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Cynthia Prieto & Agustín Carrizosa

HEALTH SERVICES SYSTEM

El Salvador

Health Sector Assessment

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ACRONYMS

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ANSAL	Health Sector Analysis in El Salvador
ANTEL	National Administration of Telecommunications
IDB	Interamerican Development Bank
BM	Bienestar Magisterial (teacher's welfare)
CEL	Hydroelectric Commission of Lempa River
CISI	International Committee for Infant Survival
COBAS	Basic Health Activities
COMURES	Municipalities Corporation of El Salvador
CSSP	Superior Council of Public Health
EDUCO	Education with Community Participation
FESAL	National Survey on Family Health
FIS	Social Investment fund
FUSADES	Salvadoran foundation for economic and social development
GAES	Economic and Social Counselling Group
GOES	Government of El Salvador
INPEP	National Public Employees Pension Institute
ISSS	Salvadoran social security institute
MAG	Ministry of Agriculture and Livestock
MASS	Metropolitan Area of San Salvador
MIPLAN	Ministry of Planning
MOH	Ministry of Health
NGO's	Non-government Organizations

NRP	National Reconstruction Plan
OPS	Pan American Health Organization
PLANSABAR	National Basic Rural Sanitation Plan
PROSAMI	Mother Health and Infant Survival Project
SEMA	Environment executive secretariat
SILOS	Local Health Systems
SIS	Social Information System
SNS	National Health System
UES	University of El Salvador
USAID	United States Agency for International Development
WB	World Bank
WHO	World Health Organization

INTRODUCTION

The current report on the health service system, is part of El Salvador Health Sector Assessment Project (ANSAL), whose main purpose is to develop an integral diagnosis of the health situation of the country.

Objective
The main purpose of this report is to define the Sector's institutions, their characteristics, strengths, weaknesses an the role they play and should play in a process of changes to enable them to optimize their health services.

Methodology
The report is the result of the analysis of information provided by secondary sources, such as revision and analysis of documents (reports, counsel, bulletins, etc); individual and group interviews with directors of the Public and Private Sector and international agencies, whose main activity is related to the topic of this report.

There was a very close coordination with the directors of the GAES (Social and Economic consultant Group of the Ministry of Planning) and with the directors of the MOH in order to integrate our task to harmonize with El Salvador's State Modernization Program.

Also field visits were held to the operative and administrative facilities of the Private and State Sector in the capital and outside the capital in order to carry out the interviews.

Specific questionnaires for each situation had been made both for the interviews and for the observation visits. The goal that the authors have set from the beginning was to recollect the most ideas and opinions possible from the people who are involved in the System, they would enable the people to come to a conclusion which would reflect the actual status of salvadoran health. Just as expected, this enriched the labor developed, whose purpose was not just a simple diagnosis.

As a part of the ethic associated with our task, the privacy of our sources has been respected to the maximum, when requested.

EXECUTIVE SUMMARY

Political, economic, and social environment
The armed conflict that recently ended had, in every field, unfavorable effects on the country. There were human and economic losses, and consequently, the current social problems increased.

Even though the Health Sector was also influenced by these effects, the efforts made by the MOH are outstanding and important when, despite such unfavorable conditions, was able to maintain and improve some aspects of priority programs such as vaccination, malaria and infant death.

The peace process, did not only mean the end of the war but also started political, economic and social changes. The democratic process had encouraged two basic elements of change in the country: first of all, participation of the community, which integrates the community to the process of public action; and the technical-administrative decentralization, which aims to achieve a more efficient operation of the operation.

The need for a larger defense forced the GOES, to develop new strategies oriented aiming to (1) make economic re-orientation and stabilization programs; (2) aim for efficiency in the activities; (3) prioritize the activities of greater impact; (4) focus resources where they are needed most and, (5) coordinate the efforts and the use of resources.

Legal frame
The legal frame which controls the Health Sectors dynamics is managed, mainly, by the National Constitution and the Health Code. The Constitution states that the state should operate as director and controller, and its direct participation only in cases of epidemic.

The Health Code controls the responsibilities of the MOH and the CSSP (Superior Council of Public Health), making the Ministry responsible for the development a National Health Program to control and coordinate all the sanitary activities in the country, and to assure, through its dependencies, the health recovery of the ill. Nevertheless for some matters, it is not yet set which is the specific control range of the MOH and the CSSP.

The Code as well as the Constitution has been written with a wide view that gives the Sector flexibility to introduce the necessary changes to improve their activities.

Sanitary policy
The Social policy of the GOES is described in the Social and Economic Development Plan 1989-1994. The line out, objectives, strategies and programs of the MOH are set in the Sanitary policy and the National Health Plan. The institutional strategies defined in the plan are: expansion of coverage; improvement of the resolution capacity of their services; institutional development; financial strengthening; technical-administrative decentralization; inter and intrasectorial coordination and foreign cooperation.

The National Health Plan has not been accomplished nationally, therefore it is currently just an institutional operating tool for the MOH. The policies stated are appropriate but their application is still insufficient. The problem is partially due to the lack of resources and the lack of participation of all the sectors involved in the discussion and formulation of the health policy. In fact, by not having evaluable goals for all the sector and a determined chronogram, their implementation becomes more difficult.

There is a need for an entity in which the sanitary policy be legitimated by consensus of all the people involved, and its implementation should be determined nationally. The MOH must act as director and controller as stated in the law.

Configuration of the Health Sector
For the objectives of this report the Health Sector is considered to comprise these three subsectors: State, Private, and user.

The state or public subsector comprises institutions that are related to the state; the major providers of health services are: MOH and the ISSS[1].

The private sub sector includes professionals and profitable services (doctors, chemists, dentists, clinics, and private hospitals, laboratories, pharmacies, etc.) and non profit organizations known as NGO's, whose main characteristic is their dedication to work and service to the community, for which they are very important to the country.

Regarding the rendering of health services the largest supplier is the MOH, followed by the Private Sector, the ISSS, the NGO's and other state institutions. The models of attention are variable, the assistance component is preponderant and great emphasis is given to medical activities.

In general the aid is neither regulated nor standardized (except for the MOH and several NGO's). There is an inter and intrainstitutional reference system, which must be strenghthened to accomplish the level of efficiency required.

The informal component for health care (medicasters, etc.) has not yet been dimentioned, except for delivery assistance by empirical midwives. Self medication and pharmacy assistance are a key aspects of informal assistance.

Coverage
Hospital assistance coverage is mainly given by the state, whereas ambulatory assistance is an important part of the Private Sector.

The analysis of the MOH's coverage shows outstanding variations; from a relatively good coverage in infant vaccination, and a succesful malaria control program to a low institutional delivery assistance.

The sanitary coverage for the most vulnerable population is deficient due to state centralization, which has a inadquate distribution of the resources benefiting: the hospital component, urban assistance and specialized medical attention, prevention damage, primary attention and focalization of high risk groups.

Other components that restrains the coverage is the little participation of the communities, the little resolution of the personnel of primary health care and the inaccessibility to health services due to either educative, cultural, economical or geographic reasons.

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[1] There are also 17 state institutions rendering health services to their workers, and the most important ones are: Sanidad Militar (military health care, Ministry of Defense), Bienestar Magisterial (teacher's welfare, Ministry of Education), ANTEL (National Administration of Telecommunications), and CEL (Hydroelectric commission of Lempa River).

Health System

There is no formal health system structured in El Salvador, although there is conscience of the need to implement one. In the National Health Plan 1991-1994, the MOH committed to "Coordinate the activities of the different institutions of the Sector, aiming to structure, a mid-term National Health System for the best use of the resources of the country. The MOH will coordinate the activities of public and private institutions related to the population's health". A National Health System, such as it was enunciated in the Sanitary Policy, has not been implemented yet.

The National Health Commission, presidential office committed to promote coordination among health institutions, is not in force.

There is some type of state interinstitutional coordination, but it has not been developed at an adequate degree yet, and it does not use the potential of the integration of services and resource complement.

There is not any systematized information on the whole of the Sector and its components, and therefore it is difficult to know about the resources it has, the services rendered, the morbidity attended, etc. The information gathered by the MOH is considered as national but it recognizes the existence of sub-records. This is a problem that could be solved with a unique and obligatory information system for all the sector, centralized in the MOH and with easy access.

ANALYSIS OF THE INSTITUTIONS OF THE SECTOR

Ministry of Health

The MOH is responsible for the formulation and execution of government policies in public health and social assistance matters. To carry this out, the MOH has to assume the role of rector and controller of the sector.

The MOH is organized basically in two levels: (1) a central level responsible for the formulation and policy and technical-administrative management decision and support; (2) an operative level constituted by its network of services.

The MOH has the widest network of services in the country (374 services and 5213 beds from the 8240 in the whole country) and it is the main user of the health human resources (21.253 functionaries). Its network of services is made up by hospitals, centers, units and community health posts and dispensaries.

Community health is the responsibility of the promoters and empiric trained midwives who need a higher level of health problems resolution for them to be more involved in the community and, as a consequence, increase the sanitary coverage in activities of primary health care.

At the moment, the MOH has several functions that forces it to deal with assistance services for a high percentage of the population (the MOH is responsible for the 75% of the hospitalizations and for the 40% of the ambulatory medical consultations).

Some important aspects can be set in relation to how the hospitals and health centers perform: (1) they require a great amount of resources; (2) the model of attention is excessively curative; (3) in some cases the management is very poor because of a lack of administrative training of its directors, and, as a consequence, (4) its efficiency is relatively low, mainly because of the percentage of occupation and long stay.

The perception of the population of a better level of attention in the hospitals (where the manager is always a doctor) added to a restricted schedule of attention at a lower complexity level makes the hospitals of the MOH to be overloaded with patients who should no be assisted there, because of a system of reference and a poor level of resolution and commitment from the technical and auxiliary level personnel and from the promoters (the institutional attention of the delivery has a great deficit and no actions tending to solve it were detected).

In recent years, the strategy of the SILOS (Local Health Systems) from the OPS has been implemented, but it is still in an incipient step; this is why it has not become a real instrument of decentralization with participation of the community.

In general, the infrastructure is deficient in relation to the maintenance and equipment, but it is adequate in relation to the amount of beds and buildings. There are facilities that urgently need a large investment in infrastructure (Health Center of Sonsonate and the Rosales Hospital, for example). The State ought to refrain from building hospital infrastructures the following years. On the contrary, it ought to invest on repairing the damaged structure and improving the equipment of the services so that unnecessary expenses can be avoided.

The human resources is a critical aspect, mainly on account of the shortage of nurses, the preponderant hiring of doctors for 2 hours and the low salary perceived especially at professional and technical levels. Many other services would be more efficient with less personnel but with higher payment. There are legal or administrative stiffnesses that do not permit to optimize the use of the resources. Moreover, the insufficient use of resources like nurses, infant technologists and promoters[2].

Despite the efforts, a high level of centralization still remain. There is a great influence of the medical ideology and an important dependence on foreign cooperation, which implies a problem of sustainability.

Summarizing, the MOH has an excess of responsibilities which weaken its specific and priority function: *be the rector of the Sector and determine the implementation of the National Plan by all its member.*

Salvadoran Institute of Social Security and other state institutions
In the field of sanitary attention in a system of health security, the major provider is the ISSS with a low coverage of population and an over-use of its services. The ISSS has a kind of standardized attention, with a privatized component of specialized attention done by third parties that needs to be revised.

A model of similar attention, but in lower scale, is that of ANTEL (the state telecommunication company), while CEL (state hydroelectric energy company) having basic state oriented health care, as an entrance door, regulator and filter of other types of health care that require more complexity, and which are privatized. The Bienestar Magisterial (Teacher Welfare), entity that covers the health care of all teachers of the State, the state component is only administrative and all the health attention is given only in the Private Sector. Other state entities keep some ambulatory health services for the attention of their functionaries, but in minor scale.

Except for the ISSS, the financial support from the beneficiaries is minimal or symbolic, and it can be considered that these systems are a labor benefit financed mainly by the administration of the entities, that is,

[2] The topic of the human resources is analyzed in the report **Recursos Humanos en Salud** (Human resources in Health), by Dr. Esperanza Martinez, still in the area of the Analysis of the Health Sector.

the users of the telephones, electricity, water, etc. All these systems have no open models of health care without restrictions, regulations nor control systems.

The Private Sector
The non-profit subsector is being analyzed by a specific project, and the results should be issued soon.

In relation to the non-profit Private subSector or Non-Government Organizations (NGO's) that work in health, their commitment is outstanding not only by number (more than 70 already studied and probably more than 90 working in the Health Sector); their focusing in the health care of high risk groups and their emphasis in the prevention and human and community development but also by their social penetration and service vocation.

Previously, most of them used to work isolated, but in recent years, several groups of coordination were created as CISI, PROSAMI, CIPHES, Eastern Coordinator and Health Coordinator, that has contributed to establish the necessary coordination to be able to work in an integral way. In relation to the coordination between the NGO's and the MOH, this is in an incipient step.

Recommendations

The MOH should:

- Assume the role of rector of Health and establish a forum of participation and intrasectorial coordination in the National Health Commission or other fitting entity which may be created (A National Council of Health, for example), to be used as basis for the implementation of a National Health System to in force a Sanitary Policy and the Health Plan nationally. To achieve this, not only the public institutions have to participate but also the private ones and the non-profit ones, the Human Resource training ones and the gild associations.

- Develop a unique, national and obligatory information system and a system of epidemiological vigilance at national level.

- Destine more budget resources to health, developing modern administration and management systems to complement the process of decentralization.

- Optimize the use of resources, giving a higher share to primary health care, and providing more power of decision to the basic services.

- Develop a policy to improve development of the human resources and avoid an overlapping of activities and necessary investments in more complex infrastructure and technology.

- Give priority to the activities of mother-infant care, prevention and environment sanitation, promoting an increase of the coverage of delivery care and giving the promoters and nurses of primary level a higher level of resolution of health problems.

- Design, according to the epidemiological profile, a set of health basic activities (COBAS) rendered and assured by the State and to all the low income population.

- Establish a system of reference that permits the accessibility of the population with the least resources to more complex levels of attention.

- Regulate and standardize the benefits of the Social security and promote its coverage expansion through the ISSS or other institutions.

- Decentralize the MOH at municipal level, putting aside the regional division and avoiding the development of a bureaucracy between the operative and the central levels. To support the process of decentralization with an intensive training and supervision process.

- Coordinate the international help, giving priority to the most vulnerable areas, according to the epidemiological profile.

I *ANALYSIS OF THE POLITICAL, ECONOMICAL AND SOCIAL ENVIRONMENT*

There are many factors involved in the health/illness relationship; and restricting it to a biological factor, would be risky and unreal. Likewise, wanting to analyze the health sector services without considering its multifaceted and multisectorial characters would be like making a partial and incomplete analysis. Therefore, this report has been initiated, describing a few factors that influence the sanitation system and that should be considered in finding the possible solutions to it.

1 Political scenario

The salvadoran political scenario is filled with political and historical events, which led to the present situations and that shall determine the future strategies. Among the major significant ones are the armed conflict, the peace process, the sociopolitical climate and the democratic consolidation.

The armed conflict
The armed conflict, lasting almost 12 years, cost approximately $1.630 million U.S. dollars. During this period, the public expenditure increased the national defenses entry (23% of 1987 budget) and the interest payments (21% in 1987). This increase forced to diminish the entry destined to the investments in the social sector and it fell from 40% to 24%.

The effects of the armed conflict and the economical crisis in the 80's was reflected in the decrease of GNP (22%). Subsequently it started to grow at an annual rate of 1,7%. According to the CEPAL estimates the decrease of purchasing power of the salary was close to 60%, meanwhile the unemployed and underemployed rates increased from 21% to 60%. The most notorious consequence was the worsening of the existing social problems in the past decade; in the areas the vulnerable groups are most affected: infant malnutrition, illiteracy, etc. A 1985 MIPLAN household survey reveals changes in the internal poverty structure at the national level. This study demonstrates that even though the poverty rate remains, the extreme poverty rate increases from 30.7% to 40%.

The cost in human lives (75,000), the migrations (out of the country 750.000, inside the country 500.000) and the social turbulence that the conflict has left, represents an aspect of perhaps one of the most difficult problems to overcome. This dimension refers to the social mentality, to the predisposition and distrust the population will have in the country and in the possibilities of a change.

The damages caused by the armed conflict to the health services system, are related to the destruction of the facilities, loss of medications, medical supplies and human resources in health moving away from their work places in the conflict areas. This situation forced the closing of 22 units and health posts in the major conflict zones. The worsening unfavorable situation of population health, preventing the normal operation of the services.

The peace process
The peace process for El Salvador did not only mean the end of the 12 year conflict, but gave way to changes in the political, economical and social structures. Starting from Chalpultepec and even before (1990), democratic reforms are initiated and turn into an introduction of a major transference of power to the civil sector, and in the decentralization of this power to the regional levels and local government (municipality). The levels of decisions were aimed at bringing closer the control and dealings to the population goal for government programs.

In 1991 the National Reconstruction Plan was initiated (NRP) framed in the philosophy Plan for Social and Economical Development for the Government of El Salvador (GOES), and placing emphasis on the most affected conflict areas (115 municipalities). With the government efforts the NRP is born to create the social and economical conditions that strengthen the process to pacification and national reconciliation. Its strategy is to encourage the salvadoran community to solidary participation in the reconstruction process and to reintegrate the members of the society mainly effected by the conflict[3], into the productive and civil life of the country. The plan emphasizes the need to include local governments, communities and non governmental organisms to this process. Consequently, it tries to incorporate the sectorial proposals and look for consensus levels in the coverage of the projects proposed.

The sociopolitical and democratic consolidation environment

El Salvador finds itself in the middle of democratic consolidation. Within the outstanding political factors are the 1994 presidential elections. For this reason the health situation has occupied a central place in the national political debate. A consensus element seems to be the need to increase the public expenditure for the sanitation system. Among the most spread proposals are: the consolidation of a National Health System, the emphasis on the decentralization for the technical administration of the sanitation system and the strengthening the primary attention in health.

Another normally debated topic is related to the need to develop cost recovery systems and the rationalization of existing resources.

Though at the start, all the political tendencies in El Salvador, previous to the March 20th elections, manifested publicly that the health services system must be improved, the same preelection effervescence did not permit to achieve a consensus about the kinds of changes that should be introduced. However, the new rulers should allow the participation of ALL the Health Sector components in order to achieve the viability of the changes that should be made. The consensus is made more necessary, as long as the democratic process of the country achieves the a greater distribution of power through the past elections.

The municipalities are profiled as much more active institutions for the future distribution of government power. This situation will accelerate the decentralization process of the Public Sector institutions; therefore, such institutions should find mechanisms to activate such processes, or else, hasten to hand the power over to local levels of the government (municipalities).

This fact has special importance for some Public Sector institutions which, because of their size and organization have lost the agility to develop activities. An example of interest for our analysis is the MOH case. This institution has been one of the first to begin the decentralizing process more than two decades ago, being unable to achieve it. The reason for this is the centralist culture of the institution, acting as an institutional inertia worsening[4] the process.

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[3] The NRP health programs try to:

- Rehabilitation of the disabled.
- The formation of health promoters.
- The opening of 800 Mother Infant Care homes.
- The formation of 125 sanitation groups.
- The rehabilitation and strengthening of health services.

[4] In this report it is called "institutional inertia" to the institutions bureaucratic resistance and response to the changes and the slowness in which they adapt to the changing necessities of there users.

2 Socioeconomic situation

The economic and social changes in the last decade have hindered the performance of the sanitary system in El Salvador. Public expenditure on health and the level of family income are some examples of the increasingly important issues determining the change in the Health Sector.

Economic reform
Starting 1990, El Salvador has attained a 3.8 % increase in the average Gross National Product (GNP). Which surpassed the Government forecast for this period of time. This growth came along with an increase in the per capita income ($1.100 US approx.) and the creation of 120.000 new job positions. Moreover, a reduction in the inflation rate and an increase in the Economic Activity Volume Index was achieved. This growth achieved by the stabilization policies and economic reorientation of the GOES did not reach the growth levels of 1978.

Another of the strategies started by the GOES (1989) was the state modernization plan; the goal was to adequate the state to its new proxy and manager role of the socioeconomic and political changes of El Salvador. In the re- definition of the government role in the economy, measures in the sense of reducing the size of Public Sector and making it more efficient were taken.

The economic reform program of the GOES has attained a vigorous response translated into economic growth rates in latter years. Furthermore, the rules of the game confronted by economic agents of the private sector have been greatly altered. However, some of the changes expected in the Public Sector were not achieved, such as: to give more emphasis to the reforms of the social policies, to promote private rendering of public services, to update the civil service law, etc.

Social strategy
According to MIPLAN, when the present government activity started in June 1989, the country was in its deepest economic and social crisis. Infant mortality reached 56 per thousand, whereas Latin American average was 52 per thousand; the daily calories intake per capita was 2.155 (around four-fifths of Latin American average) and adult illiteracy was 30 % (twice the Latin American average). More than half of the population lived in poverty conditions and around one third of then were in extreme poverty. Malnutrition affected half of the children under five. Only 42% of the homes had access to potable water and only 58% had an adequate sewage system.

The GOES social policy has, as one of the objectives in the Social Economic Development Plan 1989/1994, the aim "to improve the life level of the population and start a steady process to eradicate extreme poverty".

This policy is basically oriented to two objectives: a short term one aiming to minimize the adverse impact of the adjustment measurements in the poorer levels of the population, and a long term one to implement drastic reforms in the social sectors to increase the efficiency in the rendering of services[5].

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[5] to attain the second objective the GOES posed the following plan of action:

- Focus the social expenditure to the poorest.
- To restructure an decentralize rendering of public service.
- To provide subsidies directly to the poor instead of general price subsidies.
- To encourage the participation of the Private Sector.
- To monitor and continuously evaluate social programs.
- To articulate the rendering of services with the local government.
- To create alternative mechanisms to deliver social services.

The new social policy rejects the conception of people's state, government oriented and paternalism of the past, reorienting social development toward a responsibility shared by all salvadorans, in the identification and search of solutions to their own problems.

Two operative strategies were developed to compensate the negative impact of economic adjustment in the most vulnerable groups, the Urban Emergency Program and the Social Investment Fund (FIS). The latter is aiming to collect national and international resources to compensate the population in extreme poverty for the effects of the structural adjustment. Thereat it invests in human development through NGO's and private organizations capable to promote the conditions to fulfill the population most urgent needs.

Using the social expense as indicator of the priority that the GOES assigned to the social sector, it may be said that such expense increased from 547.84 million colones in 1978 to 1,038.85 millions in 1989. It is necessary to explain that, on account of the inflation, the social expenditure of 1989 only represented (in real terms) a little more than one third of the same expense in 1978. Which meant that the increase was only apparent.

El Salvador, though overcoming its problems, is experiencing a shortage of public resources. This implies the need to increase the efficiency in public administration in order to improve the coverage using the same resources. Furthermore, in order to optimize the usage of government resources, social expenditure is aimed at the needy ones.

Achievements and obstacles
In spite of the important changes, especially in what has to do with El Salvador's economic growth, the improvements in the social indicators were not likewise. Though some criticize the limitations in span and depth of social policies, others consider there are four situations conditioning its realization, that is: financial, law/administrative, program proxies and community participation and access conditions.

a) The *Limited financial availability* is a barrier to achieve the goals and objectives of social reform. Considering: the fiscal deficit from former years, high demographic growth and the obligation to begin paying the external debt in 1995; it is expected that financial availability will keep on being a restriction to achieve the goals of the social sector.

b) In order to cover the needs of the social sector which is dynamic and variable, public institutions must be dynamic to assure the demand to service efficiently and timely. In order to improve the response capacity of the state organ, a *process of legal and administrative modernization* of such organ has been initiated. This process has not been able to carry out all the changes expected at this time. There are reforms to the Civil Service Law and enforcement of the Salary Law not achieved yet; the Social Information System (SIS) has not been implemented. These and other pending changes are becoming a restraint for the modernization of the state and, therefore, for the development of the human and social potential of the salvadorans.

c) The Social and Economic Development Plan of the GOES and the State Modernization Program of El Salvador demand great changes even in the conception of the state. They must be beyond the concept of "benefactor and paternalism" to the conception of state as development promoter, protector of freedom and the rights of the people; for which the provision of basic services to all salvadorans must be assured. It should be underscored that in the new concept to "assure" does not meant that the state should render

• To plan and coordinate resources and sectorial and intersectorial activities.

the service, it means that the state has the obligation to search for options for the service to be rendered efficiently. The efficient supply of services frequently requires that the organization providing it should be nearer to the users. That is, that the rendering of services must be in the hands of the municipalities, community groups, private offices or NGO's. Many of the changes mentioned, are planned or executed partially; but it still finds some institutional culture constraints or deficient political resolution.

d) There are many causes and factors involved in the social problems. Therefore *the settlement of social problems should be accepted with shared responsibility with the community*; but to give the responsibility implies to delegate authority so that the new entity in charge may be able to accomplish its duty. All this means the modernization of public administration and the administrative decentralization, it requires the delegation of executive and executor responsibilities of intermediary organisms decentralized from public administration. It is necessary to generate consensus on priority health problems and the most efficient means to overcome them. This consensus could not be generated if local organisms and the community do not have the necessary decision power to solve the problems. It is necessary that trust be encouraged and that a cooperation culture between public and private sector be developed.

3 El Salvador in the world

The activities of one country influence neighboring countries. The more the potential of a country, the more ample its scope of influence. On the contrary, the weaker the country, the more the influence it receives from others. El Salvador, being a developing country, receives ideological, political or economic influences.

Ideological changes
After the end of the cold war and the breaking down of the Soviet Union world forces and interests have been reorganized. The current USA policy prioritized the attention to its own domestic problems and the strengthening of its economy; and has changed the "rules of the game" in the whole world. At the moment, nations are being organized around the market, and an increasingly global economy. This new world order has changed the dissertation of the past (communism, democracy, etc.) for a new one on which "innovation", "competitive capacity", "efficiency" seem to conceptually define the trend toward a market economy.

This reorganization in international relationship has generated "reference ideas" which are the basis of interaction among countries. Some of these fundamental ideas are democracy, sustainability, coordination and complement of efforts.

Political changes
One of the most important "reference ideas" is democracy. Without the antithesis of communism, democracy has achieved relevance and consensus as a model to administer political and social coexistence. In the American continent, the democratic model has been replacing most authority and paternalistic models of the past.

Two strategies are gaining prominence with the concept of democracy, since they strengthen and consolidate it; they are:

- Community participation: aiming to integrate the community (the recipient) in decision taking, in the control of production and in the evaluation of the finished product of public proxy. Assuring community participation not only consolidates the democratic model, but also increases the capacity to diagnose the needs of the population and to focus the programs to the most vulnerable groups.

- Technical-administrative decentralization: this strategy aims to achieve a state organization to be as close as possible to the beneficiary, thus ensuring user participation in public administration proxy process.

Thanks to the peace and economic growth achieved, the salvadoran democratic process has been strengthened in latter years. This process has resulted in the developing of mechanisms to assure community participation in the country, as well as the transference of central power to the municipalities. There have been some constraints in the necessary resources to implement it and the difficulty presented by public institutions to decentralize their technical-administrative systems.

With the new government budget system, the municipal imposing system and the FIS, it has been possible to direct financial resources to enforce decentralization. The total of these resources has become insufficient, moreover, there is still the need of management capacity to manage the process and policy decision to consolidate it.

At the Health Sector, the decentralization experiences and community participation have been plenty; just the MOH and the NGO's have developed experiences in this sense, which are still in process of consolidation. Decentralization in the MOH has included the moving of some responsibilities to regional and local levels, but participative incorporation of the beneficiary is yet to come. The NGO's have accomplished a little more community participation, in some cases, but they have not been able to incorporate themselves to a national planning and coordination system to help optimize their achievements.

Economic changes

Another "reference idea" is sustainability, which is related to the need and possibility of a country to finance its own development. World resources are becoming scant and countries tend to be concerned more on their own domestic problems: which means that foreign help is beginning to diminish, to the point that financing programs are jeopardized. Today, it is necessary to be sustainable.

Among the strategies developed to attain sustainability are:

- *Programs for economy stabilization and reorientation.* Being developed in most countries of the american continent with some variations which span from economic neoliberalism to free market social economy. Its major drawback has been the social effect they may have.

- *Efficiency.* The cost/benefit relationship is becoming an essential part in operative planning. Costs control and their connection to production is a new discourse for the public sector and especially for social sector institutions.

- *Rationalization.* It incorporates the concept of "priority" to the administration of resources in order to use them in more productive areas.

- *Focalization.* Which is to "aim" resources to the needs or risk groups of a population.

The economic growth in latter years has not been able to improve sustainability of the social sector. For instance: health expenditure in El Salvador for 1992 is estimated to be 3,7% of the GNP[6].

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[6] Fiedler Jack, *Health Sector Financing*, ANSAL, 1994

MOH's expenditure has grown to an annual average of 11,2% and it renders approximately 50% of health care in El Salvador and it only receives 22% (around 1,0% of GNP) of the total expense on health. Nearly 20% of this output is being financed by international agencies. This contribution will be gradually reduced in the years to come, which will increase the problem of sustainability for the Ministry.

To face this reality, the GOES may: (1) search and find other sponsors (not likely); (2) increase MOH's share of GOES's funds; (3) focus MOH's efforts on a more limited target population; or (4) redefine the role of the MOH to a more ruling one and as facilitator of the rendering of services in order to ensure their quality.

Changes in cooperation

A third "reference idea" in the present world which is very close to the concept of resources rationalization, which are increasingly scarce, is the coordination and complement of efforts. The concept of cooperation is increasingly integrated to the strategy to face the challenges. Whether institutions or countries, the possibility to survive, and to progress by themselves is becoming more scant every day. In this context, coordination is the only way to manage cooperation, to rationalize resources and to harmonize efforts.

In most documents which define policies and health strategies in El Salvador one may find the commitment or obligation to coordinate activities and also, with the same intensity is the little coordination among the institutions involved in the sector is acknowledged (there are no formal instruments of coordination such as meeting agendas, distribution of agendas, collecting comments, evaluation of comments, etc.)

Synthesis of the situation

When analyzing the political, economic and social environment of El Salvador and world environment, some "reference ideas" are highlighted, they frame, influence and direct the process of change in the country and enforce a possible reform of the health sector.

The armed conflict in El Salvador brought economic and Human losses as well as losses in self esteem and trust in the future. This conflict added to the world economy crisis in the 80's conditioned a setback in the economy of the country back to the level of the mid 70's.

The peace process and the social and economic development plan encouraged a very important economy development, but did not achieve a similar impact in the social sector. On the contrary, the economic adjustment measures have worsen some social problems.

The development process in El Salvador has enforced the concepts of "reference ideas" which become relevant in the planning of reforms in the health sector, such as: (a)decentralization; (b) community participation; (c) sustainability; (d) efficiency; (e) coordination; (f) cooperation.

All sectors seem to agree on the need and urgency to create a National Health System as a coordinating entity. However, there is an absence of political decision, necessary to make it formal, and to implement it.

II *CONFIGURATION OF THE HEALTH SECTOR*

The components from the Health Sector, their main responsibilities, the impact they produce upon the Sector and the nature of the interaction among them, are described in this chapter

1 Components from the Health Sector

For the purposes of the present report, the Health Sector is considered to be composed of three subsectors: state, private and users. These subsectors participate and fall into the Sector, in a different way and at different levels.

1.1 State subsector

The state health subsector is integrated by several institutions that participate in different stages and at different levels of the process: from the formulation of policies, through planing, financing and the execution , until the evaluation of the programs that fall into health.

The Political Constitution from El Salvador (1983) in its Article 65 gives to the state and to the people the responsibility to " watch over the preservation and recovery of health." The Executive Organ has the Ministry of Health (MOH) as a rector and executor organism of the health policies from the Government. Therefore, the MOH is one of the institutions that conform the subsector.

The Superior Counsel of Public Health (CSSP) was created in the Constitution of 1956 as an organism controlling the practice of professions and health services. Since then, the CSSP is a part of the sub sector.

To illustrate the complexity of the state health subsector, some of the institutions and instances that participate in different actions related directly with health will be enumerated:

- *Promotion of policies.* MIPLAN elaborates the Social and Economical Plan. In this plan the National Health Plan that represents the specific health policy and elaborated by the MOH is incorporated. The approval and promulgation of the policies belongs to the President of the Republic.

- *Financing.* There are several sources of financing. For the ordinary budget the Ministry of Treasury makes estimates of the collection and following the lineaments from Social and Economical Development Plan, establishes indicative amounts for each ministry. This indicative distribution of the budget is analyzed by the Council of Ministries in plenum joint (Economic Committee and Social Committee) modified and/or approved. The Ministry of Treasury provides the indicative amount to the MOH based on which, the latest elaborates its application. The Ministry of Treasury submits to the Legislative Organ the annual budget of the GOES for its definite approval. Internally the MOH is not concentrated toward the regional level, the budgetary elaboration and administration.

  The extraordinary budget is financed with funds from international cooperation. Ordinarily the use of funds is agreed between the executory unity and the cooperation agency. The agreements of loans should be approved by the Legislative Organ. MIPLAN participates in the management of the extraordinary budget because of its responsibility to coordinate the external cooperation.

  It should be added that the cooperation agencies frequently influence the political decisions of the GOES.

- *Planing.* It is an intrainstitutional process. The MOH has started actions that allow the regional staff to participate in the planing. The counselor could not prove to get the systematic participation of the Private Sector or the users in the process of health planning.

  Within the Development Program from MIPLAN there is a section in charge of health. It does not participate in the elaboration of the National Health Plan.

- *Execution.* Each Institution from the Sector executes its own programs independently, although it coordinates in punctual topics and not systematically.

  Within this subsector, the largest suppliers of this services are the MOH and the ISSS, followed by some government institutions like CEL, ANTEL, Teacher's Welfare and the Batallón de Sanidad Militar. There are other state branches that carry out activities related to water, sewage and environment: Secretariat Ejecutiva del Medio Ambiente (SEMA), Direction of Vegetable and Animal Health from MAG, National Administration of Aqueducts and Sewerage (ANDA), the municipalities in the recollection and disposition of solid waste, the National Plan of Basic Rural Health (PLANSABAR) from the MOH and the programs for woman health and seniors of the Secretaria Nacional de la Familia. It powerfully calls our attention the inadequate coordination between all these sectors and institutions.

- *Evaluation.* Each institution has its own system of evaluation and follow up. The MOH only receives partial information from some of those institutions which makes almost impossible to take the rector role. There is little knowledge on the participation of the different organisms from the Sector, through impact and opinion polls that are done. MIPLAN is preparing a Social Information System (SIS) that will serve for the evaluation and monitoring of the social programs. It has not been implemented yet.

1.2 Private subsector

Commercial subsector

This subsector is made up of the commercial sector that includes the private medical, dentist and biochemical attention. Other components from the commercial health sector are the drugstores that even in rural areas, have a very important role because they guide patients in the use of medicine or when to see the doctor. The level of self medication is very high in El Salvador (47%).

Other components from the Private Sector that have influence upon health, are the private universities. There are more than ninety private universities in the country. The University of El Salvador (state) and eight of the private universities are part of the health staff (the MOH is also part of it). There is no coordination nor planned direction between these institutions.

Non commercial subsector

According to some information from PROSAMI, there are about 200 Non-government Organizations in the country (NGO's), distributed in different parts and that have created strong bonds with the communities they are inserted. The resources of the NGO's come from specific projects, international donations and the community.

The NGO's have different areas of action: micro enterprise, agricultural work, infant and senior care, primary health attention, afforestation, protection to the ecology, etc. Data from USAID (Marcable 1990) indicate that there are 75 NGO's dedicated to health. One of them (PRO-FAMILIA) has national coverage in mother-infant attention with a great number of volunteer staff and paid promoters.

The statements from the public subsector and the NGO's help show the coordination between both subsectors is not enough.

1.3 User characteristics

The profile of the health service user (REACH) is the one of a rural resident or from cities from the interior of the country, whose home is very far away from the hospital or health center (23% at less than 30 minutes and 58% at more than an hour). They are people that come to the centers in a medical emergency situation and most of the times they have not gone through the peripheral institutions of the service structure: health centers, health units, etc. Generally these people have a low paying capacity and they are illiterate or with elementary education. They are superstitious, with tendency to self medication and stoic when they are ill.

2 Health System dynamics

2.1 Legal frame

The functioning of the Health Sector is regulated by the National Constitution and the Health Code that regulates its functioning, defines the State role and establishes the responsibilities and obligations of the different actors of the Sector.

The Political Constitution of El Salvador
The Constitution of El Salvador has had different directions in the composition and functioning of the Health Sector, according to the different reforms it experimented through the political history of the country.

The Constitution of 1841 established in its article 62 that what referred to health was of the domain of the Municipal Power: the group of neighbors through their representatives in the Municipal Council exercised their civil rights. This Council together with the Mayor formed the power of the local government or Municipal Power. Its responsibility according to the Constitution was: "the preserving, progress, healthiness, comfort and decoration of its neighbors".

In the Constitution of 1821 the topic of health appears under the responsibility of the Legislative Power when it points out among its attributions "the creation of a Sanitary Department, whose orders would be transmitted to all federal authorities of the States.

It was starting from the Constitution of 1950 and 1962 that there is a notorious increase of the role of the State in the economical and social life of the country. Facing this new way of State, health is considered as a public assessment and it is established as a "*primary obligation of the State the protection, preservation*, and recovery of the health, because it is considered as the most precious gift of man and it constitutes the essential condition for its progress".

In 1956 the Superior Council of Public Health was created by a constitutional disposition, as an entity of supervision and control of the Sector both for its private and public components. This Function is apparently shared with the MOH, since in the forming Decreet of the MOH (1989) the responsibility of controlling health attention was given to the latter. With the creation of the Council was also created the Vigilance Boards, which job is to control the health careers, regulating and standardizing the professional practice. Even when the important role of the State in the activities of the sanitary practice persists, the in force Constitution propitiates the health as a matter of community interest and not only to the State. Health is understood as a right and

obligation in which, both the person and the State, should play an active role under the coordination of the last one which has the responsibility to determine the national health policy and control its execution.

This Constitution manages to keep for the State a more rectorial and controlling function, establishing a direct supervision only in case of epidemics.

The Health Code
It was approved on April 1988. It provides the legal basis upon which the sanitary system of the country functions. The code shows a wide and integral idea of health and it recognizes it as a basic right of Man without race, religion, ideology or socioeconomic class distinction. The Code outlines the health control systems and the precautions for epidemics very clearly. In what refers to medical assistance the Code indicates (section 43) that the MOH, through its dependencies, should guarantee the health recovery of sick patients. For the effects of integral attention should develop a national program of public health, that regulates and coordinates all the corresponding activities in the country. The topic of coordination and the one of avoiding the duplicity of efforts is repeated several times in the Health Code.

All the first part of the Code refers to the functioning and responsibilities of the Superior Council of Public Health, and the Vigilance Boards. The CSSP and the Vigilance Boards funtion as controling organs of the sanitary services and they report to the Executive and Legislative Organ for the appointment of their authorities. Even when it is an autonomus organ by the Constitution its bufget is incorporated in the budget of the MOH. In the other hand it is not clear what is the range of control of the MOH and which is the field that corresponds to the CSSP.

The Code regulates the responsabilities and funtioning of the MOH and the Superior Councilof Public Health, but it does not make any reference to the other components of the Sector, such as: the ISSS, private subsector, etc.

It must be considered that the health field is very dinamyc and its regulation should have the necessary flexibility to cover the needs promptly.

Evaluation of the Health Sector's legal frame
El Salvador has an advantageous position on account of the legal frame that runs the Health Sector. Both the Constitution and the Health Code have been elaborated with a wide vision that allows flexibility to the sector and to the possibility to introduce the necessary reforms. This is what is emphasized here as an advantage, has been considered by some of the rpresentatives of the Public Sector as an inconvenience for its administration or they can not find in their lineamientos clear rules that regulate the Health Sector. In this way there are regulations to the Code that are necessary to make: laws related to the enviroment (process), iodation of salt or about the selling of medicines in drugstores.

An element that is not clear, neither in the Constitution nor in the Health Code, is the relation and difference of attributions that should exist between the MOH and the Superior Councilof Public Health. Both depend on the executive and the budget of the MOH. However, the CSSP has the responsability to control the funtioning of the MOH. Both have authority to regulate and both have to fulfil controling funtions. It is not clear who the CSSP reports to.

3 Health Policy

The GOES social policy is outlined in the Social and Economic Development Plan 1989-1994. This plan has two components: The Structural Adjustment Program and the Social Compensation Program.

The Structural Adjustment Program aims to promote the economic growth that will take the country out of the previous stagnation and will restitute the loss caused by the war. It incorporates the economic re orientation and stabilization.

The Social Compensation Program emerges from two facts that justify a social policy: the social cost that goes with the Structural Adjustment Programs and the poverty levels that existed in El Salvador. This program formulates the objectives of social policy at mid and short term.

The objectives of social policy at short term aim to minimize the Adjustment Program impact, using compensatory measures. The purpose of this policy is to assist the groups in poverty, through: direct subsidies, Social works, generating employments and improving family income.

The goals of the Social Compensation Program are:

- To give priority to the vulnerable groups or those under risk.
- To modernize the instruments and systems used in handling social programs, innovate them when necessary.
- To establish the basis for a continuous system of social attention.

The social midterm policies were designed to handle health, housing, social security and other needs of the sector. The strategies determined by GOES to handle the health, education, housing sectors are: (a) Decentralization; (b)Focussing of the services and, (c) Reinforcing the attention systems.

The health and nutrition component of midterm is intended to focussing health expenses to improve the coverage and attention of primary health services. It emphasizes the mother-infant care, nutritional attention, potable water and latrinezation.

Also, El Salvador Modernization Program has influenced on the health policy. This program incorporates four ministries: Health, Education, Farm and City Planning. The purpose of this program is to introduce structural changes in the public sector to improve the administration, to reinforce and decentralize the state budget and to make rendering services more efficient. The modernization Program attempts to obtain, just like the Development Plan, a major participation of the Private Sector in services offer.

Another view of GOES' social policies, is constituted by the National Reconstruction Plan (NRP). When the peace agreements were signed in Chapultepec, the PRN received the international pat in the back which gave strength and support to its execution. The PRN gives priority to the attention of the 115 municipalities most affected by the war conflict, specially to the rehabilitation and modernization of the social sectors.

There is a proposition to support the decentralization, focussing and participation of the community in the satisfaction of its necessities to consolidate the MOH and Ministry of Education institutional reforms. All this is intended to improve the quality and coverage of the services.

The National Health Plan

In February 1994 The National Health Plan 1991/1994 was approved. It contains the policy features, the objectives, the strategies and the MOH programs. It communicates the purpose of the Ministry to encourage, protect and reestablish the health of the population by integral attention to the environment and to the people.

The plan is formed by action lines that determine the expected general purposes. It does not have a chronogram to establish a time to obtain these purposes, neither goals to determine the specific expected results.

The institutional strategies that are outlined in the plan can be synthesized in: the coverage extension, the improvement of the resolutive capacity of its services, the institutional development, the financial fortification, the technical-administration decentralization, the inter and intra sector coordination and the external cooperation.

The programmatic area is divided into what is called operative programs and strategic projects that cover all of the public health and the attention doctor/assistance components. Here is a description of programmatic intentions and correspondent strategic lines, but when a chronogram or goals are not established, it is not an operative programming. This is an inconvenience to the administration and evaluation of the institutional programs.

Since this is a plan of national range, the lack of a chronogram and goals is an obstacle to the coordination with the other private and public institutions, outside MOH. These Institutions cannot have clear understanding of what is expected from them, and when; which makes the application of the plan at a national level difficult.

The National Health Plan 1991/1994 does not have a national character, instead it has been an institutional plan to which a national application has been given to. This is because in its elaboration the rest of the health sector did not participate. This reflects a failure of MOH to assume the rector function that belongs to it.

This turns into an absence of control of the health situation. For instance: The production of medicines and meals is not controlled properly. To the absence of a ruling entity the opportunity of obtaining a coordinated health system with clear rules is lost. This is a problem wheno developing health global strategies is required.

The documents related with the health strategy and the MOH function, emphasize the Sector coordination and the need of organizing and starting a National Health System (NHS). No doubt, this can be a mechanism that allows the ordering, coordination and planning of the Sector, without becoming a state interventionism contrary to the political ideology of this government. However, to think of a health plan is to think in the participation of several sectors and actors, in the organization of resources available and in the orientation of the health proxy; it implicates a negotiation space that could be the NHS. This strategic and fundamental goal did not establish the expected development between the priority realizations of the MOH. As a result, it was not possible to establish the rector role neither the necessary coordination for the system performance. This delay in the installation of the NHS had a cost: The lost opportunity of starting a sector health policy that could be really consistent and national.

3.1 Evaluating the implementation of the Policy

The Social and Economic Development Plan means a real transformation of the rules of the game for the economic agents. The response of the economic sector has been an annual average economic growth of about 3,8% of PIB, in the last four years. It is more difficult to evaluate in the short term the social development

of the sector, but we can point out that we have not gained the expected response from this sector that could be converted to a significative increase in the supply efficiency and in the quality of programs and services at national level. For instance: The extreme urban poverty was reduced only to 0,3% between 1991 and 1992, from this population 36% is illiterate. What is more, for each illiterate of the metropolitan area there are 5 illiterate people from the rural area.

There have been important achievements in the Health Sector such as: having controlled the polio, diphtheria, and having reduced the malaria from 95.000 cases in 1980 to 3.000 in 1993. The malnutrition levels are low and close to 2.000 promoters and 3.268 empiric midwives were formed and they are working in the primary attention in rural areas.

These results still insufficient before the magnitude of the health problem of the: the infant mortality and morbidity rate still high. The coverage levels still insufficient. A great portion of the budget is due to the curative assistance before the preventive attention. There is no sector coordination, neither decentralization of the services system. There is a inequity in the distribution of resources and inequality in the attention. It is twice as dangerous to get sick in the rural sector that to get sick in the metropolitan area due to the services availability; however, the risks of getting sick in the rural area are greater than in the metropolitan area.

If each of these problems is analyzed, is noticeable that there are policies enunciated that tend to solve them. What is more, the enunciated policies are correct but its application is irregular or insufficient. Where the DESFASE is produced or where the process between the implementation and formulation is interrupted. The principal factor that contributes to the problem is the way in which the policies are formulated.

If the policies are understood as commitments agreed upon, durable and respected in a determined space and time, it should be asked whether any agrrements really exist. Apparently there is no consensus between those who formulate the health policies. There are also disagreements in the implementation, as to how much, what, when, how, and who should implement it. For instance: no always it is taken into consideration the existence of resources to support what is enunciated. Finally, it is difficult to gain viable policies if a consensus is not gained around them. The consensus gives them viability and legitimacy. What is needed is a space for negotiation where it could be possible to propose, discern, negotiate and make agreements. One alternative can be a National Health Council or a similar mechanism.

The elaboration of the *Social Policies* and the *Health Plan* is the response of GOES and MOH to the health situation that is posed in the country from the war conflict and the cultural and social-economic situation.

The MOH, with the majority of the organizations, should take the responsibility of the health sector transformation and the institutional modernization, specially in the five areas: to improve the efficiency, to increment the institutional effectiveness, to optimize the use of human resources and hospitals, to change the cultural expectations and to focus on the most needy ones.

Valuative synthesis

1) There is an important insufficiency of coordination between the actors of the health sector. This turns the efficient and effective implementation of a national coverage health policy difficult.

2) There is a potential to improve the quality and coverage in the attention, if it is possible to incorporate the different actors of the Private and Public Sector at a coherent and rational manner.

3) The legal regulations are ample and give enough flexibility to the Sector for reform plans. There are some regulations that should be implemented and the health controllership function should be improved (such as the sale of medicines).

4) An instance is absent that for consensus of the different actors legitimize the Health National Plan, in order to serve as a frame for the implementation of a health integral system.

III *HEALTH SERVICES SYSTEM*

This chapter, first, makes a presentation of the different institutions that constitute El Salvador Health Services System, second, makes a description of the system (the dynamic between the supply and the demand of services), and finally, the inter relationship between the different actors of the system.

1 Services offer

The services system is formed by several institutions with different roles and characteristics. Now these institutions constitute a non-integrated system, since there is little coordination between them, neither there is a health plan to rule an integral performance of the same.

1.1 Institutions rendering health services

PUBLIC SECTOR

The public sector is formed by the MOH, ISSS, and other 17 state institutions among them Teachers Welfare(Ministry of Education), the National Telecommunications Administration (ANTEL), the Executive Hydroelectric Commission of the Lempa River(CEL) and others.

Social Assistance and Public Health Ministry
It is the largest service supplier organization of the whole system. It has 374 health centers and 21.253 officers, and 2.556 doctors among them.

With the objective of programming activities, it is estimated that MOH should be responsible for the 80% of the Salvadoran population. In the rural area the ministry has a better network services than the other system organizations.

This network of services is formed by health positions, health units, health centers, specialty and regional hospitals. Financing comes from the country general budget, funds from international agencies, and in the case of some hospitals, from recovering the costs.

Salvadoran Social Security Institute
The Salvadoran Social Security Institute was created in 1954, by the 1953 Social Security Law and from the Regulation for the application of the Social Security, which was approved in 1954.

The basic mission of the ISSS is to cover the worker in two types of risks: The immediate risk (of health and maternity) and the deferred risks (disability, old age, death). The workers of the private enterprise and the micro promoter are covered for all the risks; the retired workers and the public employees, for the immediate risks only.

The ISSS has the responsibility of approximately 580.000 persons, which include 12,5% of Salvadoran population. For this purpose, has a budget that comes from the workers contributions (between 1 and 6%), from the employer (between 2 and 7%) and from the state which makes an annual contribution of 5 million colones; in total it makes an annual income of approximately 600.1 million colones.

Its services network is obviously lower than the one of MOH because it has 44 centers and 1.386 doctors. This network has a greater concentration in the metropolitan area and at a regional level it usually hires services from MOH.

Currently is been developed the *Private External Consultation* Project, as a response to the problem of the long waiting in the services (until 55 waiting days to obtain a consultation with a specialist doctor).

Other state institutions
There are around 17 state institutions that render health services, some of them are:

- Teachers Welfare: was originated from a "Mastery Hospital and Medical Services Law". Supported by the teachers contributions (2% of their salary) and from the state. The medical services are hired from the Private Sector, in contracts form that are negotiated periodically. There isn't any type of restriction to the consultation.

- ANTEL hospital (National Telecommunications Administration):is specifically directed to its employees. It has a hospital in San Salvador and 7 clinics of ambulatory medical care. Financing comes from the employees contributions (3% of their salary) and from the contributions of the company that covers 97% of the budget.

- CEL Health Service (Executive Hydroelectric Commission of the Lempa River): covers its 3.280 employees, their wives and children. It has 15 clinics and 45 doctors that work in the company and some 500 specialist doctors under contract.

- ANDA Health Service (National Sewage and Aqueduct Administration) is constituted by 6 clinics and dispensers that render basic medicaments.

PRIVATE SECTOR INSTITUTIONS

The Private Sector is constituted by two groups: Those who are lucrative (among those are identified the medical centers and clinics) and those non lucrative organizations (the ONG's).

Lucrative Private Sector
There is little information in relation to the real dimension of the sector. It is calculated that it is formed by some 3.000 doctors and 36 hospitals.

A study of the sector is now being developed, financed by the World Bank, that will allow a better understanding of its potential.

Non Lucrative Private Sector
It is formed by organizations of different size, resources and functions. Due to the characteristic of its financing, the sustenance of those organizations is not secure and, for the same, is said that the projects they develop can not be considered of long term.

Normally they are well integrated to the communities they serve and its actions are focused in high risk areas. 70% have curatives programs and 61,5% have prevention programs.

1.2 System organization

Due to the state characteristic, the entities of the public sector tend to be more rigid in their organization and performance, than the private sector organizations. This lack of flexibility makes even more difficult the adaptation capacity, to the changes around itself or to the users requests.

In the MOH case this is truer due to the characteristic of the organization. Not all the deciding power is in the institution and depends on the participation of others to execute certain changes in its strategy. This also happens in the case of ISSS, ANTEL, BM, etc, although probably in a lower degree.

There, the private sector has a major flexibility to function. With the new social economy market policy and the organization of the rules of the game that this implicates, the competitive possibilities will be greater to this sector.

1.3 Model of assistance

Among the institutions of the health sector two models of assistance may be differentiated: (a) the curative assistance which represents the model most utilized by the sector organizations and (b) the preventive assistance, which represents the disease prevention model and basic health services.

The curative model has had a great development in El Salvador. This curative model is also implanted in the user's culture, that prefers self-medication or seek medical assistance when sick, before doing something to avoid getting sick.

The MOH includes the primary health care (APS) as one of its priority strategies, although due to the economic load that the hospitals represent the bigger part of its budget is invested in the curative assistance. For one organization only to administrate two programs so important for the health of the country such as the APS programs and the hospital programs, decision making on the priority in the appointment of resources becomes difficult. There is no freedom to decide since the demand of funds is which really decides. To confirm this, it has been considered as demands of funds: The attention of sick people that cannot be avoided (ambulatory and hospital care), the payment to personnel, the expenses caused by most doctors' tendency to cure rather than preventing, and to use modern technology (not really needed). All this gives to the MOH "little maneuverable capacity", regarding the use of funds.

The ONG's tend to render basic health services, some with little preventive component. Some of them use health promoters for outside activities. The formations of the promoters that work for ONG's is variable and goes from the organizations that constitute its promoters (using in a great part the designed course by MOH for that purpose) to those in which the MOH originates the promoters. Normally these promoters are integrated to the communities where they work.

1.4 Services offer resources

Other system component, that influences on its way of action, is the availability of the resources and its location. The next chart shows the distribution of the resources according to the institutions that render health services.

Table 1

RESOURCES OF HEALTH CARE SERVICE INSTITUTIONS, 1993

Subsector	Institution	Resources			
		Centers or clinics	Beds	Doctors	Total Personnel
State	MOH	374	5.213	2.116	21.253
	ISSS	44	1.357	1.386	9.194
	ANTEL	8	83	98	406
	Teacher's Welfare	Contract with Private Sector for all benefits			167 Administ.
	Sanidad Militar	2 hospitals and 40 nurses	300	---	---
	CEL	15 general care clinics			
	ANDA	6 ambulatory care clinics. Other benefits are rendered in the ISSS.			
Private	Private Medicine	36 Hospitals	1.219	3.000 approx	---
	Medical Insurance	Hires private services			
	NGO's	90 NGO's/health. 75 NGO's researched by Marcable			11.329 approx. 50% volunteers
	PROSAMI	Comprises 451 promoters, 93 administration officers and 127 technicians and doctors.			671

Source: ANSAL Project, 1994.

The health care system is characterized by a series of establishments and services distributed according to institutional goals of the organization they belong to.

As mentioned before, the MOH represents more than half of the system, both in resources and responsibility of assistance. However, compared to its network, the budget it manages is not greater. Which means that a clay feet giant has been created.

Table 2

DISTRIBUTION OF HEALTH CARE SERVICES BY REGION, 1992

Institution	Total	Western		Central		Metropolitan		Paracentral		Eastern	
			%		%		%		%		%
MOH	374	85	23	60	16	42	11	66	18	121	32
ISSS	44	6	14	10	23	14	32	5	11	9	20
H. Private	35	3	8	2	6	24	67	3	8	4	11
H. Militar	2	---	---	---	---	1	50	---	---	1	50
ANTEL	8	1	12,5	1	12,5	4	50	---	---	2	25
Total	464	95	20	73	16	85	18	74	16	137	30

Source: ANSAL Project, 1994.

The data form the private sector is preliminary to a sector study carried out at the moment and being financed by the World Bank. Ambulatory health clinics and private medical consultation have not been included.

Data related to geographic distribution of 40 infirmaries of Sanidad Militar have not been included nor CEL services.

As for geographic distribution of hospital beds in 1992, they may be seen in the following chart. The data is from information gathered in the institutions themselves.

Table 3

HOSPITAL BEDS DISTRIBUTION BY REGION AND POPULATION, 1992

Region	MOH	ISSS	Others*	Private Hospitals**	Total	Beds x 500
Metropolitan	1.962	1.092	283	890	4.227	28,6
Western	1.056	218	---	51	1.325	12,4
Eastern	1 234	115	100	128	1.577	14,1
Paracentral	686	---	---	92	778	11,4
Central	275	---	---	58	333	4,7
Country's Total	5.213	1.425	383	1.219	8.240	16,3

* Includes Sanidad Militar and ANTEL.
** Preliminary data from the Private Sector Study Financed by the World Bank.
Source: ANSAL Project, 1994.

When analyzing Table 3 one may notice the concentration of the resources in the Metropolitan Area of San Salvador (more than 50% of beds). This distribution is mainly because of the high concentration of the ISSS and private sector in the area. This is due to the fact that most people insured by the ISSS and more purchasing power in the case of commercial private sector in the area.

This is another element that enforces the inequity of the offer of services, to concentrate most resources in the areas of those who have more. Inequity may also be observed in the way health expenditure is managed in the different institutions of the sector and it is perceived in the uneven way to distribute the expense. The ISSS and the private sector the concentration in the Metropolitan Area is 73%, whereas for the distribution is 42% for the MOH.

2 Performance of the Service System

This part of the report refers to the dynamic interaction between offer and demand of services.

2.1 Coverage

It is hard to quantify the offer in a system that renders health care services. Some activities as the Increased Immunization Program (PAI) have been capable to cover a high percentage of the population; other as the institutional delivery assistance maintain a low coverage. The coverage is also different in the kind of assistance given by a specialized hospital than the same service given in a health center (small department hospital). Aiming to give an idea of the offer of services, some data taken from the research made by REACH/JOHN SNOW on 1988/89[7] is presented. The data show the usage the population make of the services offered by the different institutions. This information is the one which better reflects the offer of health services.

The data on the coverage are only estimates and they vary according to the hospital care or external consultation (ambulatory).

2.1.1 External consultation care

According to the results of the survey mentioned above 11% of the population interviewed received external consultation within two weeks previous to the interview. The distribution of coverage of this population was as follows:

Table 4

EXTERNAL CONSULTATION COVERAGE DISTRIBUTION, 1989

Institution	Percentage
MOH	40,0
ISSS	12,7
Others	2,3*
Private Sector	45,0

* It includes other institution of the Public Sector: ANTEL, Army, etc.
Source: Home survey REACH, 1989.

[7] Household Demand for Health Care in El Salvador, Feb. 1990. Financed by USAID.

2.1.2 Hospital Care

About hospital care (internment) the forementioned survey renderd the following information: 5% of salvadorans had been hospitalized at least once the year before the interview, for this hospitalizations the coverage given by the organisms was the following:

Table 5

DISTRIBUTION OF HOSPITALIZATION COVERAGE BY INSTITUTION, 1989

Institution	Percentage
MOH	75,5
ISSS	12,0
Others	4,0
Private Sector	9,5

Source: Reach survey, 1989.

It is important to mention that the ISSS renders a percentage of hospital care similar in population coverage represented by the people insured, which means that the increase of inward patients in the MOH is at the expense of private clients (approximately 30%). This would make one suppose that either the State is paying for the hospitalization of people in the private sector or that there are other reasons for which the people with low purchasing power prefer to make the effort to pay a private doctor consultation, rather that going to a MOH's consulting office.

2.1.3 Coverage of delivery care

Other useful information to have an image of the coverage provided by the different institutions with the services they provide, is delivery care. FESAL/1993 survey presents the following data related to such care (see Table 6).

According to the FESAL'93, only 51% of the deliveries are assisted in an institutional environment (hospital establishment) which make an adequate care possible; whereas the remaining people is not receiving an assistance which may be considered acceptable form public health point of view.

According to "Salud en Cifras 1991 del MOH" (health in figures), out of the 151.210 deliveries of the year, only 32.471 were assisted by empiric trained midwives, which means a 21.5% coverage of the deliveries.

Comparing this figures to those obtained by FESAL 93, which gives 36,4% coverage to the midwives , it may be said that the difference (36 > 21) is due to the deliveries assisted at home by midwives who do not report their activities to the MOH. Perhaps these midwives have not been trained by the institutions yet and their technical level of assistance id deficient. At the moment the MOH is carrying out an important effort to

incorporate all the midwives in its training program. On their part some NGO's are also carrying out some training courses to empiric midwives.

Table 6

DELIVERY CARE: DISTRIBUTION BY PLACE OF ASSISTANCE, 1993

Place for delivery care	% of Total deliveries
MOH's establishments	38,1
ISSS's establishments	9,7
Private Hospital	3,2
Midwife's house	1,7
At home with a midwife	34,7
At home with others	5,9
At home alone	5,3
Others	1,4

Source: FESAL/1993 survey.

2.1.4 Infant care coverage

A way to evaluate preventive ambulatory care is to analyze the data on infant care in the period between March 1989 and February 1993, where 80,8% of the infants born alive had been controlled at least one since their delivery to the date of the survey (FESAL 93). Table 7 show the distribution by place of control.

Table 7

HEALTHY INFANT CONTROL, DISTRIBUTION BY INSTITUTION PROVIDING THE CONTROL,1993

Place of Control	% Total of infants controlled
MOH hospitals	33,4
Other MOH establishments	47,4
ISSS	10,9
Private Hospital	6,8
Others	1,5

Source: FESAL/1993 survey.

The MOH has covered 80,8% of the total of infants controlled.

These figures show the level of coverage of the network of basic service (not hospital) of the MOH, carrying out almost half of the controls to healthy infant.

These percentages are average for the whole country and the coverage varies according to the place of residence of the users. In the rural areas the coverage was less, only 76% of the children were controlled and out of them 93% went to a MOH's establishment, which show the span of the rural establishments of the MOH. In the metropolitan area the total percentage of infants controlled was more than: 88,1%, out of which 60% did it at the MOH, 22,6% at the ISSS and 14,1% in the Private Sector.

2.2 The demand

Other component of the system performance has to do with the demand of health services and the characteristics of such demand. Some characteristics of the behavior of the users of the health system in relation to such services will be found in the following paragraphs.

2.2.1 User's behavior

The characteristics of the demand are given mostly by the volume of such demand, the place of residence of the users and their behavior.

Some outstanding elements influencing the behavior of the users are:

Perception of the disease
According to REACH/USAID and MIPLAN surveys, there is direct relation between the use of the preventive consultation and the educational level of the people, that is, the higher the education the more the use of preventive consultation[8].

Mobilization and waiting time
Another factor influencing the attitude of the users is the transportation and the waiting time for an appointment. The REACH/USAID survey shows 57% of the users had to travel more than 30 minutes to get to the place of consultation. This time increases for public sector institutions where 15% of the users of the

[8] There is an obvious disproportion between the people who consulted because they felt ill and those who did not do it: only 21% (REACH/USAID) of those who felt ill came to consultation. According to MIPLAN's survey out of those sick or those who suffer an accident 28% consulted trained professionals.

Out of those who perceived illness and did not consulted 27% did not do it because they considered the illness of little importance, 7% for economic reasons and 20% for other reasons (to avoid "wasting time", not getting permission at work, skepticism, dissatisfaction on previous appointments, etc.).

As for the behavior of the people who felt ill and did not consulted: 46% self-medicated (REACH/USAID). Whereas, according to MIPLAN' survey 91/92, self-medication was the behavior chosen by 51% of the people interviewed.

Contrary to the data given above, according to REACH/USAID survey, the number of people who consulted without perception of illness was 6,5% out of the total of consultations. Out of that 6,5% the greater percentages were as follows: 7,9% women; 8,2% people between 15 and 44,; 8,0% of MASS residents; 9,8% people with higher education; 16,8% of people covered by private insurance.

MOH and 14% of the users of the ISSS had to travel **more than 2 hours** for the consultation. The waiting time for the appointment was more than 3 hours in 44% of the users of MOH.

Residence of the user
According to FESAL 93' report, the place of residence and the schooling of the mother influence her access to institutional delivery care. The report states that most of hospital delivery care is in the Metropolitan area (81,6%) and mainly for those women with 10 or more years of school (85,5%). Out of the women in the rural area only 33,5% received hospital care and only 30,7% of those with no formal education. These figures express the constraints of a large part of the population (rural) to have access to the most important health activities to diminish the morbi-mortality of mother and infant, as it is an adequate delivery assistance. Those women with the worst socioeconomic conditions are the ones with higher risk of getting sick and the ones with less access to health care.

Economic and education level
The data from REACH/USAID survey render valuable information on health care for the population. Hereby the highlighted findings: 53% of the population interviewed perceived some signs or symptoms of illness during the two weeks previous to the interview. This perception was higher among: women, minors, elderly rural residents and low schooling people.

Out of the population surveyed 11% consulted for health reasons in the two weeks previous to the survey. This rate is higher in the Metropolitan Area (14%) than in other urban regions (11%) almost twice than in rural areas (8%).

It is also directly involved to the schooling level and to the monthly per capita income: 8,2% of the people without any formal education consulted, whereas 15,1% of those with technical or higher level of education did. Out of those with a per capita income below 101 colones 9,7% consulted and 13,24% of those with 401 income. This shows that though the population with low educational level and in rural areas had more perception of illness, it is the one that came to consultation in lesser number.

2.2.2 Actions taken by the user

For the home survey carried out by MIPLAN the week before the survey was used as a reference (October 1991). The results show that 24,3% of the population interviewed had been ill or had some kind of accident during that week. The action followed by the population interviewed was the following:

Table 8

ACTION TAKEN BY THE POPULATION WHO SUFFERED ILLNESS OF ACCIDENTS, ACCORDING TO HOME SURVEY, MIPLAN OCTOBER 1991 - MARCH 1992

Action	%	Person or institution providing control	
Did not consulted			
Did nothing	6,46		
Self medicated	51,25		
Consulted	42.29	Person consulted	%
		Healer	2,06
		In the drugstore	8,03
		to a nurse	0,75
		private doctor	23,10
		private establishment	10,18
		public establishment	55,88
Total	100,0	Total	100,0

Source: ANSAL Project, 1994.

According to the data gathered, out of the total of people who consulted in search of help (42,29%), 55,9% did it in the public sector, 33,3% in the private doctor sector (office or health establishment) 10.8% in the informal private sector. This means that 44.1% of ambulatory assistance was carried out by the private sector.

3 Inter and intrasectorial coordination

Generally, the Health Sector operates in forestalled compartments. There is no formal coordination of systems between the different organizations that make it up.

Even though this is a general claim of all the sector's components and when appearing in most of the documents about politics or strategies of health in El Salvador, the coordination is minimum and generally informal.

The MOH has as a Constitutional order, from the Health Code and the National Health Plan itself, the coordination of all the other public and private sectors; but has not been able to develop a coordinate health system. Also inside the public sector itself, the coordination deficit makes more difficult the introduction of more consistent programs.

An example of lack of coordination is the way how the health policies accumulate. These have two different origins: one is in MIPLAN as components of the Social and Economic Development Plan, while the other is in the MOH National Health Plan. The first policy clearly made in an economic discourse, while the other is health oriented. When we analyze the process of formulation of these policies, the representatives of both institutions have expressed the difficulty caused by such lack of coordination in their tasks. Recently some meetings have been held, but both ideas have not been united.

There is also a lack of coordination at he operative levels. Except some programs of higher integration as is the case for the safe water control program between the MOH and ANDA because of cholera or other punctual activities, the lack of sufficient coordination is the rule.

In 1974 the National Health Commission integrated by the Health Secretariat, the Work and Social welfare, the executive secretariat of National Planning Commission (CONAPLAN) and the General Health Directors of the MOH and the ISSS.

According to the organization resolution the Commission's duties are: to project, direct, and coordinate the formation, conservation, health of the inhabitants of the Republic of El Salvador.

To achieve these goals the Commission had the following responsibilities: (a) evaluate the health systems of which the state is in charge, (b) create expansion programs of the Social Security's coverage, (c) formulate the integral expansion plans of the services of the MOH; (d) analize and give suggestions regarding the law projects regarding the health of the population: (e) study and coordinate the distribution of technical and international financial aid that is given to the Government for health services and (f) appraise and periodically evaluate de execution of plans and public health and social aid programs.

This Commission worked until approximately 1978, then it stopped because of the political events that were befalling, and currently it is not operating. Its initial responsibilities have mostly been substituted by the Social Committee of Ministers Council, which coordinates the GOES actions in social matters it has more coverage than the health sector.

A great part of the needs for coordination have been replaced effectively by the Social Committee, but it would seem that an entity that could integrate the whole health sector (public and private) is still needed. This entity could serve as a regulation, negotiation and coordination space to make a formal health system possible. It would also coordinates the public and private health centers, with participation of human resource formating entities, etc. An it would assure the entities compromise with a national health policy.

This achievement will depend on the determination of the organizations making up the sector (ISSS, NGO's, ANTEL, etc.) to consolidate. This becomes difficult because in order to achieve such consolidation would mean a high degree of complementation which would normally be seen as a loss of autonomy. To define the rules of such implementation helps to reduce fears that may arise.

This organization should be made up of a political level and a support technical level for the political level.

Evaluation synthesis

1) The current Health Services System in El Salvador operates without coordination, based on the different goals of each center.

2) The infrastructure and trained personnel distribution is concentrated in the Metropolitan Area of San Salvador, which means a lack of equity in the assistance.

3) Even though the service network of the MOH is practically twice as big as the rest of the system, its budget is not proportionally higher.

4) An agreement space to integrates the different service centers with a reform of the sector that achieves a more rational distribution of the resources and a equity health system.

IV *THE MINISTRY OF HEALTH*

The Ministry of Health is the national organism that provides the higher volume of services and has the most network establishments in the country. The MOH's role, its organization and functions, its commitment to the modernization process and the foreign cooperation it receives, are described in this chapter .

1 The MOH's role

The MOH's role in the Health Sector may be analyzed from varies perspectives. By the end of the present report, the legal and political roles it takes shall be considered.

1.1 Legal frame

The National Constitution establishes in Art.65 the share of responsibilities with "The state and the people to watch over the conservation and reestablishment of health"; being the specific function of the state, according to the same article: "the determination of the national policies of health, its control and supervision". According to Art.66, the health care functions are given to the state only for the " prevention of the spreading of transitable diseases" and in Art.69, emphasizes on the sanitary vigilance which should be maintained by the state.

Another legal instrument, the health code, which on section 43 gives a greater health care role to the state, by stating that the MOH will accomplish the "functions and obligations of medical assistance and social medical care to assure the popper health recovery of patients" by means of its "dependencies". Moreover, it determines a standard and governing function when it should: formulate and implement the Public Health National Plan.

There is also Decree 24 which enforces internal regulation of the executive Organ. In its Art. 42, Chapter II it appoints the MOH with the functions of developing the health policies and the social assistance from the government. The same decree established that the MOH has the function of governing the health sector, to which is described as: " to plan, direct , coordinate and execute the policies". Another part of the same article establishes: "to dictate standards and techniques on health" and to "adequate and to enforce the Health Code. It emphasizes especially sanitary vigilance which should be developed by the MOH. It states that the health functions in the field of integral medicine and medical curative care to the population, carried out through the institutions in charge and in coordination with other entities in the sector.

1.2 Political frame

The formulation of policies on health are originated in the Ministry in two offices: MIPLAN and MOH . The dynamic of planning originates two different lines of thought on which and how should the mission of the MOH be.

MOH' line of thinking is influenced by the medical culture[9], paternalism and service oriented. It conceives as its mission to take responsibility of directly undertaking all the variety of functions and cover the health area.

[9] For this report "medical culture" would be understood as the line of thought more oriented to cure and take care of the sick rather than to prevent, educate and offer basic health care services.

As in most countries of the american continent, this has made the institution to undertake a diversity of functions other than specific public health, as is the case of: medical assistance, hospital administration, formation, education and professional qualification, etc. This diversity of activities have a cost on efficiency and depth. The MOH wears itself out in a bureaucracy which tries to control the conduct and the administration growth. Perhaps the most harmful thing for an institution is to loose perception capacity in the extrainstitutional surroundings and to adjust to such environment and the demands for a change involved in the adjustment process.

GOES's second line of thought is that of the social and economical development program (MIPLAN), oriented by economic growth policies and state efficiency, conceptually framed by the free market social economy, which promotes the reorganization and the lessening of bureaucratic organ of the state. This means to restrain MOH's functions to manage and standardize the health care system, as well as to control the quality of health service supplied and to watch over the health situation.

Many a times these policies are carried out under the pressure of structural adjustments from programs simply trying to alleviate its effects of aiming to extremely accelerate the changing processes, threatening institutional structures and creating social or institutional turmoil.

Such ideologic difference among the entities involved in the formulation of health policies, has created certain inconsistence in the implementation and form of the MOH mission. Even though the MOH's duty is stated in the National Plan of Health and in other MOH' documents, it is still unknown to many even to the managers of the institution.

In the National Health plan the general objectives are defined for the plan and the policies for the sector stated by the Ministry, which somehow gives the idea that the institution has its own mission. In such Plan there are ten health policies stated. The first one is the closest to the first line of thinking and it says: "*To promote, protect and restore the health of the population by means of integral assistance to the people and the environment, with the participation of the community and other government and non-government organizations*"

The general policy of the Plan is established within the line of thought of the Social and Economical Development Program when it introduces the component: "... *Programs directed to the priority programs in relation to the risks of the vulnerable groups*" And also in :"... *coordinating activities with other institutions to make the best use of resources available with austerity and honesty*".

Analyzing the rest of the plan: Policy development, strategies, operative program, etc.; which are included in the first line of thought is a very significant one in the MOH. This relevance could be given by "inertia and institutional culture"[10] but it should also be considered the weight of the structures and the social responsibility to cover demand.

[10] "inertia and institutional culture" is understood as the resistance of government institutions to incorporate changes in their structure and performance.

2 Organization and performance

The organization and performance of an entity as complex as the MOH is intricate, moreover, it is not one of the objectives of this report to give an exhausting description of the operation and structure of this entity, references will be made only to relevant operational and organization points.

2.1 Institutional structure

The MOH is structurally organized in: (a) a politically oriented central level (Minister, Vice Minister and Planning Director), management and administrative support (General Management) and (b) an operative peripheral (Sanitary Regions and Hospitals).

2.1.1 Central Level

The structure of the institution is outlined in the decree 24, 1989 of the Executive Organ and it basically describes a centralized organization at general management level. At the moment, due to difficulty of excessive centralization, two sub-directories have been created. The first one in charge of primary care and the second one which manages the Hospitals. This arrangement has somehow solved the jam in communication with decision offices; however, it requires more changes than to ease the negotiation and to achieve a more efficient administration.

Under the general management, but with the same level of hierarchy than that of the dub-directors are: Planning Management of Operative and Normative technical services and the administration. These levels have operated in the past independently and though there is more coordination now, it is still inadequate.

Other changes are being incorporated, such as the new organization of Human Resources Department, and the creation of the Financial Planning Department.

If the MOH continues with the same diversity and amount of functions it has now, it will nave to introduce more changes in its structure, to achieve a better distribution of the work.

Recommendations
In order to improve the performance and the complement functions to the structure it is suggested that two general directions be created: one General operative Direction and a General Technical administrative Direction. The first one would be formed by three sub-directions: sanitary Regions, Hospital and Logistics. Their functions would be to manage, implement and coordinate all the operative level of the MOH.

The second General Direction will consist of two sub-directions: an administrative sub-direction and evaluation and planning sub-direction. This general direction will have the functions of: to support the operative programs, to standardize, to plan and to evaluate the development of the programs of the MOH.

The two general directors and the five Operative and Technical Sub-Directors of the Vice-ministry will form a level of Operative Technical coordination. Once the political level is incorporated (Minister and Vice Minister) a Strategy Planning Committee would be consolidated.

2.1.2 Operative Peripheral Level

The operative level is organized in five Sanitary Regions: Western, Central, Metropolitan, Paracentral and Eastern. These regions are not centralized to the central level. Their infrastructure includes normally the first three levels of assistance: Primary Level (health dispensaries, posts and units), Secondary Level (health center and Department Hospitals) and Third Level (Regional and Specialized Hospitals)

the 15 hospitals of the MOH are decentralized entities but they are included in the budget of the MOH. This level has the highest cost of assistance and absorb around 62% of the budget, reducing the strength of the strategy of primary health care, which is the priority strategy of the MOH.

Though a large part of public health care lies on the MOH, the fact that some institutions mainly curative oriented are starting preventive programs is a positive element, that is the case of the ISSS and other state offices.

Moreover, many NGO's which are at the moment working on the health field, have an important component in preventive medicine and generally coordinate efforts with the MOH in its vaccination activities.

2.2 Performance

It is a difficult task to analyze the performance of such a complex and wide institution as the MOH, due to factors which are more historical than technical, the institution had to take charge of a diversity of functions which have reduced its efficiency and flexibility to dealings. It is not the same to develop an epidemiologic information system, than to implement a system for hospital laundry or to form technical lab workers, or to develop rural latrinization programs, etc. The diversity of functions always reduces the deepness of the proxy and the MOH, as well as other ministries of the region, had to pay the price.

Another important element of institutional performance observed at the MOH is its orientation to proficiency than to efficiency. Historically, due to paternalism characteristic of the governments, the cost of the services offered by the state was not considered important. What was important was to cover the needs of the "benefactor state" and they were considered priority, though they had a high cost.

This conception, though it is actually being overcome by most of the governments, it is still rooted in the institutional and user's culture, making the changes toward efficiency difficult and turbulent, even more when such changes may mean to give priority to specific people or programs.

2.2.1 Management systems of the MOH

The MOH as any other complex institution has several systems which go beyond its organizational structure. The main systems are stated now:

Planning system
The planning system of the Ministry has had an important development lately, with the inplementation of a local programming system as instrument of operative planning and evaluation of activities; though the system is not working in full. The first self evaluation results was carried out with this strategy in November and December of 1993. Though the results are very preliminary, they are promising.

The analysis of the programs based on functional sets, show some spreading of activities which in operative level is considered a lack of efficiency. To achieve better integration and coordination among the programs, as the one on mother-infant care, The Immunization Increased program (PAI) and the program on nutrition may increase institutional performance and to rationalize the usage of resources.

Through operative plannig, to be implemented from the Local Programming will enable the improving of programming integration and to develop a monitoring system to control the dealings at local level. This strategy (local programming) is just starting and it will need some time to integrate to operative culture of the MOH. Besides, after being unable to systematically incorporate the participation of the community in the identification and solution of health problems, it seems that this should be the way to integrate such participation to the process of decision.

Another component introduced to the planning system was financial planning, which would allow a better programming and a better budget administration control. This component should play a role in the coordination of the different financial and administrative systems in the MOH. This coordination will be essential to achieve a more complete and integrated vision in the different sources of resources, to evaluate the impact of the expenditure and have a rational control of the investment.

The lack of personnel for the performance of the Institutional Development Department, is a constraint, especially when an institutional modernization process has started.

Information system
The MOH has at the moment eight systems of information at different levels of implementation. These systems are not integrated, they work in different levels of the organization and their finance depends upon different international agencies. The information gathered is insufficient and there is no quality control of the information. The integration of a management system for decition takeing should be a high priority goal for the institution, however, this seems difficult at the moment because of the lack of human resources in the management and analysis of general management information, and due to the lack of coordination in its implementation by the sponsoring agencies.

Decision taking system
Decision taking is centralized and rather aiming to solve immediate problems. Since there is no integrated and timely information system or systematic analysis levels of options to support the decision process, the quality of the product is lost. The excessive centralization also affects the process delaying it by the different bureaucratic stages it must go through diminishing its quality by taking decisions at away from the problem. Examples of centralized decisions would be: hiring and personnel promotion paper work, management of budget (though this is being modified from the new State accounting), or some programs such as Community Health, etc.

Communication system and institutional coordination
This is determined by institutional structure. Due to its centralization characteristics shown on the organization chart (see annex I), it jams the communication at General Direction level, since it is transformed into the only level consolidated to the political level, the planning level and technical normative level, along with operative levels.

This is also reflected in the coordination. The coordination problems are due to the vertical system of some programs or the excesive influence of some international agencies on some programs.

2.2.2 Primary Health Care Level

To develop the primary health care, the MOH has been organized around the Local Health Systems (SILOS). They have started to get organized in some municipalities around a health establishment and with community participation. Among them are the SILOS from: Ilobasco, Juayúa, Apopa, Soyapango, Nueva Concepción and Chalatenango.

The concept of SILOS for the MOH represents a model of local organization. It has not been conceptualized as an operational strategy of decentralization and comunity participation. That is, a way to transfer the decition level to the user.

This model of organization in local systems works in the MOH as a form of technical-program organization and it includes very little administrative component. Moreover it has served as a variety of institutional cooperation at operative level, but without the necessary emphasis on community participation propossed by the SILOS as strategy.

Even though the MOH shares medical assistance activities with other institutions, those specific functions of public health are almost its exclusive responsibility.

In latter years the MOH has given especial support to the participation of health promoters in primary health care area with emphasys in promotion and sanitary education. Accordingly, a large number of promoters have been trained, the number aims to reache 2,000 promoters by 1994.

An issue between the MOH and the NGO's, on prevention and medication field, has been giving or not giving the promoter more resolution capacity making him able to use medication, for instance, the prescription of antibiotics for IRA's treatment.

Some NGO's working in the field of community health with primary assistance programs, as: sanitation, vaccination, nutrition and mother-infant care; working based on promoters who due prescrive medication and this creates confusion at local level.

Urged by the offer/demand dinamic of the MOH services has taken different roles, many of such are not its duty nor convenient, due to their high cost or because its specific function is deviated. Also, due to it increased coverage in the rural ares, it attends part of the people insured by the ISSS. Moreover, the MOH should have assumed a formative and training of human relations role, etc.

In great manner, the lack of an integrated and coordinated development of the sector has limited the posibilities of a more rational and efficient distribution of duties.

Despite the fact that hospitals and curative medicine are institutionally important and they constitute a constraint in preventive health development, the MOH has had a good performance in latter years in several programs of prevention; for instance: malaria control or vaccinations. Even though there are several institutions which carry out vaccinations, most of the coverage is given by the MOH.

According to the data shown in "Evaluación de actividades realizadas por el Gobierno de la República en el ramo de Salud Pública y Asistencia Social, Enero/Diciembre 1992" (evaluation of activities carried out by the republic government in public health and social assistance) issued by the Planning office of the of the MOH;

BCG 57,7%, Sabin (3 boosters) 58,4% and DPT (3 boosters) 57,8%; this on infants under 1 years of age. The antimeasles reached 73,8% on childre 1 to 4 years of age.

Promoters Activities

The MOH estimates the population assisted by its promoters to be 1.899.892. During 1992, MOH promoters carried out the following educational activities:

Table 9

ACTIVITIES CARRIED OUT BY HEALTH PROMOTERS. 1992

Field of assistance		Activities	Number of activities
Environment		Latrins	112.622
		Water	102.001
		Garbage	98.648
		Hygiene	94.679
		Total of activities	407.950
People	Infant Health	Growth and Development	92.212
		Vaccinations	86.326
		I.R.A.	66.188
		Diarrhea	62.762
		Total of activities	307.488
	Mother Health	Family Planning	66.344
		Pregnant	33.006
		Postnatal	18.918
		Total of activities	118.268

Fuente: Informe Anual de Salud Comunitaria,(Annual Community Health Report) MOH. 1993.

3 Process of modernization

The current administration of MOH has incorporated elements of institutional modernization so that a better efficiency of the proxy can be achieved. Despite the effort, no real changes have been achieved in the functioning of the organization because of two key factors:

a) Because of the institution inertia which makes all process of institutional change very difficult and slow. The culture of the organization and the weight the structure has, its legal and political responsibilities, its history and its officers are all included in the concept of inertia lead the institution into a track which is hard to follow.

b) The lack of a clear definition on what are the problems that need to be solved. There is a consensus of the necessity of change, but there is disagreement about which are priority changes and how they must be carried out. For this second factor, it is necessary to consider some relevant aspects that will undoubtedly influence the results:

- Who should participate in the process? What factors can make this process of institutional modernization effective? These might be in the institution or in the government or in the sanitary sectors, etc. The important thing to define clearly is who are they, what do they have and how can they contribute to achieve the effectiveness of the change.

- Who are the beneficiaries of the activities of the MOH? Where do they live? What do they need? These and other questions need a very precise answer. At the moment, all salvadorans have the possibility of been assisted by one service of the Ministry. It is easier for those living in the Metropolitan Area of San Salvador or for those who have better means of transportation, but the greatest needs are not there. The people with the greatest needs for health care leave in the areas which are more difficult to reach it. To define where the potential of the institution need to be directed will make it more efficient and effective.

- What model of proxy is the most convenient to achieve efficiency? At the moment, the MOH is in the process of decentralization and it seems as if there is a consensus in the institution indicating that the technical-administrative decentralization is the best model for its proxy. However, Are there actually accords in relation to this topic? Is there any other model more effective for the Health Sector in El Salvador? Is this a model imposed from outside? etc...

- Are there any accords in relation to the model of health care? The Primary Health Attention (APS) is enunciated as the most convenient strategy, but Will it really be enforced with the economical weight that the hospitals mean for the MOH? And if the decision is taken about the APS, How will this be financed?

- What other functions should the Ministry as a ruling Organ of the public health? Its functions of sanitary vigilance and of standardizing and planning the health policy being implemented, is it for the whole Sector? if not, should it be so or not?

These are only some of the questions that should be answered to define the changes to be achieved by the institution to have more efficiency and institutional equity. So far, the MOH has achieved an institutional maturity level to be able to define them more precisely.

However, an integral strategy should be developed and it will include components of the different factors mentioned above to consolidate a satisfactory institutional reform and at the same time, a real reform of the Health Sector of El Salvador.

4 Foreign cooperation

Probably, one of the weakest aspects that the MOH has is its high degree of foreign finance dependency. Approximately, 20% of the expenses of the Ministry depends upon international agencies. These are resources on which the MOH has little control and a high degree of dependence, since they are financing key operative expenses. For instance: medicines.

Other component on which the external support has leverage is the possibility of an adequate evaluation of the potential of the Ministry. The international cooperation has been and still is of vital importance for El Salvador because of the different problems it has had and some still exist, as the cholera or the poverty levels. However, this support is a situation that might restrain the real vision of the problem. A strategy of covering the expenses is being implemented. It is important to improve the coordination and the integral management of these resources to achieve a gradual the least traumatic independency possible.

Evaluating synthesis

1) The MOH is an institution excessively loaded of functions, what forces its a growth which makes it loose flexibility.

2) There still persists an excessive administrative centralization, despite its policy of decentralization.

3) The dominium of the medical ideology in the institutional proxy.

4) The high dependency on foreign financing.

V *OTHER SERVICES-SUPPLIER INSTITUTIONS*

1 Salvadoran Institute of Social Security

The ISSS is the governmental institution that was created for the social protection of the salvadoran workers Initially, it covered only the persons working in the private enterprise and industry. At the moment, it has different types of coverage for private, public, retired employees and the ensured relatives.

1.1 Legal frame

With the reforms in 1945, Article 47 was stated in the Politic Constitution of El Salvador, which stated: ".. a law of obligatory social security, with the bid of the State, of the management and the workers." In the month of december of 1953 the Legislative Power of El Salvador derogated the Law of Social Security of 1949 and decreed a new law, that was enforced since january of the next year. In april of the same year (1954), the Executive Power approved the "Rule for the Application of the Regime of the Social Security" and since May such regimen became effective for the workers in the Metropolitan Area of San Salvador.

It was until 1973 when the ISSS could cover all the national territory as the result of a series of reforms to the Chapter III of such Law.

Since then, the Institute has been extending its coverage, incorporating other groups of insured, such as the workers of the public sector in 1979. Despite of the increase of coverage of the ISSS, it continues to be one of the lowest in the region.

The world economical crisis of the decade of the 80's and the armed conflict in El Salvador meant a financial pause that produced a high unemployment index in the country, which produced a reduction in the level of coverage of about 15% of the economically active population (EAP), in 1979. From 1989 on, in part because of the program of economical recovery, the coverage increased again up to 20% of the EAP.

The ISSS covers about 12,6% of the total population of El Salvador, according to estimations.

1.2 Organization and structure

The ISSS is an autonomous entity, that has as superior authority a Board of Directors, which includes:

- The Minister of Work and Social Security, or, in substitution, the Vice-minister. The Minister of Work is the established Chairman of the Board of Directors.
- Four government representatives, one of each of the following Ministries: Treasure, Work and Social Security, Economy, Public Health and Social Assistance.
- Two worker's representatives, elected by the union of workers legally constituted.
- Two management representatives, elected by management organizations registered in the Ministry of Work.
- One representative of the Medical School of El Salvador.
- One representative of the dental Society of El Salvador.
- The General Director of the Institute or, in substitution, the Subdirector, with right of opinion but not to vote.

By Law, the Board is presided by the Ministry of Work and Social Security, has two Vice-Presidents elected every year among the rest of the members. The Secretariat of the Board is responsibility of the General Director, who also has the responsibility of the executive administration of the Institution, having the Subdirector as the second one in line.

1.3 Role and policy of the ISSS

The ISSS, in order to fulfill its function of keep the social security of the salvadoran worker, develops several types of services:

a) *The coverage for differed risks*: Old age, Disability and Death. It covers all employees from private enterprise and the microenterprisers who voluntarily register. It provides pensions for the beneficiaries who reach the retiring age or those who become definitively handicapped for the work. At the same time, it supports the funeral expenses of its insured.

b) *The coverage for immediate risks or health coverage*: Illness, Maternity and Professional Risks. The Health Coverage is divided into two categories:

(1) The General Coverage that provides medical, economical care (Subsidies for temporary incapacity and in species (Maternal basket, apparatus of prothesis and orthopedic, etc...).

(2) The Special Coverage or Health Coverage for Public Employees that covers the same medical provisions, but does not include the economical provisions nor the maternal basket.

The retired employees from the ISSS or from the National Institute of pensions for the Public Employees (INPEP) keep their coverage in the Health Coverage, so that they can keep receiving the benefits of such coverage.

As many other institutes of social security in Latin america, the ISSS is now in the process to promote the reforms to accommodate to the needs of the universality, solidarity and equity that rule the current policy of the GOES. For that effect, the Directives of the Institute have designated a group of professionals whose responsibility of defining a health institutional policy suitable for the current reality of the country. On the other hand, the Ministry of Planning (MIPLAN) has been developing the policies of the Social Security, but with an inadequate coordination with the ISSS.

1.4 Coverage

The low coverage of the ISSS prevents it from having a more active role in the health field and thus complement the activities of the MOH.

The coverage of the ISSS in relation to the general population is 12,5% with approximately 580.613 people covered. This figure is in agreement with the data from the REACH/USAID census, previously quoted, that record a 12.7% coverage of the ISSS for ambulatory attention and 12,6% for the hospital health care.

On the other hand, the FESAL/93 survey estimates in 9,2% the ISSS coverage on delivery and the ISSS itself points out figures of 10,9% coverage on deliveries.

The health coverage includes the insured, their wives or companions, widow or pensioner widower, pensioner mates, as well as the insured or pensioner's children under 3. Within the Coverage Expansion policy a gradual incorporation of insured's children was approved according to the following chronogram: Starting on January 1994, children under 4 years of age; from January 1995 on, children under 5 years of age and starting on January 1996, children under 6 years of age.

1.5 Health care model

The health care model of the ISSS is mainly curative. Its services are rendered by university professional: doctor, odontologist, etc. and based on the demand of the people insured. The health care indexes are shown in the following statistics:

Table 10

ANNUAL AVERAGE OF CONSULTATION BY THE INSURED PER YEAR, ACCORDING TO TYPE OF CONSULTATION 1987-1992

Type of Consultation	1987	1989	1991	1992
General Medicine	1,71	1,92	2,04	1,96
Specialized Medicine	0,83	1,11	1,63	1,54
Emergencies	0,52	0,49	0,59	0,69
Total	3,06	3,52	4,26	4,19

Source: *Catálogo Mínimo de Indicadores* (minimum index catalog), ISSS.

The cost per unit are higher in the ISSS than in the MOH. This is related to the type of assistance and the type of facilities of the institutions, in some cases the cost come to be 4 times higher[11].

Medical services in the ISSS are given to its insured by free demand. There is no restriction for the use of the services nor any control system to avoid abuses.

1.5.1 Utilization of specialized health care

The consultation indexes by insured (Table 10) show that there is actually an excessive use of the services by the consumers, and that, though there is a trend to diminish, there should be a better control of such trend before coming to a conclusion on it.

The document *Información para Directivos* (information for directors) of the Mexican Social Security Institute (IMSS) defines that the recommended index of specialized consultation per person/per year should be 0,74 and to represent between 12 and 16% of the total of consultations. The salvadoran index of 1,63% is 120% higher

[11] Fiedler Jack, *Health Sector Financing* , ANSAL, 1994.

than the rate recommended by the IMSS. In relation to the total of consultations carried out, specialty consultation increased from 27% of the total in 1987 to 38% in 1991.

During 1992, the specialty consultations had a 37% increase of the total and, in not definite figures corresponding to the first semester of 1993, the rate in the consultation was: general medicine 47%, specialized medicine 36% and emergencies 17%. If these levels were maintained during the second semester of 1993, it would mean a trend of leveling in a lower range of specialized consultation rate. Even though, the range would be above the optimum for this type of institution.

1.5.2 Privatization of external consultation

It is important to analyze the specialty consultation system carried out in the doctor's private offices implemented by the ISSS. The project is called *Privatized External Consultation* and it was approved on June 1990, covering only the first consultation. In 1991 it was extended to the second consultation. The remaining appointments should be carried out in the consult room of the institution.

This system emerged by pressure from the user, due to long waiting periods (Between 25 and 55 working days for the first appointment and more days for the follow ups) and not due to a privatization policy of the institution. The private consultation is made available to the insured or covered person when the assistance in the institution would mean a delay of more than 5 days.

The percentage of specialized consultations in relation to the total of specialties consultations and of the total of consultations carried out in the ISSS, which are shown in the following chart:

Table 11

TOTAL OF MEDICAL CONSULTATIONS, SPECIALIZED AND PRIVATIZED, 1991-1993

Type of consultation	1991	1992	1993*
Total of consultations	2.282.348	2.433.626	1.330.282
Specialties: total	873.625	895.398	475.085
Specialties: privatized	44.507	92.325	48.217
Percentage: privatize/total sp	5,1%	10,3%	10,1%
Percentage: privatize/total cons	1,9%	3,8%	3,6%

* Semester data January-June, 1993.
Source: ANSAL Project, 1994.

The Salvadoran Foundation for Economic and Social Development (FUSADES) carried out an important study on the External Specialty Consultation Privatization of the ISSS, with an interesting social and administrative analysis of the project.

This study conducted to the following conclusions: there is a over demand of specialized consultation. The specialties with more demand were ophthalmology, cardiology and physical and rehabilitation medicine. Out of the specialized consultation 87% is carried out in the MASS equaling the 70% concentration of the insured in the area.

The research on quality of privatized consultation was made by interviews and polls to the users, paramedic personnel, and managers. One outstanding result was that of the perception of quality by the user: 50% considered privatized assistance as "very good" and only 24% considered it to be the same as the one of given at the external consulter of the ISSS. These figures are interesting considering that the same doctors are involved.

There are several factors influencing a better acceptability of the user to this new kind of consultation:

a) *The time to get the appointment.* In the ISSS the average waiting time to get a doctor's appointment was 40 days, while in privatized consultation was only 4. Out of the people interviewed, 55% only needed 1 day to get an appointment.

b) *Time spent at the waiting room.* About 67% of the patients in the ISSS and 40% of the patients in private consultation waited for more than an hour. Even though the patient waits for a shorter time in the privatized consultation the disadvantage is that the patient does not get his medicine in the same place but must get them at the ISSS, which would mean spending a longer time.

c) *Consultation Time.* Ten minutes of less for 65% of the patients of the ISSS and more than 10 minutes for 73% of privatized consultation (around 20 minutes) This is one of the point which influence more in the perception of quality of the consultation.

Doctors are the same ones in both clinics and they have tried to explain this obvious situation to be due to a work overload. The information that only 41% of the time hired by the specialist is used for external consultation[12] and the remaining time (59%) is used for other activities (surgery, hospital visit, teaching, etc.) should be deeply evaluated by the ISSS medical authorities, even more, if it is considered that only 53% of the capacity installed for external consultation is being utilized.

There should be a follow up process of hiring third parties for specialized care, but privatizing it in the real sense: doctor's open bid, no more exclusions than ethic reasons, economic reasons or scientific capacity.

The evaluation at mid term of this project could be used to make decisions within privatization philosophy, as a national experience. This evaluation should also include the financial component. The cost study of FUSADES's report charges administrative expenses only on institutional consultation as if privatized consultation did not bring an administrative component to the proxy, administration and control by the ISSS. On the other hand, institutional consultation become more expensive due to the low percentage of doctor/hour hired which is used for such activity. It is considered then that this aspect deserves a deeper analysis, but counting it as a main value to be considered in quality perception of the user and his satisfaction.

[12] ISSS Report: Consulta de Especialidades Privada (specialties private consultation), FUSADES, 1992.

1.5.3 Productivity

A simple evaluation on the productivity of the doctors was made based on official data from the ISSS[13].

Table 12

CONSULTATIONS CARRIED OUT BY REGION, 1992

Region	Doctor/hours Worked	Consultations* by standard (A)	Consultations** carried out(B)	% Var. (B/A)
Metropolitan	155.278	621.112	547.410	-12,0
Central	8.657	34.628	47.910	+38,0
Eastern	21.939	87.756	75.531	-14,0
Western	29.469	117.876	132.102	+12,0
Total	215.343	861.372	802.983	-7,0

* Number of consultations if standard of 4 consultations per doctor/hour were accomplished.
** Consultations carried out in the consult rooms of the ISSS.
Source: ANSAL Project, 1994.

Consultations to be carried out if a minimum standard, 4 consultations per doctor/hour worked, were calculated on column (A) and column (B) shows the consultations actually carried out. It must be clear that the total of consultations is stated in the reports form the ISSS (those carried out in the consult rooms of the ISSS and in private offices). To make Table 12, only the private consult rooms were subtracted and only those carried out in institutional consulting offices. The last column at the right (B/A) expresses in percentages the rate between what it should have be done and what was actually done.

Apparently, a percentage as low as 7% should not be reason for analysis; however it is very important since if it were evaluated in terms of privatized external consultation we would have:

[13] ISSS, *Estadísticas de salud*, (health statistics) 1992.

Table 13

COST OF NOT ACCOMPLISHING CONSULTATION STANDARDS, 1992

	Cons. not made	Privatized Cons.	Not made x cost
All the country	58.389	92.325	58.389 x ¢40 = ¢2.335.560 (US$270.006)
Metropolitan Area	73.702	86.650	73.702 x ¢40 = ¢2.948.080 (US$340.818)

Source: ANSAL Project, 1994.

This means that if a minimum standard of 4 consultations per doctor/hour worked were accomplished in the Metropolitan area, 73.702 private consultation payments would be saved since they were not assisted in the consulting office of the ISSS. If the standards were accomplished in all the country the difference would be lower because in the Central and Western area doctors assist above standards. There was no opportunity to study in the field the reason for such differences, but they should be deeply analyzed by the directives of the institute. It is necessary to remember that 93% of private consultation carried out in the Metropolitan Area, where we find the higher number of consultations not made.

When the cost of not accomplishing the standards is deeply analyzed, the different service efficiency levels may be clearly distinguished. We have used the Physical and Rehabilitation Medicine Unit for the analysis considering that ut is one or the three specialties that uses privatized services more (9,4% of the consultations privatized in 1991 were out of this specialty). The ISSS had 4.691 doctor/hours available for such specialty. Some 9.061 consultations were rendered there. Had the standard been accomplished (4 consultations/hour), 18.764 consultations would have been rendered. That is, 9.703 consultations less were rendered (-52%) out of the ones given institutionally. The cost of not reaching the standard would be ¢388.120 (US$44.869). This might sound as little money, but at the same time the ethic meaning of the situation should also be considered. If the essence of "privatization" is to assist in a private office those consultations not assisted institutionally due to the unfulfillment of the standards (inefficiency), the concept of privatization is being distorted to "reward" inefficiency (since private consultation is only rendered by doctors from the Institute). On the other hand there are no incentives for the efficient ones, as doctors from other regions that attend above standards and therefore do not render private consultations in their private offices.

This type of project does not mean a real privatization since it does not accomplish the free market and free competence requirements, since the users cannot choose the doctor for consultation, nor the arrangement is available to all doctors since it only hires doctors from the institutions claiming that they already know administrative procedures of the ISSS. Curiously such argument is not valid for the hiring of pediatric doctors who give external private consultation for the ISSS in another project; since pediatric care (which is also privatized) include pediatric doctors whether they belong to the institution or not.

Privatization of pediatric consultation was a response to the lack of adequate infrastructure for infant care detected when coverage was expanded to the health of the children of the insured. At the beginning they proceeded to hire pediatrics by the hour for private consulting office assistance; but when they detected of low performance they proceeded to restructure the hiring procedure paying the doctor by medical act.

1.6 Sustainability

The model of health care of the ISSS do not offer any kind of restrictions to its insured making room for abuses which increase the cost of the services and constitute in themselves an inequity taking such resources away from other people who may need the assistance. The lack of standardization in the treatments, an enormous list of medication and the absence of regulation in medical assistance may jeopardize the sustainability of the Institution.

This situation has already been detected by its authorities and efforts are being made to manage the medical assistance and to control its quality by means of auditory and evaluations of performance. The fixed inscription of the user to the service of its area, with the implementation of a good reference and cross reference system, as well as a control of service usage, will achieve a more rational utilization of the resources.

1.7 Preventive medicine

The ISSS has started to implement preventive medicine activities carrying out a sanitary education program directed to the user of services and factory workers. Focusing some priority areas such as on the on the job accident prevention.

This is very important considering the great amount of accidents recorded in the labor environment: Job accidents for 1991, were 11.947, in 1992, there were 14.235 (19% more). In an official document of the institution it is reported as one of the achievements accomplished in the 1989-1993 period, that is the enforcement and development of Health Education Program, on which health educators carry out activities to train and orient workers by means of educational talks. Such activities have been increased according to the following statistics: in 1990, 4.580 educational visits; in 1991, 6.060 and in 1992, 15.056.

It is important to carry out this kind of activities, and it may be possible to increase coverage by utilizing voluntary occupational Health promoters from unions and employees associations, extending also educational activities to family groups; especially to mothers to promote mother-infant care, nutrition, etc.

It should be highlighted that the ISSS is also developing a vaccination program according to MOH standards. Being outstanding its BCG coverage with 16.262 vaccines applied to newborns, 17.252 deliveries assisted (94%). Likewise, a large quantity of children protected with vaccines may be seen which in itself is a highly positive fact to highlight.

Conclusions

The ISSS should considerably increase its coverage of the population as well as its efficiency, aiming for a more adequate model of assistance, standardized, emphasizing prevention and basic assistance. With a constant monitoring of the use of its services. Privatization should be open to all professionals and it should have and efficient monitoring system of personnel performance.

2 Bienestar Magisterial (Teacher's Welfare)

On February 22, 1968, by Decree number 588, the Legislative Assembly of the Republic of El Salvador creates the "Medical and Hospital Services for the Body of Teachers Law" for cases of illness and maternity in favor of the teachers who work for the Sate. These services were financed by a contribution from the teachers 2% of their salary and the state was obliged to cover the necessary difference for the total rendering

of service. The requirements for the beneficiary were and still are, to work a minimum of 4 hour/class a day an not to be included in the Social Security.

By decree number 257 of the 21 of April of 1977 retired teachers are included in the benefits of the Law as long as they render 2% of their monthly pension. After several other Decree, such as number 614 of March 9, 1981, which fixes monthly retention to ¢8,85 per teacher, disregarding his salary, the teacher gives a fixed amount. The following are beneficiaries of the benefits: the teachers, their spouses, and children up to 21 years of age. This law is implemented by an office of the Ministry of Education, Called Bienestar Magisterial (teacher's welfare) which is at the moment carries out benefits in three fields: Hospital-doctor services, grants and recreation.

For hospital-doctor services, some private doctors and hospitals are hired. The contracts are dealt periodically with special fees.The list of services hired is broadcasted among the teachers and they may go to the doctor of their choice as long as he is included in the list. The medicine are given in the teacher's welfare pharmacy (on the first floor of the institutions facility in San Salvador) or in private drugstores hired by the institution in : Santa Ana, San Miguel, Sensuntepeque, Santa Tecla and other cities in the country and in some areas in the MASS: Mejicanos, Concepción street, etc.

Consultation is free for all beneficiaries. There is no regulation nor control and the medication is given freely despite the fact that in theory they are limited to two prescriptions per doctor. Vaccination is carried out in private services as well as all auxiliary diagnostic methods (laboratory, X rays, etc.) without any kind of limitations.

The legal frame makes it possible to hire services with state hospitals, but this is not done because it is considered that their consumers would not wish to receive this type os services. Such an open system requires a deep financial evaluation. Perhaps state contribution is very large causing frequent delay in the payments. This has developed the need to carry out an updating study on the institution, to be carried out in January 1994 and which will render valuable information for decision taking in the future.

The Total of beneficiaries in the system are:

Table 14

BENEFICIARIES OF BIENESTAR MAGISTERIAL, 1993

Active Teachers	26.000
Retired Teachers	4.878
Subsided Teachers	29
Family Group	108.284
Total	139.191

Source: Bienestar Magisterial, Ministerio de Educación.(teacher's welfare, Ministry of Education).

This figure indicates a coverage of 2,76% of the population, in a Health System with a hospital-doctor assistance mainly curative, with no regulation and totally privatized.

Table 15

TOTAL MEDICAL CONSULTATIONS BY TYPE, 1992

Type de consultation	Beneficiaries	Percentage
General	29.000	72,0
Specialized	98.000	25,0
Emergency	13.200	3.0
Total of medical consultation	401.200	100,0

Source: Bienestar Magisterial, Ministerio de Educación.

Comparing the stablished rates to those of the ISSS we have that:

Table 16

MEDICAL CONSULTATION RATE MEDICA TOTAL AND BY TYPE AT BIENESTAR MAGISTERIAL AND ISSS, 1992

Type of consultation	B.Magisterial	ISSS
General	2,07	1,96
Specialized	0,70	1,54
Emergency	0,09	0,69
Total of consultation	2,86	4,19

Source: ANSAL Project, 1994.

Obviously, the specialized consultation rates for Bienestar Magisterial is the ideal according to the standards established for this kind of entities (0.74). Its medical consultation rates in total is below that of the ISSS in a 32% and that of specialized consultations in 55%.

In average the ISSS gave out 2,93 medicaments by medical act (consultation + discharge), whereas Bienestar Magisterial gave out 1,91. Bienestar Magisterial's hospitalizations were 5,14% in relation to the total of beneficiaries and the ISSS it was 11,29%. This difference cannot be explained. This system, despite of being totally privatized in its assistance does not have overusage as the ISSS does. It might be because the amount

paid by the ensured is high in the ISSS system, and it encourages the people to use his or her insurance excessively just as what happens in private commercial insurance.

There are 167 people working in the administration of the system at the Ministry of Education: 15 managers, 73 professionals or technician (including 3 doctors), 55 administrative and 24 of services. The higher level of the institution is formed by the Dirección Nacional de Bienestar Magisterial (National Board of Teacher's Welfare) It has the following offices: Legal inquiry, Public Relations and Press, Auditory, Collect-Payment of the General Board of Treasure under Bienestar Magisterial. Hospital medical health care, promotion and social recreation planning and administrative services. Moreover it has regional offices in the east and the western regions. Due to the lack of statistic system of services rendered and morbidity, the data could not be gathered. The directors are conscious of the need to establish an information system in health and they expect to be able to do it in a short term. Being this the only Health system which is totally privatized of the country it is important to carry out a profound evaluation, both in cost and efficiency and the level of satisfaction of the user.

3 Health System of the National Administration of Telecommunications (ANTEL)

This service started in order to render health benefits to the employees of this state office, and it grew up to its actual size. Besides the hospital located in the capital of the country (with 82 beds), it has 7 medical clinics of ambulatory health care in: San Miguel, Usulután, Santa Ana, Chalatenango and three clinics in the Metropolitan Area. The system benefits active employees of the institution, their wives, children (up to 18 years of age), their parents and retired employees.

The financing is mainly state. The law which rules the service states that the contribution of the official should be 3% of his salary, at the same time it limits such contribution to ¢20 a month. This kind of financing has a high content of inequity since the one that receives more contributes in a lower proportion to the one who receives less. It is estimated that the office finances 97% of the budget which was 37,5 million of colones for 1993.

The actual number of officers at ANTEL is 6.540 and it is estimated that beneficiaries is 47.000 people. The Health System has 406 employees, ANTEL's officials out of which 374 render services in the Hospital and the rest in peripheral clinics. Out of these employees 98 are doctors. 111 are nurses or auxiliary nurses. There are other professionals and technicians, such as dentists, physiotherapists, lab operators. etc.

A wide range of medical services are rendered: general medicine, specialties, emergencies (both ambulatory and hospital care), surgery, maternity, radiology, laboratory, odontology, etc. They have intensive care services, dialysis, showing a high level of complexity in curative assistance and at the same time carrying out preventive medication such as: vaccination (following MOH standards), sanitary education, mother-infant care programs and labor medicine.

Table 17

TOTAL OF CONSULTATIONS BY PLACE OF ASSISTANCE
ANTEL'S HEALTH SYSTEM, 1992

Type and place of consultation	Number
A. At the Hospital	
General Medicine	29.189
Specialties	79.582
Emergencies	30.894
Total in Hospital	139.665
B. In Peripheral Clinics	
Consultations	72.211
Total of Consultations (A+B)	211.976

Source: ANTEL's hospital, Monthly Report, 1992.

There is a monthly statistic report of services rendered (but not on morbidity) from which the data shown on the chart 17 was taken. It is estimated that the index of annual consultation for beneficiary is around 4,5, superior to the ISSS (4,19). It is not possible to assure that amount for not having the exact users quantity. The rate of the specialties consultations respecting the general total is 37,5% a little higher than in ISSS (36%) and of Emergency consultations is 14,6% lower than in ISSS (17%).

In the hospitals, there were 3.170 discharges performed, with a 44,3% bed occupancy percentage and an average of 5 day hospitalization. A total of 263 deliveries were attended in the year with an average of 18% caesarean. The cases that required specialized attention which the hospital is unable to provide are attended in ISSS, through an agreement.

4 Health Service of the Executive Hydroelectric Commission of the Lempa River (CEL)

CEL health system benefits its employees, their wives, children and retired of the institution which are included in INPEP, making a total of 14.486 beneficiaries in 1992, which were distributed as follows: 3.726 workers, 3.094 spouse and 7.666 children. The children receive integral health care until they are 5 years old, then from that age they receive consultation and laboratory services only. In case of disability, they receive integral health care coverage for life.

The system renders medical consultation assistance through 15 clinics: one in San Salvador and others distributed in the different energy plants of the country: Ahuachapan, Acajutla, El Cerron, La Chorrera, San Lorenzo, San Miguel and Guajoyo. Moreover, in Santa Ana, Sonsonate, Ahuachapan, Soyapango, Santa Tecla, San Rafael and San Miguel.

These clinics are responsible for 45 doctors that render general attention, 23 nurses and nurseling auxiliary. The attention of medical specialties, psychology, odontologic, hospitalary and diagnosis auxiliary methods (laboratories, radiology, etc.) is performed in the private sector for agreements to thirds. Also are included in those agreements the services of MOH in Ahuachapan, San Vicente and Sonsonate. Also the Health Military Hospital of San Miguel.

There is more than 500 doctors under contract for the specialized medical attention. They provide its beneficiaries with a high complexity attention such as cardiac surgery, renal or medullar transplant, etc. Vaccinations are performed including, moreover than PAI's, vaccine against mumps, measles and meningitis. They are directed by the Pediatric American Society standards for the vaccine application. They also perform educative talks to the workers in the central and develop an Occupational Security and Sanitation Plan. They are implementing a medical statistics system through a daily census, but they do not have yet a systematized information.

The medicines are given in the clinics dispensaries that have a basic frame that covers 85% of the prescriptions and the rest is distributed in private pharmacies. Due to certain detected abuses the prescriptions were limited to 3 per doctor and some auditings were performed.

The system is financed by a contribution of 1% from the functionary salary and the rest is covered by the company.

5 National Administration of Sewage and Aqueducts (ANDA)

It renders health care services through 6 clinics: 2 in San Salvador, 2 in Santa Ana and 2 in San Miguel. These clinics are one of general medicine and one of pediatrics (the functionaries children are treated until they are 11 years old), where basic nursing care is rendered such as healings, nebulization, etc.

There are dispensaries of basic medication at the clinics and this account takes a high share of the budget. Thus, during 1992, 9.524 adult, and 6.103 children consultations were performed, spending ¢269.559. Up to October 1993, ¢306.744 colones were invested to provide medicications for 13.071 consultations. An average of ¢24.00 of medications per consultation.

The officials are insured by ISSS and they go there for specialized attention, hospitalization, etc. The wives are attended in ISSS since they do not have the right of attention in the ANDA system. The odontology attention is performed by a private consultation contract, the company takes the responsibility for 70% of the fees and the remaining 30% is paid by the employee.

A Work Security and Sanitation Plan is being developed(with the regulations of the Work Ministry, ISSS and its own) also a Sanitation Education Plan with emphasis in the prevention of sexual transmitted diseases, alcoholism, drugs, etc. The functionaries are submitted annually to a chest radiography and a SEROLOGICAL test of V.D.R.L. (to detect syphilis).

6 Private Sector

For this report the private sector is constituted by two types of institutions:

a) The profit private organization, among which are included the health centers, clinics, and private hospitals that render services to gain economic benefits and

b) Non profit organizations (NGO's) some which offer free health services or subsidized costs to benefit the needy.

6.1 Lucrative Private Sector

There will be a brief review on the findings of the study performed in 1987, by contract with AID, for the I.P.M. company (Market and Population Investigation), in the San Salvador metropolitan area (AMSS), on: "Current situation of installed service capacity and health facilities"[14].

In 1987, for the I.P.M. survey, the whole universe of private institutions to be studied, within the AMSS was the one shown in the chart 18.

Table 18

PRIVATE HEALTH ESTABLISHMENTS, 1987

Establishments		Coverage of survey	
Type			%
Hospitals	18	15	83
Medical Clinics*	22	11	50
Consulting office	1700	1,30 (Sample)	8
X-ray Clinics	3	2	67
Dentist Clinics	7	5	72
Clinical and Pathological Analysis Lab	50	37	74
Pharmacies	377	Inventory and Location	

* Groups of Doctors for external consultations.
Source: IPM, Actual State of installed health services and facilities capacities 1987.

The hospitals and clinics included in the survey were studied by medical specialties attended, number of doctors and the total of medical hours hired (4 hospitals were excluded because they did not give any information: Bautista, Clínica Mater, Ojos y Otorrino and Centro Médico El Salvador).

[14] Between November 1993 and May 1994, a Private Sector study was performed by Lic. Roberto Iunes, complementary to ANSAL, financed by the World Bank. Since it is still in process, it was not possible to include the results of that study in this report.

Table 19

RESOURCES IN PRIVATE HOSPITALS BY SPECIALTY IN THE METROPOLITAN AREA OF SAN SALVADOR, 1987

Specialty	Hospitals	Beds		Doctors working		
			%		Total dr/hours	Average p/doctor
General Medicine	8	267	50	41	3212	78
Surgery	8	100	19	86	3248	38
Gynecology/obstetrics	5	109	20	123	2964	24
Pediatric	5	58	11	34	1524	45
Total of hospitals	11	534	100	284	10948	39

Source: IPM, Estado Actual de la Capacidad Instalada de Servicios y Facilidades de Salud (Actual State of installed health services and facilities capacities) 1987.

Table 20

MEDICAL RESOURCES IN PRIVATE CLINICS BY SPECIALTY IN THE METROPOLITAN AREA OF SAN SALVADOR, 1987

Specialty	clinics	Active Doctors		
			Total hours/month	Average p/doc
General Medicine	10	29	2610	90
Surgery	4	6	632	105
Gynecology/obstetric	5	11	658	60
Pediatric	4	10	628	63
Total of medical clinics	11	56	4528	81
X-ray Clinics	2	4	610	152
Dentist Clinics	5	12	1448	121

Source: IPM, Estado Actual de la Capacidad Instalada de Servicios y Facilidades de Salud (Actual State of installed health services and facilities capacities), 1987.

Table 21

PERSONNEL BY TYPE MEDICAL ESTABLISHMENT METROPOLITAN AREA OF SAN SALVADOR, 1987

Establishments		Doctor		Paramedics		Administrative		Total personnel	
Type			%		%		%		%
Private									
- Hospitals	15	248	33	286	33	298	34	868	100
- Med. Clinics	11	56	57	15	15	27	27	98	100
Public									
- Hospitals	1	60	22	94	35	118	43	272	100
- Med.Clinics	29	90	34	88	33	88	33	266	100

Source: ANSAL Project, 1994, IDB/WB.

This comparison clearly show than in the private sector, where they make efforts to reduce the costs to increase the benefits, they try to optimize the efficiency of the personnel and to reduce its number; whereas in the public sector there is a hypertrophy of the administrative component which makes health care unnecessarily expensive. Since this increase in cost is financed by the State there is probably lack of conscience of the need of better efficiency in the public sector.

At the moment of whiting this report, a survey of private sector financed by the world Bank was in process. Preliminary data results in the following information on private hospitals: number of private hospitals: 36, number of beds 1,219.

6.2 Non-government Organizations

There is no doubt that under such name there are many entities included differing in their size, origin, financial capacity, type of activity, resources, etc. But, in general , they all have in common the desire to actively participate in the solution of social problems in the country. Most of them act based on non permanent resources, generally external, which gives them a fragile sustainability at long term, to avoid this they should change their activities and dealings aiming to proxy themselves, community participation and community entities or to charge for their services to state institutions; such as the case to hire NGO's for primary health care, to promote community development, etc. Some have already faced activities to achieve sustainability in the future, as is the case of the Salvadoran Demographic Association, with the project of acquisition and exploitation of a private hospital, with social and profit activities at the same time.

It should be highlighted that the NGO's have a great social sensibility and they focus their efforts to high risk populations: rural and difficult access areas, exconflict areas, and in genera, areas of low state coverage, and deficient socioeconomic condition, developing programs of high priority for the country, for instance: mother -

infant care, family planning, vaccination and environment assistance emphasizing on basic sanitation. As most of the times their efforts are integral having community development plans, promotion of agriculture production (including consumption areas), development of micro enterprises, credits and community organization, etc. their penetration power in the communities is valuable and it is expected that the impact of their activities be important ad mid and long term.

Due to having focus their activities in high risk areas it makes such coverage in socially important though it may not be numerically important.

One study carried out by Marcable consultant in 1990, sponsored by USAID, on non profit private institutions rendering services in the health field in El Salvador, obtained the following results:

- Twenty-six NGO's are grouped under the coordination of the CISI intersectorial committee of infant survival).
- Twenty-six NGO's are grouped under the coordination of CIPHES (coordinating council for private human promotion institutions in El Salvador) out of which 16 rendered health services.
- In total 75 NGO's were found to work in the health sector as can be but we were able to collect data only of 65 of them (including the two coordinators: CISI and CIPHES). The data gathered gave out the following information:
    - Out of the NGO's studied 50,1% had been rendering services for more than 10 years and 35,4% had been working between 5 and 10 years, which means that most of them have a large experience .
    - Respecting the kind of services they render in the health field, in general , they carry out several types of health care simultaneously: 70,8% have curative health programs, 61,5% have preventive care and 26% have support activities such as donations, technical support etc. Some 37% claimed to have programs aimed to the women, 55% aimed to children, 75% to males and females at all ages. Some have some kind of specific assistance for one disease or program. Out of the total of the survey 81,5% showed some interest to increase they activities on mother-infant care.
    - As for administration: 75% have accounting, 54% have external auditory, and 78,5% prepare budget. 75,5% of the ones given information acknowledged their willingness to receive support form USAID.
    - Studying the relationship among their personnel and the population coverage it may be seen that 68% have a high degree of absorption (efficiency). Extracting information of the 75 NGO's surveyed by Marcable in 1990, we get the following Table of Human Resources :

Table 22

TOTAL OF HUMAN RESOURCES BY AREA OF ASSISTANCE, 1989

Area	People
Institutional Personnel	
Management, technical and professional Personnel	720
Administrative	331
Services	902
Operational	509
Others and not specified	688
Institutional Subtotal	3.150
Voluntary personnel	
Volunteers	5.859
Volunteers Subtotal	5.859
Health personnel	
Doctors	234
Nurses and Aux.nurses	105
Dentists	15
Health Technologists	31
Lab operators and pharmacists	17
Paramedics	33
Other health technicians	65
Other health professionals	25
Health Promoters	1.795
Health Subtotal	2.320
Total of people working in NGO's	11.329

Source: Study on non-profit private institutions rendering health care, Marcable, 1990, USAID.

It should to be highlighted that the persons in the management and top management levels of these institutions are also volunteers; it can be said that 50% of the persons who work in the NGO's do not receive a salary.

The total of beneficiaries is difficult to estimate because not all of the NGO's report their coverage, but according to the information reported in the study of Marcable, more than 1.200.000 people benefitted from the health attention, prevention and promotion activities performed by these NGO's.

The PROSAMI project began in august, 1990, with 25 million dollars financing from USAID, which will continue up to august, 1997. This project coordinates the activities of the 36 NGO's which have been consolidated in several steps: in 1991 the "first round" was incorporated with 9 NGO's, in 1992 the "second round" with 10 and in 1993 the "third round" with 17 NGO's. Those from the first and the second rounds are

already working in the field while those from the third one are in a training step. The NGO's included in the project to develop seven technical or component areas:

- Control of the Serious Respiratory Infections (IRA).
- Control of the Serious Diarrheic Illnesses (EDA) and Parasitosis.
- Mother Health: by means of pregnancy attention, the puerperium and the empiric midwives for the attention of the delivery.
- Expanded Program of Immunizations.
- Neonatal health.
- Growth and Development Control (CCD) and Nutrition.
- Organization and Community Participation.

The project is ruled by the MOH standards for the development of the health programs and for the training of the midwives and promoters, except for the use of the sulfa with trimetoprim by the promoters for the treatment of the IRA, while MOH promoters are not authorized to do so.

The project has from 5 to 6 indicators for each technical area or component and requires its NGO's to set goals for each activity. The effectiveness is evaluated every six months. The budget should be in accordance to the activities programmed for each component.

The NGO's are supervised by consultant doctors from PROSAMI and meetings are held monthly for information interchange, to evaluate advances, to program activities, etc. The information of activities developed by each NGO's is presented to PROSAMI every three months, in a form designed for that purpose. An evaluation the goals achievement is carried out at PROSAMI every six months and this is presented to the NGO's directives. This system of evaluation and information has developed a management maturity in the NGO's and it is one of the most positive aspects of the project.

The NGO's focus their activities in areas non-protected by the MOH, low economical resources areas and areas with difficult access; 57% of their activities are done in ex-conflictive areas, including the National Reconstruction Plan.

The human resources that the NGO's from PROSAMI are the following:

Table 23

NGO'S INCORPORATED TO PROSAMI, BY "ROUNDS"

Round	Of NGO	Employees	Technicians	Adminis.	Promoters
First	9	225	35	26	164
Second	10	194	43	26	125
Third	16	252	49	41	162
Total	35	671 (100%)	127 (19%)	93 (14%)	451 (67%)

Source: ANSAL project, 1994.

A minimal rate of administrative personnel is found again in relation to the technical personnel (doctors, nurses, mother-infant technologists, etc.) and operative (health promoters), which means a rationalization of expenses.

If this is compared to the distribution of personnel of a state institution:

Table 24

NGO'S AND MOH PERSONNEL, BY AREAS OF DEVELOPMENT

Institution	Employees	Prof./Tech.	Administrative	Promoter
PROSAMI's NGO's	671 (100%)	127 (19%)	93 (14%)	451 (67%)
MOH*	21.253 (100%)	12.371 (58%)	7.440 (35%)	1.442 (7%)

* There is personnel by contract which has not been classified because the type of labor done is not specified. It is estimated that most of them are is administrative or of service personnel.
Source: ANSAL project, 1994.

Most of the NGO's are considered to be worthy agents for community change and it deserves more support in their efforts, under a system of organized coordination and evaluation.

VI *CONCLUSIONS AND RECOMMENDATIONS*

According to the analysis in the previous chapters, the most critical aspects detected are the following:

1) There is insufficient definition of the Role of the State in aspects of Health.

2) It is necessary to implement a Policy of Health that has National in force.

3) Insufficient intrasectorial coordination and, in some cases, interinstitutional.

4) The MOH needs to be modernized to fulfill its role of manager of the Health System in the country efficiently and coordinate the reform process of the sector.

5) The process of Decentralization of the Health Sector, especially of the MOH, is being done too slow.

6) Insufficient sanitary coverage and the need to develop more preventive attention.

1 Sanitary policy

The Sanitary Policy of the MOH is not nationally in force. It is important that a sanitary policy to prioritize the primary health care, the mother-child health and environment sanitation; which should be in force in all the institutions of the Sector and not only in one. The participation of the entities that make up the Sector in the discussion of the health problems of the country and also in the policies that will be developed to overcome them will in force a National Sanitary Policy of consensus and will compromise these institutions in its implementation, under the coordination of the MOH.

2 Intrasectorial coordination and National System of Health

It is necessary to create a space of concertation enabling the discussion, coordination and dialogue on the sanitary reality and the elaboration of policies that becomes the basis for the participative planning of the National System of Health and its implementation. In this instance of concertation, all the entities and organizations of the sector such as: Non-Government Organizations (NGO's), the private sector, the body entities and those trainers of human resources should be invited to participate. This, which is indispensable for the System to be in force and also for its vitality, requires a larger leadership and negotiation ability from the MOH.

It is important that a new institution not be developed for the implementation of the System, but that the existing state and private resources be used.

The aspects that should be developed initially in the System are:

1) implementation of the Sanitary Policy and the National Plan of Health;

2) to seek mechanisms that guarrantee the fulfillment of the sanitary rules;

3) to achieve the definition of a policy of human resources in health that includes the training, capacitation and administration of such resources;

4) to implement a sole system of statistic information;

5) to achieve the participation in the implementation of sanitary campaigns, such as: PAI, AIDS, mother lactation, etc.

In a second step: to organize and implement a National System of Epidemiological Vigilance.

3 Role of the institutions

When analyzing all the SNS, it seemed to be very clear that there is no precise definition of the responsibility that each of the components of such System has. In the following paragraphs, some ideas on the aspects that should be defined with priority, are provided:

Ministry of Health
In order to fulfill its responsibility in a more efficient manner, the MOH should assume those functions that are inherent to as function of health rector:

- To plan and implement the National Sanitary Policy, according to the sociological-economical situation of the country and to its epidemiological profile.
- To control the health situation in the country, developing the activities and programs necessary to protect the health of the population. Among them, to keep a system of epidemiological vigilance of national coverage.
- To promote the extensions of the coverage of an integral sanitary attention, opportune, just and efficient in order that the accessibility to the health services of the least protected sectors and the prioritary groups can be assured.
- To issue the necessary rules for the Health Code to be applied adequately and to develop and implement sanitary rules to preserve the health of the population; besides, to control the fulfillment of such rules and laws.
- To promote the individual and collective responsibility in the health care and the environment. To coordinate the development of the activities of sanitary education.

The Ministry should take the lead of the National Health System, be on the watch for the implementation of the sanitary policy at a national level, promote the inter and intrasectorial coordination, optimize the use of such resources at national levels and take charge of the control of the health of the population all over the country.

Social Security
All workers have to be insured in a social security system, but it is not necessary nor convenient the monopoly of an institution.

It is indispensable to separate the administration that corresponds to the benefits of the Differed Risks completely (old age, disability and death), from the administration of the health benefits, if it were possible, in different institutions, giving the insured options, and developing the free competence to promote quality and efficiency.

The increase on coverage of the health component of the social security has to be considered in order to promote a better health level for the population. The mechanisms to achieve at long term and in a planned manner the universal coverage have to be searched, being the State the SECURER for the insolvents.

Other government institutions
A deep evaluation of these institutions is suggested, above all from the financial point of view, of other government systems of medical assistance (independent from ISSS), as a way to define their strength and weakness and their financial sustainability. In general, the other systems as ANTEL, CEL and Bienestar Magisterial have low quotas which implies the state subsidy that infringes the concept of equity. On the other hand, they are closer to the users and have greater compromise with their satisfaction. Each of them has a different model rendering services: Bienestar Magisterial is completely private, ANTEL completely institutional, and part of CEL is institutional and another part is private. It is going to be very useful to evaluate the experience of these services, as well as the level of satisfaction of the users.

4 Rationalization of the use of resources

The state institutions should be constantly developing and implementing mechanisms that allow to increase the quality an efficiency of its performance, incorporating modern concepts of planning, managing and monitoring, to achieve a greater impact at a lower cost. There is lack of efficiency in the institutions due to the lack of standards for the use of resources or for their non-fulfillment, as well as for the absence or lack of validity of an evaluation system that determines incentives and sanctions.

A especial point of interest is the financing of the system, especially the state component, both because the way of financing the necessary amounts, and their distribution, which gives priority to healing activities. The MOH should develop more the cost recovery, with the purpose of strengthening the system of several sources of financing.

As for substructure; it is disturbing to see the desire of the government to keep on building hospital services which are not necessary at the moment. The expenses they have in state substructure should be limited to re-function, rehabilitation and maintenance of the existing services, as well as completing the necessary basic equipment to comply with the level of assistance assigned to each unit. The only investment in increasing substructure that could be justified is the construction of health centers in critical rural areas, whenever they respond to a small design, appropriate to primary health assistance.

The state debt with the ISSS should be paid by giving the Specialty Hospital to the Institute in a definite way and giving greater in force to "special programs" to ensure the access to specialize assistance to poor patients assisted in the MOH institutions. This solution could be possible if there were a political decision about it.

Another of the most critical points within the State Health System is the one of human resources, which is considered further in another report.

5 Model of assistance

In general, the models of assistance of the institutions of the Sector are esscencially curative, based in the medical activity and this is observed even in the MOH institutions. in the services which have doctors, the other professionals or technicians have little attention or rather work as assistants of the doctor. Since they are the most important ones we will consider the models of the MOH and the ISSS.

Ministry of Health
In visits to the MOH facilities, it is evident that, in general, the Directors of the health services of the MOH emphasize the importance of preventive medicine. But when they have an opportunity to ask for some kind of support or resource they ask for healing services: surgical equipment, enlargement of hospitals, etc.

It is noticeable that the institutions lack technical or professional staff especially trained for attending deliveries. The nurses perform this job in cases that is not possible to have medical assistance, but it should be remembered that one of the critical points within the health field is the lack of nurses.

There is not enough technical staff that could replace the nurses in their jobs. Accordingly they are used for hospital and assistance jobs and in a very little proportion they fulfil community jobs. The technical and infirmary staff should participate more in health assistance, giving them a more decision power.

That is why the Community Health programs rest upon promoters and trained empiric midwives. They are people of good will but with little education; with little supervision from the staff of infirmary and obstetrics.

The basic attention to high risk population, that is: rural and poor zones, rest in great proportion upon people with low capacity of solving problems. The Directors leave in the hands of specific supervisors the direction and evaluation of the promoter's jobs.

Salvadoran Institute of Social Security and other state institutions that render health services
These institutions, even when they are restricted to their beneficiaries, have extremely open models of attention, without any kind of regulation and without control mechanisms. It is important for the models of attention of each of the institutions to be clearly defined and regulated in order to avoid misuse and waste of resources. The priority of actions should be determined in relation to the socioeconomic and sanitary context of the country. Although this institutions have primarily a healing model, it should be emphasized as a positive aspect the changes in the last years and the preventive component, having more emphasis. This change should be supported and encouraged because it involves an optimization of the use of resources and a correct and integral interpretation of the function of the health entities.

6 Decentralization

Practically none of the state institutions are decentralized, but no doubt the most damaged one for the excessive decentralization is the MOH. At the Central level it takes decisions regarding the operative level, leaving little space for movement to this. The budget is not decentralized in the regional services and it is not designed differentiating each service, so it is very difficult to determine how the distribution of resources is done. The regional level also centralizes the decision power and increases the distance between the operative and central level, using a large number of human resources for its operation. As an example it can be quoted that in one region, the regional offices had 144 officials, many of them could be more useful at the operative level.

After years of functioning the regions are not decentralized and the Regional Director, act as a representative of the central level of the MOH, reproducing at the operative level the central bureaucracy with little capacity to solve problems, except as the representative of the services in his charge.

The regional heads have more resources than department ones. The implementation of SILOS (Local Systems of Health) is intended, but they are implemented from a centralize planning, according to a design that looks more for the geographic subregionalization according to regional groups of supervision, than the

decentralization of resources and decisions with community participation. The result was that the regional bureaucracy increased and produced an intermediate technical level that separates the service more from the level of regional decision. It is necessary for the decentralization to be done at a department level, with basis on the concept of equity. Afterwards this decentralization should be going down to operative levels of the district or municipalities, being able to use or not the figure of SILOS.

According to long term and mid term plans of COMURES the decentralization in health services will be looked for through the municipalization, after strengthening the municipalities in a managing and economical way that, in general, are still little developed. This project should receive all the possible attention from the MOH in order to evaluate its feasibility.

7 Coverage increase

The universal coverage of the health services within the context of social security, quoting the state for the indigent ones, could be a long term possibility, whenever the access to this system is widely open to independent workers, farmers, etc. The sustainability of this option is related to the type of attention that is rendered; to the possibility of restricting the use of institutional medicine and to establish tariffs for some actions of specialized attention and diagnostic means, even for those beneficiaries covered by the conventional social security.

At a short term, the increase in the coverage for primary attention to a rural level could be achieved by giving more decision power to the promoters and nurses in health Posts and Units, making the last ones responsible for attending deliveries. It is essential for the staff from the health services to live in, and integrate themselves with the community. The schedules of attention and the quality of it should be revised, in order to avoid patients going to more complex services because they can not find the necessary attention at their community level.

Another mechanism to increase the coverage of primary attention in rural areas, is the better use of NGO's actions. The role of the NGO's in primary health attention is undeniable and the MOH should take advantage of that potential in order to give better attention to the rural zone, through coordinated actions, service agreements, etc.

8 Foreign help organisms

The necessity to improve a better coordination of external help is very important in order to avoid duplicity and superposition of actions. The prioritazion of a program by the fact that it has external help, the implementation of "parallel programs" and the inappropriate use of resources because of the lack of coordination, of integration or for exclusiveness of the use of a resource for a specific program, it could be easily avoided with team work from the organisms that support government work. It is not clear in the basis of what kind of prioritazion the internal help is directed in the MOH.

The decision to develop several and, apparently incompatible systems of information contrasts with the permanent low institutional assistance to delivery. There seems be little emphasis in women health care, in the prioritazion of external help toward several "parallel systems" of information. The fact that the foreign financing is assigned to pay recurrent expenses such as salaries, for example, should be reverted avoiding this situation in the future.

9 Proposals

In basis of the analysis of the situation of the Health Sector of El Salvador the following recommendations are made out .

a) *To implement the National Health System.* In basis of the National Health Commission, as a coordination entity and, without their integrants losing their institutional autonomy they should integrate to SNS, be regulated by the sanitary standards of the State, carry out the Sanitary Policy, The Health Plans of the country and a share a common system of information. The National Health System would be a forum of discussion and concert between entities that render health services, the groups and the institutions training human resources. It will serve to look for concerted solutions to the sanitary problems of the country. The Private Sector, both the business and the NGO's, should participate in the system.

b) *The Ministry of Health should determine the basic package of sanitary actions that would be given to the population.* The State will finance this package for the poor population and this financing will have priority over all the others. The services included in this package could be given by the NGO's or by other entities, under the coordination of the Ministry of Health which will be the largest rendering services. These basic sets of sanitary actions would be determined in function of the sanitary priorities of the country, with emphasis on the main epidemiological problems of the country.

c) *To decentralize the State Institutions in basis of departmentalization.* This project could include other institutions such as Ministry of Education and included with decision within the Modernization of the State Program. This kind of decentralization would end at a middle term with the differences between departments, region heads and the ones that are not. It is completely justify when just departments that are not region heads, are the ones that need more assistance: Morazán, Chalatenango, Cabañas, etc.

d) *To essentially increase the coverage of the Social Security,* with a regulated model of attention, regulating and increasing the actions in the field of preventive medicine: ocupacional therapy sanitary education, family planning, breastfeeding, etc. The increase in health coverage through a social security system should not be exclusive of the ISSS; being able to include in them to other systems and institutions.

e) *To improve the efficiency of the State services developing management systems that allow a better use of resources.* A better use of the existing resources will be searched developing agreements between public and private entities that render services. To avoid the construction of more hospitals. Decentralizing the decision power and the resources, to the interior of the country.

f) *To promote the population accessibility to the assistance in the Private Sector, supporting initiatives of medical cooperatives and the making of groups of professionals that render a more economically accessible medical assistance.* To promote the development of community and preventive health programs: sanitary education campaigns, infant nourishment, AIDS, to promote family planning, etc. carrying them out by private enterprises; encouraging them with tax or commercial advantages.

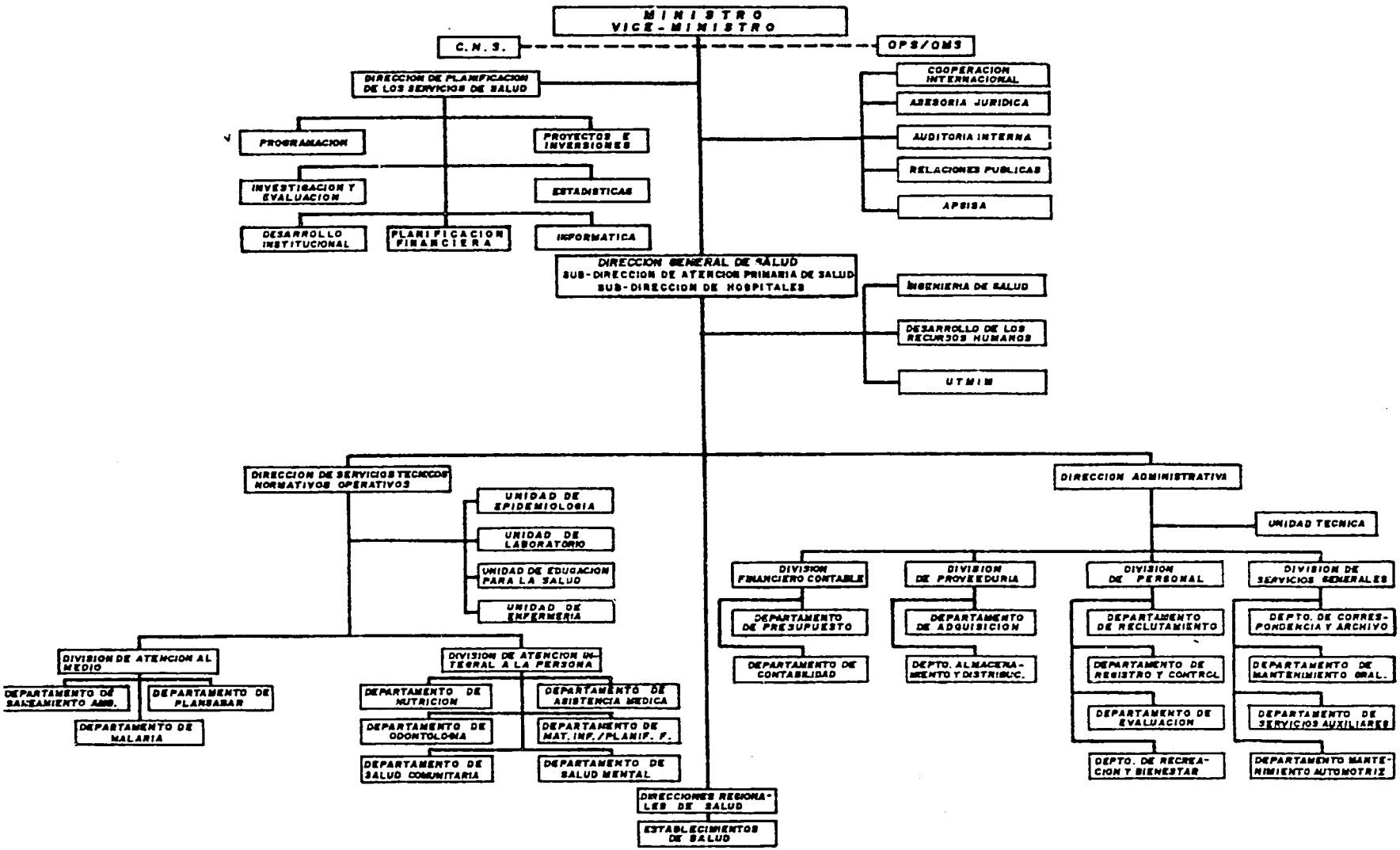
g) *To support the development of actions and strategies that give sustainment to the NGO's that render health services, by means of hiring their services or by giving them tax encouragement to those enterprises that become financially responsible of them.* Through agreements, the State should use the NGO's to increase the sanitary coverage especially of those areas where they are already working.

h) *To coordinate the foreign cooperation avoiding superpositions and responding to the need of operative services and the sanitary situation of the country.*

i) *To substantially increase the taxes to those dangerous products for the health: cigarettes, alcohol, as well as gambling.* To assign the collected funds to a Social Health Fund for the assistance of especial cases included in the system of state reference, as well as for the focalization of sanitary actions especially in unprotected or vulnerable populations.

ANNEXES

ESTRUCTURA ORGANIZACIONAL DEL MINISTERIO DE SALUD PUBLICA Y ASISTENCIA SOCIAL



MARZO DE 1993

Annex 2

Process of revision of the preliminary reports

Introduction

The project Analysis of the Health Sector in El Salvador (ANSAL) was conceived as part of the efforts aiming to accelerate the economical and social developments of the country. The analysis of the organization and performance of the institutions of the sector should lead to the identification of constraints which, if overcame, will result in the improvement of the sector and the health conditions and welfare of the population.

Generally, the projects tending to accelerate the social and economical development are conceived and designed by experts in the subject covered by the project. They gave their professional knowledge and their experience to identify the problem, choose the possible solutions and design the components of the projects. In this process, the exchange of opinions is generally restricted to leaders both in the sector and in society. The potential user and the personnel involved directly in the production of the good or the service analyzed are not frequently included in this process of consultation. The resultant projects do not benefit from the cultural perceptions and from the accumulated experience by those who are in the front line of the battle and, as consequence, they can be seen as strangers by the same benefitted community.

Procedure

The terms of reference of ANSAL established a wide process of consultation that avoided the limitation pointed at in the introduction. There, it is established that the shared process has similar transcendency to the content of the analysis. To achieve this, it was indicated that the preliminary results of ANSAL's work, gathered in nine drafts of Technical Reports, were widely diffused among institutions and persons in the health sector for them to be checked and commented. This focus is part of a "participative facing" of the efforts of development. To fulfill this requirement, a strategy was designed and it includes the following components:

1) *Written comments.* About 100 institutions and people with experience in the functioning of the health services were invited to comment, in written form, about:
   - the veracity and integrity of the presented data;
   - the logic of the analysis used;
   - the feasibility of the recommendations presented.

2) *Meetings with the health personnel and members of the community.* Ten meetings were held in different places in the country to cover most of its territory. Health personnel in different levels of capacity (promoters, empiric midwives, doctors and pharmacists), leaders from the served communities (Majors, members of the Support Boards of establishments from the MOH or Patronage, members of the Education Community Associations or EDUCO schools and local community leaders) and regional and local functionaries and authorities from the MOH were invited to participate.

3) *Workshops with leaders of the sector.* Workshops were held for two days with leaders of public organisms related to the social and health sectors (MOH, MIPLAN AND ISSS), with directives of the NGO's active in health and from the Medical School and directives of the health area from several political parties. The Dean of the Faculty of Medicine of the UES was invited but he did not show up.

Results

The participation was intense and useful to make valid or discard the preliminary results of ANSAL. About 30 institutions, the main organizations from the public sector (MOH and MIPLAN) and the NGO's, among them, sent written comments.

About 250 people representing the three components mentioned previously participated in the community workshops. From these three groups, the community leaders had the lowest participation.

Twelve of the thirteen leaders invited to the Workshops participated; those who did so, stayed until the exercise was over.

Except for the opinions of the central technical hierarchies of the MOH (Directors of Programs and Departments and Regional Directors), who expressed objections to some discoveries of ANSAL, the comments pointed to the principal problems of the sector and the most effective way to face them. The specific comments are summed up in each one of the Technical Reports. The following correspond to this report.

CONTRIBUTION OF THE COMMUNITY WORKSHOPS

Health service systems
Analyzing several key points it may be perceived the need to develop a model of attention according to the real needs of the user which should be sustained in the following aspects:

- To increase the schedule of attention (in the afternoon hours, for example)
- To consider the cultural characteristics of the population that is being covered.
- To treat the user more warmly.
- To improve a system of reference and counterreference.
- To give more emphasis to the preventive medicine.
- To give more emphasis to the participation of the community (for example, at the schedule set, identification of the most urgent problems, etc.).

Sanitary education
The need of enforcing the Education for Health through the mass communication and small groups (on which existing community groups could be benefitted: family, mothers, children at school, etc.) was underscored.

Accessibility
The following problems were mentioned several times as factors that difficult the accessibility:

- The distance between the user's residence and the health establishment.
- The lack of education of the population.
- The cultural patterns and the perception of sickness that the user has .
- The payment capacity for transportation and medicines.
- The economic losses that cause to be absent at work when there is a needed to go to a health.
- The inadequate treatment received.

Coordination
There was a consensus in the majority of the contributions on the urgency to reinforce the coordination system among the different institutions that conform each sub sector. A conclusion was reached that is of vital importance to health improvement, to develop a more effective coordination system between the entities of the Private and Public sector, specially with the NGO's.

There is a difference on which and how this coordination should be. On one hand, MOH promotes a coordination that strengthen the rector function of the Ministry within the sector and which allow the establishment of regulations that harmonize the interaction of the system participants. For its part, the NGO's understand for coordination a better distribution and use of the resources, however, they are cautious when they talk about submitting themselves to the direction of MOH with an entity managing the system.

In spite of the conceptual differences mentioned, in several occasions has been developed in the local levels, an adequate and functional coordination between both sectors, without affecting the work the dome problems.

Decentralization
The decentralization was one of the priority themes in the different discussion groups, which reached the consensus that the decentralization and the handling of resources to the primary levels is insufficient.

As the coordination theme, there are several conceptions on the decentralization:

- The Public Sector, specially MOH, propose a decentralization intra institutional, that is to say, it refers to the transaction of the deciding power and the handling of resources at the primary health care (Health Unity).

- There are some that think that the decentralization should be done through municipality administration. To this group, the directing (Decision making) should be focused in the city halls and in the municipality organization systems.

- The third conception is referred to a "mixed" system in which services organizations representatives should be included, which will participate in the activities planning, budget administration and design, etc.

- There are some that think that the services should be transferred to private organizations (profit or non profit) for its administration.

Management
This subject was discussed by the state officers, whose referred, mainly, to the obstacles that makes difficult the proxy, as the case of the excessive bureaucratization, some programs which are not being carried out and the need of improving the information systems.

Health Policies
All the meeting participants, emphasized the necessity of giving a major diffusion to the Health National Plan. Also was suggested that in the elaboration of future health plans, should be included the participation of the other sector organizations and the beneficiary communities, in particular, in a manner that all the participant of the sector know the plans and use them as an instrument of coordination in the actions.

WRITTEN COMMENTS

Preventive/curative attention
- There is a consensus concerning that the health should be integrally treated, that is to say, the preventive attention as well the curative attention should be provided the same. If it is true that the demand of curative medicine can be reduce with a good preventive program, there will always be sick people to cure.

Private Sector

- The NGO's have had experiences and interventions mainly in the primary health care level and less in the other levels.

- The NGO's sustainability in the future is still undefined.

- About the Business Sector, there is not enough information related to its real capacity of health services and to its operation costs.

Standardization

- There is a need to establish regulation parameters and standards for the performance and organization of the sector.

Social Security

- Before performing the Social Security universal coverage Policy, should be performed updated and feasible studies, and also find out how to use the experiences of other countries. Not doing so, will jeopardize the sustainability of these institutions.

Coordination with NGO's

- The non government organizations should organize and function in close relation with the Public Sector, with regulations that adjust this relation. Moreover, should look for the mechanisms by which the NGO's could receive the state financing as a way of strengthening this cooperation.

MEETING WITH THE LEADERS OF THE SECTOR

There was a consensus in the following aspects:

1) It is urgent to give more emphasis in the Primary Health Attention (APS).

2) The decentralization should be used with a proxy model.

3) New Sector financing sources that guarantee the attention to the poor should be looked for.

4) The effectiveness, efficiency and sustainability are three elements that should be the base of every reform process.

Annex 3

INTERVIEWS

Dr. Gustavo Argueta, Viceministro de Salud. *(Vice Minister of Health)*

Dr. José Antonio Pereira, Director de Planificación del Ministerio de Salud Pública y Asistencia Social. *(Planning Director from the Ministry of Health)*

Dr. Alcides Urbina, Sub Director General del Ministerio de Salud *(General Sub Director of the Ministry of Health)*

Dra. Sonia de Melchor, Jefe del Depto. de Salud Comunitaria. *(Chief of the Community Health Department)*

Dr. Jorge Roldán, Jefe de la División de Asistencia Médica. *(Chief of the Medical Assistance Division)*

Dra. Morena Rivas de Teves, Encargada del Sistema de Información Gerencial. *(Incumbent of the Managerial Information System)*

Lic. Marlene de Barrientos, Asistente del Proyecto de Implementación del Sistema de Información Gerencial. *(Assistant of the project of Implementation of the Managerial Information System)*

Dr. Gustavo José Domínguez, Subdirector de la Región Sanitaria de Oriente *(Sub Director of the East Sanitary Region)*

Dr. Juan Héctor Juvis, Supervisor Médico Regional de la Región Sanitaria de Occidente. *(Regional Medical Supervisor of the West Sanitary Region)*

Dr. Jaime Arturo Salmán, Director del Centro de Salud de Chalchuapa. *(Director of the Health Center of Chalchuapa)*

Dr. Francisco Zeledón, Asesor de Suministros del Centro de Salud de Chalchuapa. *(Supply Adviser of the Health Center of Chalchuapa)*

Dr. Salvador Linares, Jefe de Residentes del Centro de Salud de Chalchuapa.*(Chief of Residents of the Health Center of Chalchuapa)*

Sra. Leticia Castillo, Administradora del Centro de Salud de Chalchuapa. *(Manager of the Health Center of Chalchuapa)*

Sra. Carolina de Portillo, Enfermera Supervisora del Centro de Salud de Chalchuapa. *(Supervisor Nurse of the Health Center of Chalchuapa)*

Srta. Rosa Marina Arévalo, Estadístico del Centro de Salud de Chalchuapa *(Statistics of the Health Center of Chalchuapa)*

Lic. Edwin Morales, Administrador del Hospital Regional de Santa Ana. *(Manager of the Regional Hospital of Santa Ana)*

Dr. Víctor Manuel Umaña, Jefe del Servicio de Emergencia del Hospital Regional de Santa Ana. *(Chief of the Emergency Service of the Regional Hospital of Santa Ana)*

Dr. Carlos Pérez Beltrán, Director del Centro de Salud de Cojutepeque. *(Director of the Health Center of Cojutepeque)*

Sr. Manuel Hernández Bernal, Administrador del Centro de Salud de Cojutepeque. *(Manager of the Health Center of Cojutepeque)*

Dra. Gina Cañas, Coordinadora del Sistema de Información Gerencial, del Hospital de Maternidad. *(Coordinator of the Managerial Information System of Maternity Hospital)*

Sra. Clotilde Diez, Administradora del Hospital de Maternidad. *(Manager of the Maternity Hospital)*

Sra. Coralia Machuca, Jefe del depto. de Estadística del Hospital de Maternidad. *(Chief of the Statistics of the Maternity Hospital)*

Dr. Roger Vidal Fuentes Umanzor, Director del Hospital Rosales. *(Director of Rosales Hospital)*

Dr. José Max Molina, Director del Hospital Zacamil. (Director of Zacamil Hospital)

Dr. Hugo Villegas, Representante de la Organización Panamericana de la Salud en El Salvador. *(Representative of the Panamerican Health Organization in El Salvador)*

Ing. Eduardo Carrillo, consultor de O.P.S. en Sistema de Información Gerencial. (Adviser of O.P.S. in Managerial Information System)

Dr. Rafael Antonio Olivares, Subdirector General del Instituto Salvadoreño de Seguridad Social.*(General Sub Director of the Salvadoran Institute of Social Security)*

Lic. Camilo Rodríguez, Director de Planificación del Instituto Salvadoreño de Seguridad Social. *(Planning Director of the Salvadoran Institute of Social Security)*

Lic. Edgar Soto, Jefe de Estadísticas del Instituto Salvadoreño de Seguridad Social. *(Chief of Statistics of the Salvadoran Institute of Social Security)*

Dra. Ana María de Gamero, Directora de la División de Salud del Instituto Salvadoreño de Seguridad Social. *(Director of the Health Division of Salvadoran Institute of Social Security)*

Dra. Elizabeth Burleigh, Directora del Proyecto PROSAMI. *(Director of the PROSAMI Project)*

Ing. Carlos Castaño, Director de Clapp & Maine, Proyecto APSISA. *(Director of Clapp and Maine, APISA Project)*

Dr. Ricardo Martinez Royo, Asesor de Sistemas de Información Gerencial de Clapp & Mayne, Proyecto APSISA. *(Consultant of the Managerial Information System of Clapp & Mayne, APISA Project)*

Dr. Juan Ramón Umaña Cerros, Director del Hospital de ANTEL. *(Director ofthe ANTEL Hospital)*

Dr. Rafael Vazquez, Jefe del Servicio de Consulta Externa del Hospital de ANTEL. *(Chief of External Consultation of ANTEL Hospital)*

Lic. Celina de Choussy, Directora de Proyectos de FUSAL (Fundación Salvadoreña para la Salud y el Desarrollo Social). (Director of Projects of FUSAL *[Salvadoran Fundation for Health and Social Development]*)

Dr. Herbert Betancourt, Consultor en Salud Pública de FUSAL. *(Advisor of Public Health of FUSAL)*

Lic. Sandra de Barraza, FUSADES.

Dr. Miguel Murga, Presidente del Colegio Médico de El Salvador. *(President of the Medical Collegiate of El Salvador)*

Lic. Manuel Gómez Benítez, Director de Bienestar Magisterial, Ministerio de Educación. *(Director of Bienestar Magisterial, Ministery of Education)*

Lic. Carlos Abraham León, Jefe de Planificación de Bienestar Magisterial. *(Planning Chief of Bienestar Magisterial)*

Sr. José Lino Cardozo, funcionario del Depto de Planificacion de Bienestar Magisterial. *(Official of the Planning Department of Bienestar Magisterial)*

Capitán Luis Roberto Solis, Jefe de la Sección IV Logística del Batallón de Sanidad Militar. *(Chief of the IV Logistic Section of the Batallón de Sanidad Militar)*

Lic. Marta Elizabeth Alfaro de Chávez, Jefe del Depto. de Bienestar Social de ANDA. *(Chief of the Social Welfare of ANDA)*

Dr. Manuel Enrique Angulo, Superintendente de Servicios Médicos de CEL. *(Medical Services Superintendent of CEL)*

Dr. José Antonio Valle, médico del Servicio Médico de CEL. *(Doctor of the Medical Servive of CEL)*

Lic. Carolina Franco, Jefe de la Sección Suministros Médicos de CEL. *(Chief of the Medical Supply Section of CEL)*

Lic. Eduardo Emilio Zepeda Calderón, gerente de la Asociación Salvadoreña de Empresas de Seguros. *(manager of the Salvadoran Association of Insurance Enterprises)*

Lic. Ana de Fonseca, encargada de los proyectos de salud de la Secretaria de Reconstruccion Nacional. *(incumbent of Health Projects of the National Secretariat of Reconstruction)*

Lic. Miriam Hirezi de Meléndez, Coordinadora del Equipo Técnico de la C.D.D.M. (Comisión Coordinadora del Proceso de Descentralización y Desarrollo Municipal) de COMURES. (Coordinator of the Technical Team of C.D.D.M. *[Coordinating Comission of the Decentralization Process and Municipal Development]* of Comures)

Lic. Ramón Calderón Araoz, integrante del Equipo Técnico de la C.D.D.M. de COMURES. *(Member of the technical Team of the C.D.D.M. of COMURES)*

Sr. John Gillespie, Sr. John Wolf y Lic. Maria Esperanza Gutiérrez, consultores de la misión de evaluación del Proyecto APSISA. *(Consultants of the evaluation mission of the APISA Project)*

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