantage of economies of scale and make more efficient use of public funds.

4. USAID Involvement with Other Donors

A number of international financial donors are active in Guatemala. Projects funded by the World Bank, the Inter-American Development Bank, the Pan American Health Organization, and the United Nations Latin American Institute for Social and Economic Planning were underway at the time the

field trip for this case description took place. All of these interventions are expected to have some influence on the country's HCF strategy as well as on the implementation of such a strategy. Some of these interventions are linked to financial aid with conditionality, while others provide technical assistance to the GOG in gathering the information required to make decisions about needed reforms. Thus, it is extremely important the USAID policy dialogue explicitly considers the participation of other donors, so that this becomes a joint effort to help the country obtain better health standards for its population. Furthermore, USAID can play a leadership role of coordinating the actions of international donors. In Guatemala, as in other countries in the LAC region, the Agency is in a position to exercise this leading role.

APPENDIX I: PERSONS AND PLACES VISITED

Mr. Joe Hill, Acting Deputy Director USAID/G
Mr. Thomas Kellerman, Program Officer USAID/G
Ms. Mary Ott, Economist USAID/G
Mr. John Massey, Health Officer USAID/G
Mr. Andrew Krefft, Child Survival Liason USAID/G
Mr. Alfredo Szarate, Water and Sanitation Officer USAID/G
Lic. Miriam Castañeda, USAID/G (Formerly with SEGEPLAN)
Mr. Larry Day, USAID Consultant
Mr. Dave Lazar, USAID Consultant
Lic. José Mauricio Rodríguez, Vice-Minister of Finance
Dr. Pablo Werner Ramírez, Vice-Minister of Health
Dr. César del Aguila, Advisor MOH
Lic. Marco Castillo, Chief of Social Sectors, SEGEPLAN
Dr. Carlos Estrada Sandoval, Health Analyst, SEGEPLAN
Lic. Luis Alfonso Hernández, Legal Counselor to the General Manager IGSS
Ing. Alejandro Castro, Acting representative PAHO
Dra. Telma Duarte, PAHO
Lic. Marilú Castellanos, SIECA
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