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**ASSESSMENT OF
COMMERCIAL SECTOR
OPPORTUNITIES FOR FAMILY
PLANNING AND BASIC HEALTH
CARE IN EL SALVADOR**

Conducted by the PROFIT and Initiatives Projects

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ACRONYMS

ADS	Asociacion Demografica Salvadorena (Demographic Association of El Salvador) The principal NGO in El Salvador providing family planning services, methods, and social marketing
AMSS	Area Metropolitana de San Salvador (San Salvador Metropolitan Area)
ANEP	Asociacion Nacional de Empresas Privadas (National Association of Private Enterprises)
ANES	Asociacion Nacional de Enfermeras Salvadorenas (National Nursing Association of El Salvador)
ANSAL	Health Sector Analysis, El Salvador (USAID/ES, May, 1994)
ANTEL	National Telephone Company
ASI	Asociacion Salvadorena de Industria (Salvadoran Association of Industry)
CEL	Comision Ejecutiva del Rio Lempa (National Electric Company)
CLUSA	Cooperative League of the USA
CSSP	Comision Superior de Salud Publica (Superior Commission on Public Health) - Responsible for professional registration and licensing of physicians, dentists, pharmacistists, nurses, and pharmaceuticals.
GIDRHUS	Grupo Interinstitucional para el Desarrollo de Recursos Humanos en Salud (Interinstitutional Group for Human Resources in Health)
GOES	Government of El Salvador
HMO	Health Maintenance Organization
HPN	United States Agency for Development/El Salvador, Office of Health, Population and Nutrition
IDB	Inter-American Development Bank
ISSS	Instituto Salvadoreno de Seguro Social (Salvadoran Social Security Institute)

MIPLAN	Ministerio de Planificacion (Ministry of Planning)
MSPAS, MOH	Ministerio de Salud Publica y Asistencia Social (Ministry of Public Health and Social Assistance)
PAHO	Pan American Health Organization
PPO	Preferred Provider Organization
UE	Universidad Evangelica
UES	Universidad de El Salvador
UNES	Universidad Nueva de San Salvador
USAID/ES	United States Agency for Development, El Salvador
USAID/G/POP	United States Agency for Development, Office of Population, Washington
UCRAPROBEX	National Association of Coffee Cooperatives
WB	World Bank

EXECUTIVE SUMMARY

Background

This assessment was undertaken in response to a request from USAID/ES/HPN in order to fortify its understanding of the commercial sector and potential opportunities for commercial involvement in both Family Planning and Basic Health Care activities in El Salvador. Two requests were made: one to the PROFIT Project and another to the Initiatives Project. Since the scopes of activities overlapped to a considerable degree, it was decided to form an integrated team from both projects.

Main Purposes

This assessment has five main purposes:

- Describe and assess the provision of family planning and basic health care services provided by the private, commercial sector in El Salvador
- Assess the potential for increasing the incorporation of family planning and basic health services in the private commercial sector
- Determine the financial (and other) vehicles by which such incorporation might be enhanced
- Describe the policies of government entities with respect to service provision and decentralization
- Provide findings and recommendations related to enhancing the commercial sector's potential in providing family planning and basic health services

Assessment Activities

The team fielded consisted of five professionals with skills in family planning, basic health care, management, finance and economics. Field work was conducted during the period 26 September - 6 October, 1994. Face-to-face interviews were conducted with 54 entities principally in the commercial sector, but also including senior representatives from relevant agencies and ministries in the public sector in order to establish the environment in which family planning and basic health care currently takes place. In addition thorough reviews of available statistical literature

were conducted to understand present health-seeking behavior and project future possibilities.

Principal Findings - Brief Summary

- 1 The economic climate in El Salvador is good. Growth estimates run from 5%-8% over the next five years.
- 2 Family Planning and Basic Health Care is predominantly provided by the public sector (including the Social Security Institute).
- 3 Considerable numbers of "middle"- and "upper"-class women use public sector health and family planning services.
- 4 There is wide recognition by employers of the relation between productivity and a healthy work force.
- 5 Some large employers are duplicating Social Security services due to perceived loss in productivity due to delays in patient attention and related factors.
- 6 There is an apparent over-supply of physicians and an over-concentration in the San Salvador Metropolitan Area.
- 7 There is an under-supply of nurses and their legal ability to act as family planning and basic health providers is very limited.
- 8 The concept of managed care facilities is poorly understood.
- 9 Insurance companies are providing (limited) group health insurance coverage.

Principal Recommendations - Brief Summary

- 1 Encourage the establishment of managed care organizations
- 2 Encourage continued linkage of employers with Social Security
- 3 Consider "pooling" of mid- and small- enterprises to qualify them for group insurance
- 4 Identify credit resources or establish "guarantees" for young physicians who practice in under-served areas of the country

- 5 Strive to enhance the training and roles of nurses as family planning and basic health providers and permit them to establish private services
- 6 Encourage the establishment of a "business" or health management curriculum within medical schools.
- 7 "Free Zones" should be exposed to various modalities, including on site clinics, group health insurance, etc.
- 8 Information needs to be obtained on the "informal" sector as they are not covered by Social Security

Conclusions

In general the climate for increasing private investment and involvement in basic health care and family planning service is good. The economy is on the rise; employers recognize the relationship between health and productivity; some insurance companies are less risk averse and are writing group health policies; some collaboration is under negotiation between the government and the private sector with respect to health issues.

On the other hand, the process is bound to be slow. As noted below, in the detailed list of Principal Findings, there are numerous obstacles that will need to be overcome before the private commercial sector absorbs a substantial portion of basic health care and family planning. Nevertheless the analyses and findings of this assessment tend toward an optimistic point of view.

I. PRINCIPAL FINDINGS and RECOMMENDATIONS

The assessment examined both the **supply and demand** aspects of commercial delivery of family planning and basic health services as well as the general **environment** in which the commercial sector operates. The findings highlight the opportunities and obstacles to expanding the commercial sector's role in providing these services. The findings are outlined in the following tables.

A. FINDINGS

PRINCIPAL FINDINGS	
OPPORTUNITIES	OBSTACLES
ENVIRONMENT	
Favorable Policy Environment (Both MOH and ISSS support private sector involvement)	Limited role for non-physicians, especially nurses
	Lack of coordination in health sector between public and private commercial sectors
Economy is growing by 5% plus each year, with much of the growth in the formal sector	Limitation on percentage of overall population who can be covered through employers
Banks have excess liquidity in the short-term (money to lend)	Perception among lenders that physicians are high risk borrowers because of lack of business-like orientation and business experience
Medical cooperative has experience lending money to physicians and has about 1% default rate	
IDB will be funding social sector reform efforts which may mean availability of funds for private sector	Possible difficulty of donor coordination between USAID, PAHO, IDB and WB.
National business associations exist with technical capability to carry out studies and promote the idea of family planning and basic health services, and develop awareness among employers	Low participation of commercial health providers in business associations and dialogue
	Lack of common language between providers and business community

PRINCIPAL FINDINGS	
OPPORTUNITIES	OBSTACLES
Good local technical assistance capability to carry out studies (e.g. FUSADES, FUNUNGO)	Lack of demand information on willingness to pay, etc.
	Inability or unwillingness of government to act on issues raised
Lack of Regulation in both the health sector and insurance industry (open market)	Lack of Regulation (no quality standards enforced)
ISSS reform efforts (potential of ISSS clinics in factories, sharing burden of providing health services to employees; contracting with private providers)	Perception by employers that they are paying twice for health benefits (through ISSS and private insurance)
	Resistance from ISSS employees and physicians to reform efforts

PRINCIPAL FINDINGS	
OPPORTUNITIES	OBSTACLES
SUPPLY	
Existing institutions within the commercial sector (providers and insurance)	Curative orientation, specialty focus
	Target higher income groups
	Perceived low quality of services
	Lack of management experience among private providers, ISSS, MOH
Large number of new physicians graduated each year	Lack of information on alternative organizational structures: HMO, PPO, group practice, etc.
	Focus on specialization; individual practice
Over supply of physicians in metropolitan areas	Lack of incentive to establish practices in rural or under-served areas
Nurses qualified to provide family planning and basic health services	Under-supply of nurses
	Inadequate training facilities
	Lack of autonomy, e.g. no nurse-practitioners
	Pay and advancement limitation
Younger physicians appear more responsive to market pressures	More established physicians less responsive to market pressures
Well developed pharmaceutical industry, distribution networks	Social marketing program makes contraceptive market uncompetitive, pharmaceutical industry unwilling to enter market
Low import tariffs	
Employers and private providers may be more willing to provide family planning services if they can have access to subsidized contraceptives through the social marketing program	

PRINCIPAL FINDINGS	
OPPORTUNITIES	OBSTACLES
DEMAND	
Majority of employers contacted were providing some health benefits (either through group insurance or private provider contracts) in addition to ISSS	Most benefits focus on curative services
	Low wage earners often not covered
Majority of employers contacted understood the importance of preventive and family planning services as a means to address issues of absenteeism, etc.	Lack of options and incentives for developing preventive and family planning programs for employers, e.g. HMO, PPO
Existence of well organized agricultural cooperatives and cooperative associations with existing infrastructure	Limited existing health delivery systems which target cooperatives, especially rural cooperatives

B. RECOMMENDATIONS

The assessment team has tried to organize the recommendations around common concepts or themes. Nevertheless, it is recognized that there is overlap in many cases. While we believe there is considerable fertile ground for involvement of the commercial private sector in both family planning and basic health care the recommendations will not be easy to implement, as noted by the obstacles articulated in the preceding tables.

In addition, while we have tried to ensure that the analytical framework in the preceding table has been incorporated into the recommendations, the recommendations themselves are at a higher level of generalization.

A.. EXPANDING COMMERCIAL DELIVERY OF BASIC HEALTH AND FAMILY PLANNING SERVICES

1. Identify and contact young physicians or physician groups who may be interested in providing basic health and family planning services. Target dissemination of alternative delivery models. Encourage linkages with potential clients (e.g. employers, cooperatives) and private insurance companies.
2. Work with employers to add basic health and family planning services to current employee benefits. Consider low-cost health insurance and/or well managed provider groups to expand coverage to low-wage earners.
3. Work with insurance companies to provide lower cost packages which focus on basic health and family planning services, and target appropriate markets. Encourage linkages with employers, cooperatives, and well managed providers.
4. Encourage and monitor linkages between private providers and MOH/ISSS, under decentralization/deconcentration models.
5. Encourage and lobby for increased role of nurses, especially in the provision of family planning and selected basic health services.

B. PROMOTING ACCESS TO EQUIPMENT AND PHARMACEUTICAL

6. Identify credit sources or establish guarantees for providers who do establish managed care facilities to purchase medical equipment and pharmaceutical. This could serve as an incentive for physicians to engage in this activity, especially those who are younger and have no access to major sources of credit. Private physicians and hospitals often are not provided credit through

importers and therefore must pay cash up front for medical equipment. Thus, most of the private sector purchases used equipment with limited service and guarantees.

- 7 . Encourage local pharmaceutical manufacturing industry to respond to private sector family planning needs:
 - a. identify opportunities for private distribution of selected biologicals (i.e. vaccines);
 - b. as noted above, SOMARC success has inhibited the industry from engaging in the manufacturing or importing of contraceptive products.

8. Consider dissemination and utilization of generics. Imported generics are generally suspect due to lack of labeling and packaging.

C. IMPROVING COORDINATION

9. Improve coordination between private and public health and family planning efforts. Coordination forum should include private sector (under MOH decentralization plan, this modality is contemplated at departmental levels).
10. Maintain close coordination among donor organizations.
11. Encourage development of a human resource manager association as a vehicle to create awareness about preventive care and disseminate information on basic health and family planning services within their companies

D. TRAINING AND DISSEMINATION OPPORTUNITIES

12. Dissemination of available, actual or potential, information on alternative health care delivery schemes, e.g. managed care (HMOs, PPOs, etc.).
13. Increase managerial capacity among private health sector providers (no School of Public Health or health care management training exists in El Salvador at present).
14. Encourage improved and expanded training for the nursing profession.
15. Encourage improved rationalization of numbers of individuals admitted to medical schools.

E. FILLING INFORMATION GAPS

16. Increase knowledge about demand for private health care services in general; willingness and ability to pay, etc. Additional data is needed to explore potential response to managed care systems, etc. This can be done through market studies, etc.
17. Statistically assess needs and demands; care seeking behavior, etc., of the informal sector
18. Increase utilization of local consulting capability to carry out research and other analytical activities.
19. Identify role of voluntary service groups as an information exchange/coordination/networking mechanism, e.g. Lions Club, Rotary Club
20. Investigate and identify critical incentives to increase private sector participation.
21. Investigate with insurance companies the possibility of "pooling" groups of small and mid-size employers to qualify for group insurance schemes

II. INTRODUCTION

The main purpose of the assessment is to describe the economic climate in El Salvador (i.e. factors relevant to private commercial investment) with respect to family planning services and product distribution, and basic health services provision through the commercial sector.

USAID/El Salvador (USAID/ES), Office of Health, Population and Nutrition (HPN) requested technical assistance from the PROFIT and Initiatives Projects to provide an assessment of the commercial sector potential in Family Planning and Basic Health Services, respectively. Because the tasks had considerable overlap, it was determined that a joint effort would be the most efficient means of obtaining and collating the requisite information.

Family planning is defined as the use of methods designed to space or limit the number of births by women, based on their reproductive intentions and provided through competent providers with appropriate information. Neither abortion, nor abortion counselling are considered in this document.

Basic health services are those often defined as "primary health" care, including pre-natal attention, appropriate immunizations for women and children, and other early care services related to preserving healthy status of children and mothers.

Due to the conceptual and operational similarities of the requests,, a joint team was assembled from both PROFIT and Initiatives representing expertise in basic health services, family planning, management and finance.

This assessment provides an overview analysis of both the public and the private health systems in El Salvador, and places them within the context of the contemporary Salvadoran commercial economic sector.

Recommendations made reflect the opinions of both the medical and financial communities. While there are differences, these opinions tend to suggest that there are significant opportunities for integration of medical and financial expertise. It should be noted at the outset, that private, commercial resources are generally under-utilized. Similarly, public resources are stretched and limited. This report strives to explicate this under utilization and provide suggestions for change.

It is important to note that commercial enterprises are already taking some initiative for this, and are incurring "double" expenditures for employee health plans in the formal sector. Contrary to previous studies in which cost-benefit analyses were employed to "convince" employers of decreased productivity due to basic health and family planning issues, the individuals interviewed in El Salvador have identified this issue and are working to overcome it.

Part of the impetus for this assessment stems from the recent Health Sector Analysis (ANSAL) which recommended significant reform of the public health sector (1994). In addition it is part of a larger trend in USAID/Washington to encourage commercial investment in basic health and family planning sectors on an international scale.

The Scopes of Work (SOW) submitted by PROFIT and Initiatives are detailed in Appendices E and F. The similarities between the two are obvious. One change should be noted, however. The Initiatives SOW, paragraph 2(a), indicated that NGOs/PVOs would form a significant part of their activities. At the initial briefing with USAID/ES/HPN, it was stated that the main thrust of this team's activities was to be directed solely to the commercial sector¹

A. MAIN PURPOSES OF THE ASSESSMENT

The main purposes of the assessment are:

- Describe and assess the provision of family planning and basic health services in El Salvador, focussing on the private commercial activities and
- Assess the potential of incorporating family planning services and products, and basic health services, into the commercial sector
- Determine the kinds of financial vehicles by which incorporation of such activities might be facilitated
- Describe legal and regulatory restrictions and opportunities to the incorporation of these services into the commercial sector
- Describe the policies of the Ministries of Health and Planning with respect to decentralization policies and plans
- Provide findings and recommendations related to commercial sector potential in family planning and basic health services

In addition, at the debriefing with USAID/ES/HPN on Thursday, October 6, the team was requested to include a Follow-on Work Plan for an incoming design team which will be responsible for the Social Sector Reform Project Design (SSRP) which encompasses both the health and education sectors.

1 It should be noted that a separate technical assistance team is working parallel to the PROFIT/Initiatives team with the specific mandate to evaluate the PROSAMI Project, an umbrella organization which provides assistance to local NGOs.

USAID/ES indicated that this \$15 million project will emphasize the Ministry of Health (MOH) decentralization plan, and will work in collaboration with major funding from both the World Bank and International Development Bank (IDB).

B. METHODOLOGY EMPLOYED

The assessment focused on the commercial sector, only interviewing other entities and sectors: (the Ministries of Health and Planning, the Social Security Institute (ISSS), a major NGO, university schools of medicine and professional associations) as appropriate, to determine the environment in which the commercial sector operates. The team broke down the assessment into twelve broad groups including associations, employers, insurance companies, pharmaceutical companies and public sector organizations. A complete list with specific contacts within each group is outlined in Table I.

Groups that could provide a broad picture of their specific sector and potential additional contacts were interviewed as early-on as possible. These included the Ministry of Health, commercial associations, professional groups, and key individuals. While the interviews were unstructured, interview guidelines were developed for the more specific groups such as employers, providers, insurance companies and pharmaceutical companies. The guidelines provided a tool to ensure that similar types of information were collected at each interview.

Typically a two-person team, comprised of different skill areas (e.g. health/family planning professional and, commercial sector/management/financial expert), interviewed each contact. This provided a dual perspective for the interview. Detailed notes were taken at each interview, reviewed and revised by each person who attended the meeting and then disseminated to the other team members. These notes formed the database for the assessment, and were analyzed to form the major findings and recommendations.

A total of fifty-four (54) entities or individuals were interviewed. Only four entities were unable to meet with the assessment team. Table I provides the categories of entities represented and the names of the organizations represented by the individuals interviewed.

It is important to note that the content of this document is based principally on triangulation of qualitative interviews, rather than survey or statistical data. While this type of data collection and analysis is basically subjective, it is substantiated by the qualifications and experience of the team members.

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Daily meetings were held among team members. Information was cross validated and challenged. Thus, while this effort is based on qualitative information, satisfactory cross-checking and analysis was performed by the team members to provide confidence in the findings and interpretations.

Further, as can be determined from Table I, the variability of interviewees cross-cut the medical, economic, insurance and financial spectrum of the current Salvadoran environment.

TABLE I LIST OF CONTACTS BY CATEGORY OF ENTITY

LIST OF CONTACTS BY GROUP			
ASSOCIATIONS	BANKS AND FINANCIAL	COOPERATIVES	EMPLOYERS
Asociacion National de Empresas Privada (ANEP)	Banco Salvadoreno	URCAPROBEX (Union de Cafe)	Compania Azucarera Salvadorena (CASSA)
Camera de Comercio	Banco Central	Cooperative League of USA (CLUSA)	HILASAL
Assn. Salvadorena de Industriales	Multi Sectorial*	FINCA (credit association)	TACA
Assn. de Aseguradores			DIDEA
Assn. de Farmacueticos			Sigma
Commision de Desarrollo Azucarero			CIDEMA
			Prieto, S.A.
			El Pedregal**
			El Progreso**
			Constancia
			Bon Appetit
			Shell

* Banco Multisectorial de Inversiones (a new division of the National Bank)

** Free Zones

TABLE I (Continued)

LIST OF CONTACTS BY GROUP			
HOSPITALS PRIVATE	INSURANCE COMPANIES	NGOS	PHARMACUETICAL PRODUCERS & DISTRIBUTERS
Centro de Diagnostico	Ase Suiza	Assn. Demografica de Salvadorna	DADA
Hospital de la Mujer	Centro Americana	Fundacion Masquilihuat	Lab. VIJOSA
ADS-Profamilia	Pan-American Life Insurance Co. (PALIC)	Fundacion UNGO	Lab. ANCALMO
	Medicard	FUSADES	Codifarma
	Salud Total		C. Imberton
			Stadler

TABLE I (Continued)

LIST OF CONTACTS BY GROUP			
PROFESSIONAL GROUPS	PUBLIC SECTOR	UNIVERSITIES	OTHER
Colegio Medico	Ministerio de Salud Publica y Asistencia Social (MSPAS)	Univ. de El Salvador	INCAE
Assn. Nacional de Enfermeras Salvadorna	Instituto Salvadoreno del Seguro Social (ISSS)	Univ. Evangelica	Organizacion Panamericana de la Salud (PAHO)
	Ministerio de Coordination del Desarrollo Economico y Social (MIPLAN)	Univ. Nueva San Salvador	Banco Interamericano de Desarrollo (IDB)
			USAID*
			Clapp & Mayne

* Personal and telephone interviews and informal conversations with:
 Health, Population and Nutrition
 Office of Planning and Economic Affairs

III. PROVISION OF FAMILY PLANNING AND HEALTH CARE SERVICES IN EL SALVADOR

A. OVERVIEW

The purpose of this section is to characterize the supply of health and family planning providers in El Salvador, and to discuss several issues affecting current and potential expanded patterns of service delivery, principally in the private commercial sector. This section builds upon information available in previous reports and on the qualitative assessment carried out under the terms of this assignment.

There are a number of individual and institutional providers of health care and family planning services in El Salvador.

- In the private, commercial sector, the most important individual providers are physicians. Physician supply is increasing rapidly, well above the increase in population growth rates. Medical schools have proliferated and there is little effort to coordinate training activities. Physicians, particularly those trained in private universities, have a strong specialty care orientation. Most physicians practice in the San Salvador Metropolitan Area (AMSS), resulting in areas of effective undersupply elsewhere.
- Nurses play a secondary, but increasingly significant role. Nursing personnel shortage is a critical problem in service delivery at present. Private hospitals and clinics are the most common settings for delivery of inpatient care, whereas doctors' offices are the most common setting for delivery of curative, ambulatory care. In general, quality of privately delivered health care is high, as are its costs. Hence, natural customers of this type of care are generally the economically advantaged.
- Private pharmacies are important providers of medical advice and play an influential role in care seeking behavior and drug utilization. Although the role of traditional providers, e.g. traditional birth attendants, has not been explored in this analysis, further examination is necessary given their ascendancy among the urban poor and rural populations.

B. INDIVIDUAL PROVIDERS

1. Physicians

a. Supply

The current estimate is that there are about 5,000 doctors in El Salvador today, equivalent to 9.2 doctors per 10,000 population. There are seven medical schools in the country and another is being established at the time of this analysis. About 350 new doctors graduate every year from all medical schools combined.

The largest and most important medical school is the Universidad Nacional de El Salvador (UES), a government-run university. This institution trains the majority of health personnel in about 10 different areas, including medicine and nursing. About 5,000 students are presently enrolled in all areas, with about half in medicine. In the early 1970s the university adopted an "open door" policy. This resulted in a significant increase in student enrollment over a short period of time, with no expansion in infrastructure and other resources.

Although increased enrollment and output are not seen as problems by the current UES leadership because "the country requires more physicians and nurses," the medical school is moving towards rationalizing student enrollment. An annual entry quota of 300-400 new students was established over the last 2 years, with graduating classes of about 250 per year. These quotas were defined in terms of perceived needs at the national and departmental levels; the public sector's ability to provide employment; the university's ability to offer reasonable training (i.e. availability of equipment and faculty); and appropriate budget levels. To be sure, this effort to rationalize physician output is unique to UES, but it is not clear how the public or private sectors play any role in determining needs or future employment levels.

UES' budget basically comes from national resources, and the allocation has not increased since 1979. It is only recently that symbolic fees have been introduced to partially support the operating budget. Initially a fixed c/.40 monthly fee (US\$5) was introduced, but currently there is a sliding scale fee ranging from c/.0 to c/.150 per month (US\$17), based on the student's ability to pay. This symbolic fee makes up a very small proportion of the medical school's operating budget (no actual figure was cited).

Universidad Evangelica (UE) was founded in 1980 in response to the temporary shut-down of UES. It was the first private medical school established in the country. Universidad Evangelica is a not-for-profit organization offering professional training in medicine, nutrition, and dentistry. Although all of the university's trustees must be Evangelicals, the church does not formally support

the university. The medical school supports itself largely from students' fees. Enrollment costs about c/.200/year (US\$23) and tuition is about c/.400/month (US\$46). Most faculty are young and salaries are kept low. Public facilities are used to offer clinical training. After seven years of training, including the year of social service, Universidad Evangelica graduates about 50 doctors per year. Many pursue specialty training, and this is seen as a measure of success by the medical school.

Another private university is Universidad Nueva San Salvador (UNSS). Its medical school was established in 1983. UNSS has about 500 medical students, and graduates about 50-60 doctors per year. It has about 70 part time faculty and uses a public, 300-bed hospital in Santa Tecla for clinical training. The medical school charges about c/.300/year (US\$35) for tuition. This medical school also has a clear orientation towards specialization.

b. Distribution

Although a first hand, comprehensive analysis of physician distribution was not possible, simple observation made evident a significant concentration of physicians in metropolitan San Salvador (about 3,900). The city has a few established hubs for medical services, where most specialists render services. Other information indicates that smaller urban areas outside AMSS are slowly attracting physician practices, as long as they are seen as profit making locations.

c. Types of Physicians

UES emphasizes training on basic and preventive health care, particularly after the curricular reform adopted about 6 years ago. UES believes new graduates are demonstrating interest in practicing primary care and may be choosing practice locations away from urban areas. Nevertheless, as indicated above, most private universities emphasize specialty training. Most physicians are established in individual practices. Although some doctors are organized in groups, these are not true group practices in the sense that they may provide one-stop shopping to customers. Doctors may work together in a location to minimize overhead expenses, but rarely do referrals within the group, for example.

d. Efficiency

As in many other Latin American countries, a large majority of doctors in San Salvador, particularly older specialists, have multiple employment sites with a combination of public sector assignments and private practice. Frequently physicians may have two or more part-time institutional appointments (a typical appointment is 2 hours/day), thus they shuttle across the city to meet their

schedules. Because of this model of high medical mobility productivity and quality are often perceived as less than satisfactory.

Part-time duties in the public sector, e.g. MOH or ISSS, are often inadequately satisfied (i.e. a two-hour appointment is supposedly fulfilled in half an hour), with the ensuing decay in quality of care (i.e. rushed physicians seeing 8-10 patients per hour). In contrast, the same physicians may spend much more time establishing rapport and evaluating patients in their private office.

Fees for an office visit to a private specialist may range between c/.80-110 (US\$9-13). In comparison, outpatient charges in the public sector (mainly the MOH) range between c/.10-25 (US\$1.15-3.0). Private office charges do not necessarily reflect practice costs of doing business. Rather, they are often established based on the competition or on a subjective assessment of ability to pay by selected individuals. This assessment allows for some cost shifting. Fee for service is by and large the most frequent payment modality. Few doctors provide services on a capitated or on a salary basis. ISSS has experienced with subcontracting of specialty, ambulatory services under a capped fee-for service mode. CEL, ANTEL, and Bienestar Magisterial are examples of other cases where medical services are purchased for a fee or under a capitation scheme. In some instances, physicians are salaried employees. CEL functions as an insurance company, negotiating discounted fee schedules for professional services. With the advent of private health insurance, some doctors accept discounted fee schedules in exchange for patient volume. This approach is fairly new and has created some resistance among older, established doctors.

According to some anecdotal accounts, infrastructure for ambulatory care may be significantly under-utilized, by as much as fifty percent in some cases. Given the large number of doctors in AMSS, the relatively limited size of their potential clientele, and doctors' attitudes to "maximize income during their productive years" (35-60 years of age), costs for private medical care seem to be soaring well above inflation. This makes private medical services increasingly inaccessible to many.

e. Discussion of current issues

1. Oversupply and Training

From the foregoing, it is clear that production of physicians in El Salvador occurs in a vacuum with little or no coordination by a responsible agency, such as MOH or Ministry of Education. This liberal environment is causing an oversupply of physician of questionable quality, according to some observers. The public sector is unable to absorb an output of about 300 new doctors per year. In addition, since the predominant orientation in

private practice is specialty care, graduate training in this area is effectively limited to those able to travel overseas to get it or to those with influence to enter into any of the local programs. Doctors are ill prepared to enter the highly competitive environment of private practice. Medical schools provide no business training and the country has no local capacity to educate professional health care administrators.

The majority of graduating physicians face an uncertain future, including un- or underemployment, particularly in urban areas. These consequences of oversupply are not readily perceived in El Salvador as in other Latin American countries. Most of newly established medical practices may be best characterized as store front operations. These services often suffer from inadequate infrastructure and equipment, conditions which, added to the doctors' poor quality of training, may result in greater risks to consumers.

2 Quality Oversight

Although there are at least two entities responsible for monitoring supply and quality of professionals (Consejo Superior de Salud Publica and Junta de Vigilancia de la Profesion Medica), their activities are generally perceived as ineffective. Existing health codes are very often by-passed or simply not applied.

3 Organization and Efficiency

Private-for-profit physician services are generally considered to be poorly organized and often under-utilized. Most doctors are in individual practice, the least efficient mode of medical practice. This results from the highly competitive environment as well as from the limited knowledge about alternative delivery schemes, e.g. group practice. Inherent inefficiencies, physician attitudes to maximize income, and tend to drive costs and prices up, making private physician services inaccessible to many.

An organization with potential to influence medical practice is the Salvadoran Medical Association (Colegio Medico de El Salvador). Its active membership is about 3,300 physicians, or about 75% of all doctors in the country. Although representatives interviewed recognize the important role of private practice, they state reservations about efforts to expand this sub-sector due to the following:

- A significant proportion of the population (maybe 60%) lives under conditions of poverty and severe poverty. Thus these people have no purchasing power to buy privately-produced services;
- ISSS covers about 12-15% of the total population, mostly workers in the formal sector of the economy. Thus, demand for health services by the

working class is already being satisfied, albeit with many problems. An effort was made by past leadership to get physicians involved in the policy debate. The problem is that few doctors apparently understand issues related to health care economics, such as effectiveness or efficiency. They consider these "political" rather than "technical" issues, and are thus reluctant to participate in any debate.

4. Health Insurance

Health insurance, world-wide, generally is not a basic insurance line. It is considered a "loss-leader" in that it tends to be made available to companies with other profitable more profitable lines with the companies. Exceptions, of course are HMOs (Health Maintenance Organizations), PPOs (Preferred Provider Organization), etc. where health maintenance is emphasized, and co-payment by patients enhance profitability schemes and spread risk.

The availability of private health insurance, nevertheless, has become an important force in the organization of medical practice in El Salvador. Health insurance appears in response to many of the problems in ISSS (e.g. lack of medicines, long waiting time, and unavailability of certain treatments) and in the MOH, as well as a mechanism to finance medical and hospital care offered through private providers. Other factors which favor insurance development are physician oversupply and employer interest. As to physician supply, insurance companies enjoy a buyer's market, negotiating fee schedules, coverage, etc. from a position of relative strength. Employers see private insurance as a mechanism to develop and fortify employee loyalty and productivity.

Physicians, although reluctant to accept lower reimbursement rates, see insurance coverage as a mechanism to make medical services accessible to more people, beyond the traditional market for private services (i.e. those well off). It is no coincidence that representatives from the medical association indicate that "private health insurance is here to stay...thus doctors will have to accommodate and learn to negotiate with them."

2. Nurses

a. Supply, distribution, and work settings

Many perceive that El Salvador faces a critical shortage of nurses. Service delivery organizations are enticing nurses to come out of retirement to fill some crucial posts. This shortage is the result of the closure some years ago of training facilities run by the MOH. Today the ministry is about to re-initiate baccalaureate-level training of nurses through several modalities. The first is to open three

training centers in different areas of the country. The second is to offer off-site training to chosen nurse aides. Finally, a work-student program, also sponsored by the MOH, will be developed for selected individuals. These strategies should begin to produce about 180 new registered nurses within the next three to four years.

There are approximately 20 private schools of nursing and other allied health personnel in the country, according to the Nurses' Association of El Salvador (ANES), a professional association of about 5,000 members. UES has no undergraduate training program in nursing, although they run a master's level program with emphasis on service administration (licenciatura). Graduates of this program may not help address the need for basic care ("floor") nurses, as they are more likely to occupy managerial or bureaucratic posts. Universidad Evangelica offers no professional training in nursing and does not intend to pursue one. Available training institutions are sometimes perceived as money-making diploma mills.

There is scant data about distribution and work settings for nurses. In all likelihood nurses follow physicians in staying where most resources are established, i.e. in urban areas. Work settings in the private sector are mostly acute, short term hospitals and clinics. Few nurses work in physicians' offices. Most nurses are employed in the public sector, MOH or ISSS, on a full time basis.

b. Current Issues in Nursing Supply

It is clear that El Salvador suffers a nurse shortage. Currently there is roughly one nurse per practicing doctor, while international standards recommend about four nurses per doctor. Lack of appropriate training facilities is partly to blame. Another factor is inadequate incentives: salaries and promotions.

- Despite a nurse advancement law was recently passed (ley de escalafon), and established career paths for nurses in the public sector, salary improvements are yet to come. This may be the single most important problem associated with shortages, according to the Asociacion Nacional de Enfermeras Salvadorenas (ANES).
- Another factor is a lack of autonomy in the nursing profession. Although traditional nursing curricula has a heavy orientation towards disease prevention and health promotion, nurses cannot work independently offering these services. At most they are allowed to administer prescribed injectables or solutions, or to provide basic emergency care (cleaning/management of mild wounds and injuries, for example). Unlike other Latin American countries where autonomous, professional nurse midwives are allowed, El Salvador has no functional equivalent. Changes in

this direction may be difficult to come, especially due to physician opposition.

3. Pharmacists and other health personnel

Due to time constraints, very little information was gathered on other health personnel such as nutritionists, nurse aides, physical therapists, etc. A key group of providers are pharmacists. Although required by law to be degreed professionals (doctors in chemistry and pharmacy), many pharmacists operate without this requisite. Establishing a pharmacy is an easy affair in El Salvador, no more difficult than opening a corner grocery store. These providers are important in the formal delivery system because they are often the only contact a patient may have with it.

People may turn to help from a pharmacist out of simple convenience and/or in order to avoid the relatively higher costs of physicians office visits, including diagnostic workup and full treatment. Some of the problems with this type of care is that it is often inappropriate, and can lend itself to irrational use of multiple and ineffective drugs (antibiotic resistance is associated with this practice).

4. Traditional Providers

Although traditional providers were not examined as part of this assessment, they undoubtedly play an important role in the provision of basic health care. Traditional birth attendants are particularly important in the management of uncomplicated pregnancies, including labor and delivery. As made evident from the most recent DHS survey, traditional birth attendants are responsible for a substantial proportion of maternal care, especially in rural areas. These providers enjoy community support and are readily accessible. With additional training and appropriate incentives, these providers may constitute a major resource to expand basic health care coverage. Further examination of their supply, distribution, practice characteristics, and financing is clearly in order.

C. INSTITUTIONAL PROVIDERS

1. Private Hospitals

The majority of private hospitals are located in the AMSS. A recently created Association of Private Hospitals currently groups 16 institutions. The association is developing membership criteria and bylaws, in order to achieve full GOES recognition as a legal entity. Interestingly, the hospital run by Asociacion Demografica Salvadoreña (ADS) is not part of the association.

In an interview with the president of the hospital association we learned that, on average, private providers have about 50% occupancy or utilization rates. In his opinion, this is valid for hospitals, laboratory services, diagnostic services, and doctors' offices. The conclusion is that the private sector has enough reserves to satisfy unmet demand in the country. Hospitals in this category are heterogeneous. Size, medical technology, professional expertise, resource use, and case mix vary significantly. Thus, in case the GOES would decide to use these hospitals to expand access to inpatient care, agreements would have to take into account these inter-institutional differences. Private hospitals are almost exclusively acute, short term facilities for inpatient care. Apparently none of them offers ambulatory care or any other vertically integrated services.

This model may run opposite to modern hospital management. Technological and managerial progress, changes in reimbursement for hospital care, and different consumer expectations make the free standing hospital an outmoded model, particularly in the US.

In developing countries, hospitals may face a similar future, although at a different scale. Since the late 1970s, the emphasis has been on primary care. While this does not imply that hospitals are no longer needed, the implication is that hospital resources ought to reflect sound investment decisions from a societal and economic standpoint. This is where the regulatory function of the state may come into play in order to rationalize the availability of this costly resource.

2. Asociacion Demografica Salvadorena (ADS) Hospital

The ADS hospital was opened in June, 1994. The decision to organize hospital services was made as a strategy to increase revenues which, in turn, might be used to subsidize family planning services. Although it is too early to reach final conclusions, the hospital is currently not generating resources as anticipated.

In fact, it is losing money, and it is expected to do so for the next five years in all likelihood, or until it reaches an occupancy rate of 55%. The current occupancy rate is between 30-40% with 36 beds at present (a daily census of 14 patients), with a potential for expansion to up to 100 beds within the next 3 years. No ambulatory care is provided, except for emergency care. Preventive care includes sterilization services, and biosafety training to hospital staff against AIDS, hospital infections, and disasters. The hospital has a pharmacy, and projected expenditures for FY95 are 1.6 million colones (about US\$184,000), plus c/.500,000 (US\$58,000) for disposable supplies.

The hospital has open admitting privileges, providing services in up to 23 medical specialties, plus diagnostic and laboratory services. There are 180 associated physicians, but other physicians in the community may also admit patients as

needed. These physicians are not salaried by the hospital. The medical staff is composed of 8 physicians by shift (total of about 32), with 2 doctors serving in the emergency room. There are 45 nurses, 18 nurses' aides, 4 x-ray technicians, 5 clinical laboratory technicians, 15 people in support functions, and 5 administrative staff. It is evident that the hospital is overstaffed, and this is one of the causes for financial concern.

ADS Hospital charges are on average 30-40% lower than the competition. These charges are estimated based on projected costs and revenue. Lower charges and thus potential savings are passed on to patients. These prices have created uneasiness among other private providers of hospital services. They are trying to pressure physicians not to use ADS Hospital, unless they are willing to risk admitting privileges in other private hospitals. The hospital is marketing its services mainly to physicians in the community, not to patients. Administrators are confident that the hospital is a viable enterprise, although they acknowledge the fact that the process will not be easy at the beginning. If nothing else, the hospital is already serving as an image enhancer for ADS, and that is worth the investment, according to hospital principals.

3. Clinics

No direct observation of clinics was possible during this assessment. Other evidence suggests that these are the most common settings for acute, curative services (there may be around 60 clinics in the country). They differ from hospitals in that clinics are smaller, minimally out-fitted, and with questionable standards of care. They may well be classified as primary level facilities with limited inpatient support capability. The bulk of their service mix is pregnancy care, including labor and delivery, and basic emergency care.

Younger physicians tend to organize small clinics and reports were received of a few located in marginal urban areas. This type of health care facility requires further first hand information.

4. Current Issues of Institutional Facilities

Private hospitals and clinics are the major providers of acute, inpatient care in El Salvador. This is a heterogeneous group. A recently established association of private hospitals is trying to introduce criteria for classification of private facilities. Although their primary interest is to get organized in order to gain influence and power, it is clear that their interest is also to establish differences with competing, but lower quality, organizations, such as store front clinics, where medicine may be practiced more as a craft than as a scientific and technological endeavor.

- Larger private hospitals, including the ADS hospital, offer no direct ambulatory care. This may be interpreted as a liability which has the potential to jeopardize the very survival of hospitals. Private hospitals do not express interest in establishing linkages with providers in the community, i.e. joint ventures, although the situation may be evolving.
- Private hospitals are underutilized and some may suffer from severe inefficiencies, such as ADS hospital. The cost of these inefficiencies is carried over to the customer, resulting in higher charges, or is absorbed as losses. Lack of hospital management expertise and business skills are clearly a problem. Little evidence of institutional strategic planning was found in our limited assessment.
- The hospitals' interest in expanding basic health and family planning services, is not seen as their natural function. The prevailing orientation is towards acute, curative care, using intensive, high tech, and costly interventions. Due to this circumstance, private hospitals may not be suitable partners in efforts to expand family planning and basic health services at least at the present time.

D. SUMMARY OF PROVIDER SYSTEMS

1. A trend towards physician oversupply is clear. This implies a buyer's market environment in favor of insurance companies, employers purchasing physician services, and other potential buyers. Physicians see their bargaining power decline as numbers increase. This may be creating uneasiness particularly among older doctors. No systematic effort is being made to curb physician supply, although some mechanisms seem to be available. The fact that doctors' demographics are changing (i.e. younger, more women) implies opportunities for development of alternative service delivery schemes in the private, commercial sector, such as managed care and greater emphasis on preventive care.

2. Managed care includes alternative organizational settings such as HMOs, PPOs, etc., along with cost and utilization controls. The concept of managed care, however, is very little known, by providers, employers, and insurance companies.

In the private market of physician services quality of providers and quality of care are key issues. Quality of providers is not being monitored, despite existence of control entities (CSSP, Junta de Vigilancia). The role of the Consejo de Protección del Consumidor is unclear as to medical services oversight.

3. Quality of care is not well monitored, despite control mechanisms. The relevance of this issue rests in the fact that consumers will be willing to pay for services perceived to be of acceptable, if not of good, quality. Productivity in the ambulatory level appears low. Ambulatory care providers would benefit from management training in order to maximize productivity and efficiency. Prices of ambulatory care reflect competitive pressures or physician attitudes more than real cost structures.
4. There is a significant shortage of nurses, but some measures are being taken to remedy this problem in the mid-term. Nurses claim for greater autonomy and salaries and are slowly making gains, e.g. ley de escalafon. Their role in expanding access to basic health and family planning as independent providers is yet to be defined, but may run into physician opposition.
5. Although there is a significant number of private hospitals and clinics, particularly in the AMSS, there is a paucity of data on their principal characteristics and dynamics. Quality of infrastructure, equipment, technology, and providers vary. In general, there is evidence of about 50% occupancy rate. There is underutilized capacity. Costs are high. There may be an issue with efficiency of some organizations, e.g. ADS hospital (overstaffed).
6. There is a major need to incorporate business skills to hospital management. There may be a need to make hospitals understand the concept of vertical integration, where they link up with primary care providers as sources of referral, or with less expensive institutional settings (long term care or skilled nursing facility) for the chronically ill. Referrals from community providers may be critical for hospital survival. Another issue is for hospitals to explore innovative delivery models, such as outpatient surgery centers. These are effective alternatives to costly inpatient care.
7. The policy environment for private provider growth and expansion needs serious re-examination. The fact that little control and regulation exists is a clear incentive for a laissez faire approach. This may be counterproductive for consumers. For an ideal market of medical services to exist, consumers need to be more sophisticated; thus the importance of education in general, and of relevant information about provider quality and price, in particular. Government will have to play a stronger regulatory role, to protect consumers against provider abuse, poor quality, and excess price (mainly through encouraging competition, not price controls). Government needs to strengthen its institutional capability to play this new role, in lieu of direct service delivery.

8. The role for AID should be to catalyze the modernization process in the private sector. It should support and effectively disseminate relevant information available (dissemination of managed care concept and delivery models; hospital vertical integration, etc.). It should continue to support the development of information systems at the government level to improve monitoring function, and to assess efficiency and effectiveness (through targeted technical assistance. There is a need for greater information on health care economics and management within the private sector: cost structure, purchasing, efficient staffing, price impact, practice variation, the role of high technology, etc.

A private, independent policy analysis and research capability would be an important feature in a policy reform project (to carry out health services/systems research at the public/private levels and inform policy makers of relevant choices).

IV. THE MARKET FOR FAMILY PLANNING AND BASIC HEALTH SERVICES IN EL SALVADOR

A. INTRODUCTION

Many factors influence the relative family planning and basic health market shares of the public and private sector (commercial and non-for-profit). Government policy, method preference, income and poverty levels, and supply of health infrastructure and human resources all play a role in determining market share.

Comparing family planning market segmentation (measured by source of modern contraception methods) in El Salvador with an average of nine countries in Latin America shows that the country's profile differs significantly from the regional norm (see Graph 1). The public sector (MSPAS and ISSS) share is 69% in El Salvador, almost twice the regional average of 38%. The percent of Salvadoran women using non-subsidized, commercial sources (pharmacies & private practice) is 14%, less than one-third the regional average of 42%. The NGO market share in El Salvador is 16%, equal to the regional average.

Another indication of the relatively small role of the private sector in El Salvador's family planning market is found in comparing the private sector's family planning market share to the private sector's share of overall health spending. In four countries in Latin America for which data are available, private sector family planning coverage exceeds private health expenditure (or is about equal, in the case of Peru) (See Graph 2). In contrast, in El Salvador, the private sector's share as a source of modern contraception (31%) is significantly lower than its share of overall health expenditure (53%).

In basic health, the public sector similarly dominates service provision. El Salvador has relatively low infant and child mortality rates in comparison to other Central American countries (52/1000 live births). Only Mexico and Costa Rica have lower rates (FESAL 93). Assuming a correlation between the use of basic health services and childhood mortality rates, El Salvador's rate indicates that people are using the services related to child health. Data from FESAL-93 show that the MSPAS bears the greatest burden for the provision of basic health services. For example, MSPAS facilities provide 70.9% of prenatal care services, 38.1% of all deliveries (75% of hospital or clinic deliveries), and 80.8% of the well-baby check-ups. In comparison, the private sector (for and not-for-profit) only provides 12.2% of prenatal care, 3.2% of the deliveries (6% of hospital or clinic deliveries), and 6.8% of the well-baby check-ups (FESAL 93).

A number of reasons may explain why the current market profile in El Salvador so heavily favors the public sector, including:

- Long-term and continuing strong government support for family planning and basic health programs;
- The traditionally large role of the public sector in provision of low-cost basic health services, including family planning;
- A large percentage (about 60%) of the population living in relative or extreme poverty, with limited or no ability to pay for market-priced services;
- A marked preference for female sterilization (about 60% of overall prevalence);
- The traditionally strong curative focus of the private, commercial sector providers (physicians, clinics, hospitals and insurance companies); and
- A reluctance among certain private providers to provide some family planning methods, out of religious conviction.

Despite the current heavy orientation towards the subsidized sector, several factors point towards an expansion of the market share of the private, commercial sector in the near future. Indeed, there has already been some shift, although limited. Between 1988 and 1993 the subsidized (MSPAS and NGO) sector's role as a source of contraception dropped slightly, from 70% to 65%, while the commercial sector's share increased slightly, from 13% to 14% (FESAL-93, p. 84). Recent factors which favor a greater role for the commercial sector include:

- An upturn in the economy in the last two years and projections of sustained real growth in wages and per capita GDP. Health consumers will have greater disposable income, use less public services (considered an inferior good) and more private services.
- Government resolve to downsize its service provision role, shift overall health burden to the private sector, and target the poor.
- A trend towards greater flexibility of private providers (physicians, insurance companies) to respond to demand for preventive care, and greater competition among providers, resulting in lower cost commercial sector services.
- A trend in the ISSS towards contracting out some family planning and basic health services to private providers.

B. ANALYSIS OF SERVICE USE BY SOURCE AND SOCIOECONOMIC LEVEL

One way of measuring the commercial sector's potential for family planning and basic health service provision is to examine current use by method, source and user's socioeconomic level. If the analysis finds many women from higher socioeconomic levels using subsidized services, governments and donors working with limited resources and with a mission to serve the poor may want to reconsider current pricing and incentive structures in the services being provided by the public sector and subsidized NGOs. Options include charging higher-income women more for services or actively pursuing policies which encourage these women to use commercial sources at market prices. On the other hand, a government may rightly feel that some of these services, such as child immunization, are public goods which justify the continued subsidy. The analyses that follow give a broad view of how the markets for family planning and basic health are working in El Salvador.

We use the variable for socioeconomic level constructed by FESAL-93 in the market structure analysis. FESAL-93 constructed an independent variable for socioeconomic level combining indicators of household possession of 12 goods and services (e.g., ownership of a television, electricity hookup, etc.) (FESAL-93, p. 301). Of the women surveyed in FESAL-93, the study classified 30.7% as low socioeconomic status, 37.7% middle, and 31.6% high.² Note that this variable is a rough proxy for income levels and that the survey sample may not be representative of socioeconomic level. Nevertheless, it does provide some guide to the relative economic condition of the households of the women surveyed.

1 Analysis of Family Planning Market

a. **Female sterilization** is by far the preferred contraceptive method in El Salvador. Of the 53.3% of women in union aged 15-44 using a contraceptive method almost 60% are sterilized. The subsidized sector (MSPAS and ADS) provides a large part (80%) of female sterilizations (see Graph 3). The rest are provide by private doctors (4%) and ISSS (16%) An analysis of the socioeconomic status of users by source (see Graph 4) reveals that more than one-fifth (21%) of the women sterilized in subsidized facilities are from the high socioeconomic group. 21.5% of women sterilized in the MSPAS and 20.5% of women sterilized in ADS fall in the high status group. Many of these women could conceivably pay for sterilization at commercial sector prices, although the high up-front cost of the procedure in a private clinic (around c/ 1000³) may discourage some women.

² By comparison MIPLAN classifies 27% of Salvadorean households in extreme poverty, 30.5% in relative poverty, and 42.5% above the poverty line. MIPLAN, "Encuesta de Hogares de Propósitos Múltiples Urbano y Rural". Octubre 1992 - Marzo 1993.

³ Exchange rate: c/ 8.7 = 1 \$U.S.

To better approximate the current market for sterilization services, we narrowed the scope of analysis to those women who were sterilized in the last five years (1988-93). The analysis shows that the subsidized sector's share during the five-year period was 74% vs. 6% for private doctors, and 20% for ISSS. 16% of women sterilized in subsidized facilities fall in the high income group (see Graphs 5 and 6). For the group of women sterilized in the past five years, we also looked at the breakdown between postpartum and interval sterilizations⁴. Overall, 55% of sterilizations were done postpartum; 70% of MSPAS sterilizations, 59% of ISSS sterilizations, and 59% of private practice sterilizations were done postpartum. ADS only provides interval sterilizations. In the MSPAS, over three-quarters (76%) of high-income women who were sterilized received the service in the postpartum period (see Graph 7).

How can we interpret the finding that many high-income women use MSPAS sterilization services and a large majority receive sterilization in the postpartum period? One explanation may be that high-income women use MSPAS birth services to receive postpartum sterilization. Postpartum sterilization in the public sector is no-cost or low-cost and widespread. The commercial sector currently does few postpartum sterilizations and charges market rates. Thus, a high-income woman who wants a postpartum sterilization may decide to use MSPAS birth and sterilization services for reasons of cost and availability. What this interpretation also points out is that just because many high-income women are getting sterilized in the MSPAS, this does not necessarily mean that the commercial sector can or should assume the service burden for these women. While the MSPAS already has considerable infrastructure in place, whereas it may not be readily available in the commercial sector without significant investment in training and equipment. Rather than trying to shift clients from one sector to another, the MSPAS may consider instituting sliding scale fees for sterilizations services. ADS has already started such a plan, setting a two-tiered price for sterilization--50 colones for low-income women and 300 colones for higher-income women.

b. Oral contraceptives are the second most popular method in El Salvador, accounting for 16% of contraceptive use. The subsidized sector provides more than half (54%) of the supply of orals, with pharmacies providing slightly more than one-quarter (27%)⁵, ISSS 13%, and private practice 2% (see Graph 8). An

4 FESAL-93 asked women the month and year of sterilization and the day, month, and year of last live birth. Women whose month and year of sterilization matched the month and year of last live birth were assigned to the postpartum sterilization group.

ADS's social marketing oral contraceptive, Perla, sold through pharmacies makes up a large percentage of pharmacy sales. Overall pharmacy oral sales are not available. Also, FESAL-93 did not question oral users on the brand they use. However, we can indirectly calculate Perla's share using prevalence data. The 292,580 Perla cycles sold in 1993 are adequate to cover the annual contraceptive needs of 22,500 users. This represents over one-third of the roughly 60,000 orals users in the country. Comparing this coverage rate with the FESAL-93 finding that pharmacy's oral market share is 26.7% demonstrates the

examination of socioeconomic status of oral users by source (see Graph 9) shows that 13% of women using subsidized outlets (MSPAS and ADS) are in the high status group. 11% of MSPAS oral users and 23% of ADS oral users fall in the high status group. As with sterilization, the high-income group is a significant user of subsidized services. This situation again raises policy questions regarding the fairness of continuing to provide subsidized services to this group of women. The data also raise a question about the efficiency of providing a relatively large percentage of a supply method through clinical outlets. A more aggressive campaign to distribute through commercial channels could result in cost savings for consumers, the public sector and donors. However this needs to be evaluated vis a vis national family planning policy.

c. Injectable contraceptives are a fast-growing portion of contraceptive use in the country. Of the 7% of contracepting women who use injectables, 42% are supplied from subsidized outlets. Another 40% get their injectables from pharmacies and 6% are supplied from private physicians (see Graph 10). 18% of women receiving supplies from MSPAS or ADS are in the high socioeconomic status group (see Graph 11).

d. Condoms and IUDs are used by relatively few Salvadoran women. Each account for only about 4% of total prevalence. The number of cases for analysis by source and socioeconomic level are small and therefore should be interpreted with caution.

Most condom users (66%) are supplied through the commercial sector, with 17% receiving supplies from subsidized outlets and another 17% using ISSS as a source. One-quarter of subsidized condom users fall in the high-income group (see Graphs 12 and 13) The MSPAS and ADS provide the bulk of IUD services (62%), with another 30% provided by ISSS and 7% by private physicians. Twenty-three percent (23%) of MSPAS and ADS users are women of high socioeconomic status (see Graphs 14 and 15).

e. Combining all modern methods, the data show that 69% of women use a subsidized source, 15% use the commercial sector, and 16% are ISSS users (see Graphs 16 and 17). Of women using a subsidized source, one-fifth (20%) belong to the high-status group. These findings underscore the extent to which subsidized family planning services are supporting women who, in theory, have the ability to pay some or all the cost of their contraceptive decisions and behavior.

f. Market Realignment. We can examine the effect on the current market for family planning resulting from shifting high-income women from subsidized to unsubsidized services. Graph 18 shows that currently 79% of women use a

dominance of the social marketing product on the market.

subsidized source for clinical methods (sterilization, IUD) and that 21% of subsidized users are high-income women. Graph 19 shows the effect of shifting all high-income women from subsidized to commercial services. The commercial sector's market share increases from 4% to 19%, while the subsidized sector's share drops from 79% to 62%. Graph 20 shows source of supply methods (oral, injectable, condom). Currently 46% of women use subsidized services. Of subsidized users, 15% are high-income women. Graph 21 shows the effect of shifting all high-income women to nonsubsidized sources. The commercial sector's share increases from 41% to 47%, while the subsidized sector's share drops from 46% to 39%.

g. Unmet Need for Family Planning. It is important to examine both the current and potential market for family planning. Women with unmet need represent potential consumers of family planning services⁶. Here we analyze birth-spacing preferences by socioeconomic level and potential source for women with unmet need. The results indicate how the market--private and public--might respond to the needs of these women, and what types of policies may be pursued in El Salvador.

Overall, 9.2 percent of women age 15-44 have unmet need, representing about 109,000 individuals. In the analyses we have further limited the potential market to those women with unmet need who expressed a desire to use a family planning method. This group consists of slightly more than one-half (51.8%) of all women with unmet need, or about 56,000 women. If the family planning needs of this group were met, it would mean an increase of 18% in the number of women contracepting.

Appendix table 37 shows that most of the unmet need (84%) is concentrated in the low and medium socioeconomic groups. The women with unmet need who prefer spacing their next birth (62%) outnumber those who desire no more children (38%). Using this information on birth preference and socioeconomic level, we can assign women with unmet need to the method and source which hypothetically reflects their birth preference and ability to pay. Those women who are limiters are assigned to a clinical method (sterilization or IUD); those who are spacers are assigned to a supply method (oral, injectable, or condom). Women in the low and middle-income groups are assigned to either a subsidized source or ISSS⁷

⁶ We use the following definition of unmet need, taken from FESAL-93, p. 111, "Women are defined as being in need of family planning services if they: Did not report infertility, are not pregnant, do not currently desire a pregnancy, are sexually active, and are not using a contraceptive method."

⁷ Women are assigned to ISSS based on the percentage of women in the socioeconomic group that currently name ISSS as their source of services. Currently, 2.2% of low-income women use ISSS as a source for clinical methods; 4.9% use ISSS as a source for supply methods. Currently, 14.3% of middle-income women use ISSS as a source

We can now examine two scenarios. In the first, unmet need is distributed among sectors according to birth preferences and ability to pay and we hold current market share unchanged. Graph 22 shows that adding services to women with unmet need leaves current market segmentation between subsidized and unsubsidized sources of clinical contraception almost unchanged. This result reflects the relatively small numbers of high-income women with unmet need. In terms of absolute numbers of women served, subsidized sources increase their services 10% and unsubsidized sources by 18% (see appendix tables 11 and 40). Looking at supply methods, Graph 23 shows that the addition of services to women with unmet need results in an increase in market share for subsidized sources, from 46% to 53%, and a decrease in share for unsubsidized sources, from 41% to 35%. Again, this finding follows from the large number of low and middle-income women with unmet need relative to the number of high-income women. However, in terms of numbers of women served, both sectors increase their markets (42% for the subsidized sector and 4% for the commercial sector--see appendix tables 11 and 42).

In the second scenario, unmet need is distributed among sectors according to birth preferences and ability to pay and current market shifts high-income women to unsubsidized services (as shown in the market realignment exercise above). Graph 24 shows the clear effect of the market realignment of current users. Users of subsidized services fall from 79% to 64%, with a corresponding increase in use of commercial sources from 4% to 18%. These shifts translate into a drop of almost 20,000 in the number of women served by subsidized sector and a rise of 34,000 women served by commercial sources (see appendix tables 11 and 44). The examination of the effect of these changes on supply method source tells a different story, as shown in Graph 25. Market share remains relatively unchanged; all sectors increase services in terms of absolute numbers (see appendix tables 11 and 45).

Attempts to reorient the market should be accompanied by greater coordination among institutions supplying contraception, including joint strategic planning exercises, and coordination among donors providing resources for family planning service provision and promotion. As Lininger's report points out, there is currently little or no coordination between the major providers of family planning services. This type of market analysis, combined with strategic planning exercises may be a good way of encouraging dialogue and communication among institutions.

for clinical methods; 14.1 use ISSS as a source for supply methods. See appendix table 11.

2. Analysis of the Basic Health Market

As with family planning services, the potential market for basic health services can be measured by examining place of service by socioeconomic levels. It is assumed that higher socioeconomic levels have the means to purchase basic health services through the commercial sector. If the services were made accessible and were of higher quality, consumers with the financial means could be shifted from the public sector to the private sector.

a. Prenatal services are being used by 68.7% of women, with 58.2% of the low socioeconomic level, 71.3% of the medium socioeconomic level, and 87.9% of the high socioeconomic level receiving prenatal care. The MSPAS provides the largest percentage of the care (71%), followed by ISSS (14%) then the private sector (12%) (see Graph 26). Graph 27 breaks down the use of MSPAS, ISSS, private sector and other prenatal services by socioeconomic level. The graph illustrates that 12% of the services provided by MSPAS are used by the high social economic level women. This segment could potentially purchase services from the commercial sector, freeing up MSPAS resources to target the poor, and the large percentage (43%) of low-income women who currently are not receiving prenatal care. In addition to shifting some of the MSPAS burden to the private sector, the private sector could also expand its market by targeting women of mid and high socioeconomic level who currently do not receive prenatal health care.

b. Hospital Deliveries: 51% of the deliveries in El Salvador occurred in hospitals. Of these, 75% were in MSPAS facilities. Only 6% of in-hospital deliveries took place in a private hospital (see graph 28). Graph 29 illustrates that 18% of MSPAS deliveries were to women of high socioeconomic level.

c. Well-baby Check-up: 81% of all live births were taken for well-baby care at least once. Of those who received services, 81% were seen at MSPAS facilities. Only 7% received well-baby check-ups through private sector facilities (see Graph 30). Graph 31 delineates point of service by socioeconomic level, showing the potential market for the private sector. 12% of MSPAS well-baby clients were in the high socioeconomic level group.

C. CONCLUSIONS

This analysis is limited in its characterization of the complex workings of the family planning and basic health markets. Nevertheless, it clearly shows that potential exists to either shift a significant number of family planning and basic health users from the subsidized to the commercial sector or institute policies which reduce the subsidy for high-income women and families.

The analysis has considered the impact of shifting only high-income women from subsidized to unsubsidized services. When taking into account the large numbers of middle-income women also receive subsidized services, the potential for changes in relative market shares is even greater. These findings, together with the factors favoring a greater role for the commercial sector outlined above, point towards ample opportunities for an expansion of the commercial sector's coverage.

More in-depth analysis of the market for sterilization services should look at variables not covered in this report, including parity. Also, more analysis is needed of alternative market scenarios and market response to women with unmet need. This analysis should be coordinated closely with relevant authorities at the MSPAS, ADS, and ISSS. More analysis is also needed of the commercial sector's likely capacity to absorb a greater share of the market, especially for interval and postpartum sterilization. Additional analysis of FESAL-93 data on basic health services, not available in the published report, are also needed.

Preliminary conversations with RAPID project staff indicate a willingness on their part to coordinate their current work and continue some of the analyses begun in this study. The Mission may want to consider using the services of RAPID staff to this end.

V. ASSESSMENT OF THE POTENTIAL FOR INCREASING THE INVOLVEMENT OF THE COMMERCIAL SECTOR IN BASIC HEALTH AND FAMILY PLANNING SERVICES

This section presents the findings of the assessment in the area of provision of basic health and family planning services through the commercial sector. The opportunities identified apply equally to family planning and basic health services, so no separate analysis was made by type of service. For the purposes of this report, basic health services are defined as first level health care including preventive, promotional, and basic curative care.

The assessment team examined both the supply and demand sides of the market. Demand was mainly comprised of employers, cooperatives and insurance companies, and supply was comprised of providers. It proved difficult to categorize all groups into either demand or supply as some, such as employers and insurance companies, both demanded and provided services. As such this section breaks down the major findings by the key groups rather than by supply or demand categories.

As described below, the commercial sector offers key opportunities for providing family planning and basic health services, which can supplement the services currently provided through Ministry of Health and ISSS.

A. EMPLOYERS

The assessment team interviewed representatives of three employer associations and twelve employers. Specific contacts are listed in Table I, "Methodology" Section. The employers were large to mid-sized, with a range of 90 to 3000 employees. The types of industries represented in the sample include textile, financial, services (airlines), processing (sugar), and manufacturing. Due to time limitations, the assessment team did not interview any small employers. Opportunities with small employers should be examined such as organizing them to jointly procure services (pooling).

Of note is the positive reaction the assessment team received from the employers. The team typically spoke with the President or CEO of the company, with a only a few meetings with Directors of Personnel or Human Resources. Their willingness to spend their time discussing issues pertaining to health and family planning and their understanding of the relationship to commercial productivity, demonstrates their strong interest in the area.

1. Current provision of health benefits

All of the employers interviewed are providing some health benefits to their employees in addition to their contribution to ISSS. The type of benefit varies greatly between the employers. At a minimum, employers offer group health insurance to their executive level employees. Some of the employers include spouses and dependents in the coverage, while others offer their employees the option to purchase additional coverage for their families at the group rate. In addition to group insurance, many employers provide lower level employees health services either through company run clinics or through contracts with private providers. As with health insurance, some employers allow spouses and dependents to use the company clinics/contracted providers and others restrict it to employees.

Most of the employers' health benefits only cover curative care. The insurance plans typically cover catastrophic care with a 80/20 split in payment between the insurer and the insured. The clinic services provided are typically basic curative up to the level of minor surgery. Employees that need additional care are referred to the ISSS facilities. Only three of the employers interviewed are actively providing and promoting preventative and family planning services. The services provided include immunization campaigns, peri-natal care, and free family planning commodities. Other employers may provide some health promotion/prevention such as occupational safety, personal hygiene, or a free breakfast and discounted cafeteria. However, these activities are limited in scope.

The employers reported a uniform reason for providing health benefits in addition to their contribution to ISSS --- dissatisfaction with ISSS services. The driving force behind their dissatisfaction is ISSS' inability to provide sufficient services at the primary care level, and the lack of facilities near the worksite. This leads to significant travel time and then long waits at the ISSS facility. In addition, there is blanket 3-day paid leave given to ISSS patients diagnosed with an illness. From the employers' perspective, these factors translate into significant employee absenteeism. Another concern expressed by several employers was the perceived poor quality of the ISSS services, with one employer mentioning sending some of his employees to his own private physician because ISSS did not provide them with adequate services. It is for these reasons that employers find it in their best interest to provide additional health benefits, even though they must pay twice for employee health care -- through the required ISSS payments and their own health benefits. Besides the dissatisfaction with ISSS, employers also mentioned that liberal benefits made their companies more competitive in the labor market and encouraged employee loyalty.

All employers interviewed believe that ISSS needs major reforms. Suggested reforms include separation of the pension and health activities, and contracting

with the private sector. However, few employers believed that any reform efforts would be successful in the short-term. Instead of developing a parallel system to ISSS, several employers are actively negotiating with ISSS to develop services which would better serve their needs. Examples include TACA, who is negotiating to have an ISSS administrator placed at their company clinic. TACA would continue to pay the salaries of the clinic providers. The ISSS administrator would certify prescriptions and lab specimens, and would forward them to an ISSS facility via messenger for processing. Filled prescriptions and lab results would then be sent back to the TACA clinic via return messenger. This system would allow TACA employees to receive all the services on site, limiting employee absenteeism, while relieving ISSS of the burden of supporting the actual providers. Other employers have requested that ISSS open a satellite clinic within their facilities, in a space the employers would provide.

The existence of health benefits of some level at all the employers interviewed offers a clear opportunity to build upon the existing structure. By encouraging employers to expand coverage to include low wage earners and to include basic health and family planning services, the commercial sector's role could be significantly expanded.

2. Interest in providing family planning and basic health services

Almost all employers interviewed understand the importance of providing preventive and family planning services to their employees. They see it as an investment in their labor force leading to lower absenteeism, better performance and higher productivity. For example, one employer reported that none of his employees contracted cholera in a recent epidemic, citing their preventive program as the reason. Employers who have a large number of women employees expressed a particular interest in the provision of family planning services. As one employer reported, 60% of his quality control department was pregnant and would be on maternity leave (three months by law) around the same time. These situations highlight the potential benefits to be gained by employers if they provide preventive and family planning services.

The only resistance encountered was in relation to the provision of family planning services. The few employers who expressed any reservations tied it to the moral and religious beliefs in El Salvador, stating that they did not see it as an employer's role to become involved in a moral issue. Several employers mentioned that family planning has become highly politicized due to the Cairo conference, and warned that any program associated with abortion would receive stiff opposition. One made the suggestion that any promotion be done through personal managers and supervisors who have received the appropriate training, as the workers would have more confidence in them than in outsiders.

The greatest constraint faced by employers in adding preventive and family services to their benefit package is not having access to these services. Most available insurance plans either do not cover these services or only provide limited coverage, and most of the private providers focus on curative services. Several employers have had conversations with ADS concerning the provision of family planning and basic health services, but have not been successful in developing an ongoing relationship with them. ADS did provide family planning and MCH services for one employer in return for 'donations.' However, the relationship ended when ADS reported that the cost of the services was too high to be covered by the donations and the company did not respond accordingly. The employers interviewed would be interested in either a health insurance plan or a group of providers that could provide low priced, basic health and family planning services.

3. Limitations of providing basic health and family planning services through employers

When designing an employer-based program, two potential limitations should be taken into consideration. The first pertains to the limited population that would be covered by employer-based services. Large employers only employ a small proportion of the population in El Salvador. Any employer-based program would only provide coverage to that limited population plus a potential number of employee spouses and dependents. This translates into absolute numbers ranging from 500 to 12,000 per employer. The numbers reached would have to be weighed against the costs of implementing an employer-based program.

The second potential limitation of pursuing an employer-based program in El Salvador is the possible ISSS reform. If ISSS were to undergo drastic reform, and meet the needs of employers, employers' demand for additional health benefits would diminish. Employers are currently willing to pay twice for health coverage of their employees as the ISSS-provided health services are inadequate to meet their needs. However, with successful reform, the need for employers to provide additional coverage for employees to address issues such as absenteeism would lessen. The consensus among employers is that ISSS will not be able to make the necessary reforms to address employers' needs in the foreseeable future. However, the potential of future ISSS reform and how it would effect employer-based services must be taken into consideration when developing an employer-based program.

4. Future options for employer-based services

The potential for expanding employers role in providing basic health and family planning services is considerable, even within the confines of the limitations outlined above. Employers are concerned about health issues, and understand the benefits of preventive and family planning services. Thus, it is not necessary to

conduct cost-benefit analyses in order to convince employers about the benefits of basic health and family planning services. Instead, the focus should be on making these services available at a reasonable price for employers. This would require working with both insurance companies and private providers to develop low cost, well managed services that focus on basic health and family planning. One example would be to develop a managed care model with a group of young physicians, linked with a local insurance company. Specific opportunities for expanding the role of both health insurance companies and private providers in the provision of family planning and basic health services is detailed below.

For those companies that already have a clinic, their services should be expanded to include basic health and family planning. The assessment team did not have the opportunity to visit any of company clinics, so it is difficult to determine the level and type of assistance required. It may be possible to work with the clinics to make their services more efficient and less costly, thereby freeing funds to provide additional services or expand the services to the employees' families. It may also be more cost effective for the employer to contract out for the services rather than provide them directly.

Of the employers interviewed, several offer interesting opportunities which should be explored more thoroughly. Both Sigma and Hilasal provide generous health benefits to their employees and their families, including preventive and family planning services. Their clinics should be assessed to determine whether they could serve as a model for other company based clinics. [will they agree to this or will it be considered a competitive advantage]

Another opportunity lies with Grupo Aristos, a holding company for several other ventures including fast food franchises, and a free zone. Grupo Aristos is run by a young, progressive entrepreneur. Currently no health benefits are provided to blue collar staff, however this entrepreneur strongly believes in enhancing his employee's well-being. He would be interested in options for providing basic health and family planning services. Another benefit of working with this group would be the opportunity to work in a free zone. The free zones employ large numbers of workers most of whom are women, making them logical points of entry for family planning and basic health services.

Finally, Bon Appetit, which is managed under the Costa Rican concept of *solidaridad* offers a third option. In the *solidaridad* system, labor and management work together to direct the policies of the company. They formed an association which manages an employee fund which drawing on both company and employee payments. The association is interested in providing health benefits to members with some of the income generated from the fund, and would be interested in any low cost options that are developed. Several other companies in El Salvador use

the solidarity system, so it offers the potential to develop a model that could be replicated elsewhere.

B. AGRICULTURAL COOPERATIVES

The assessment team met with representatives of the Cooperative League of the U.S.A. (CLUSA), a U.S. PVO, and UCRAPROBEX, a union of coffee cooperatives. Specific contact information is located in Attachment ##. CLUSA assists agricultural cooperatives develop the appropriate management and organizational skills to support the production of non-traditional export products. They are currently working with 52 cooperatives and 3 or 4 associations of cooperatives. CLUSA is an excellent resource because of their extensive experience with the cooperatives. They can provide key insights into individual cooperatives' management capabilities, which would be essential for developing any health programs.

UCRAPROBEX has 67 member coffee cooperatives who grow, process and export coffee. The cooperatives range in size from 90 to 2500 members, with small cooperatives forming between 60 and 70% of UCRAPROBEX's membership. The General Manager estimated that the cooperatives have 14,000 workers forming a total potential beneficiary group of 90,000 when including their family members. UCRAPROBEX offers an existing structure and network which could organize and manage the provision of basic health and family planning services to member cooperatives, whether through health insurance or development of a health system similar to the GUATESALUD model⁸.

The assessment team was not able to visit any individual cooperatives due to time constraints. Further investigation needs to be conducted to determine the level of assistance and the specific options for the development of basic health and family planning programs. Attachment ## contains fact sheets on the cooperatives CLUSA staff thought would be good starting points. UCRAPROBEX could provide additional direction.

1. Current provision of family planning and health services

CLUSA and UCRAPROBEX both stated that several of the larger cooperatives are providing some services to their members and surrounding communities. The services are provided either through cooperative-run clinics or contracts with private providers, and cover first level curative care. In addition to the cooperatives currently providing health services, many others have an existing

⁸ GUATESALUD is a not-for-profit organization that provides health and family planning services to finca workers in Guatemala. By training health promoters to provide the first line of care, GUATESALUD keeps the price of services affordable by the finca workers, allowing them to cover a population of 40,000 on a sustainable basis.

infrastructure upon which to build. Prior to the armed conflict, more cooperatives provided health care to their members. However, the services, which collapsed during the armed conflict, have not been re-established since the peace accords.

CLUSA has actually discouraged some of their cooperatives from continuing to provide health services, because they were subsidizing the services through their production credit. The clients who were receiving the services only paid 1 to 2 colones per visit, and the remainder was paid by the cooperative. CLUSA believes that the clients can afford to pay more for the services, and that higher fees along with better management would allow the health services to be provided on a sustainable basis.

As the assessment team did not have sufficient time to visit any cooperatives, no specifics on the services (such as type, fee schedules, and clinic management) is available. Site visits to several cooperatives should be made to collect the necessary data for planning.

2. Interest in providing family planning and basic health services

CLUSA and UCRAPROBEX are extremely enthusiastic about the potential of developing a sustainable program of delivering basic health and family planning services through the cooperatives. Both described the need to provide preventive and family planning services to the cooperative population, stating that many did not have access to even basic services. Because of the lack of access, health problems are not addressed until they worsen to a critical condition. The person must then be rushed to the nearest hospital to receive high cost care, which frequently could have been prevented if detected and treated in a more timely manner.

Based on the interviews with CLUSA and UCRPROBEX, there is sufficient demand and ability to pay to support the provision of family planning and basic health services on a sustainable basis. Many cooperative members have the discretionary income necessary to pay for basic health services if they were made available. Cooperatives have demonstrated their interest through their attempts to provide some type of services to their members. UCRAPROBEX has also investigated the possibility of purchasing health insurance to provide coverage to their members. However, the currently available plans are too expensive.

As with the employers, the cooperatives are interested in providing the services, they just lack access to low cost family planning and basic health options. Cooperatives offer an already organized demand that could support a low cost health insurance and/or a managed care model of service delivery. Because of the basic health needs of the cooperative population, non-ph.ysicians supervised and

supported by a physician may be an appropriate means for providing the services. This could ensure that the cost can be afforded by cooperative members.

3. Limitations of providing basic health and family planning services through cooperatives

Cooperatives and their members earn their income through the sale of the agricultural products. The market for these products can vary considerably from year to year which is reflected in the amount of income earned. An example of this is the coffee market. Prices for coffee have increased 2 to 3 times in the last year, because much of the Brazilian coffee crop was destroyed through frosts. While this is good for the El Salvadoran coffee growers in the immediate future, coffee prices will eventually drop. For the members, this translates into varying amounts of discretionary income which can be used to purchase health and family planning services. Any program working through the cooperatives would need to develop a mechanism to ensure that services can still be provided even when income levels fall. One option could be developing a fund where money could be saved when incomes are higher and used when incomes are lower.

A limitation for commercial (for-profit) involvement is the marginal nature of the cooperatives. While having some discretionary income, most of the cooperative members still fall into a low socio-economic level. Any program would have to be well managed, in order to keep the prices affordable. While it may generate enough income to be self-sustaining, it may not generate significant profits and, therefore, not be an attractive venture for a commercial firm. It may be more appropriate to provide the services through a not-for-profit rather than a commercial organization.

4. Future options for cooperative-based services

Cooperatives provide the opportunity to reach a large number (90,000 potential beneficiaries through UCRAPROBEX alone) of the underserved rural population. Through the sale of their products, many cooperative members have the ability to pay for low cost family planning and basic health services. Even with the limitations outlined above, this is an attractive option for expanding the private sector's role in delivering basic health and family planning services.

Further meetings should be held with UCRPROBEX to discuss options for increasing the access of member cooperatives to family planning and basic health services. They are very interested in participating in the development of a program directed toward cooperatives. UCRAPROBEX offers the advantage of a pre-existing organization which encompasses 67 individual cooperatives.

One potential option is linking them with MEDICARD (described below). MEDICARD, who is willing to provide coverage for low income earners, is interested in meeting with UCRPROBEX to introduce their services. Further examination is necessary before it can be determined whether MEDICARD is appropriate for the cooperatives. MEDICARD would need to develop a means to control utilization. As MEDICARD works similar to a credit card, there is the risk of overutilization. By restricting the services covered to family planning and basic health, utilization may somewhat limited. Another potential issue is that MEDICARD is only a payment mechanism, not a provider of services. Due to their rural nature, some of the cooperatives may not have access to private clinics or providers who would accept payment with MEDICARD.

Another option to examine is developing a model similar to GUATESALUD. GUATESALUD provides basic health and family planning services to finca workers and the surrounding community in Guatemala. GUATESALUD trains health promoters to provide the first line of care. The promoters are supervised and supported by physicians to ensure that the quality of care remains high. By using the promoters, the cost of the care is made affordable for the finca workers. They also receive a discount on the services they receive, if they referred to a physician by a health promoter rather than going directly to the physician. The finca owners contribute by providing clinic space and paying for medications. In the case of the cooperatives, this role could be filled directly by the cooperative.

VI. EL SALVADOR'S ECONOMY :AN OVERVIEW OF THE COMMERCIAL SECTOR AND BASIC HEALTH AND FAMILY PLANNING ACTIVITIES

A. BUSINESS CLIMATE

The country's economy is experiencing a sustained and accelerated growth since the signing of the "Peace Agreements" in early 1993. These agreements led to the end of the declared civil conflict, with regional and international overtones, that lasted over a decade. Confidence has grown on the part of the productive and commercial forces regarding the seriousness of the agreements. This confidence has been reinforced by the commitment between the parties in conflict (the government and the "Frente del Movimiento de Liberacion Nacional (FMLN) to collaborate. The FMLN is now a legitimate political party. Additionally, conditions favorable to an open market and free competition for local and imported goods are being promoted by the government. All this has generated an intensive activity in identifiable industries and economic sectors.

Another factor contributing to the current economic "boom" period is an unusually high degree of liquidity both in the banking system and the population. Higher prices in coffee and other exports, international support concentrated in development activities, and a massive influx of dollars (estimated between \$800 to \$1,200 Million per year) that Salvadoran refugees send from the US to relatives who principally comprise the low income population.

Among the most active sectors are housing/commercial construction and real estate, due to the deficit/shortfall resulting after years of restriction and availability of credit; commerce on imported goods which pay moderate duties; restaurants, leisure and entertainment due to increases of discretionary income in the population.

Inflation is moderate (reported 12 percent by Central Bank) and projected growth in the next years is five percent of the Gross Domestic Product (GDP) per annum or higher. However, the industrial sector and production of export goods, is not expanding proportionately, due to an intense competition from imported goods and lack of expanded capacity of existing facilities. This formula for growth will not be sustained in the medium term because it is based on short term factors. Coffee prices will eventually drop, international help will decline, and the condition of the Salvadoran refugees may change in different ways (since the conflict is over a condition of "refugee" no longer applies), some may return voluntarily and others may be deported.

The Commercial Sector, or "Sector Empresarial", even though participating in the on-going economic recovery, is fully aware of the situation described above (which summarizes the opinions gathered in this assessment). This sector recognizes that

a true restructuring of the national strategy in social, legal and economic terms is required to provide the climate for sustainable growth.

B. LEGAL ISSUES AND CONSIDERATIONS

The team identified several economic activities and industries that are experimenting with changes in the laws that regulate their operations. These changes will affect the rules of the game in these particular businesses, and may or may not, change the potential for commercial sector participation in the provision of basic health and family planning services.

1. The law that regulates the Salvadoran Institute of Social Security (ISSS) is currently under revision. The core idea is to foster conditions that will facilitate a more active participation of the "Sector Empresarial" in policy making and direction of the institution. Also, as a result of a local exposure to Chilean experiences, the revised law would allow structural changes, such as the separation between the management of pension funds and health services, traditionally under the same governmental management.

2. The Central Bank has just split its operations into two separate functions. As Central Bank, it will (1) concentrate on monetary policies and regulations, and (2) function as the ultimate financing resource to stabilize the national financial system. A new entity has been created, "Banco Multisectorial de Inversiones" (BMI). This will be the source of financing for medium-long term investments to the private and public sectors, acting as a second instance resource through the commercial banking system. BMI has taken responsibility for the portfolio of all the unilateral, bilateral and multilateral financing contracted by the country. Its operational targets and procedures have yet to be defined, but it will include guarantee funds that will be available to final borrowers when the lack of collateral of the loans may require it. Among other interests, BMI will facilitate the financing of business ventures in the health sector.

3. The insurance industry has been operating during the last few years without a defined law. Traditionally, the industry had been regulated by governmental decrees following criteria from the government officers responsible for the supervision of this industry. These practices were discontinued and in the last few years, the industry has been working practically without any restriction; virtually under a total mercantile basis. A law is being developed but the process is moving slowly and in the short term this lack of regulation (or self-regulation only) will prevail in this industry.

4. A new "Family Code" has been approved. This will provide more equal conditions and rights to women and men in the family nucleus. Children will also have more independence and will be considered as adult upon reaching 18 years of

age instead of 21. Judges of Family will be established to administer justice for this code. Lawyers are studying this new law as to identify its social and economic implications.

C. SPECIFIC FAMILY PLANNING LEGAL AND REGULATORY ISSUES

As described above, the commercial sector in El Salvador plays a relatively small role in provision of family planning services. This circumstance, coupled with our finding of a large potential for switching middle- and high-income health consumers from subsidized to unsubsidized services, points toward the importance of examining how the country's legal and regulatory framework may influence current conditions in the health market. The analysis that follows looks at whether existing laws and regulations inhibit or encourage the commercial provision of family planning services.

To organize this section, we use four groupings suggested by Kenney (1993):

1. Regulations that Constrain Contraceptive Options.
2. Tax and Import Policies.
3. Advertising and Promotion Regulations.
4. Other Regulations Affecting the Commercial Sector.

1. Regulations that Constrain Contraceptive Options

a. Restrictions on Specific Methods

- Prohibitions on provision of certain methods

No methods are currently prohibited. Abortion, which is not considered a family planning method, is illegal in El Salvador. Norplant implants are in trial stage.

- Restrictions on who may receive a method and under what circumstances

See Table II

Table II Restrictions on Who may Receive a Method and Under What Circumstances^{9, 10}

Method	Restrictions
Female Sterilization	MSPAS norms limit sterilization to women 30 or older with at least one child; 25-29 with two or more children; of any age with 3 or more children ^a . No spousal permission is required ^b . ISSS norms do not involve age or parity. No spousal permission is required ^b .
Oral Contraceptive	No restrictions contained in MSPAS norms.
Injection	No restrictions contained in MSPAS norms.
Condom	No restrictions contained in MSPAS norms.
IUD	Medical restrictions only in MSPAS norms.
Vasectomy	No restrictions contained in MSPAS norms.
Norplant	
Vaginal Tablets	No restrictions contained in MSPAS norms.
Rhythm/Billings	No restrictions contained in MSPAS norms.

b. Restrictions on Service Delivery and Distribution

- Prescription requirements

By law, pharmacies can only provide drugs to a customer who presents a doctor's prescription. In practice, as in many other Latin American countries, prescription drugs--including contraceptives--are widely available in pharmacies without a prescription. Condoms and vaginal tablets are available over-the-counter without a prescription.

- Regulations on sale, distribution, or delivery of services (See Table III)

⁹ MSPAS, Direccion General de Salud, Normas Integradas de la Atencion Materno Infantil, 1990

¹⁰ Lininger, Charles A., ANJAL Family Planning Report. Draft, 23 Feb, 1994.

Table III Regulation on Sale, Distribution, or Delivery of Family Planning Methods¹¹

Method	Restrictions
Female Sterilization	Only physician may provide ^a .
Oral Contraceptive	In clinical setting, all levels of health worker can provide orals, including community health agents ^a . In commercial sector, can only be sold in pharmacies.
Injection	In clinical setting, can be provided by all providers except community health workers ^a . In commercial sector, can only be sold in pharmacies.
Condom	All levels of health workers can provide ^a . Can be sold without prescription in nonpharmacy commercial setting (store, motel, etc.)
IUD	Can be inserted by physician, nurse, or maternal-child technologist ^a .
Vasectomy	Only physician may provide ^a .
Norplant	Not clear
Vaginal Tablets	All levels of health workers can provide ^a . Can be sold without prescription in nonpharmacy commercial setting (store, motel, etc.)
Rhythm/Billings	No restrictions.

c. Registration, Licensing, and Certification Policies

- Approval and registration of contraceptive products, formulations, or packaging

No special regulations exist for the approval, registration, formulation, or packaging of contraceptive products.

¹¹ MSPAS, Direccion General de Salud, "Normas Integradas de la Atencion Materno-Infantil, 1990.

- Certification of family planning providers and clinics

Quality oversight in the certification of family planning providers and clinics by regulating authorities is minimal (see Quality Oversight discussion in section on Individual Providers).

c. Limitations on Private Practice

- Barring private practice

Few restrictions exist for certified physicians to set up private practice (see section on Individual Providers for more detail).

- Who can practice and where

Physicians can locate their practice anywhere, once they have completed their year of post-graduate social service. Nurses and other nonphysician health professionals are barred from private practice.

2. Tax and Import Policies

a. Tax Policies

- Sales taxes/value added taxes

Condoms and vaginal tablets are subject to sales taxes (IVA). Prescription medicines are not subject to sales tax.

b. Import Policies

- Import tariffs

Importers pay a 5% tariff on contraceptives, the same as with other medicines. Condoms are considered a rubber product, therefore a 10% value-added tax is charged on their sale. As a result of low tariffs and a vigorous local drug manufacturing industry, institutions in El Salvador can purchase drugs at prices which are reasonable relative to international standards. The percent of the average international price paid for a group of essential medicines was 114% in the MSPAS, 111% in the ISSS, and 99% in ADS¹².

¹² ANSAL, *Administración de Productos Farmacéuticos*, p. 10.

- Import quotas

Do not exist to our knowledge.

- Exchange Controls

Not a factor to our knowledge. The colon is considered by some to overvalued, a circumstance which favors imported pharmaceuticals over those produced locally.

3. Advertising and Promotion Regulations

- On prescription drugs

Advertising for any prescription medicine is prohibited.

- On family planning products

The general ban on prescription drug advertising extends to family planning products. Condoms and vaginal tablets are exempt from this ban. General advertising on the benefits of family planning is allowed, without mention of specific brand names.

- On use of point of purchase materials or mass media

Point of purchase promotional materials are allowed. ADS has designed and used a set of these materials for its social marketing and commercial products, but they are not widely used.

4. Other Regulations Affecting the Commercial Sector

- Patent and trademark laws can restrict local manufacture of medicines and contraceptive methods, except under specific license from the owner

This restricts the local production of "generic" or local brand name drugs

- Discouragement of foreign investment

Government policy encourages foreign investment

- Statutory price controls

Pharmacies are legally allowed to add a maximum of 25% above cost of drug. In practice, this regulation is rarely enforced.

Summary of Findings

A positive legal and regulatory climate exists in El Salvador for the commercial provision of family planning services. There are few restrictions on specific methods, who may receive a method, and provision of services. An important impediment to commercial service delivery is the prohibition on private practice by nonphysicians. Of note is the fact that, within a clinic or hospital, nurses can provide all methods, except for sterilization. Another barrier is the prohibition on advertising for prescription contraception, condoms are an exception. As noted, this ban applies to all medicines equally.

VII. PRODUCTIVITY: THE MOTIVATION FOR THE COMMERCIAL SECTOR TO PARTICIPATE IN THE RESTRUCTURING OF THE NATIONAL HEALTH SYSTEM

A. BASIC ISSUES

Virtually all members of the commercial sector interviewed shared the opinion that good health status for their employees and family members plays a key role in worker productivity and hence profitability and company growth. They also realized that the current systems in place tend to mitigate against productivity. Consequently, some of these employers have put parallel systems in place to enhance productivity. Our key findings are:

1. The importance of a healthy labor force as a key factor for the productivity in the commercial sector is fully understood by representatives, entrepreneurs, managers and technicians. Large employers recognize health, and to a certain extent family planning services, as a competitive advantage in their business strategies. In many instances, preventive medicine, basic health care and family planning are considered as important as curative services, not only to the employees but also to their dependents.

2. A consensus exists among all people interviewed in the sector, that the structures, mechanisms, procedures and funding of the ISSS and "Servicio Integrado de Salud" in the Ministry of Health, are inefficient and work in detriment to both employers and employees.

3. To overcome these deficiencies, employers and employees incur additional and even duplicate costs to procure the services through private sector mechanisms. For example:

- A large industrial plant has setup a fully equipped clinic and an intensive program of preventive care, including credit to employees for medicines bought in participating pharmacies.
- A bank has a plan that reimburses employees up to 15,000 colones a year in medical expenses.
- A progressive employer in the packaging industry provides health care services that includes provision of generic medicines bought and conveniently packaged in individual doses by the company.

Companies that cannot afford to cover these duplicate costs have to contend with less motivated workers, absenteeism, turnover, and therefore low productivity.

B. COMMERCIAL SECTOR RELATIONS WITH THE ISSS

The motivation to participate and work out alternatives to a better, efficient service is virtually unanimous among those interviewed. Some are positive about the possibilities while others are skeptical about the real opportunities to make changes in the existing system particularly in the ISSS. Many representatives from the commercial sector have participated in the direction and supervision of the ISSS with minimal results and high frustration. These individuals emphasize the lack of motivation, objectivity, and professionalism in the decision-making process and management of the core operations and service provision.

The financial capacity and well equipped facilities in the ISSS are inconsistent with the low quality service provided to the average user.¹³ Those interviewed believe that the unit cost of medical treatment in hospital facilities in the ISSS is significantly higher than the potential price for the same service in a private clinic. For users, the worst bottlenecks are at the entry process for the ambulatory and emergency services, laboratory and pharmaceutical services.

The most difficult constraint to potentially viable solutions is the mercantile way of doing business with the ISSS of certain physicians related to the institution. Stories abound about doctors receiving full time paychecks who barely work two hours a day, or doctors who prescribe permits for three-day disability ("notas de incapacidad") too liberally, further hampering business and industrial productivity.

Employers report that most permits of disability given to their employees are for three days, the period that the salary of the employee incapacitated is paid by the employer. ISSS payments for incapacity (similar to workman's compensation) activate after three days if disability continues.

The "Servicio Integrado de Salud", the branch of the MOH that provides services to the population who does not belong to the ISSS (and cannot afford private services) is also reported to be inefficient. The commercial sector has no direct relation with this population and the effects of such an inefficiency are not in direct relationship to the conduct of normal business activities, except with respect to casual laborers and seasonal agricultural workers. The participation of the commercial sector in this area is only in the provision of services and supplies to the MOH system.

¹³ This sentiment was expressed by virtually every interviewee in the study.

C. POTENTIAL AREAS OF PARTICIPATION FOR THE COMMERCIAL SECTOR.

As a result of the analysis, the team found that there are three principal ways in which the commercial sector could participate more actively and directly in basic health care and family planning activities. Some opportunities could be developed more easily than others that require major legal and structural changes in the existing government institutions.

1) Direction, management and supervision of the provision of the services to the labor force and their dependents. Large employers consider that a combination of

(a) a portion of the contributions by the companies and workers to the ISSS,

(b) the costs for additional health services and health insurance covered by the companies, and

(c) the funds spent by employees in private doctors and medicines, could allow better or more extended services under a well coordinated and managed plan between the companies and the ISSS. Smaller companies may pool together to achieve the economies of scale that large companies achieve individually.

2) Provision of financial, management, logistic, maintenance and procurement services to the ISSS and "Servicio Integrado de Salud" and to the medical practice. There is a vast array of services that the commercial sector can provide efficiently and at lower costs instead of the current practices of in-house provision. This concept can be applied to small vendors and service providers, to large financing and technical services. People in the health sector interviewed agree that there is a substantial amount of under utilized health facilities, and medical equipment, whether in the public sector or private practice, that could be put to work more efficiently if organized by function instead of around self-supported units.

These services run the gamut from service use charges for such high technology equipment such as MRIs (Magnetic Resonance Imaging) to increase utilization and decrease fees, to more modest service provision: laundry, security, meal services, and so forth. Contracting of such services could result in reduced overhead to both public and private sector activities as well as stimulation to the commercial sector.

3) Provision of businesslike strategic and organizational techniques for the realignment of both health government institutions. The "Sector Empresarial" has much to offer in terms of system analysis, strategic and business planning,

organizational design and development, control and accountability mechanisms, technical supervision, etc. This could boost the planning and implementing of the intended realignment, and the "Sector Empresarial" is highly motivated to make this type of contribution. Nevertheless, it is important to note that this participation can only be sought under commercial agreements with profit potential to the participants.

The "Sector Empresarial" is accustomed to work in a highly competitive environment that emphasizes productivity. Competition is the mechanism in the commercial sector that promotes efficiency in the use of capital, financial, technical and human resources. Companies strive for competitive pricing and quality products/services to develop, maintain and expand market share. Since governmental institutions neither receive pressure from competition nor have incentives to make efficient use of resources, cost containment is difficult to achieve. Therefore, if health service provision is opened to the commercial sector and competition is promoted (based on quality, timely delivery and completion of services), the overall results will be beneficial for the government and the population.

D. OPPORTUNITIES IDENTIFIED IN SPECIFIC ACTIVITIES WITHIN THE COMMERCIAL SECTOR

Business people normally express their views and perceptions with tangible facts and specific issues, instead of sectorial or programmatic concepts. This pragmatic attitude was the norm during the interviewing process. The team took advantage of this to collect information about interests, ideas and on-going initiatives, that can be transformed into specific opportunities to connect business managers, investors and entrepreneurs, with health institutions and service providers. These connections could be mutually beneficial while providing better services in health and family planning services to wider population sectors.

1) Financial opportunities: The above normal liquidity experienced in the short term by the commercial banks makes them more willing to take higher risks in the lending operation.

- A commercial bank agreed to finance the acquisition of a hospital facility by the Asociacion Demografica Salvadorena (ADS).
- The Hospital de Diagnostico has been offered unsolicited financing by financial institutions.
- The Hospital Central is from a bank standpoint a better risk. This hospital has a very desirable formula where a manager and a doctor have joined expertise to run the hospital facility.

- Nevertheless, banks credit analysis remains focused on business viability and managerial competence. A board member in a bank mentioned a discussion over a loan request introduced by a successful hospital to buy additional high-tech equipment. Financial capacity and high respect for the medical competence existed. And yet, the interest in the new equipment was for better service, without regard to the hospital's under-utilization rates or cost benefit analysis. Analysts concluded that additional investments in expensive equipment could push the hospital to raise prices and reduce its market share.

This banking approach to the financing of medical ventures has to be viewed objectively, since it in no way implies disrespect or impugns the qualifications of the medical profession. It is important to look deeper into the commercial banking sector to find other experiences and motivations that could allow a fluid communication and business connection with health care activities. As decentralization or privatization of MOH's facilities and services proceeds, investors and management technicians would be interested in doing business with MOH. Commercial banks can play a role of paramount importance in the process.

BMI will open additional opportunities for long term investment and guarantee funds in the health area, but the commercial banks will do the credit analysis. The local stock exchange was not investigated. This could be an alternative in the long term, when the health sector might project a sound business image. Stock exchanges only deal with healthy companies based on highly rigorous structural and financial analyses of the business.

Restrictions to financial opportunities are principally seen in the limited business and commercial experience existing in private health services. Exposure and training in business management and management of health activities and organization will contribute greatly to potentiate a consummation of these opportunities. Business plans need to be developed prior to any attempt to apply for or negotiate a loan from a bank. Financial viability to pay commercial interest rates and principal as a result of the operational cash flow must be demonstrable. The interest rate would be determined by the credit committee of the bank (currently between 14 and 22 percent) depending on the level of the qualification of risk in each particular case by the bank.

2) Insurance opportunities: Potential linkages between health services and commercial insurers should be studied at length with coordinated participation of both sides. The international trend in health security is moving in this direction, since the financial conditions intrinsic in the securing of these services are typical of the conditions that give existence and life to the insurance business.

The desirability of larger participation of commercial insurers is based on expectations of reasonable improvements in cost containment and quality of service per beneficiary. Insurers have experience in cash/financial management and access to catastrophic protection through international reinsurers. However, possibilities for a rapid expansion of health coverage in the country seems very low in the short term.

In the opinion of a conservative insurer, ways and means traditionally used to procure-provide these health services in the country disallow the possibility for a wide connection between both activities. The portion of population with enough resources to pay for private insurance is very small, as it is the portion who belongs to organizations with economic power to pay for group insurance (i.e. companies, cooperatives). A preventive health care culture is still to be introduced among the vast majority of Salvadorans, which also is in detriment of the introduction of health insurance.

Nevertheless, a few insurers (Medicard, PALIC) are taking the initiative to make inroads into population strata of lower levels of income. They are taking the risk to offer types of health insurance in the lower levels of the current market expecting to attract enough volume to spread the risk and generate a prudent return on the investment at risk.

These experiences suggest that advice from commercial consultants in insurance and reinsurance would be beneficial to analyze alternatives for the realignment of the health services. This may open opportunities to financially secure health services to larger sectors of population and significant savings to MOH and ISSS. Such commercial relationships should be established cautiously and protected with strict regulations as to promote balanced benefits to both sides.

3) Pharmaceutical opportunities: The local pharmaceutical industry is considered the most developed in Central America. This represents a national strength that can support the desired improvement/expansion of basic health services.

Strict quality control standards and commercial incentives, like larger purchase orders from institutions, could induce the expansion/availability of low cost medicines (those no longer protected under patent laws internationally) produced and packaged under local brands. The standards should be extensive to the quality/purity of the raw materials imported. Packaging materials and products bought for pharmaceutical use should be exempt of IVA, as package components of imported medicines are also exempt.

As pharmaceutical companies further develop and their local and regional markets expand, competition and economies of scale would result in better quality, broader

product variety and lower cost of supply to MOH and ISSS as well as the commercial sector.

Nevertheless, at least with respect to contraceptives, the pharmaceutical companies and associations interviewed indicated that they could not compete successfully with the ADS. One company manufactures one month injectables, and only one company imports condoms.

4) Large employers: Companies with sizable labor force (e.i. TACA, Hilasal, Compania Azucarera Salvadorena, Sigma, La Constancia) have invested time and resources to provide their employees with more efficient and effective services than ISSS, despite the employer-employee contributions to the institution. Employers have recognized the importance of a healthy labor force as a competitive factor and are willing to pay extra for it.

The traditional managerial efficiency in the commercial sector has resulted in imaginative and no-nonsense procedures in the delivery of these services. The results are, effective mechanisms that satisfy the needs in health services that the relationship employee-employer requires.

A mix of alternatives: in-house medical facility/capacity, referral to private physicians, private insurance, purchase of generic medicines in bulk, are among the most frequent alternatives reported by the interviewees. Companies have defined their means according to the best options to each one's particular conditions. Location, gender, activity, are some of the conditions normally included in the formula to create a suitable medical plan.

These company managers (particularly personnel managers) have improved their understanding of the importance of health care for their companies. The pattern is similar in all the commercial activities contacted: industrial/commerce, free zones, agriculture, food, automobile, oil byproducts. Each company has come up with its plan independently and finance/manage without any connections with other companies.

An aggregation of the financial and human resources involved in these services plus the employer-employee contributions to ISSS are considerably high. These resources can finance more extended services to the employees and their dependents. The use of these resources can be planned and managed by employers, employees and ISSS proportionately to the investment made. Each partner can provide the expertise in their particular domains and supervise the component of the service that more affects their particular interest.

Pilot tests with some of these large companies would help to gain experience and learn about the best ways to expand these experiences to other companies. Some

initiatives are already underway. TACA and Hilasal reported that they are negotiating ISSS direct participation in their in-house health programs with different formulas and ISSS is responding positively.

These initiatives should be followed and evaluated. Important clues could be identified which could be useful in the design of viable mechanisms that can be systematized and extend to other large companies with similar interests. Representative associations like National Association of the Private Enterprise (ANEP), Association of Salvadoran Industrialists (ASI), and Chamber of Commerce, would be very cooperative and could pick up the leadership after a project initiative might show to them potential benefits for their members.

5) Mid-sized companies: Companies in this category (Shell, Banco Salvadoreño, CIDEMA, Ommiplastics) reported the same interest and motivation to provide the health services that their workers need in similar terms as larger employers did. However, their economic potential does not allow them commensurate levels of involvement. Their managerial and financial experience restrains them from a comprehensive provision of services paid 100 percent by the companies, and they provide as much as possible without jeopardizing their financial stability.

Some mid-sized employers indicated that perhaps the ideal solution would be a coordination of several companies in the same neighborhood to pool resources and negotiation power to facilitate similar solutions like the ones identified as suitable to large employers.

6) Production cooperatives: Through an American PVO (CLUSA), the team learned about a group of 67 production cooperatives engaged in export crops, who are very well organized in a union type of organization (UCRAPROBEX). The union represents a population base of 14,000 members, and several of the coop members already have reached financial sustainability.

The manager of the union was interviewed. He reported that one of his major concerns is the need of basic health care services among the member farmers and their dependents. A few of these coops have contributed to the operation of clinics in their locations, but these were later closed because the coops did not have experience or funding to sustain the clinics' operations. Still, the possibility is to assist in developing a mechanism to reinstall and expand these medical services, with financial contributions by the coops and the union. A possibility is an insurance policy with coverage limited to basic and preventive care, with UCRAPROBEX acting as underwriter.

7) Informal economy: The assessment could not include interviews with informal employers (those who do not have legal status). These companies do not register with ISSS. Owners and employees fill their needs for medical services in pharmacies, private clinics and in MOH hospital facilities for emergencies and surgical services.

Nevertheless, ASI reported that this sector in the Salvadoran economy is growing at a considerable pace. Those who grow with financial success find themselves impelled to legalize the status of their companies so as to have access to banks (which means larger loans and lower interest rates) and better business relations to boost their growth. This group represents an important target for the expansion of private medical services. But their current non-registered legal status makes them difficult to identify and evaluate, except for those who receive credit or training from institutions and NGOs.

Project resources could be dedicated to make contact with these institutions and evaluate all relevant information available, so as to identify subsectors (percentiles) in the group with payment capacity at different levels of coverage (from full to zero payment) for medical services. These conclusions would facilitate the design of MOH programs to provide them with decentralized/private medical services under which the beneficiaries would assume a fair share of the financial burden and concomitant benefits.

In the final analysis, it is in the commercial sector's best interest to encourage and participate in the maintenance of a healthy and productive work force. As mentioned in various parts of this paper, the understanding of this relationship is universal among those interviewed. To maintain productivity, some are already providing parallel systems to ISSS. Others would, given the resources.

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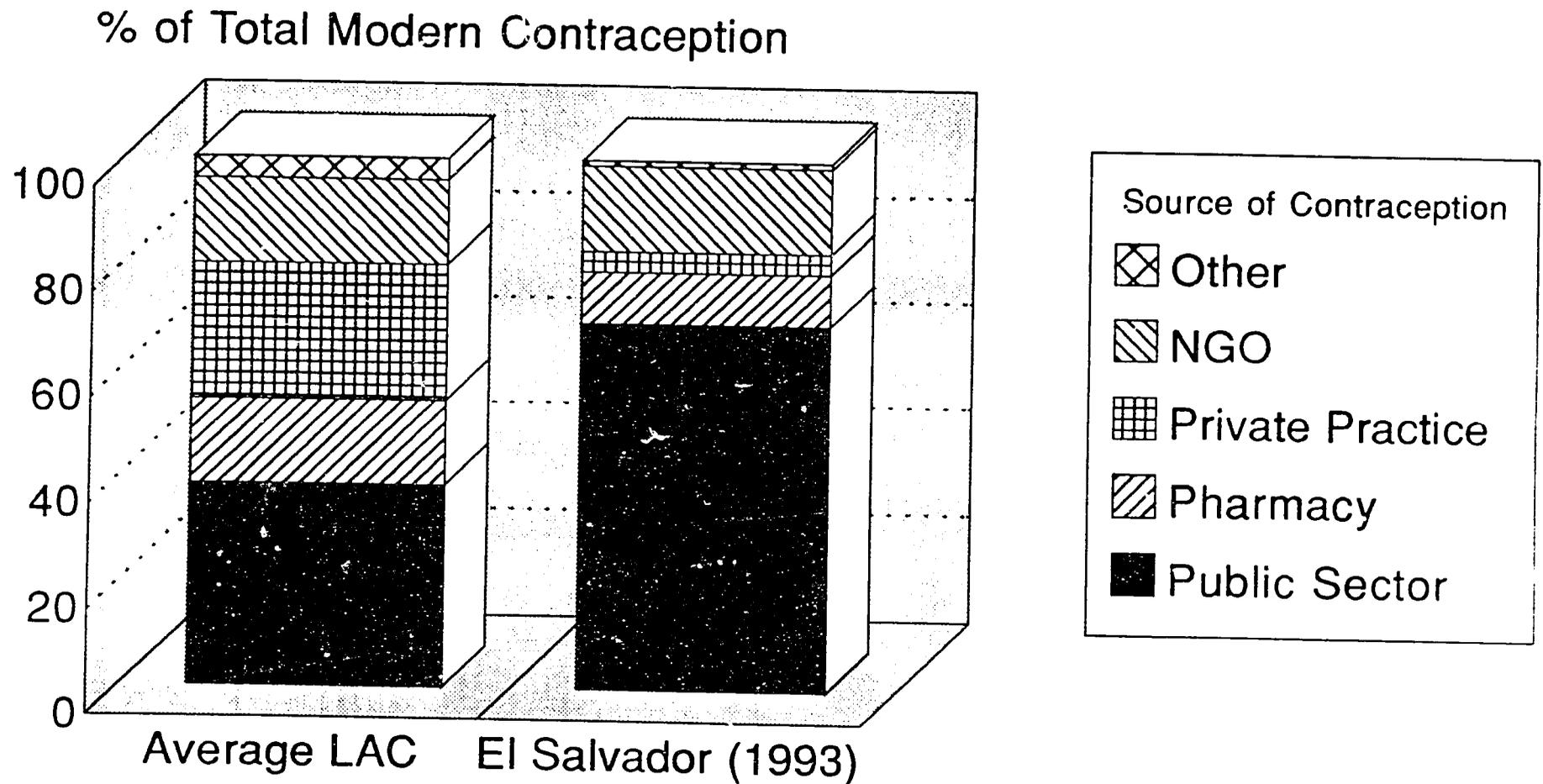
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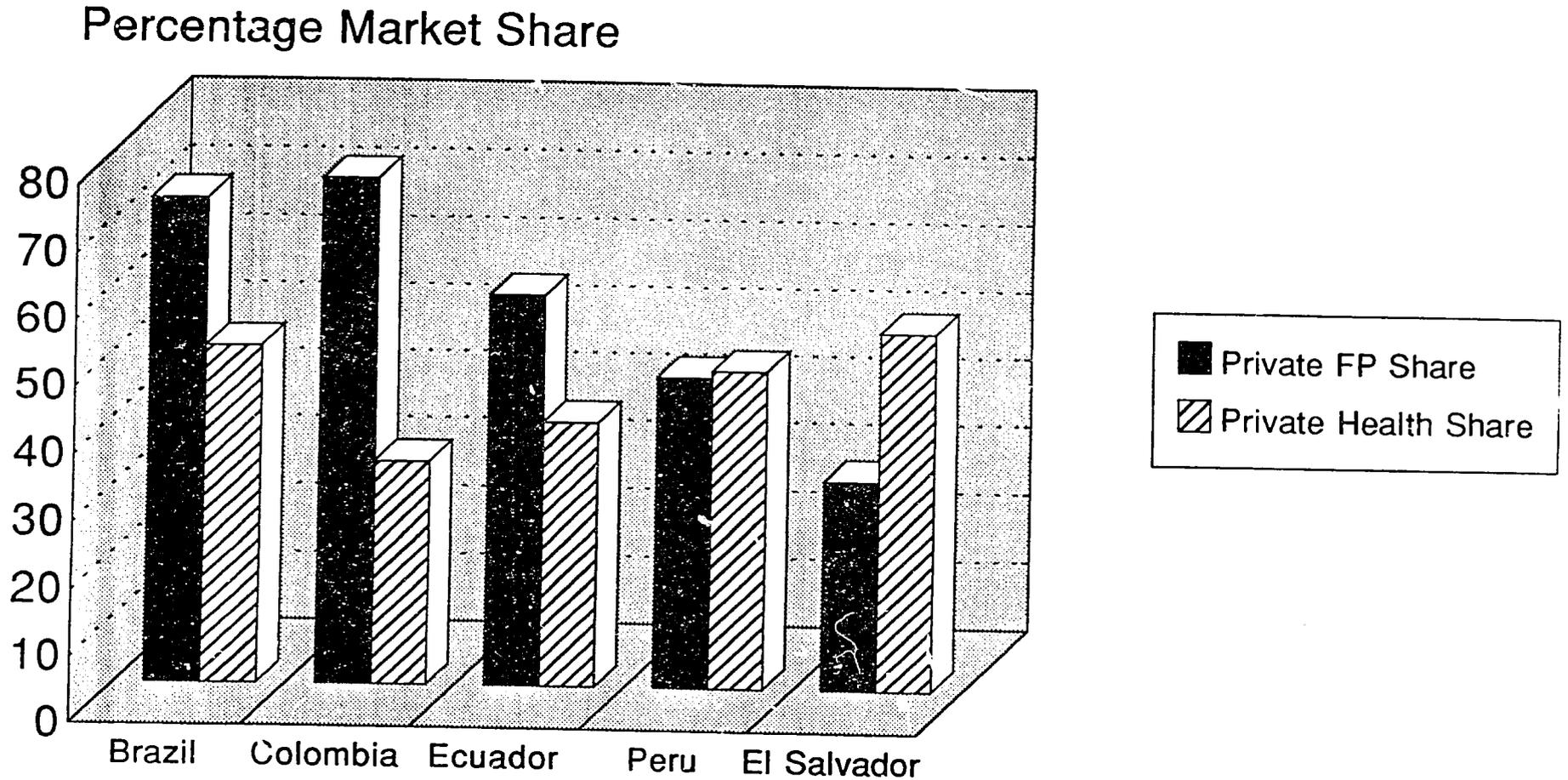
Source of Modern Contraception

As a Percentage of Overall Modern Method Use
 Data from Various LAC Countries and El Salvador



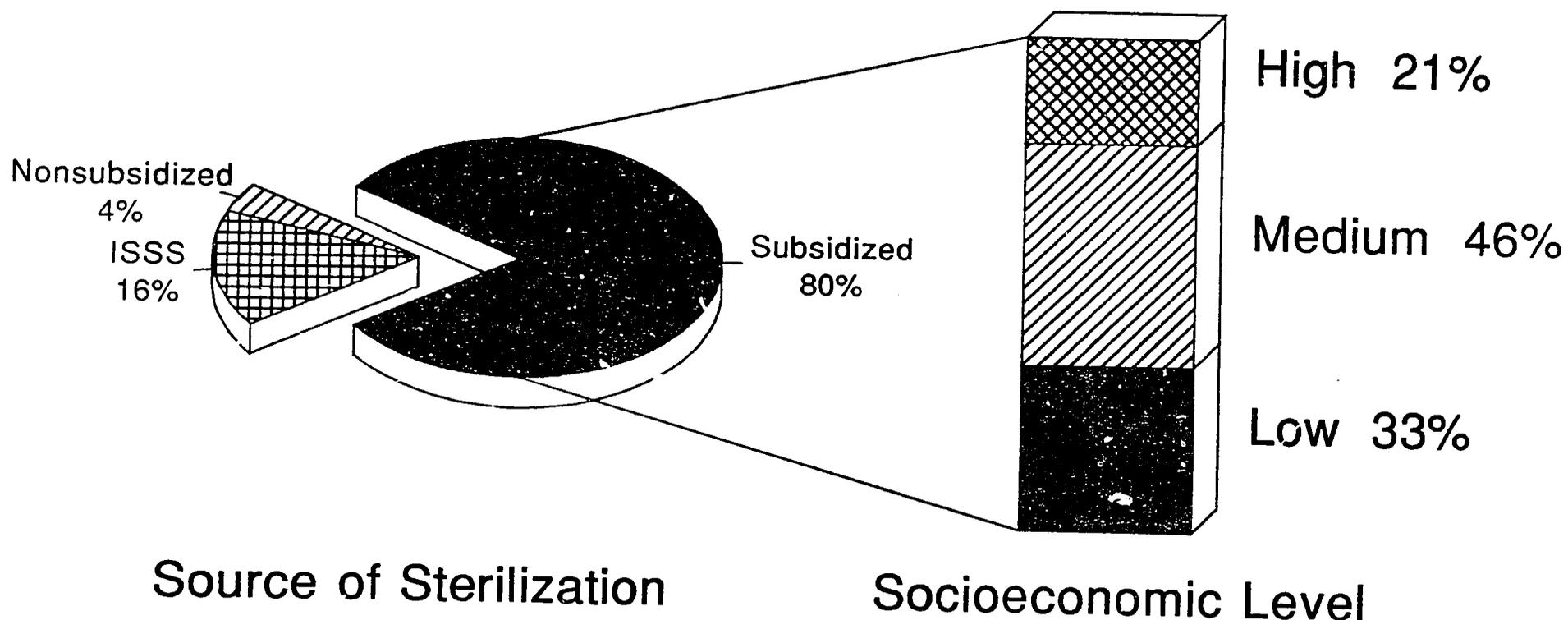
Source: Foreit, 1992 and authors' calculations from FESAL-93 data.

Private Sector Coverage of Family Planning vs. Private Share of Health Care Expenditure Comparison of Five LAC Countries, Including El Salvador



Sources: Foreit, 1992, p. 9; Calculation from FESAL-93 Data; ANSAL, Informe Final, p. 58; Lininger, p. 1.

Source of Female Sterilization & Socioeconomic Level of Subsidized Clients El Salvador, 1993

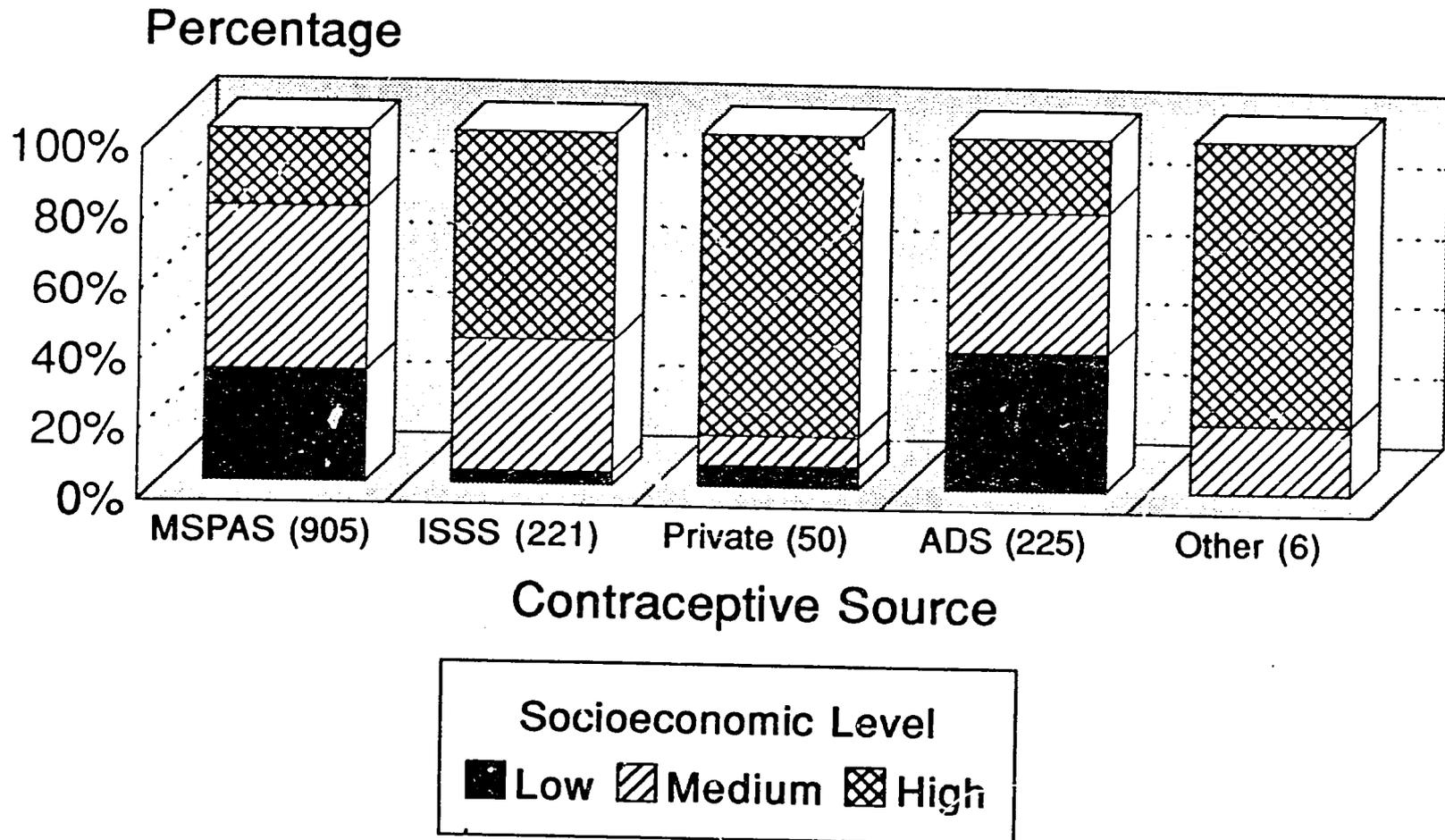


Source: FESAL-93, p. 86 and further analysis of FESAL-93 data.
Subsidized includes MSPAS and ADS clients.

Source of Female Sterilization

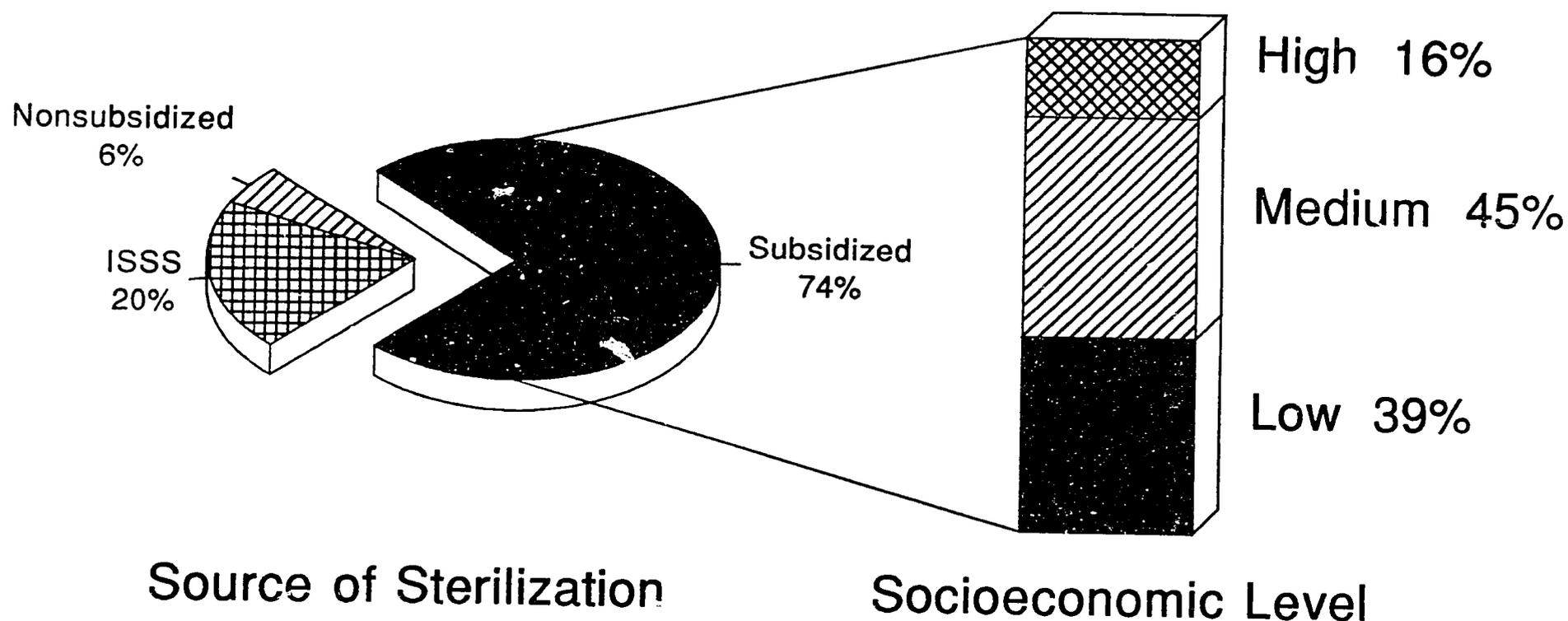
By Socioeconomic Level

El Salvador, 1993



Source: Further analysis of FESAL-93 data.
 Weighted Number of Cases in Parentheses

Source of Female Sterilization & Socioeconomic Level of Subsidized Clients El Salvador (Women Sterilized Between 1988-1993)

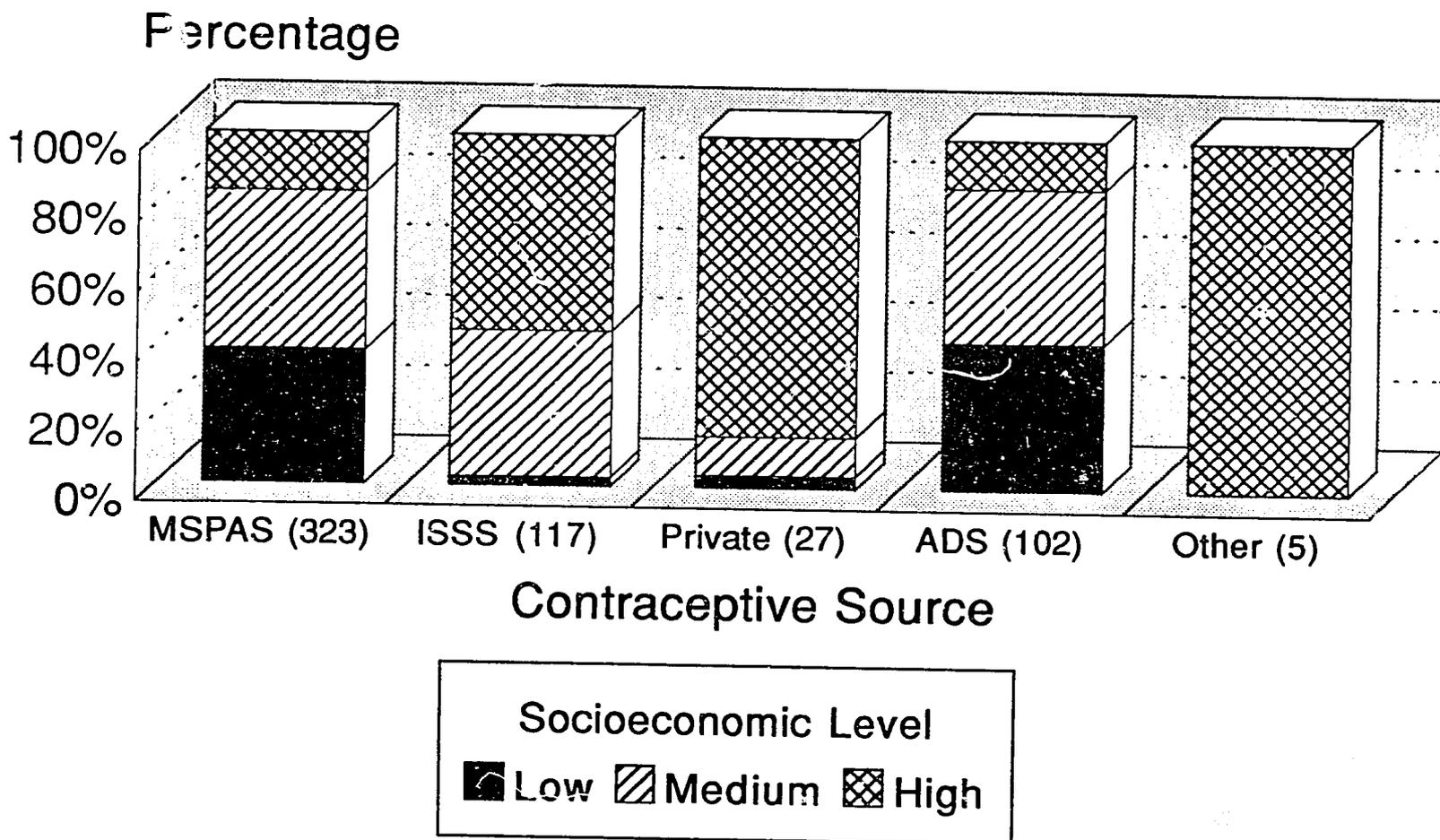


Source: FESAL-93, p. 86 and further analysis of FESAL-93 data.
Subsidized includes MSPAS and ADS clients.

Source of Female Sterilization

By Socioeconomic Level

El Salvador (Women Sterilized between 1988-1993)

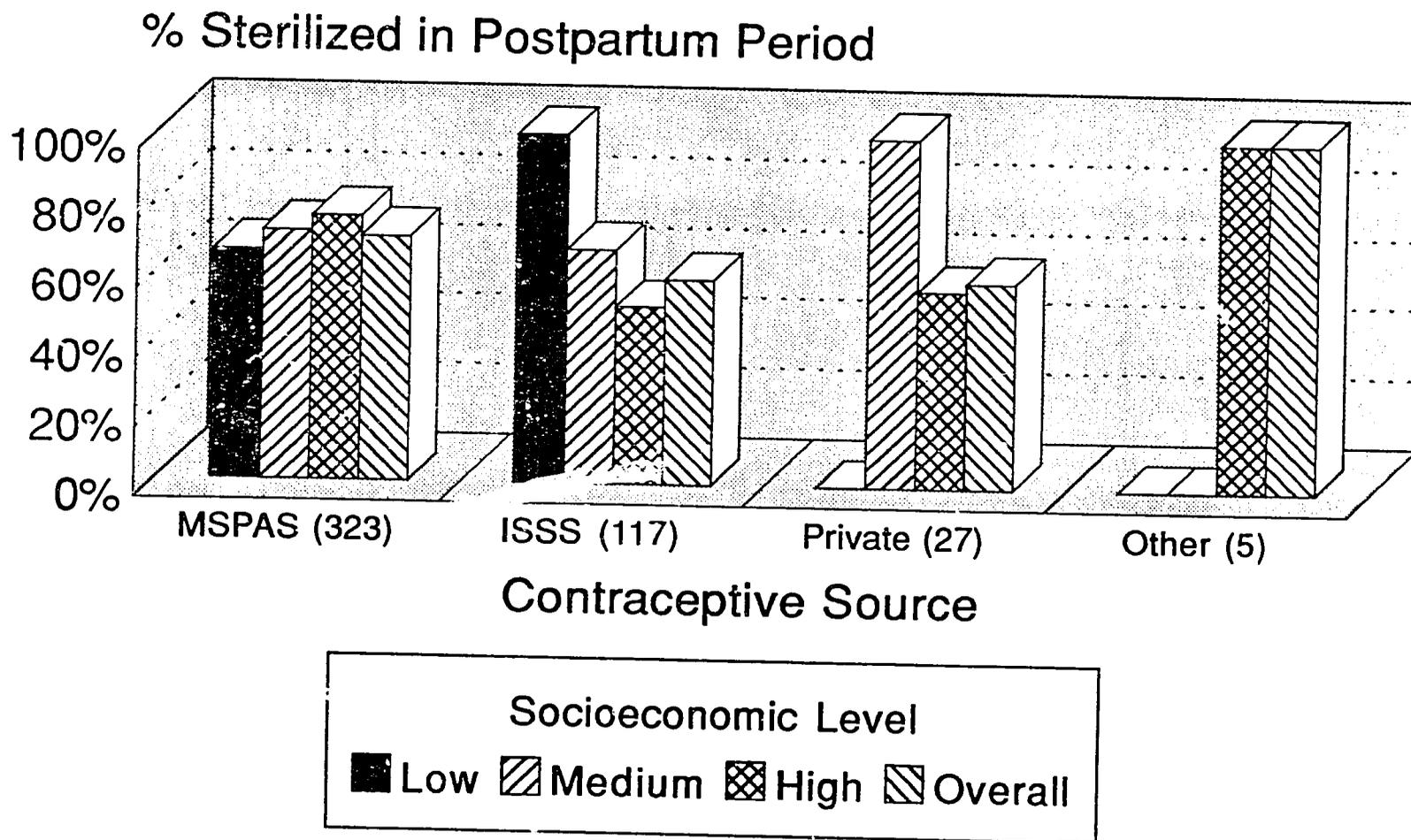


Source: Further analysis of FESAL-93 data.
Weighted Number of Cases in Parentheses

Postpartum Sterilization

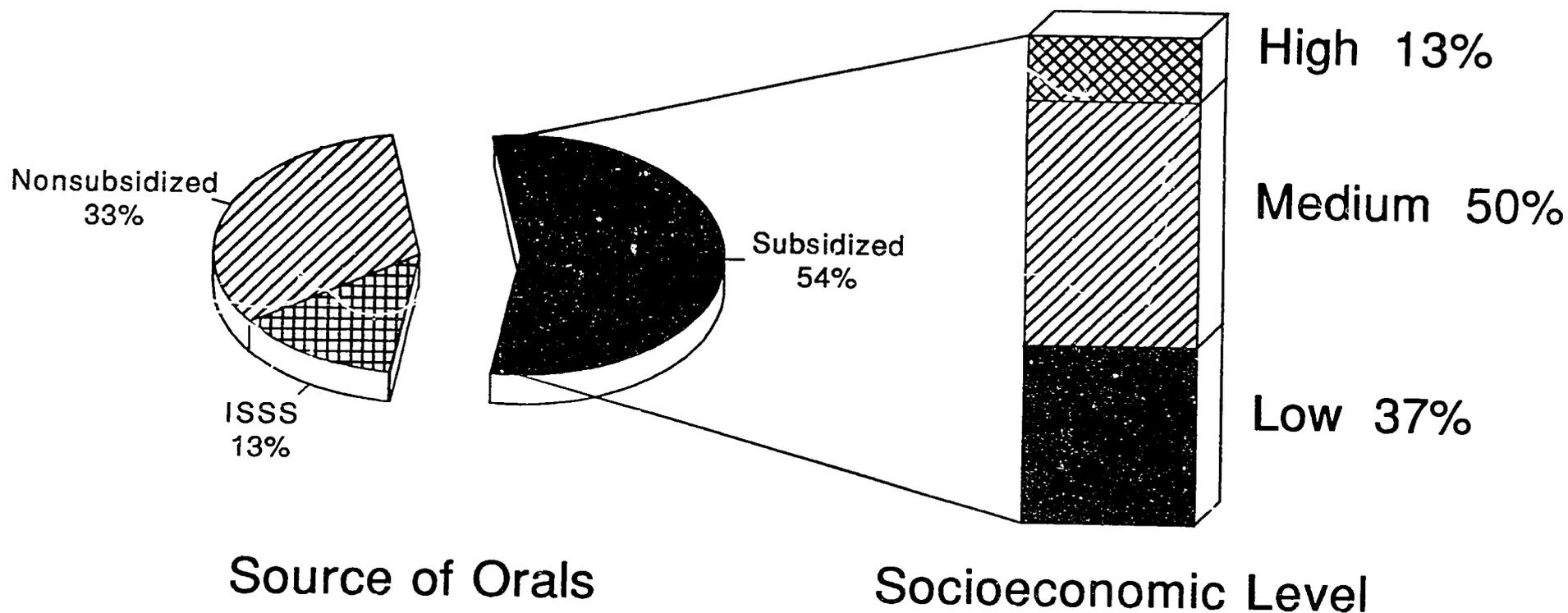
By Socioeconomic Level and Source

El Salvador (Women Sterilized between 1988-1993)



Source: Further analysis of FESAL-93 data.
 Weighted Number of Cases in Parentheses

Source of Orals & Socioeconomic Level of Subsidized Clients El Salvador, 1993

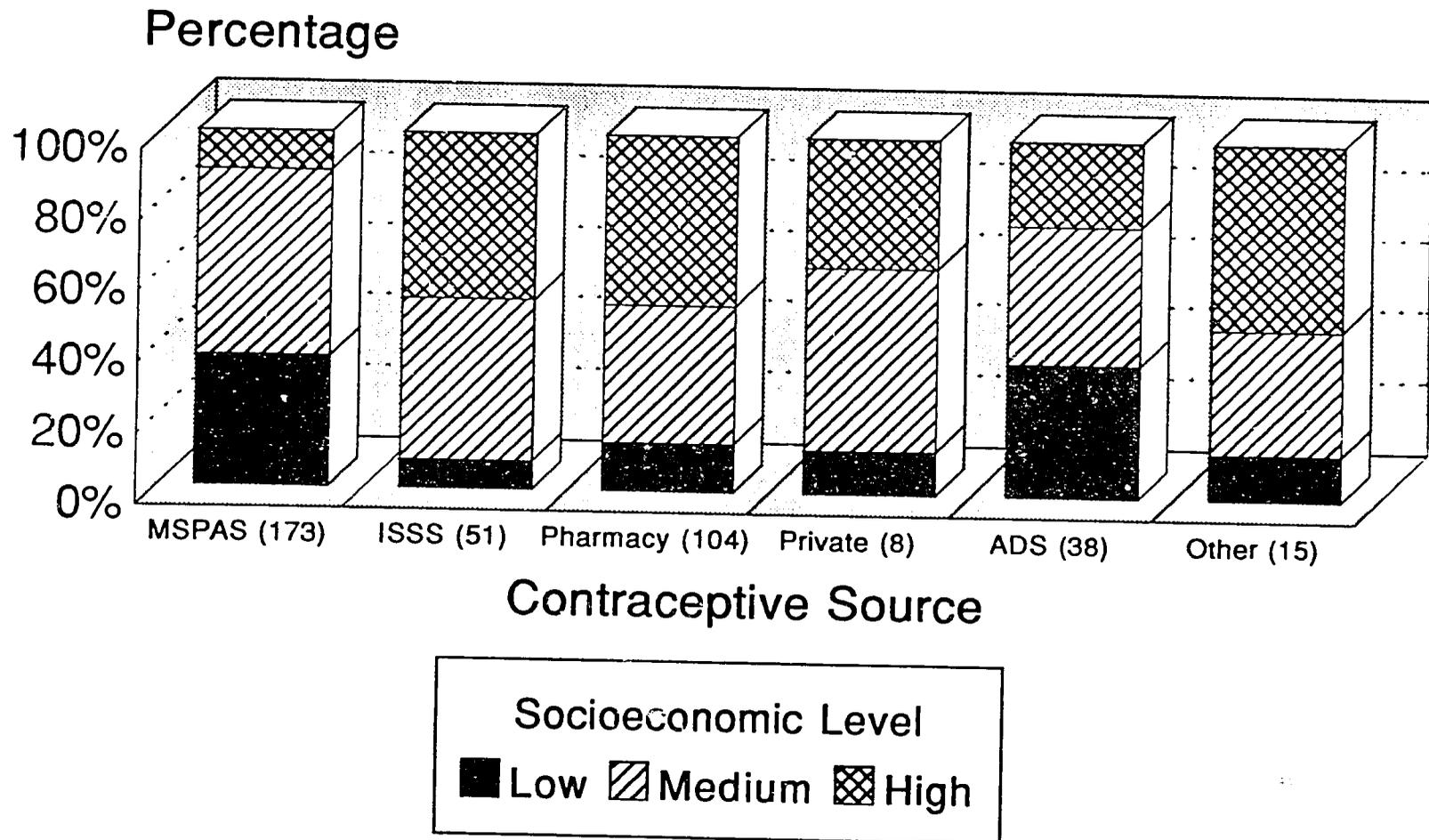


Source: FESAL-93, p. 86 and further analysis of FESAL-93 data.
Subsidized includes MSPAS and ADS clients.

Source of Orals

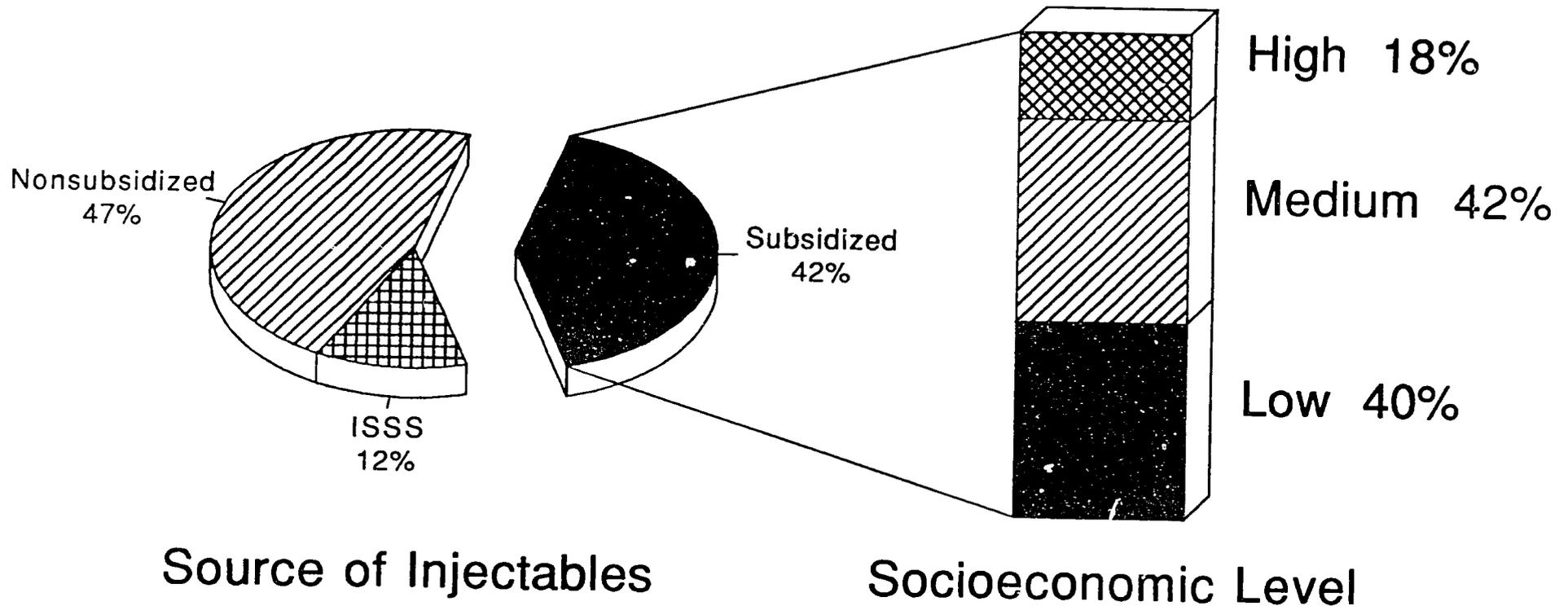
By Socioeconomic Level

El Salvador, 1993



Source: Further analysis of FESAL-93 data.
 Weighted Number of Cases in Parentheses

Source of Injectables & Socioeconomic Level of Subsidized Clients El Salvador, 1993

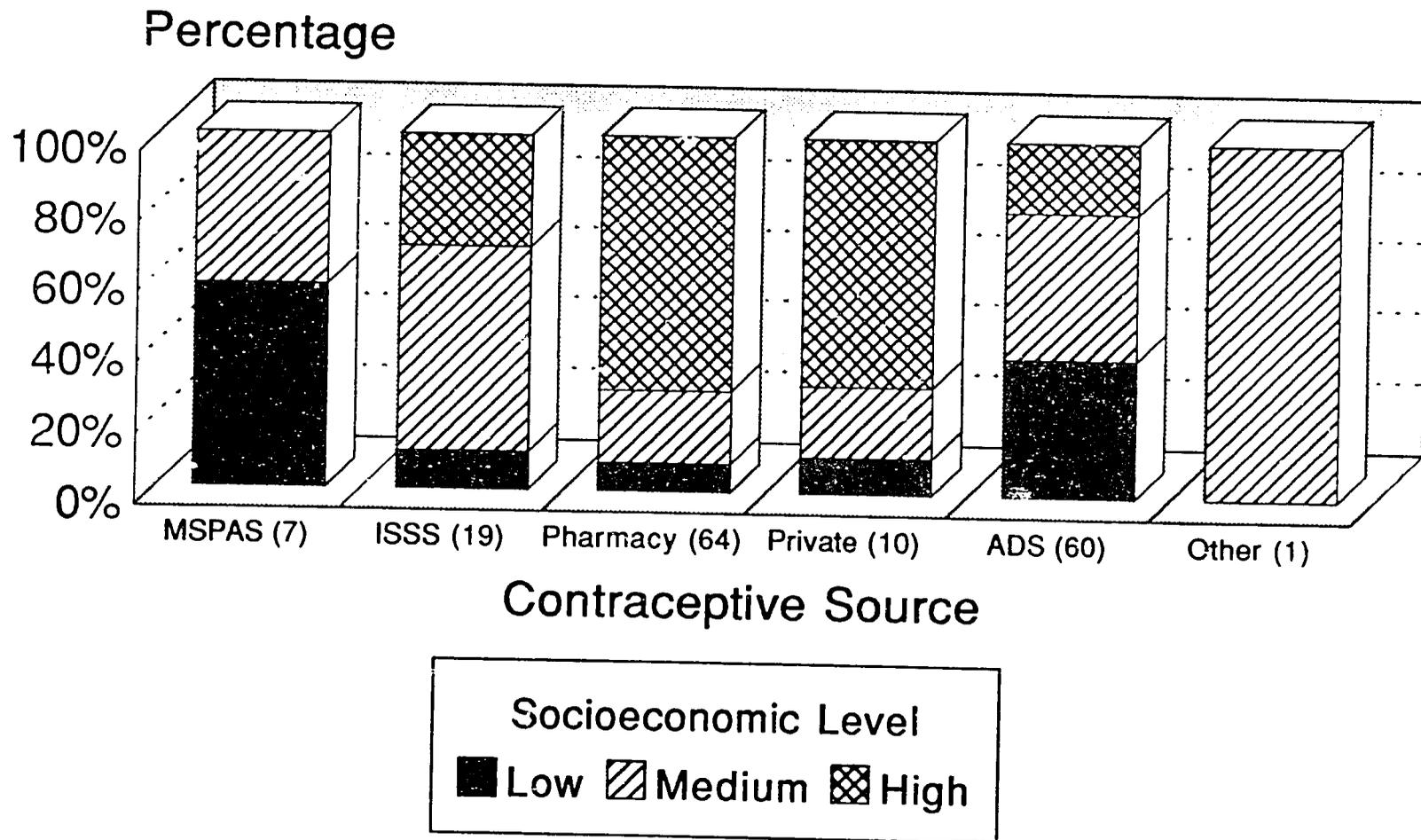


Source: FESAL-93, p. 86 and further analysis of FESAL-93 data.
Subsidized includes MSPAS and ADS clients.

Source of Injectables

By Socioeconomic Level

El Salvador, 1993



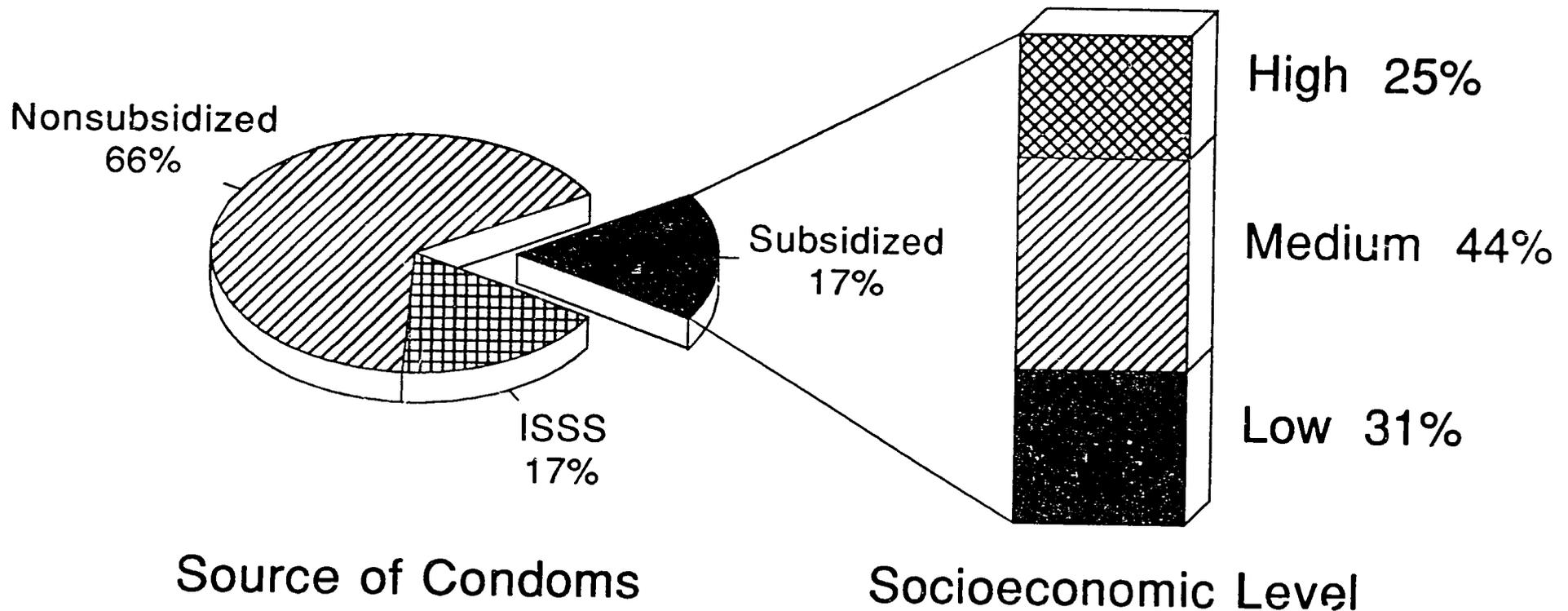
Source: Further analysis of FESAL-93 data.
 Weighted Number of Cases in Parentheses

GRAPH 12

Source of Condoms

& Socioeconomic Level of Subsidized Clients

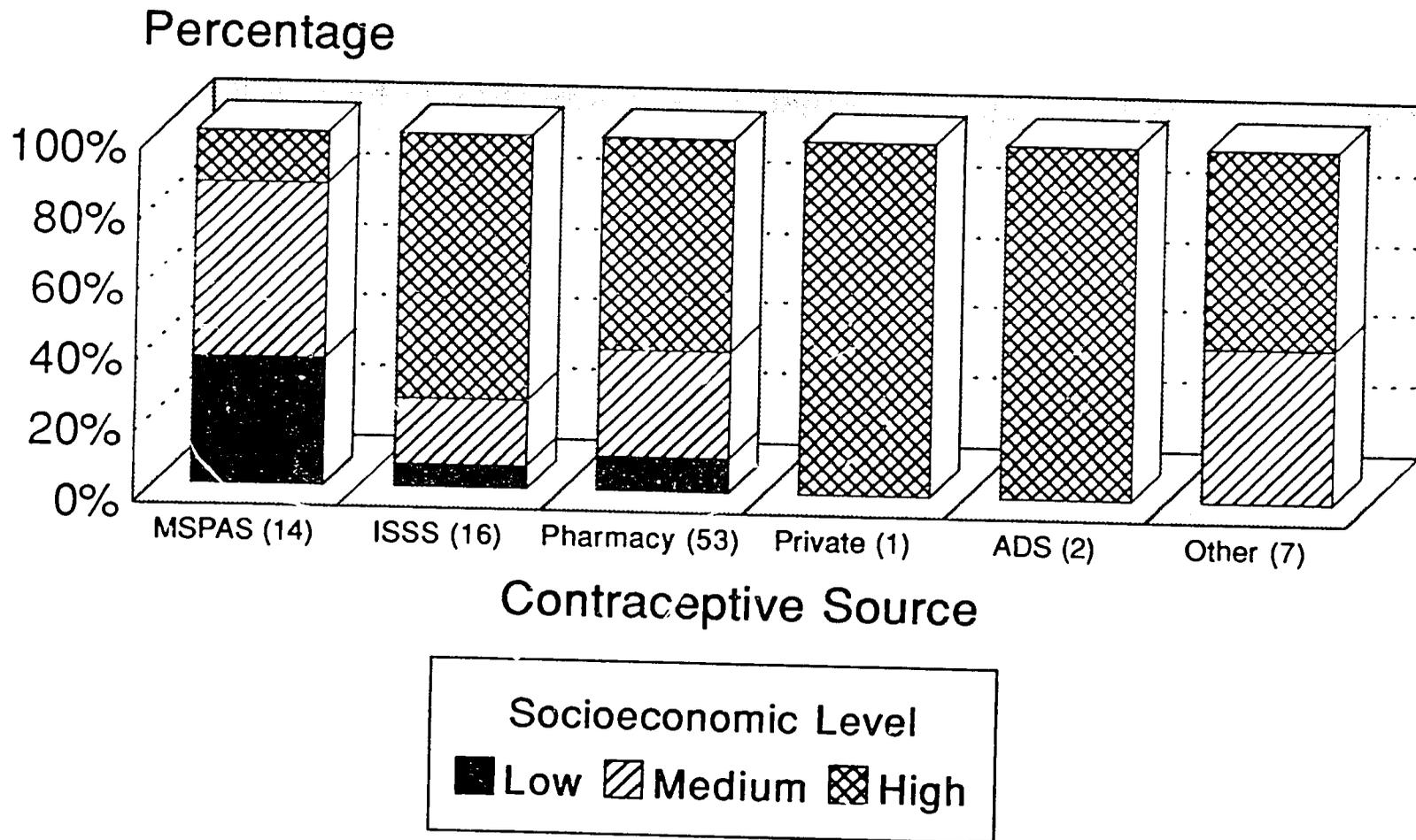
El Salvador, 1993



Source: FESAL-93, p. 86 and further analysis of FESAL-93 data.
Subsidized includes MSPAS and ADS clients.

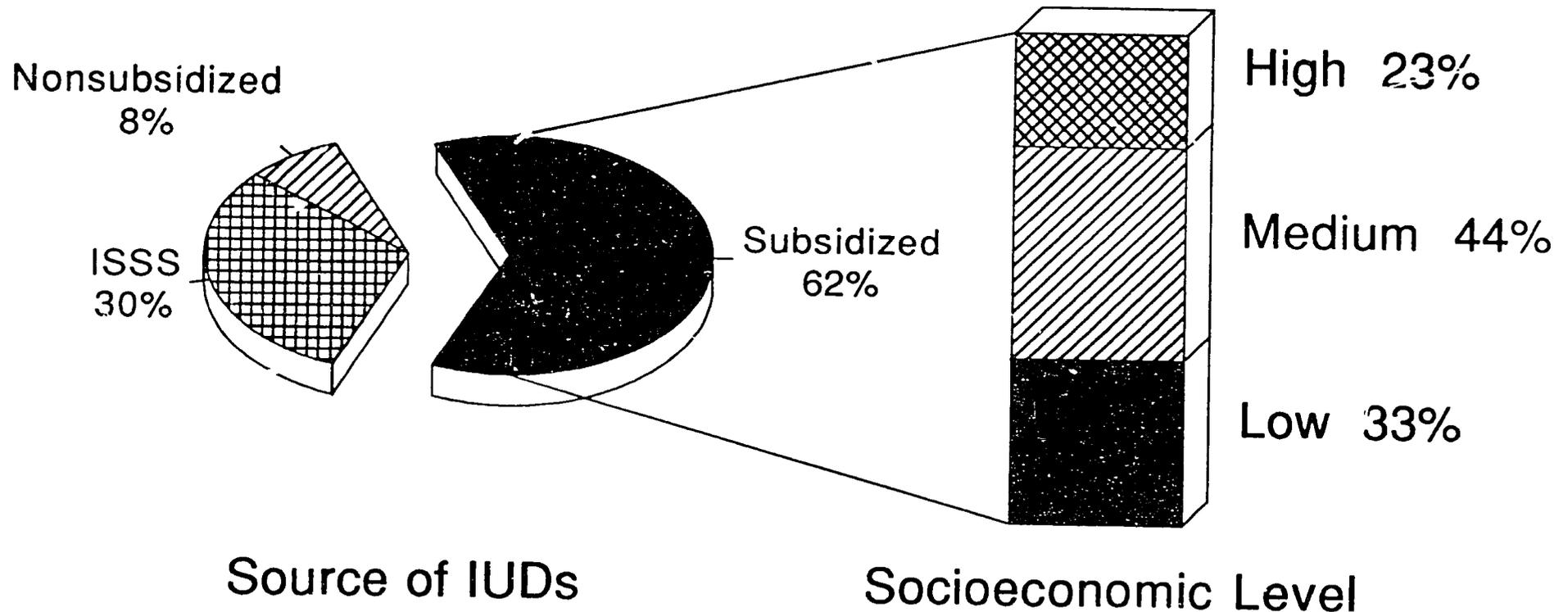
Source of Condoms

By Socioeconomic Level
El Salvador, 1993



Source: Further analysis of FESAL-93 data.
Weighted Number of Cases in Parentheses

Source of IUDs & Socioeconomic Level of Subsidized Clients El Salvador, 1993

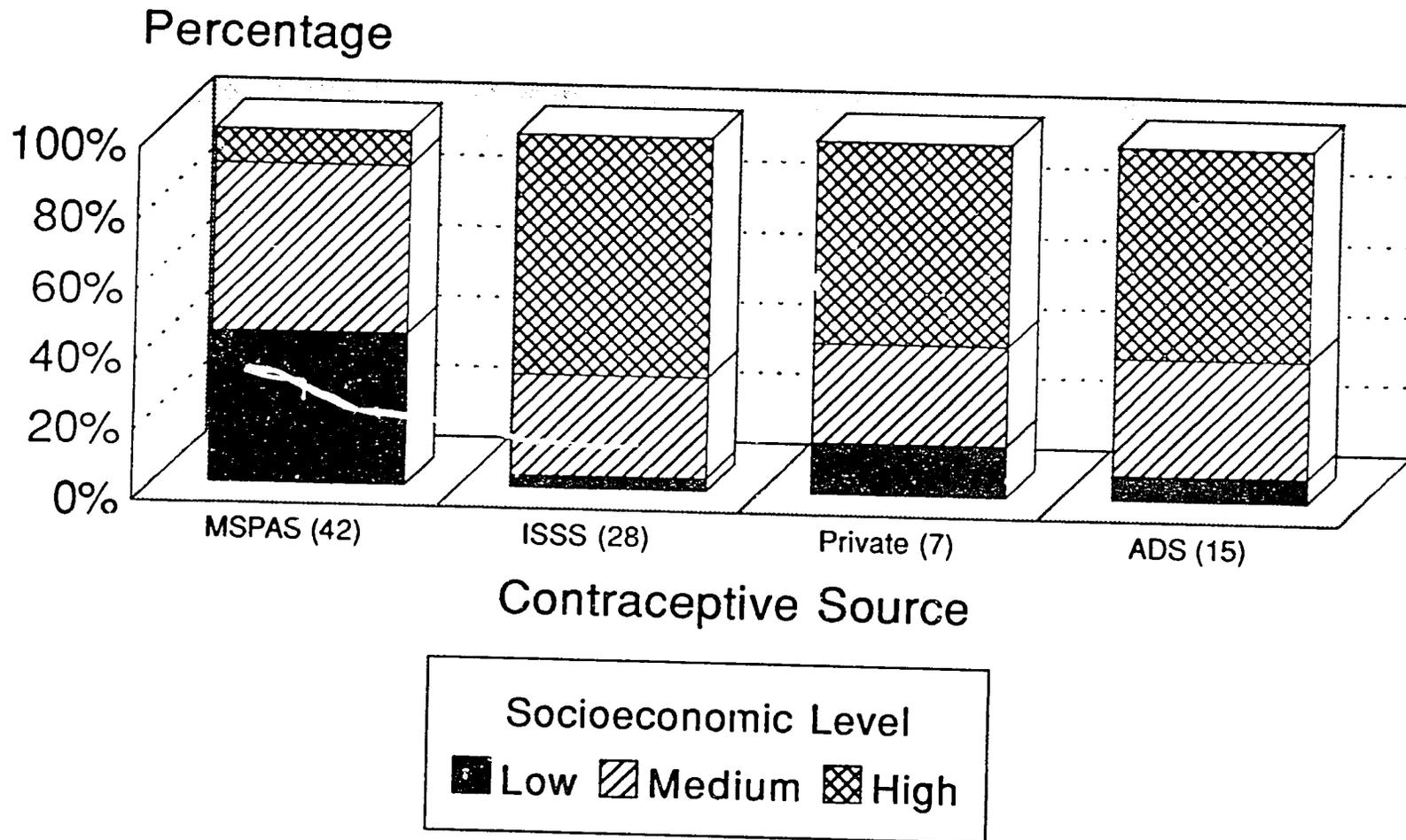


Source: FESAL-93, p. 86 and further analysis of FESAL-93 data.
Subsidized includes MSPAS and ADS clients.

Source of IUDs

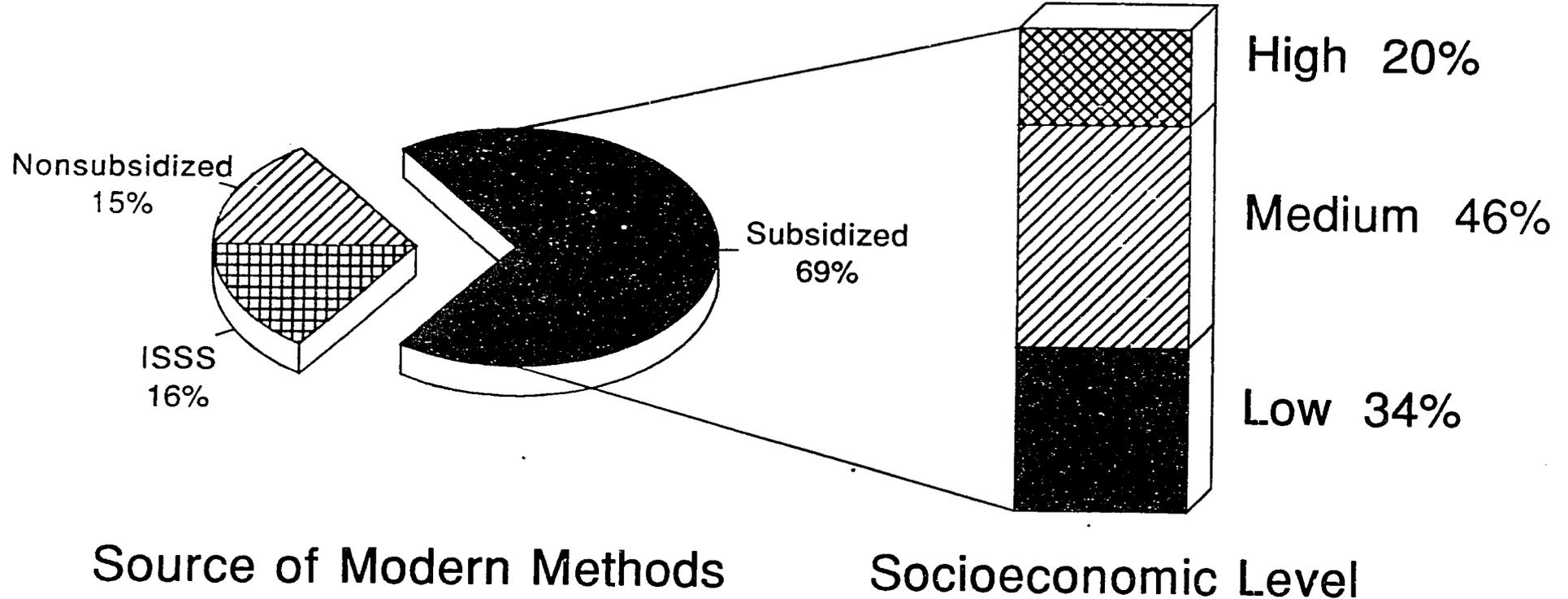
By Socioeconomic Level

El Salvador, 1993



Source: Further analysis of FESAL-93 data.
 Weighted Number of Cases in Parentheses

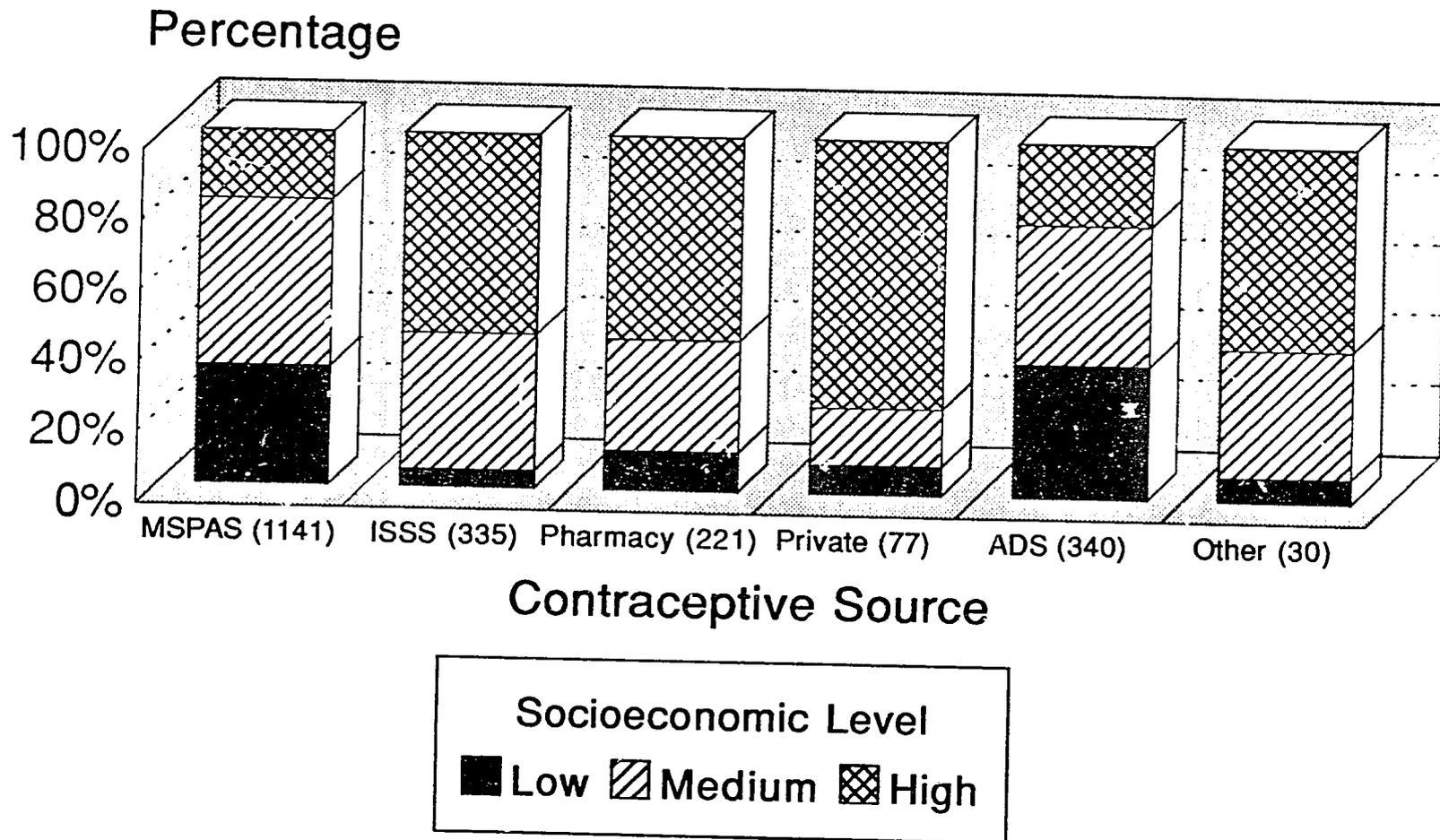
Source of Modern Methods & Socioeconomic Level of Subsidized Clients El Salvador, 1993



Source: FESAL-93, p. 86 and further analysis of FESAL-93 data.
Subsidized includes MSPAS and ADS clients.

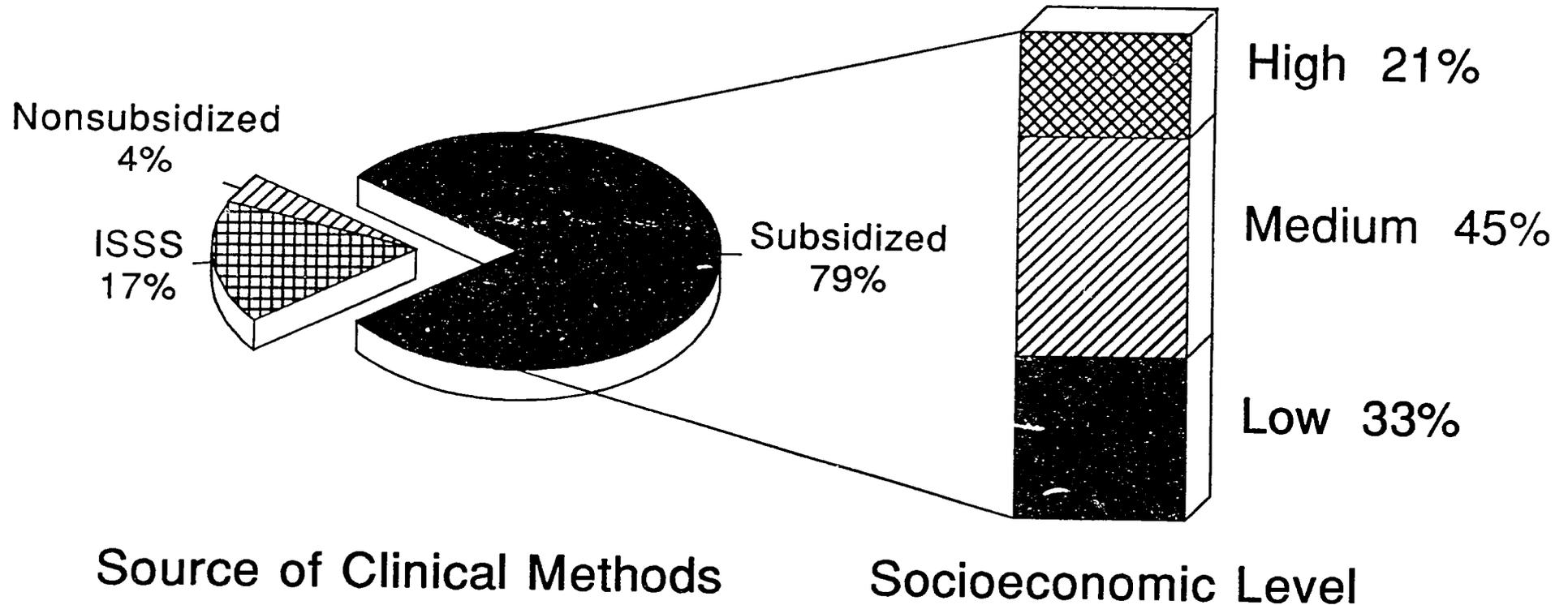
Source of Modern Methods

By Socioeconomic Level
El Salvador, 1993



Source: Further analysis of FESAL-93 data.
Weighted Number of Cases in Parentheses

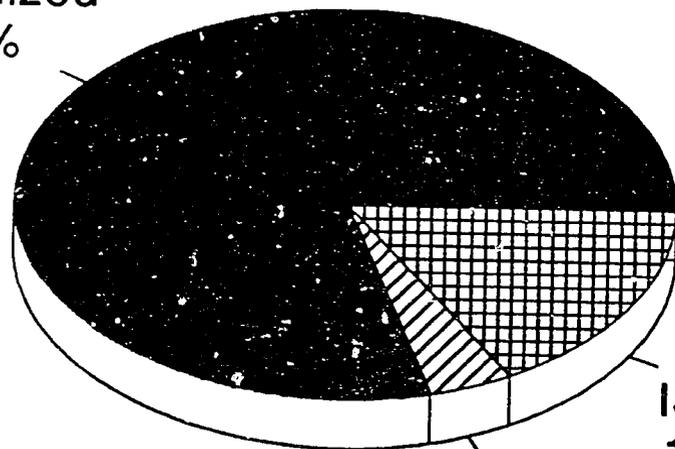
Current Source of Clinical Methods & Socioeconomic Level of Subsidized Clients El Salvador, 1993



Source: Further analysis of FESAL-93 data.
 Subsidized includes MSPAS and ADS clients.
 Clinical methods include female sterilization and IUD.

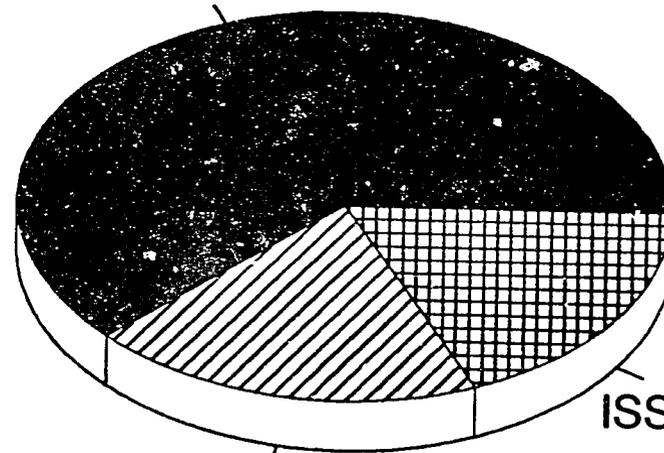
Current & Adjusted Source of Clinical Methods Adjusted for Ability to Pay El Salvador, 1993

Subsidized
79%



Current Source of Clinical Methods

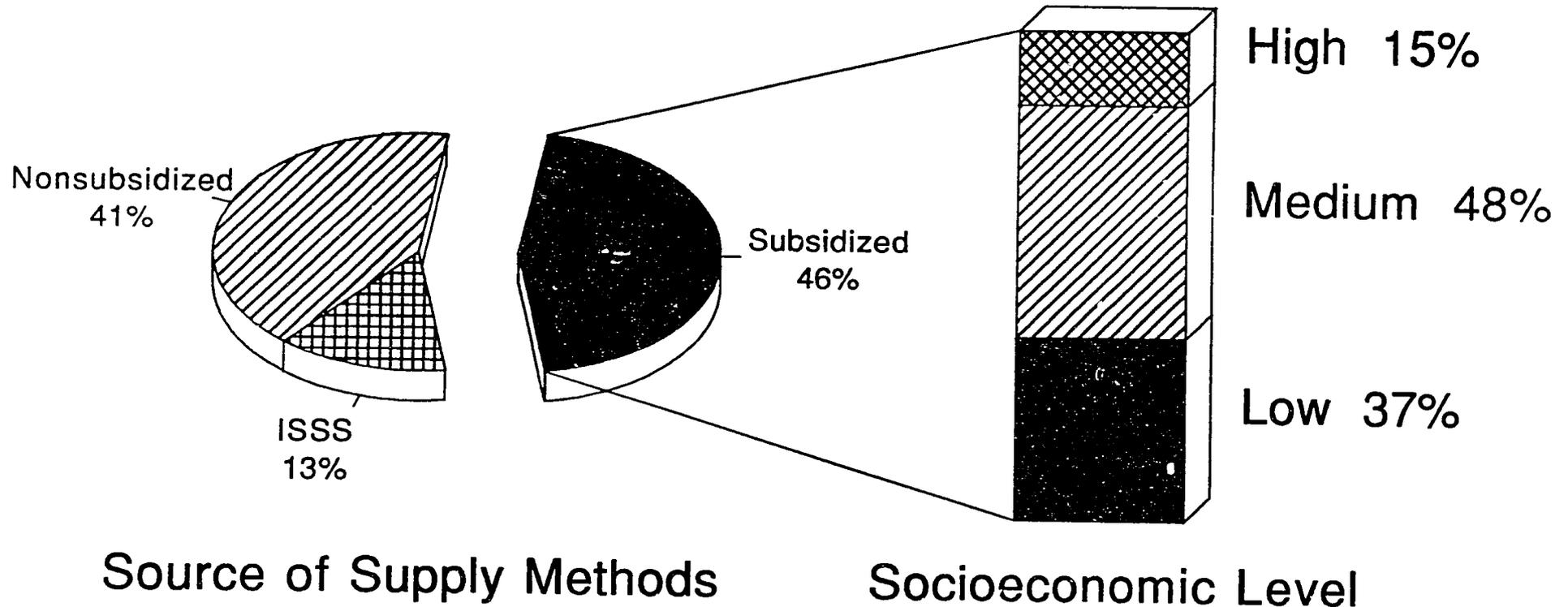
Subsidized 62%



Adjusted Source of Clinical Methods

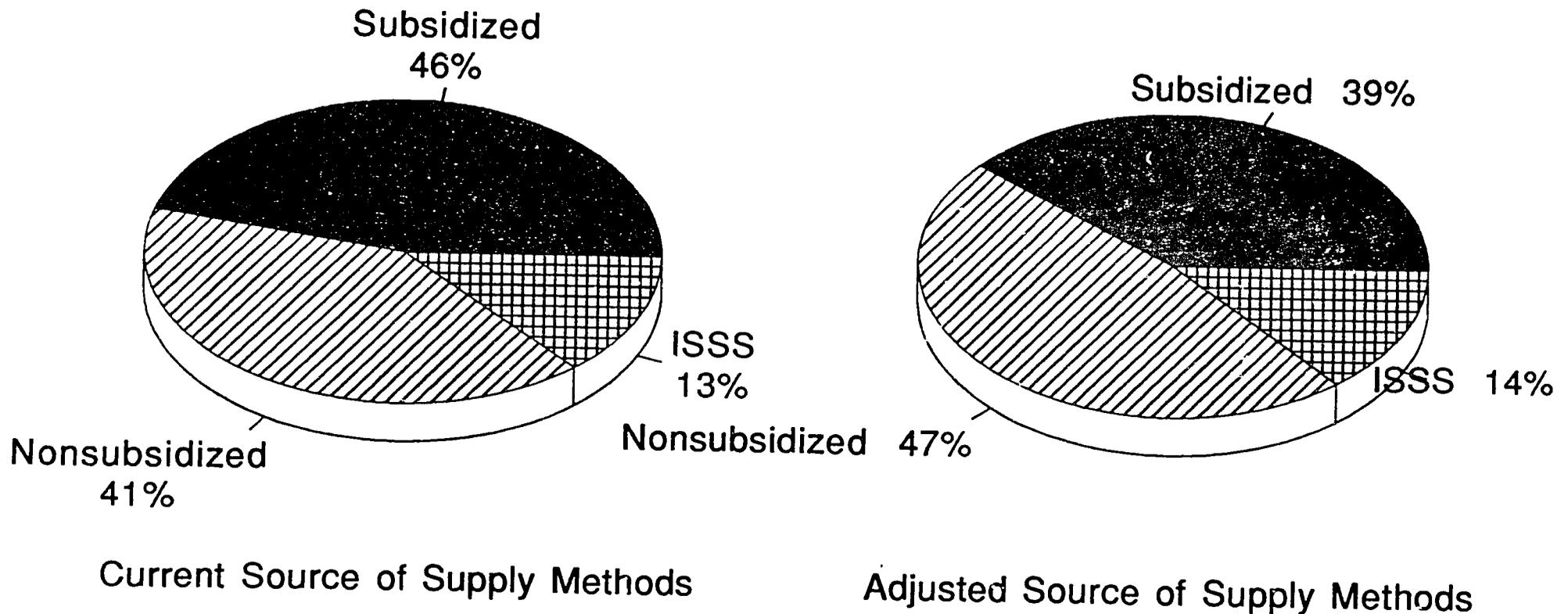
Source: Further analysis of FESAL-93 data.
Subsidized includes MSPAS and ADS clients.
Clinical methods include female sterilization and IUD.

Current Source of Supply Methods & Socioeconomic Level of Subsidized Clients El Salvador, 1993



Source: Further analysis of FESAL-93 data.
Subsidized includes MSPAS and ADS clients.
Supply methods include oral, injectable, and condom.

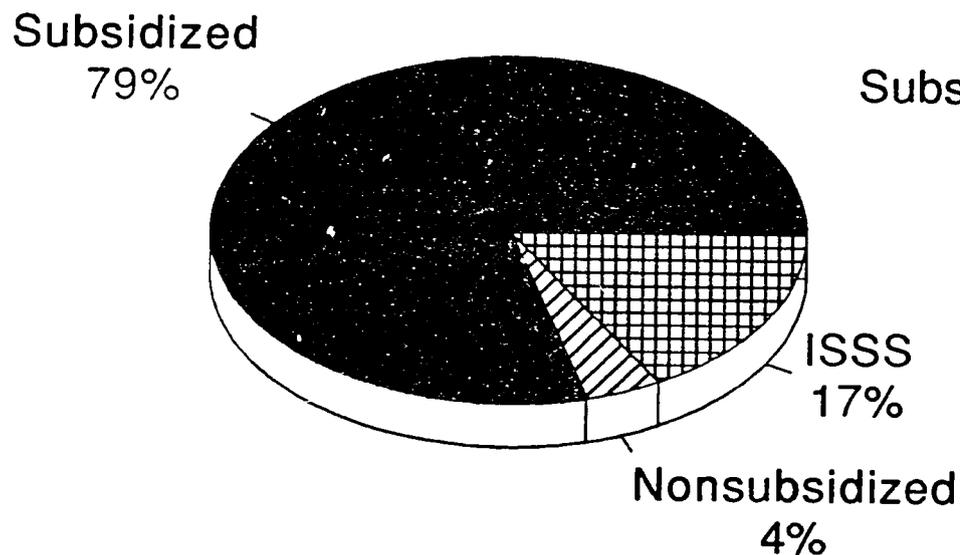
Current & Adjusted Source of Supply Methods Adjusted for Ability to Pay El Salvador, 1993



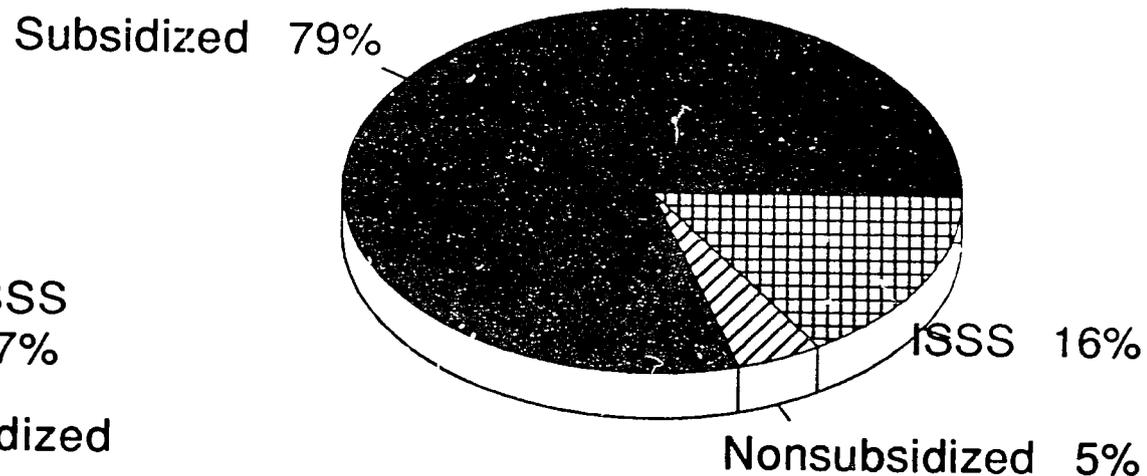
Source: Further analysis of FESAL-93 data.
Subsidized includes MSPAS and ADS clients.
Supply methods include orals, injectables and IUDs.

GRAPH 22

Source of Clinical Methods Including Unmet Need El Salvador, 1993



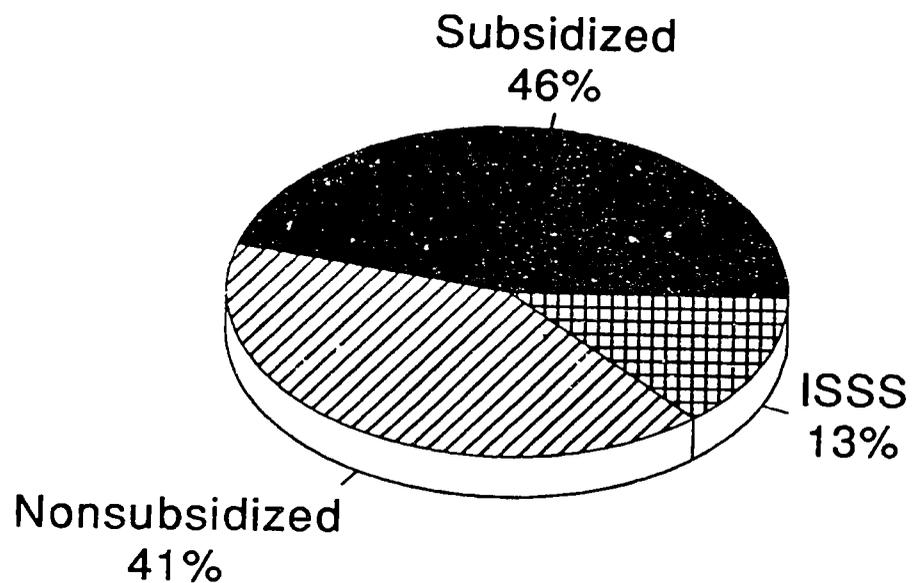
Current Source of Clinical Methods
(Total Women: 213,817)



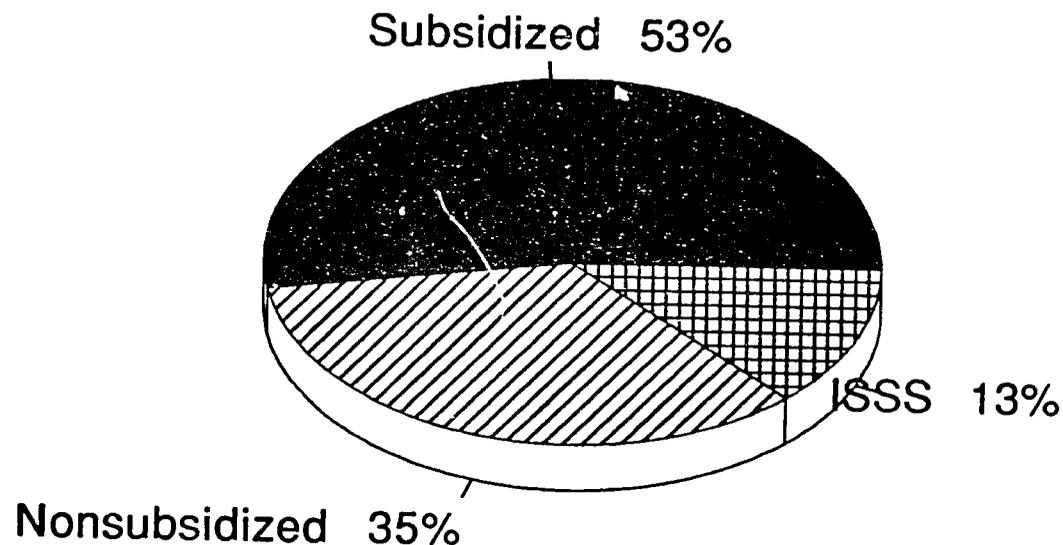
Source Including Unmet Need
(Total Women: 235,143)

Source: Further analysis of FESAL-93 data.
Subsidized includes MSPAS and ADS clients.
Clinical methods include female sterilization and IUD.

Source of Supply Methods Including Unmet Need El Salvador, 1993



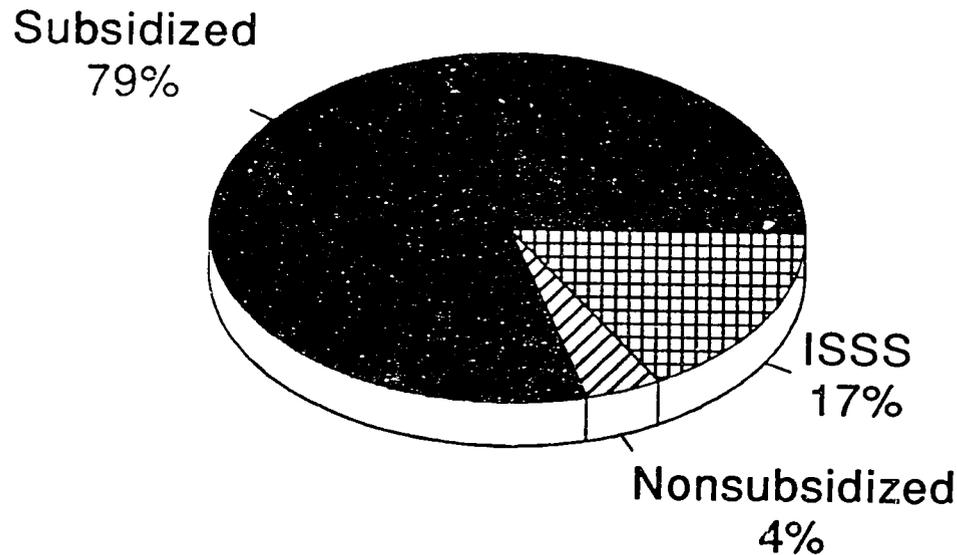
Current Source of Supply Methods
(Total Women: 91,636)



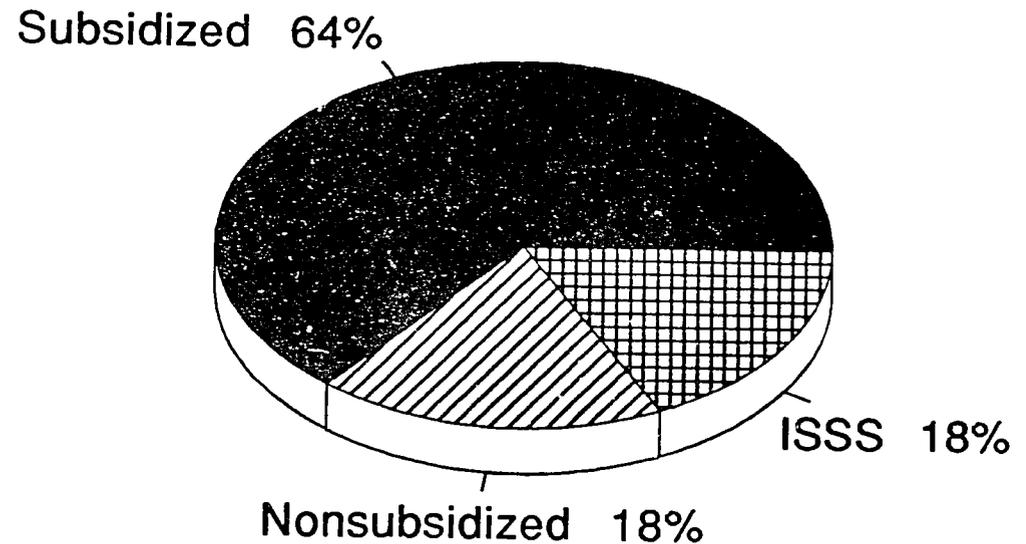
Adjusted Source of Supply Methods
(Total Women: 112,961)

Source: Further analysis of FESAL-93 data.
Subsidized includes MSPAS and ADS clients.
Supply methods include orals, injectables and IUDs.

Source of Clinical Methods Adjusted for Ability to Pay & Including Unmet Need El Salvador, 1993



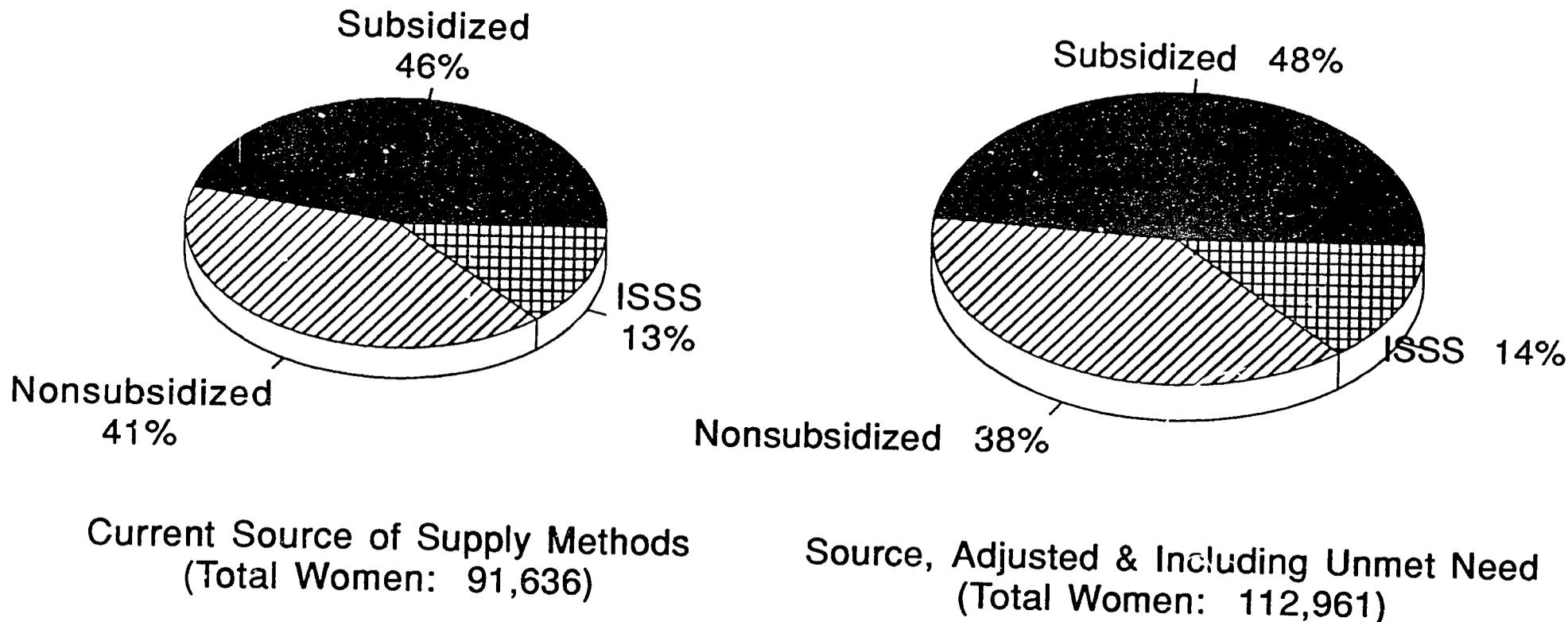
Current Source of Clinical Methods
(Total Women: 213,817)



Source, Adjusted & Including Unmet Need
(Total Women: 235,143)

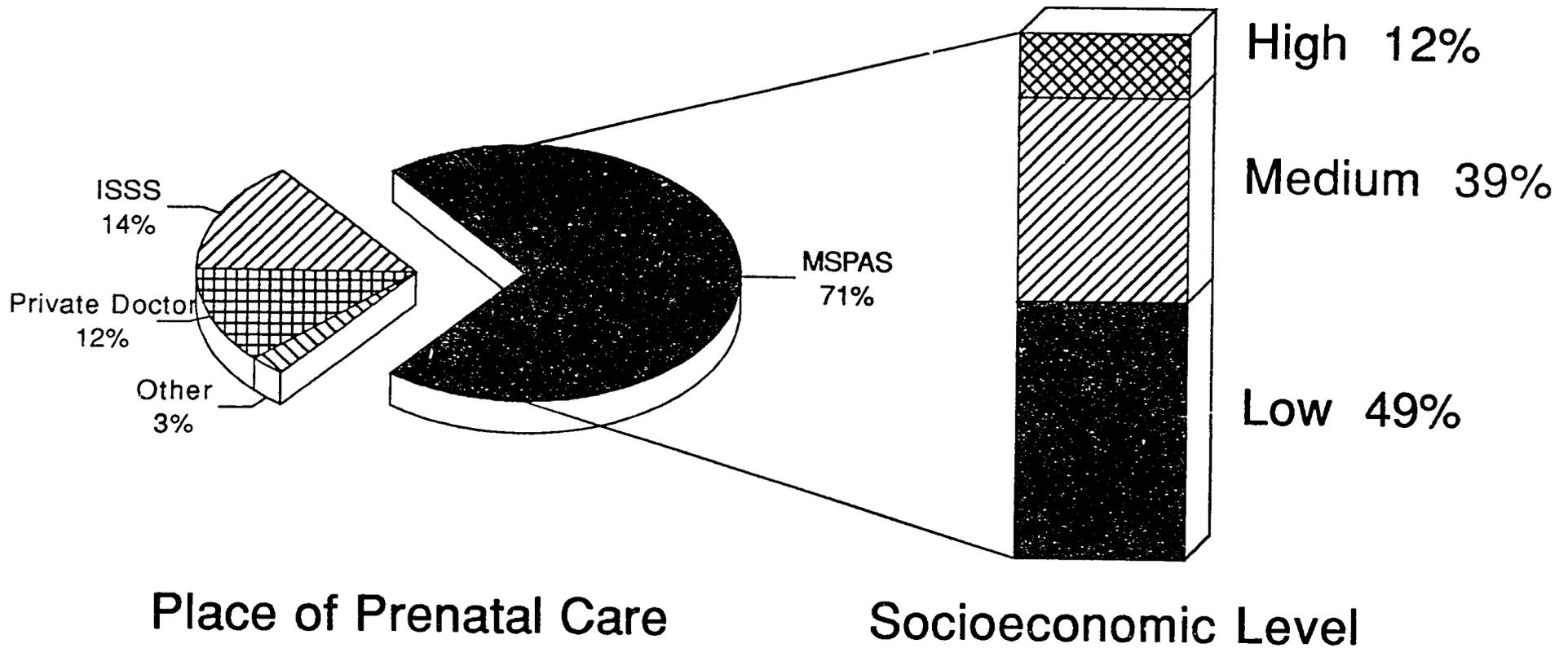
Source: Further analysis of FESAL-93 data.
Subsidized includes MSPAS and ADS clients.
Clinical methods include female sterilization and IUD.

Source of Supply Methods Adjusted for Ability to Pay & Including Unmet Need El Salvador, 1993



Source: Further analysis of FESAL-93 data.
 Subsidized includes MSPAS and ADS clients.
 Supply methods include orals, injectables and IUDs.

Place of Prenatal Care & Socioeconomic Level of MSPAS Clients El Salvador, 1993

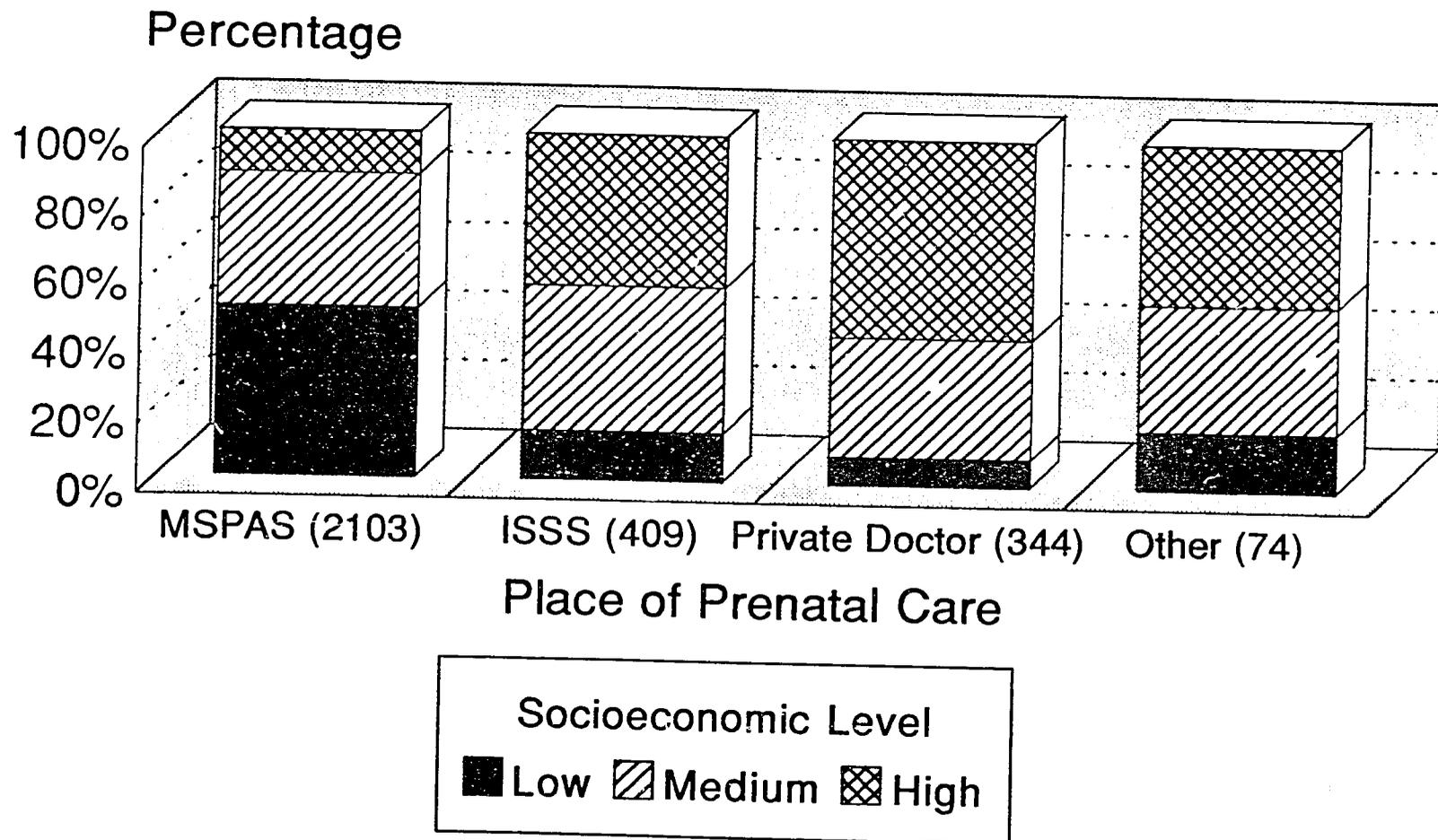


Source: FESAL-93, p. 148 and authors' calculations.

Place of Prenatal Care

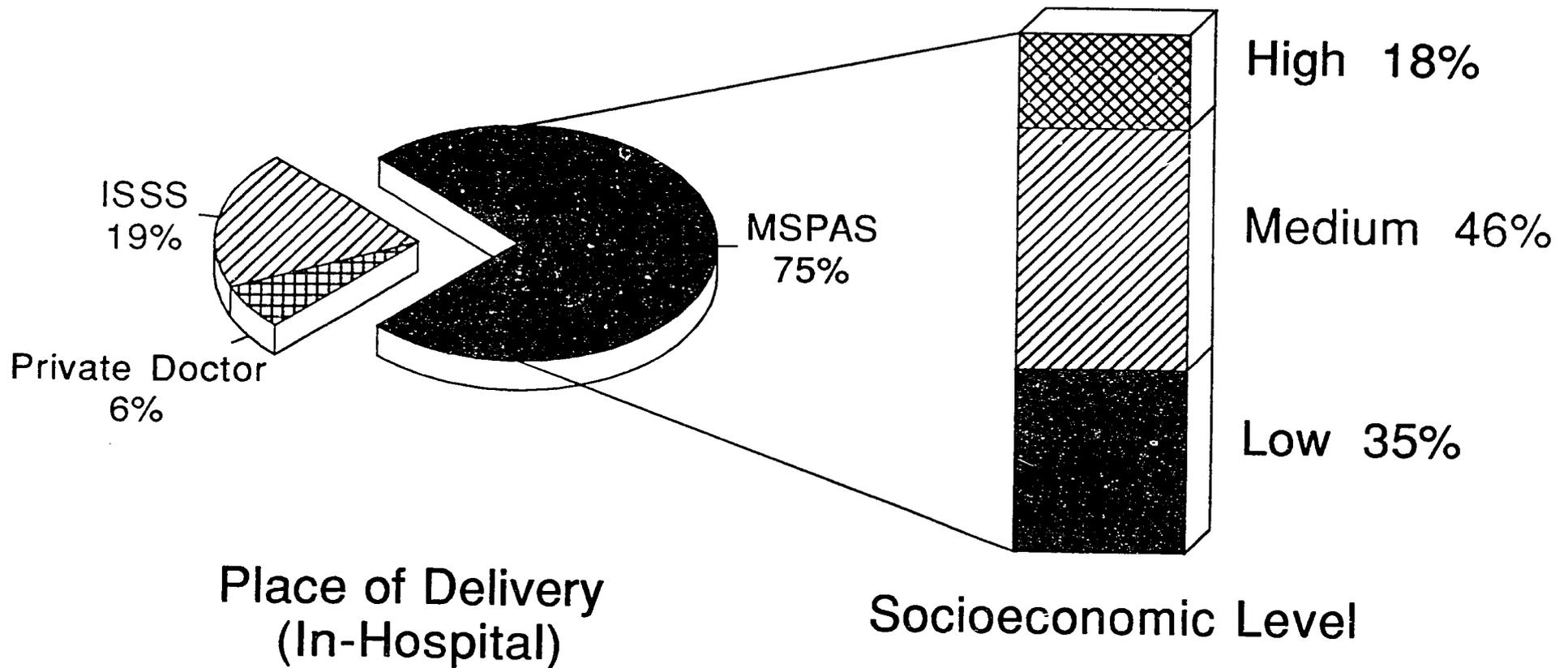
By Socioeconomic Level

El Salvador, 1993



Source: Further analysis of FESAL-93 data.
 Number of Cases in Parentheses

Place of Delivery (In-Hospital) & Socioeconomic Level of MSPAS Clients El Salvador, 1993

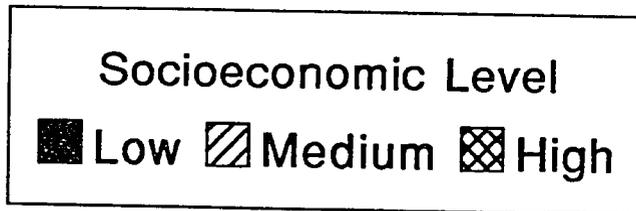
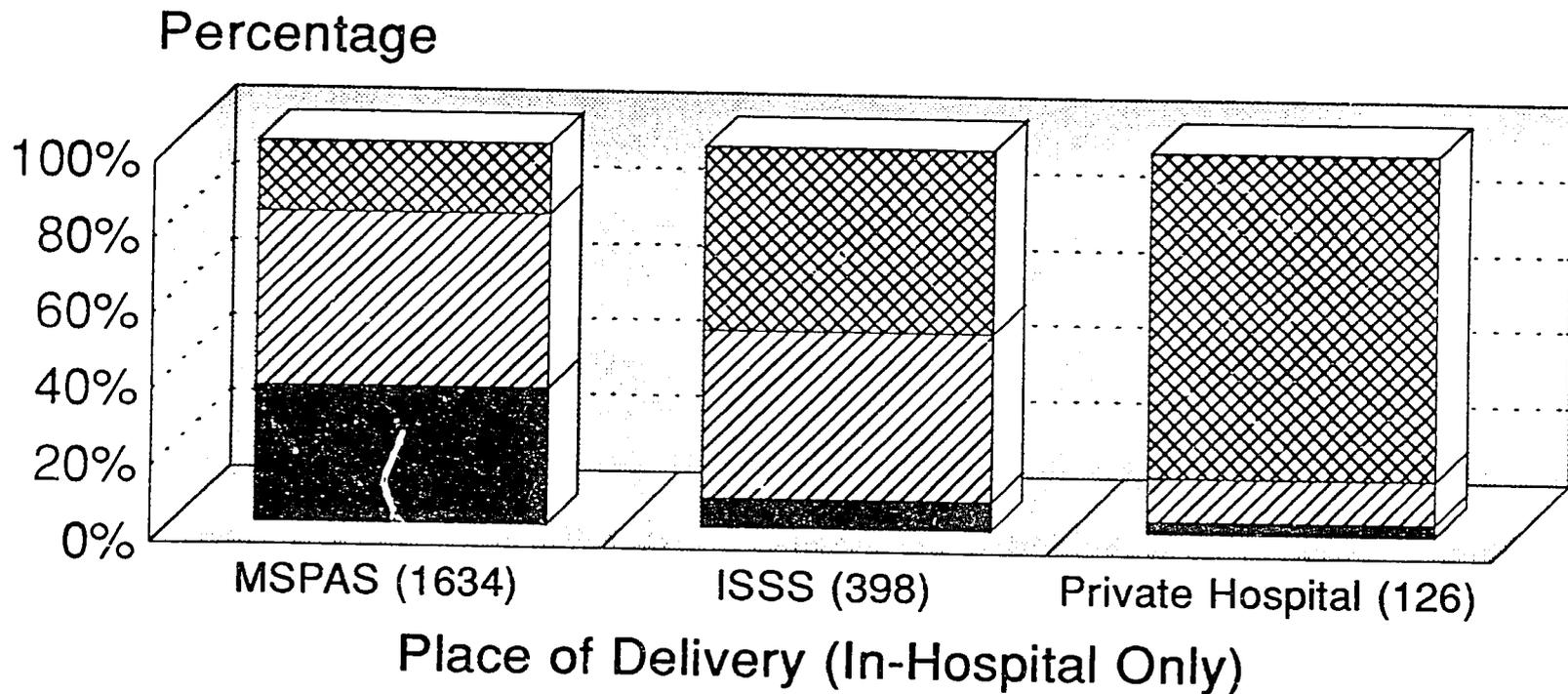


Source: FESAL-93, p. 154 and further analysis of FESAL-93 data.

Place of Delivery (In-Hospital)

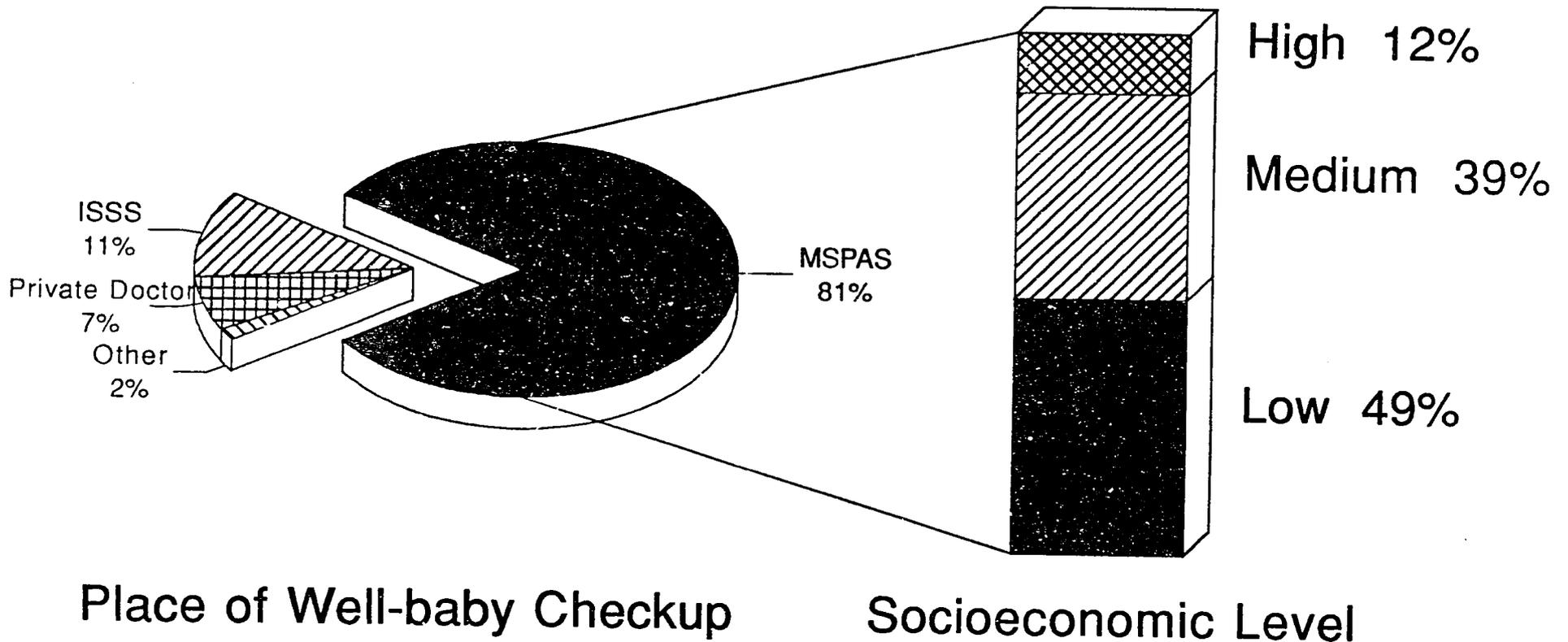
By Socioeconomic Level

El Salvador, 1993



Source: Further analysis of FESAL-93 data.
 Number of Cases in Parentheses

Place of Well-baby Checkup & Socioeconomic Level of MSPAS Clients El Salvador, 1993

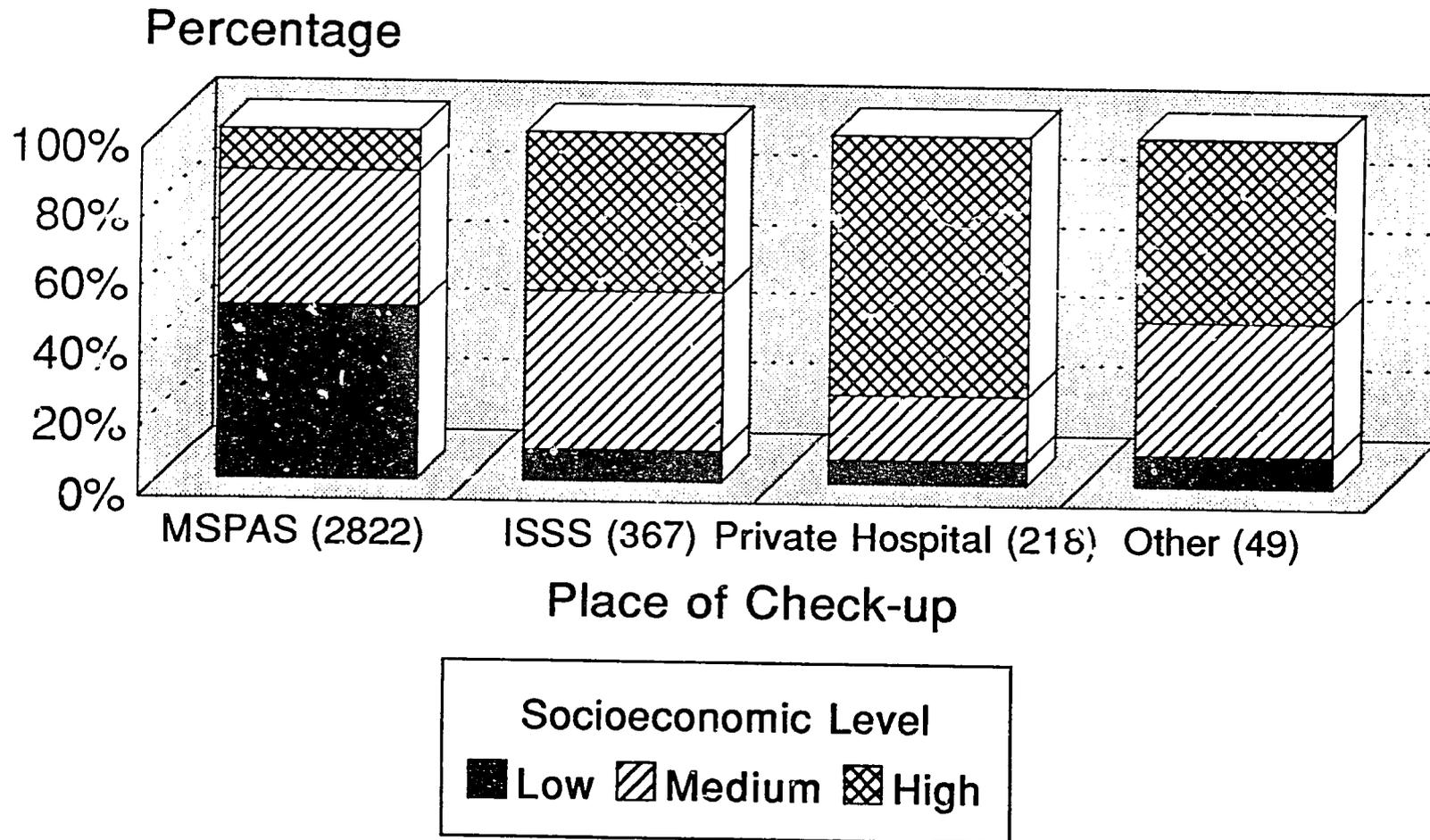


Source: FESAL-93, p. 164 and further analysis of FESAL-93 data.

Place of Well-baby Check-up

By Socioeconomic Level

El Salvador, 1993



Source: Further analysis of FESAL-93 data.
 Number of Cases in Parentheses

APPENDIX D

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Table 1.
Distribution of Spending on Health
El Salvador, 1993

<u>Source</u>	<u>% of Total</u>
Households	53.1%
MSPAS	22.0%
ISSS	19.6%
Other Public	5.3%
Total	100.0%

Source: ANSAL, Informe Final, p. 58.

Table 2
Waiting Time for Health Services
El Salvador, 1989

<u>Establishment</u>	<u>Average Wait (minutes)</u>
Hospital	148.56
Health Post	146.29
NGO	101.56
ISSS	89.47
Private Doctor	61.08
Pharmacy	9.35

Source: REACH 1989 cited in ANSAL Informe Final.

Table 3
Distribution of Household Health Spending
El Salvador, 1991

<u>Type</u>	<u>Percent</u>
Dental Care	1.0%
Doctor Visit	18.0%
Eye Care	5.0%
Medicines	47.0%
Other	30.0%

Source: MIPLAN, 1991, cited in
ANSAL, Informe Final, p. 65

Table 4
 Source of Contraception Among Users of Modern Methods
 As a Percentage of Overall Modern Method Use
 Data from Various LAC Countries, Including El Salvador

Country	Overall Modern Prevalence	Source					Total
		Public Sector	Pharmacy	Private Practice	NGOs	Other	
Bolivia (89)	12	34	9	54	1	2	100
Brazil (86)	56	28	46	23	1	2	100
Colombia (90)	55	25	29	11	32	3	100
DR (86)	47	42	4	44	1	9	100
Ecuador (87)	36	42	6	35	17	0	100
Guatemala (87)	19	32	7	18	40	3	100
Honduras (87)	33	19	15	10	52	4	100
Mexico (87)	45	63	22	14	0	1	100
Peru (86)	23	54	2	31	2	11	100
Average LAC	36	38	16	27	16	4	100
El Salvador (93)	48	69	10	4	16	1	100

Source: K. Foreit, 1992, p. 6 and authors' calculations using FESAL-93 data

Table 5
 Private Sector Coverage of Family Planning
 vs. Private Share of Health Care Expenditure
 Comparison of Five LAC Countries, Including El Salvador

<u>Country</u>	<u>Family Planning</u>		<u>Health Expenditure</u>	
	Modern Prevalence Rate (%)	Private Sector Share (%)	Per Capit Spending (\$u.s.)	Private Sector Share (%)
Brazil	56	72	n.a.	50
Colombia	55	75	69.60	33
Ecuador	36	58	46.11	39
Peru	23	46	62.12	47
El Salvador	48	31	46.22	53

Sources: Foreit, 1992, p. 9 (other countries);
 Author's calculation from FESAL-93 (non-public sector share);
 ANSAL, Informe Final, p. 58 (total health spending and percent private);
 Lininger, p. 1 (total population for per capita calculation).

Table 6
Source of Contraceptive by Socio-economic level
El Salvador, 1993

Method: Sterilization		Source						Total	No. Cases (weighted)
Socioeconomic Level	MSPAS	ISSS	Pharmacy	Private Practice	ADS	Other			
Low	74.4	2.1	0	0.8	22.8	0	100.1	386	
Medium	70.3	13.8	0	0.7	15.1	0.2	100.1	602	
High	46.5	31	0	10.3	11	1.2	100	419	
								1407	
Method: Orals		Source						Total	No. Cases (weighted)
Socioeconomic Level	MSPAS	ISSS	Pharmacy	Private Practice	ADS	Other			
Low	64.3	4.1	14.3	1	14.3	2	100	98	
Medium	51.1	12.9	22.5	2.3	8.4	3	100.2	178	
High	16.8	21.2	44.3	2.6	8	7.1	100	113	
								389	
Method: Injectable		Source						Total	No. Cases (weighted)
Socioeconomic Level	MSPAS	ISSS	Pharmacy	Private Practice	ADS	Other			
Low	11.4	5.7	14.3	2.9	65.7	0	100	35	
Medium	5.5	20	23.6	3.6	45.5	1.8	100	55	
High	0	8.5	64.8	9.9	16.9	0	100.1	71	
								161	
Method: Condom		Source						Total	No. Cases (weighted)
Socioeconomic Level	MSPAS	ISSS	Pharmacy	Private Practice	ADS	Other			
Low	45.5	9.1	45.5	0	0	0	100.1	11	
Medium	24.1	10.3	55.2	0	0	10.5	100.1	29	
High	3.8	22.6	60.4	1.9	3.8	7.5	100	53	
								93	
Method: IUD		Source						Total	No. Cases (weighted)
Socioeconomic Level	MSPAS	ISSS	Pharmacy	Private Practice	ADS	Other			
Low	85.7	4.8	0	4.8	4.9	0	100.2	21	
Medium	57.1	22.9	0	5.7	14.3	0	100	35	
High	11.1	52.8	0	11.1	25	0	100	36	

Source: Further analysis of FESAL-93 data.

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Table 7
Source of Contraceptive by Socio-economic level (NUMBER OF CASES)
El Salvador, 1993

Method: Sterilization	Source						Total
	MSPAS	ISSS	Pharmacy	Private Practice	ADS	Other	
Socioeconomic Level							
Low	287	8	0	3	88	0	386
Medium	423	83	0	4	91	1	603
High	195	130	0	43	46	5	419
Total	905	221	0	50	225	6	1408

Method: Orals	Source						Total
	MSPAS	ISSS	Pharmacy	Private Practice	ADS	Other	
Socioeconomic Level							
Low	63	4	14	1	14	2	98
Medium	91	23	40	4	15	5	178
High	19	24	50	3	9	8	113
Total	173	51	104	8	38	15	389

Method: Injectable	Source						Total
	MSPAS	ISSS	Pharmacy	Private Practice	ADS	Other	
Socioeconomic Level							
Low	4	2	5	1	23	0	35
Medium	3	11	13	2	25	1	55
High	0	6	46	7	12	0	71
Total	7	19	64	10	60	1	161

Method: Condom	Source						Total
	MSPAS	ISSS	Pharmacy	Private Practice	ADS	Other	
Socioeconomic Level							
Low	5	1	5	0	0	0	11
Medium	7	3	16	0	0	3	29
High	2	12	32	1	2	4	53
Total	14	16	53	1	2	7	93

Method: IUD	Source						Total
	MSPAS	ISSS	Pharmacy	Private Practice	ADS	Other	
Socioeconomic Level							
Low	18	1	0	1	1	0	21
Medium	20	8	0	2	5	0	35
High	4	19	0	4	9	0	36
Total	42	28	0	7	15	0	92

Method: All Modern	Source						Total
	MSPAS	ISSS	Pharmacy	Private Practice	ADS	Other	
Socioeconomic Level							
Low	377	16	24	6	126	2	551
Medium	544	128	69	12	136	11	900
High	220	191	128	58	78	17	692
Total	1141	335	221	77	340	30	2143

Source: Further analysis of FESAL-93 data.

Table 8
Source of Contraceptive by Socio-economic level (NUMBER OF CASES)
El Salvador, 1993

Method: Sterilization	Source			
	Subsidized	Non-Subsidized	ISSS	Total
Socioeconomic Level				
Low	375	3	8	386
Medium	514	5	83	603
High	241	48	130	419
Total	1130	57	221	1408

Method: Orals	Source			
	Subsidized	Non-Subsidized	ISSS	Total
Socioeconomic Level				
Low	77	17	4	98
Medium	106	49	23	178
High	28	61	24	113
Total	211	127	51	389

Method: Injectable	Source			
	Subsidized	Non-Subsidized	ISSS	Total
Socioeconomic Level				
Low	27	6	2	35
Medium	28	16	11	55
High	12	53	6	71
Total	67	75	19	161

Method: Condom	Source			
	Subsidized	Non-Subsidized	ISSS	Total
Socioeconomic Level				
Low	5	5	1	11
Medium	7	19	3	29
High	4	37	12	53
Total	16	61	16	93

Method: IUD	Source			
	Subsidized	Non-Subsidized	ISSS	Total
Socioeconomic Level				
Low	19	1	1	21
Medium	25	2	8	35
High	13	4	19	36
Total	57	7	28	92

Method: All Modern	Source			
	Subsidized	Non-Subsidized	ISSS	Total
Socioeconomic Level				
Low	503	32	16	551
Medium	680	92	128	900
High	298	203	191	692
Total	1481	327	335	2143

Note: Subsidized includes MSPAS and ADS.
 Unsubsidized includes Pharmacy, Private Practice & Other
 Source: Further analysis of FESAL-93 data

Table 8, cont.

Source of Contraceptive by Socio-economic level (NUMBER OF CASES)
El Salvador, 1993

Method: Clinical (Steril. + IUD)	Source			Total
	Subsidize	Non-Subsidized	ISSS	
Socioeconomic Level				
Low	394	4	9	407
Medium	539	7	91	638
High	254	52	149	455
Total	1187	64	249	1500

Method: Supply (Oral, Injectable, Condom)	Source			Total
	Subsidize	Non-Subsidized	ISSS	
Socioeconomic Level				
Low	109	28	7	144
Medium	141	84	37	262
High	44	151	42	237
Total	294	264	86	643

Note: Subsidized includes MSPAS and ADS;
 Unsubsidized includes Pharmacy, Private Practice &
 Source: Further analysis of FESAL-93 data.

Table 9
Source of Contraceptive by Socio-economic level (Percentages)
El Salvador, 1993

Method: Sterilization		Source						Total
Socioeconomic Level	MSPAS	ISSS	Pharmacy	Private Practice	ADS	Other		
Low	31.7%	3.7%	0.0%	6.1%	39.1%	0.0%		
Medium	46.8%	37.6%	0.0%	8.4%	40.4%	19.3%		
High	21.5%	58.8%	0.0%	85.5%	20.5%	80.7%		
Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		
Source of Sterilization	64.3	15.7	0	3.6	16	0.5	100.1	
Method: Orals		Source						Total
Socioeconomic Level	MSPAS	ISSS	Pharmacy	Private Practice	ADS	Other		
Low	36.4%	7.9%	13.5%	12.2%	36.9%	12.8%		
Medium	52.6%	45.1%	38.5%	51.1%	39.3%	34.8%		
High	11.0%	47.0%	48.1%	30.7%	23.8%	52.4%		
Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		
Source of Orals	44.5	13.1	26.7	2.1	9.8	3.8	100	
Method: Injectable		Source						Total
Socioeconomic Level	MSPAS	ISSS	Pharmacy	Private Practice	ADS	Other		
Low	56.9%	10.5%	7.8%	10.1%	38.3%	0.0%		
Medium	43.1%	57.8%	20.3%	19.8%	41.7%	100.0%		
High	0.0%	31.7%	71.9%	70.1%	20.0%	0.0%		
Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		
Source of Injectables	4.4	11.8	39.7	6.2	37.3	0.6	100	
Method: Condom		Source						Total
Socioeconomic Level	MSPAS	ISSS	Pharmacy	Private Practice	ADS	Other		
Low	35.7%	6.3%	9.4%	0.0%	0.0%	0.0%		
Medium	49.5%	18.7%	30.2%	0.0%	0.0%	43.4%		
High	14.4%	75.0%	60.4%	100.0%	100.0%	56.6%		
Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		
Source of Condoms:	15.1	17.2	57	1.1	2.2	7.4	100	
Method: IUD		Source						Total
Socioeconomic Level	MSPAS	ISSS	Pharmacy	Private Practice	ADS	Other		
Low	42.9%	3.6%	0.0%	14.4%	6.8%	0.0%		
Medium	47.6%	28.6%	0.0%	28.5%	33.3%	0.0%		
High	9.5%	67.8%	0.0%	57.1%	59.9%	0.0%		
Total	100.0%	100.0%	0.0%	100.0%	100.0%	0.0%		
Source of IUDs:	45.7	30.4	0	7.6	16.3	0	100	
Method: All Modern		Source						Total
Socioeconomic Level	MSPAS	ISSS	Pharmacy	Private Practice	ADS	Other		
Low	33.1%	4.8%	10.9%	8.0%	37.1%	6.6%		
Medium	47.7%	38.2%	31.2%	16.1%	40.0%	35.8%		
High	19.3%	57.0%	57.9%	76.0%	23.0%	57.6%		
Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		

Source: Further analysis of FESAL-93 data.

Table 10
Source of Contraceptive by Socio-economic level (Percentages)
El Salvador, 1993

Method: Sterilization	Source		
	Subsidized	Non-Subsidized	ISSS
Socioeconomic Level			
Low	33.2%	5.4%	3.7%
Medium	45.5%	9.6%	37.6%
High	21.3%	85.0%	58.8%
Total	100.0%	100.0%	100.0%
Source of Sterilization	80.3	4.1	15.7
Method: Orals	Source		
	Subsidized	Non-Subsidized	ISSS
Socioeconomic Level			
Low	36.5%	13.3%	7.9%
Medium	50.2%	38.8%	45.1%
High	13.3%	47.9%	47.0%
Total	100.0%	100.0%	100.0%
Source of Orals	54.3	32.6	13.1
Method: Injectables	Source		
	Subsidized	Non-Subsidized	ISSS
Socioeconomic Level			
Low	40.3%	8.0%	10.5%
Medium	41.8%	21.3%	57.8%
High	17.9%	70.7%	31.7%
Total	100.0%	100.0%	100.0%
Source of Injectable	41.7	46.5	11.8
Method: Condoms	Source		
	Subsidized	Non-Subsidized	ISSS
Socioeconomic Level			
Low	31.2%	8.2%	6.3%
Medium	43.6%	31.2%	18.7%
High	25.1%	60.6%	75.0%
Total	100.0%	100.0%	100.0%
Source of Condom	17.3	65.5	17.2
Method: IUD	Source		
	Subsidized	Non-Subsidized	ISSS
Socioeconomic Level			
Low	33.4%	14.4%	3.6%
Medium	43.8%	28.5%	28.6%
High	22.8%	57.1%	67.8%
Total	100.0%	100.0%	100.0%
Source of IUD	62.0	7.6	30.4

Table 11
Source of Contraceptive by Socio-economic level (Percentages)
El Salvador, 1993

Method	All Modern	Source		
		Subsidized	Non-Subsidized	ISSS
Socioeconomic Level				
Low		34.0%	9.8%	4.8%
Medium		45.9%	28.1%	38.2%
High		20.1%	62.1%	57.0%
Total		100.0%	100.0%	100.0%

Method	All Modern	Source (% of all Users)			
		Subsidized	Non-Subsidized	ISSS	Total
Socioeconomic Level					
Low		23.5%	1.5%	0.8%	25.7%
Medium		31.7%	4.3%	6.0%	42.0%
High		13.9%	9.5%	8.3%	32.3%
Total		69.1%	15.3%	15.6%	100.0%

Method	All Modern	Source (number of users)			
		Subsidized	Non-Subsidized	ISSS	Total
Socioeconomic Level					
Low		71712	4571	2298	78581
Medium		96908	13096	18246	128250
High		42462	28961	27199	98622
Total		211082	46628	47743	305453

Method	Clinical (Steril + IUD)	Source		
		Subsidized	Non-Subsidized	ISSS
Socioeconomic Level				
Low		33.2%	6.4%	3.7%
Medium		45.4%	11.6%	36.6%
High		21.4%	81.9%	59.8%
Total		100.0%	100.0%	100.0%

Method	Clinical (Steril + IUD)	Source (% of all Users)			
		Subsidized	Non-Subsidized	ISSS	Total
Socioeconomic Level					
Low		26.3%	0.3%	0.6%	27.2%
Medium		35.9%	0.5%	6.1%	42.5%
High		16.9%	3.5%	9.9%	30.3%
Total		79.1%	4.2%	16.6%	100.0%

Method	Clinical (Steril + IUD)	Source (number of users)			
		Subsidized	Non-Subsidized	ISSS	Total
Socioeconomic Level					
Low		56193	584	1299	58076
Medium		76844	1057	12984	90885
High		36194	7438	21224	64857
Total		169231	9078	35508	213817

Method	Supply (Oral+Inj+Condom)	Source		
		Subsidized	Non-Subsidized	ISSS
Socioeconomic Level				
Low		37.1%	10.6%	8.2%
Medium		47.9%	32.1%	43.0%
High		15.0%	57.3%	48.8%
Total		100.0%	100.0%	100.0%

Method	Supply (Oral+Inj+Condom)	Source (% of all Users)			
		Subsidized	Non-Subsidized	ISSS	Total
Socioeconomic Level					
Low		16.9%	4.3%	1.1%	22.4%
Medium		21.9%	13.1%	5.7%	40.8%
High		6.8%	23.5%	6.6%	36.8%
Total		45.7%	41.0%	13.4%	100.0%

Method	Supply (Oral+Inj+Condom)	Source (number of users)			
		Subsidized	Non-Subsidized	ISSS	Total
Socioeconomic Level					
Low		15525	3984	999	20509
Medium		20072	12032	5262	37366
High		6273	21511	5977	33761
Total		41871	37527	12238	91636

Note: Subsidized includes MSPAS and ADS.
Unsubsidized includes Pharmacy, Private Practice & Other.
Source: Further analysis of FESAL-93 data.

Table 12
Source of Female Sterilization
By Socioeconomic Level
Sterilizations Performed 1988-1993
Weighted Number of Cases

Socioeconomic Level	Source						Total
	MSPAS	ISSS	Pharmacy	Private Practice	ADS	Other	
Low	124	3	0	1	43	0	171
Medium	145	49	0	3	45	0	242
High	54	65	0	23	14	5	161
Total	323	117	0	27	102	5	574

Table 14
Source of Female Sterilization
By Socioeconomic Level
Sterilizations Performed 1988-1993
Percent of Total by Source

Socioeconomic Level	Source						Total
	MSPAS	ISSS	Pharmacy	Private Practice	ADS	Other	
Low	38.4%	2.6%	0.0%	3.7%	42.2%	0.0%	
Medium	44.9%	41.9%	0.0%	11.1%	44.1%	0.0%	
High	16.7%	55.6%	0.0%	85.2%	13.7%	100.0%	
Total	100.0%	100.0%	0.0%	100.0%	100.0%	100.0%	
Source of Sterilization	56.3	20.4	0.0	4.7	17.8	0.9	100

Source: Further analysis of FESAL-93 data.

Table 13
Source of Female Sterilization
By Socioeconomic Level
Sterilizations Performed 1988-1993
Weighted Number of Cases

Socioeconomic Level	Source		
	Subsidized	Non-Subsidized	ISSS
Low	187	1	3
Medium	190	3	49
High	68	28	65
Total	425	32	117

Table 15
Source of Female Sterilization
By Socioeconomic Level
Sterilizations Performed 1988-1993
Percent of Total by Source

Socioeconomic Level	Source		
	Subsidized	Non-Subsidized	ISSS
Low	39.3%	3.1%	2.6%
Medium	44.7%	9.4%	41.9%
High	16.0%	87.5%	55.6%
Total	100.0%	100.0%	100.0%
Source of Sterilization	74.0	5.6	20.4

Source: Further analysis of FESAL-93 data.

Table 16
Source of Postpartum Female Sterilization
By Socioeconomic Level
Postpartum Sterilizations Performed 1988-1993
Weighted Number of Cases

Socioeconomic Level	Source						Total
	MSPAS	ISSS	Pharmacy	Private Practice	ADS	Other	
Low	82	3	0	0	0	0	85
Medium	104	33	0	3	0	0	140
High	41	33	0	13	0	5	92
Total	227	69	0	16	0	5	317

Table 18
Source of Postpartum Female Sterilization
By Socioeconomic Level
Postpartum Sterilizations Performed 1988-1993
Percent of Total by Source

Socioeconomic Level	Source						Total
	MSPAS	ISSS	Pharmacy	Private Practice	ADS	Other	
Low	36.1%	4.3%	0.0%	0.0%	0.0%	0.0%	
Medium	45.8%	47.8%	0.0%	18.8%	0.0%	0.0%	
High	18.1%	47.8%	0.0%	81.3%	0.0%	100.0%	
Total	100.0%	100.0%	0.0%	100.0%	0.0%	100.0%	
Source of PP Sterilization	71.6	21.8	0.0	5.0	0.0	1.6	100.0

Table 20
Source of Postpartum Female Sterilization
By Socioeconomic Level
Postpartum Sterilizations Performed 1988-1993
Percent of Total Sterilizations

Socioeconomic Level	Source						Total
	MSPAS	ISSS	Pharmacy	Private Practice	ADS	Other	
Low	66.1%	100.0%	0.0%	0.0%	0.0%	0.0%	49.7%
Medium	71.7%	67.3%	0.0%	100.0%	0.0%	0.0%	57.9%
High	75.9%	50.8%	0.0%	56.5%	0.0%	100.0%	57.1%
Total	70.3%	59.0%	0.0%	59.3%	0.0%	100.0%	55.2%

Source: Further analysis of FESAL-93 data.

Table 17
Source of Postpartum Female Sterilization
By Socioeconomic Level
Postpartum Sterilizations Performed 1988-1993
Weighted Number of Cases

Socioeconomic Level	Source		
	Subsidized	Non-Subsidized	ISSS
Low	82	0	3
Medium	104	3	33
High	41	18	33
Total	227	21	69

Table 19
Source of Postpartum Female Sterilization
By Socioeconomic Level
Postpartum Sterilizations Performed 1988-1993
Percent of Total by Source

Socioeconomic Level	Source		
	Subsidized	Non-Subsidized	ISSS
Low	36.1%	0.0%	4.3%
Medium	45.8%	14.3%	47.8%
High	18.1%	85.7%	47.8%
Total	100.0%	100.0%	100.0%
Source of PP Sterilization	71.6	6.6	21.8

Table 21
Source of Postpartum Female Sterilization
By Socioeconomic Level
Postpartum Sterilizations Performed 1988-1993
Percent of Total Sterilizations

Socioeconomic Level	Source		
	Subsidized	Non-Subsidized	ISSS
Low	49.1%	0.0%	100.0%
Medium	54.7%	100.0%	67.3%
High	60.3%	64.3%	50.8%
Total	53.4%	65.6%	59.0%

Note: Subsidized includes MSPAS and ADS.
Unsubsidized includes Pharmacy, Private Practice & Other
Source: Further analysis of FESAL-93 data.

Table 22
Place of Prenatal Care
By Socioeconomic Level
Percent of total by Socioeconomic Level
El Salvador, 1993

Socioeconomic Level	Place of Prenatal Care				Total	No. Case
	MSPAS	ISSS	Private Doctor	Other		
Low	91.4	5.1	2.4	1.1	100	1126
Medium	71.9	15.2	10.5	2.4	100	1135
High	38.5	26.8	29.6	5.1	100	669
Total	70.9	14.3	12.2	2.6	100.0	2930

Source: FESAL-93, p. 148.

Table 23
Place of Prenatal Care
By Socioeconomic Level
Number of Cases
El Salvador, 1993

Socioeconomic Level	Place of Prenatal Care				Total
	MSPAS	ISSS	Private Doctor	Other	
Low	1029	57	27	12	1126
Medium	816	173	119	27	1135
High	258	179	198	34	669
Total	2103	409	344	74	2930

Source: FESAL-93, p. 148.

Table 24
Place of Prenatal Care
By Socioeconomic Level
Percent of Total by Place of Care
El Salvador, 1993

Socioeconomic Level	Place of Prenatal Care			
	MSPAS	ISSS	Private Doctor	Other
Low	48.9%	14.0%	7.9%	16.8%
Medium	38.8%	42.2%	34.6%	36.9%
High	12.2%	43.8%	57.5%	46.3%
Total	100.0%	100.0%	100.0%	100.0%

Source: FESAL-93, p. 148.

Table 25
Place of Delivery
By Socioeconomic Level
Percent of total by Socioeconomic Level
El Salvador, 1993

Socioeconomic Level	Place of Delivery				Total	No. Casos
	In Hospital			Outside		
	MSPAS	ISSS	Private Hospital	Hospital		
Low	29.5	1.5	0.2	68.9	100.1	1954
Medium	48.1	11.1	0.9	39.9	100.0	1574
High	39.6	25.6	14.3	20.5	100.0	758
Total	38.1	9.7	3.2	49.0	100.0	4286
Total (In-Hospital)	74.7	19.0	6.3			

Source: FESAL-93, p. 154

Table 26
Place of Delivery
By Socioeconomic Level
Number of Cases
El Salvador, 1993

Socioeconomic Level	Place of Delivery				Total
	In Hospital			Outside	
	MSPAS	ISSS	Private Hospital	Hospital	
Low	576	29	4	1346	1956
Medium	757	175	14	628	1574
High	300	194	108	155	758
Total	1634	398	126	2130	4288

Table 27
Place of Delivery
By Socioeconomic Level
Percent of Total by Place of Delivery
El Salvador, 1993

Socioeconomic Level	Place of Delivery			
	In Hospital			Outside
	MSPAS	ISSS	Private Hospital	Hospital
Low	35.3%	7.4%	3.1%	63.2%
Medium	46.3%	43.9%	11.2%	29.5%
High	18.4%	48.7%	85.7%	7.3%
Total	100.0%	100.0%	100.0%	100.0%

Source: FESAL-93, p. 154

Table 28
Place of Well-baby Checkup
By Socioeconomic Level
Percent of total by Socioeconomic Level
El Salvador, 1993

Socioeconomic Level	Place of Checkup				Total	No. Casos
	MSPAS	ISSS	Private Hospital	Other		
Low	96.5	2.2	1.0	0.3	100.0	1430
Medium	83.2	12.4	3.0	1.4	100.0	1336
High	47.9	24.6	23.7	3.8	100.0	689
Total	80.8	10.9	6.8	1.5	100.0	3455

Source: FESAL-93, p. 164

Table 29
Place of Well-baby Checkup
By Socioeconomic Level
Number of cases
El Salvador, 1993

Socioeconomic Level	Place of Checkup				Total
	MSPAS	ISSS	Private Hospital	Other	
Low	1380	31	14	4	1430
Medium	1112	166	40	19	1336
High	330	169	163	26	689
Total	2822	367	218	49	3455

Table 30
Place of Well-baby Checkup
By Socioeconomic Level
Percent of Total by Place of Checkup
El Salvador, 1993

Socioeconomic Level	Place of Checkup			
	MSPAS	ISSS	Private Hospital	Other
Low	48.9%	8.6%	6.6%	8.7%
Medium	39.4%	45.2%	18.4%	38.0%
High	11.7%	46.2%	75.0%	53.2%
Total	100.0%	100.0%	100.0%	100.0%

Source: FESAL-93, p. 164

Table 31
 Family Planning Market Realignment
 Shifting All High-Income Users of Clinical Methods
 From Subsidized to NonSubsidized Sources

Socioeconomic Level	Source (no. of users)			Total
	Subsidized	Non-Subsidized	ISSS	
Low	56193	584	1299	58076
Medium	76844	1057	12984	90885
High	0	39732	25125	64857
Total	133037	41372	39408	213817

note: % of subsidized clinical users eligible for ISSS benefits = 18.03%
 Source: Further analysis of FESAL-93 data.

Table 32
 Family Planning Market Realignment
 Shifting All High-Income Users of Supply Methods
 From Subsidized to NonSubsidized Sources

Socioeconomic Level	Source (no. of users)			Total
	Subsidized	Non-Subsidized	ISSS	
Low	15525	3984	999	20509
Medium	20072	12032	5252	37366
High	0	27420	6341	33761
Total	35598	43436	12602	91636

note: % of subsidized supply users eligible for ISSS benefits = 11.90%
 Source: Further analysis of FESAL-93 data.

Table 33
 Family Planning Market Realignment
 Shifting All High-Income Users of Clinical Methods
 From Subsidized to NonSubsidized Sources

Socioeconomic Level	Source (Percent of total)			Total
	Subsidized	Non-Subsidized	ISSS	
Low	26.3%	0.3%	0.6%	27.2%
Medium	35.9%	0.5%	6.1%	42.5%
High	0.0%	18.6%	11.8%	30.3%
Total	62.2%	19.3%	18.4%	100.0%

Source: Further analysis of FESAL-93 data.

Table 34
 Family Planning Market Realignment
 Shifting All High-Income Users of Supply Methods
 From Subsidized to NonSubsidized Sources

Socioeconomic Level	Source (Percent of total)			Total
	Subsidized	Non-Subsidized	ISSS	
Low	16.9%	4.3%	1.1%	22.4%
Medium	21.9%	13.1%	5.7%	40.8%
High	0.0%	29.9%	6.9%	36.8%
Total	38.8%	47.4%	13.8%	100.0%

Source: Further analysis of FESAL-93 data.

Table 35
 Women 15-44 with Unmet Need for Family Planning
 Socioeconomic Level by Birth Preference
 (No. of Weighted Cases)
 El Salvador, 1993

Socioeconomic Level	Birth Preference		Total
	Limit	Space	
Low	68	89	157
Medium	50	84	134
High	15	45	60
Total	133	218	351

Source: Further Analysis of FESAL-93 data.

Table 36
 Women 15-44 with Unmet Need for Family Planning
 Socioeconomic Level by Birth Preference
 (Percentages)
 El Salvador, 1993

Socioeconomic Level	Birth Preference	
	Limit	Space
Low	51.1%	40.8%
Medium	37.6%	38.5%
High	11.3%	20.6%
Total	100.0%	100.0%

Source: Further Analysis of FESAL-93 data.

Table 37
 Women 15-44 with Unmet Need for Family Planning
 Socioeconomic Level by Birth Preference
 (Number of Women)
 El Salvador, 1993

Socioeconomic Level	Birth Preference		Total
	Limit	Space	
Low	10903	14271	25174
Medium	8017	13469	21486
High	2405	7215	9621
Total	21326	34955	56280

Source: Further Analysis of FESAL-93 data.
 Lininger, 1994

Table 38
 Unmet Need for Family Planning
 Assignment of Women with Unmet Need for Clinical Method to Source
 Numbers of Women
 El Salvador, 1993

Socioeconomic Level	Source		ISSS	Total
	Subsidized	Non-Subsidized		
Low	10659	0	244	10903
Medium	6872	0	1145	8017
High	0	1618	787	2405
Total	17531	1618	2176	21326

Table 39
 Unmet Need for Family Planning
 Assignment of Women with Unmet Need for Supply Method to Source
 Numbers of Women
 El Salvador, 1993

Socioeconomic Level	Source		ISSS	Total
	Subsidized	Non-Subsidized		
Low	13951	0	319	14271
Medium	11545	0	1924	13469
High	0	4854	2361	7215
Total	25496	4854	4605	34955

Table 40
 Combining Current Use With Unmet Need for Family Planning
 Clinical Methods
 Numbers of Women
 El Salvador, 1993

Socioeconomic Level	Source		ISSS	Total
	Subsidized	Non-Subsidized		
Low	66852	584	1543	68979
Medium	83716	1057	14130	98902
High	36194	9056	22011	67262
Total	186762	10697	37684	235143

Table 41
 Combining Current Use With Unmet Need for Family Planning
 Supply Methods
 Numbers of Women
 El Salvador, 1993

Socioeconomic Level	Source		ISSS	Total
	Subsidized	Non-Subsidized		
Low	26185	3984	1243	31412
Medium	26944	12032	6407	45383
High	6273	23129	6764	36166
Total	59402	39145	14414	112961

Table 42
 Combining Current Use With Unmet Need for Family Planning
 Clinical Methods
 Percent
 El Salvador, 1993

Socioeconomic Level	Source			Total
	Subsidize	Non-Subsidize	ISSS	
Low	28.4%	0.2%	0.7%	29.3%
Medium	35.6%	0.4%	6.0%	42.1%
High	15.4%	3.9%	9.4%	28.6%
Total	79.4%	4.5%	16.0%	100.0%

Table 43
 Combining Current Use With Unmet Need for Family Planning
 Supply Methods
 Percent
 El Salvador, 1993

Socioeconomic Level	Source			Total
	Subsidize	Non-Subsidize	ISSS	
Low	23.2%	3.5%	1.1%	27.8%
Medium	23.9%	10.7%	5.7%	40.2%
High	5.6%	20.5%	6.0%	32.0%
Total	52.6%	34.7%	12.8%	100.0%

Table 44
Combining Market Realignment with Unmet Need for Family Planning
Clinical Methods
Numbers of Women
El Salvador, 1993

Socioeconomic Level	Source		ISSS	Total
	Subsidized	Non-Subsidized		
Low	66852	584	1543	68979
Medium	83716	1057	14130	98902
High	0	41350	25912	67262
Total	150568	42990	41585	235145

Table 45
Combining Market Realignment with Unmet Need for Family Planning
Supply Methods
Numbers of Women
El Salvador, 1993

Socioeconomic Level	Source		ISSS	Total
	Subsidized	Non-Subsidized		
Low	29477	3984	1318	34779
Medium	31617	12032	7186	50835
High	0	32274	8703	40977
Total	61094	48290	17207	126591

Table 46
Combining Market Realignment with Unmet Need for Family Planning
Clinical Methods
Percent
El Salvador, 1993

Socioeconomic Level	Source		ISSS	Total
	Subsidized	Non-Subsidized		
Low	28.4%	0.2%	0.7%	29.3%
Medium	35.6%	0.4%	6.0%	42.1%
High	0.0%	17.6%	11.0%	28.6%
Total	64.0%	18.3%	17.7%	100.0%

Table 47
Combining Market Realignment with Unmet Need for Family Planning
Supply Methods
Percent
El Salvador, 1993

Socioeconomic Level	Source		ISSS	Total
	Subsidized	Non-Subsidized		
Low	23.3%	3.1%	1.0%	27.5%
Medium	25.0%	9.5%	5.7%	40.2%
High	0.0%	25.5%	6.9%	32.4%
Total	48.3%	38.1%	13.6%	100.0%

APPENDIX E
SCOPE OF WORK - PROFIT

THE PROFIT PROJECT
SCOPE OF WORK
ASSESSMENT OF COMMERCIAL FAMILY PLANNING POTENTIAL
EL SALVADOR

Introduction and Background

The PROFIT Project has been requested to undertake an assessment of the potential for expanding commercial sector participation in family planning activities in El Salvador. Such an assessment comes at a particularly important time in the country's evolution, following nearly three decades of change and uncertainty created through regional instability. Available information indicates that El Salvador has a strong and capable public health sector, and family planning activities are reinforced by robust NGOs such as the Salvadoran Demographic Agency (Agencia Demografica Salvadorena), an affiliate of IPPF.

The purpose of the proposed assessment, in keeping with USAID's interest in expanding the role of the private sector in family planning services, is to identify areas where commercial sector participation could significantly expand the availability or quality of family planning services and products in El Salvador.

The principal avenues for expanded commercial sector participation in family planning are: marketing and distribution of contraceptives; service provision by private health care providers, including the financing of such services through health insurance schemes; and through the participation of employers in providing family planning services or coverage to their employees. Accordingly, the assessment will examine:

1. **Marketing and distribution of family planning products through commercial channels.** This will include an analysis of legal and regulatory issues affecting the importation and licensing of contraceptives, and any Government policies constraining the distribution or availability of contraceptives. The analysis will include commercial sector participation in distribution of contraceptives through wholesale channels and retail outlets such as pharmacies, stores, supermarkets, etc. Opportunities for expanding the commercial sector's role will be addressed, including regulatory, business, media and financial activities.
2. **Provision of family planning services through the private sector.** This would include, but not be limited to significant private health providers (hospitals, clinics, HMOs) who are currently providing reproductive health related services on a commercial basis. In addition, the analysis would extend to the role of the insurance industry in covering family planning related services, and potential mechanisms for expanding such coverage.

3. **Employer-supported family planning service provision.** Potential opportunities to expand family planning services through the support of large employer groups will be explored. Such groups would include:
 - a. Agricultural enterprises (coffee) with large stationary labor forces;
 - b. Major industrial enterprises, such as industrial parks and processing zones, particularly in or near San Salvador (e.g., Hilasal)
 - c. Cooperatives and other independent associations

Proposed Tasks

The assessment will be conducted in two phases:

Phase I: Literature review and development of contacts

1. The assessment team will conduct a detailed review of the substantial current documentation of the Salvadoran health sector, with a focus on family planning activities, such as the "Análisis del Sector de Salud de El Salvador". These studies shall provide PROFIT with the background necessary to plan and conduct the assessment.
2. Identify specific organizations and commercial entities (and individuals if possible) for field interviews, including:
 - Pharmaceutical companies, importers and distributors of contraceptives, major retail outlets, large pharmacies.
 - Medical Associations (to understand the range of family services being provided)
 - University Schools of Medicine (identification of physicians who provide family planning services)
 - Regional health organizations, such PAHO, INCAP, Center for Disease Control, etc., to identify regional family planning networks
 - Family planning providers, including private physicians, midwives, etc.
 - Commercial associations (national coffee growers association, fabric industry, dairy industry, etc);
 - Health insurance companies (what services are covered and under what types of policies; who are the major insurers; how does the coverage work?)
 - Large employers, such as industrial parks, processing zones, etc.

Phase II: Field Work and Interviews in El Salvador

The team will conduct a detailed assessment of potential opportunities to expand private sector participation in family planning and maternal health in El Salvador. The team will utilize field interviews with organizations and private sector firms to determine appropriate areas for commercial sector intervention. In addition, the team will identify specific projects for funding by PROFIT or other funding sources.

Field activities will consist of 20 person days. A team of two professionals will conduct interviews with selected individuals, organizations and commercial entities. While it is premature to develop a specific assessment format, the following areas will be explored:

- a. Legal and regulatory barriers to the importation, distribution or sale of contraceptive products.
- b. Distributors and wholesalers' present and potential involvement in family planning commodities.
- c. The role of commercial marketing/distribution outlets for contraceptive products: pharmacies, non-medical retail outlets, supermarkets, convenience stores, etc.
- d. Integration of family planning products with other health and personal hygiene sales and distribution .
- e. Activities, current and projected, of donor agencies in commercial sector family planning activities.
- f. The role of market-based providers in the delivery of family planning services: current involvement, constraints and opportunities for expansion.
- g. Health professionals' attitude towards commercial, private family planning services provision.
- h. Legal and/or medical barriers impacting private providers: regulations regarding facilities, medical procedures, etc., that may limit service provision.
- i. Involvement of the insurance industry in covering family planning related services: key financial issues affecting coverage, policies, insured population. Legal and regulatory issues affecting the role of the insurance industry in family planing.
- j. Opportunities and constraints within various industries for employer based family planning services.
- k. General financial, credit and business issues in the Salvadorean economy affecting private sector provision of family planning services or products.

1. Identification of specific opportunities, both in the commercial and the NGO sector where PROFIT's assistance (financial and technical) could support expansion of sustainable family planning activities.

Proposed Level of Effort

1. One week (5 person days) preparation time at PROFIT's headquarters to review the presently collected literature for purposes of identifying field interviews, contacts, information resources, etc.
2. Two weeks (20 person days) in El Salvador to conduct field interviews and to perform the proposed technical assessment, as detailed above. A written draft of major findings and recommendations will be left with the Mission prior to completion of field work.
3. Three person weeks (15 person days), to organize the field and preparation material and prepare an assessment report. The final report will be delivered within 15 days of receiving Mission comments on the draft.

Staffing

PROFIT proposes that a bi-lingual senior health finance or family planning specialist be retained to conduct the assessment. He/she will address the marketing/distribution components of the assessment, along with the analysis of service delivery opportunities.

In addition, a senior business/finance consultant with experience in health and/or family planning issues will be identified who is bi-lingual in Spanish and English. His/her role will be to conduct interviews with commercial companies and financial institutions with respect to the business climate and potential commercial opportunities for family planning ventures.

Proposed Schedule

1. Preparation. Review of documents and development of contacts: 12 - 16 September, 1994
2. Field Activities: 19 - 30 September, 1994. A debriefing would be made to USAID/El Salvador of the major findings and recommendations, to be detailed in a report. A written draft of major findings and recommendations will be left with the Mission prior to completion of field work.
3. Report preparation. A draft report would be produced and submitted to USAID/El Salvador by October 21. The final report will be delivered within 15 days of receiving Mission comments on the draft.

APPENDIX F
SCOPE OF WORK - INITIATIVES

Initiatives

Scope of Work

for

Assessment of Private Sector Potential
to Provide Basic Healthcare Services to Low-Income Urban Populations in
El Salvador

PURPOSE: Assess the potential for providing basic health services to low income urban and periurban populations through the private sector in El Salvador

SPECIFIC TASKS:

The assessment team will:

1. Review existing information on the Salvadoran health sector, with a focus on private sector health and family planning activities.
2. Identify and meet with specific organizations and individuals whose participation could contribute to a fundamental change in the delivery of basic health and family planning services to low-income populations in urban and periurban areas, such as:
 - PVOs/NGOs (e.g. PROSAMI)
 - medical associations
 - health and family planning providers -- physicians, nurses, midwives
 - health insurance companies
 - large employers
 - commercial associations
 - schools of medicine
 - regional health organizations
 - medical and pharmaceutical supply companies
3. Assess the potential opportunities to expand private sector participation in basic health and family planning services delivery through the exploration of:
 - the current and potential role of market-based providers of health and family planning services, and the constraints and opportunities for its expansion
 - the extent to which existing or anticipated government policies help or hinder the provision of basic health and family planning services through the private sector
 - legal and medical barriers impacting private health providers: regulations regarding facilities, medical and family planning supplies, medical procedures, marketing, that may limit service provision

- client perceptions of private providers of health and family planning services
- health professionals' attitude towards private sector provision of basic health and family planning services
- involvement of the insurance industry in covering basic health and family planning services: coverage, policies, cost to consumer or company
- opportunities and constraints for employer-based provision of basic health and family planning services
- general financial, credit and business issues in the Salvadorean economy affecting private sector provision of basic health and family planning services