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Equity in The Provision of Health Care: Ensuring Access of The Poor to Services Under User Fee Systems

A Case Study: Ecuador

By
David H. Collins
Management Sciences for Health

with Research Collaborators
Mercy Balarezo
and
Joaquin Paguay

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David H. Collins
Management Sciences for Health

with

Joaquin Paguay
Research Collaborator

and

Mercy Balarezo
Research Collaborator

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David Collins is Director of the Health Financing Program for Management Sciences for Health in Boston. He is a Chartered Accountant with a Masters in Rural Development and has many years of experience providing technical assistance in health care financing and financial management in developing countries.

Joaquin Paguay and Mercy Balarezo are Ecuadorean economists with many years' experience in different sectors, especially health, water and sanitation. Mr. Paguay currently works as an independent consultant based in Quito. Ms. Balarezo works for the Banco del Estado in Quito.

Acronyms

AIDS	Acquired Immunodeficiency Syndrome
APROFE	*Asociación Pro-Bienestar de la Familia Ecuatoriana* (Association for the Well-being of the Ecuadorean Family)
BASICS	Basic Support for Institutionalizing Child Survival
CEMOPLAF	*Centro Médico de Orientación y Planificación Familiar* (Center for Health Advise and Family Planning)
CEPAR	*Centro de Estudios y Paternidad Responsable* (Centre for Studies and Responsible Parenthood)
HHRAA	Health and Human Resource Analysis for Africa
IESS	*Instituto Ecuatoriano de Seguro Social* (Ecuadorean Institute of Social Security)
INNFA	*Instituto Nacional del Niño y Familia* (National Institute for the Child and Family)
JBG	*Junta de Beneficiencia de Guayaquil* (Welfare Society of Guayaquil)
MSP	*Ministerio de Salud Pública* (Ministry of Public Health)
PVO	Private Voluntary Organization
SSC	*Seguro Social Campesino* (Peasant Social Security)
USAID	United States Agency for International Development

Executive Summary

During the last few years, many countries have introduced user fee schemes to generate additional revenue for underfunded health services. Many of these schemes have not, however, considered or dealt adequately with the impact on access to health services for the poor and other vulnerable groups, despite wide acceptance that health care is a basic right and access should be based on need and not ability to pay.

This study is one of five country studies aimed at determining which mechanisms can be used to ensure cost recovery efforts do not restrict access of the poor to services and payment of fees does not result in financial hardship. Ecuador was chosen for one of the country case studies because of its variety of cost sharing schemes and concerns about access for the large number of poor people to services in light of recent attempts by the Ministry of Public Health to introduce a user fee policy.

The study focuses on a number of private voluntary and municipal organizations that currently have official fee collection policies and systems. It excludes Ministry of Public Health facilities because most of the staff was on strike at the time of the visits to Ecuador. Many different mechanisms aimed at facilitating access to services were encountered, including general fee subsidies, reduced fees for services in poorer locations, exemptions and reduced fees for certain services, means testing, sliding fee scales, waivers, special government funds, and fast track services. The experiences show that the choice and use of mechanisms, and the volume and value of waivers, tend to vary with the financial needs of providers, which appear to fall into two groups: those who rely heavily on fee revenues and those who do not.

In the main, the providers included in the study do not have policies in place to exempt vulnerable groups, and instead, charge for all services and use pricing structures or waiver mechanisms to make those services affordable. Some providers rely heavily on fees for the bulk of their income and maintain some access for the poor through low prices, made feasible by low costs and some element of external subsidy. However, fees at these facilities are not always low enough to attract the poor, and the number of waivers is generally small because their availability is not widely known. Other providers who also rely heavily on fee revenue, but only for funding non-staff costs, maintain access through very low prices made feasible by the high subsidies. The volume and value of waivers are small and focused on poor patients with high bills, and additional assistance is obtained from other government bodies with the payment of such bills. Providers who rely less on fee revenue tend to be more liberal, maintaining access through a mixture of very low prices, exempt services, and a significant volume of waivers.

From the mechanisms encountered, certain elements appear to be effective. The model of setting outpatient consultation fees on the low side and only granting waivers by exception for indigents is likely to be the most cost effective system for general outpatients. Means testing is then only used for more expensive care, such as surgery or hospital stays. The use of different economic categories seems to be a reasonable method for means testing, but it is probably better to use those categories to assign the patient a fee level on a sliding scale than to assign a percentage that may then require negotiation with the patient to determine the actual amount to be paid. The policy of interviewing all inpatients upon admission makes sense when there is a likelihood many patients will not be able to afford the full fees. The use of a fee card valid for one or two years is also appropriate, but is probably best used with a sliding scale system so that the actual amount to be paid does not have to be negotiated each time the patient uses a facility. Such a card could also be used across a network of facilities.

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In terms of the administrative cost of the different mechanisms, it would appear that at the clinic level, it is appropriate to use receptionists and other general staff to handle waivers, and the decision-making processes do not need to be that formal. At the larger facilities, it is appropriate to use social workers to handle waivers since they are in place and carry out other related social work tasks. It is important, however, to have an efficient decision-making process and not to use expensive staff to make decisions on low value waivers. It is also essential to have a proper recording and reporting system to ensure that managers can easily monitor the volume and value of waivers. In general, issues of cost-effectiveness should be examined within the context of the overall user fee system because the waiver systems elements cannot be isolated.

It is clear from the study that protection of access for the poor and vulnerable to services under user fee schemes depends to a great degree on the goal of the organization and availability of external subsidies. Every provider, whether government or non-government, must generate the funding it needs to provide good quality services to its target population. If the organization has a mission to provide care to the poor, and the poor are not able to cover the cost of the service, the funding shortfall must be covered from external subsidies or profits made from providing services to better-off people. In a competitive environment the latter option is limited because patients will change providers if profit margins become too high. The availability of funding for services to the poor is therefore highly dependent on the amount of external subsidy. However, the efficient and effective use of resources is also critical, since the unrecovered cost of services needed by the poor and vulnerable is generally much higher than the amount of external subsidies available.

The tasks of determining the demand for services, providing such services in a cost-effective way and setting appropriate fee, exemption and waiver policies to generate enough revenue are difficult ones. Determining appropriate fee levels is a critical factor in this exercise. If fees are on the high side, this may result in low service utilization in general, little use of services by the poor or a high number of waivers. On the other hand, if some services are free or fee levels are too low, insufficient revenue may be generated and service quality may suffer. This may result in higher costs to patients if they have to seek elements such as tests and drugs outside the facility, if they have to visit another provider or if recovery from illness is delayed.

In order to successfully determine fee, exemption and waiver policies, providers must have clear goals about whom they aim to serve and must have realistic service and financial plans based on the epidemiological and economic profile of the catchment population. They must also have effective monitoring systems to assess if goals and targets are being achieved. None of the providers visited in Ecuador have all these elements in place, and they are unable to determine on an ongoing basis if they are meeting the need to protect the poor. The establishment of such policies and systems is a priority for individual facilities as well as government health bodies, who need to ensure that services are accessible to all.

1. Introduction

Many developing countries have had a tradition of free public provision of all health services. In recent years, however, many of these countries have experienced poor economic performance, decreasing government revenues, and rising demand for health care, which have created a need for additional sources of revenue to operate public health services. The result has been increased recourse to user fees as a form of cost sharing. As noted by Gilson and Russell in a recent study, the policy debate has shifted from the issue of whether or not to introduce user fees to how such systems should operate (Gilson forthcoming). Many user fee schemes have been designed with the primary objective of generating revenues to replace or supplement government funds, and often little consideration has been given to other aspects. As such schemes have become more widespread, concerns have grown about their impact on access to health services for the poor and other vulnerable groups on the grounds that health care is a basic right and access should be based on need and not ability to pay.

1.1 Targeting mechanisms

Various mechanisms have been developed in different situations to protect the poor and vulnerable from the impact of user fees. These mechanisms fall into three main categories, which are defined in the methodology for the case studies (Newbrander 1995) and can be summarized as follows:

- *Direct targeting*: provision of free or reduced-price benefits to people who cannot pay because of low income, often using some form of means testing to determine how much people can afford to pay.

- *Characteristic targeting*: provision of free or reduced-price benefits to people with certain attributes regardless of income level (e.g., certain contagious illnesses or vulnerable groups such as children).

- *Self targeting*: provision of free or reduced-price benefits to people who select themselves for participation (e.g., by attending special clinics for low income groups).

The two problems commonly identified with targeting for the poor are **undercoverage** and **leakage** (Grosh 1994). Undercoverage occurs when the poor do not receive intended benefits, i.e., they do not have access to services. Leakage occurs when the non-poor receive benefits intended for the poor, i.e., the problem of charging people less than they can afford to pay, or **undercharging**. A third important problem has been less clearly identified. That is **overcharging**: the payment of fees for service when the poor obtain the services but pay more than they can afford, thus reducing their ability to pay for other basic needs (e.g., food or shelter).

Since direct targeting involves identifying the ability of individuals to pay, it ought to be more accurate in discriminating between poor and non-poor, but this system is considered to require more information and administration than characteristic targeting (Gilson forthcoming). Characteristic targeting, on the other hand, is likely to result in more undercharging or leakage, when people pay less than they are able to pay.

From a managerial perspective, the term **waiver** is sometimes used for a fee reduction based on assessment of ability to pay — generally made in the health facility or in the community — and is therefore synonymous with "direct targeting." Likewise, the term **exemption** is sometimes used for "characteristic targeting," when the services are automatically free and thus involve no decision-making process in the facility.

Since characteristic targeting can take different forms, it is useful to describe some of them. Characteristic targeting can be used for services with positive externalities, for political reasons and as proxies for income levels. The most common of these is the use for services with positive externalities, i.e., benefits which go beyond the individual person receiving care, such as a reduction in the spread of disease through immunization. These services not only represent cost-effective interventions, but may also benefit the poor more than the non-poor. As Gilson notes, subsidies in cost-effectiveness interventions disproportionally needed by the poor also disproportionally benefit them. The following represent some types of characteristic targeting.

Public health (which benefits the community or protects the vulnerable)

- services to the especially vulnerable, such as young children or the elderly.
- contagious illnesses such as tuberculosis, sexually transmitted diseases, or AIDS.
- preventive services such as immunizations, prenatal check ups, or family planning.

Political (which benefits groups of political importance)

- occupation status: people belonging to a particular occupation group (e.g., military, civil servants, health workers).

Poverty (which benefits groups in which the majority are expected to be poor)

- geographic origin: patients residing in poorer areas.
- occupation: students, prisoners, or the unemployed.

Some of these exemptions can contribute to greater equity, but others often do not. For example, in many countries free immunizations in public health centers will generally benefit lower income groups because they are the ones who most use those facilities. However, political exemptions, such as for civil servants, do not usually benefit the poor because civil servants are generally not poor, even though many of them have low salaries. In addition, the inequity of certain types of characteristic targeting is sometimes resented by public health staff, who argue, for example, that a rich man should not receive free treatment for a sexually transmitted disease.

1.2 Study purpose

This study focuses on those direct, characteristic and self-targeting mechanisms that aim to ensure cost recovery efforts do not restrict access for the poor to services and payment of fees does not result in financial hardship. In order to help determine which mechanisms work best under different circumstances and disseminate the information to African policy makers and implementors, the Health and Human Resource Analysis for Africa (HHRAA) project of the USAID Africa Bureau contracted the BASICS project to develop a methodology, use the methodology to carry out five country case studies, synthesize the lessons learned from the country case studies, and prepare a summary of options and

guidelines. The BASICS project was chosen for this task because of its child survival focus and the importance of ensuring access to services for the most vulnerable children — those from poor families.

It is also intended that the case studies will be of practical, immediate use to host country governments, public and private non-profit providers, and USAID missions by providing an analysis of the effectiveness of existing systems in those countries and recommendations for improvements, if necessary. Ecuador was chosen to be one of the country case studies because of its variety of cost sharing schemes, and concerns about access for the poor under the likely future official reintroduction of user fees by the *Ministerio de Salud Pública* (Ministry of Public Health).

The relevance of the study to Ecuador was highlighted by the publicity given to *Ministerio de Salud Pública* (MSP) problems at the time of the study. This included a Channel 12 news broadcast (25 February 1996) investigating the hardship caused by ad hoc fees at MSP Hospital Regional de Azuay. The broadcast showed patients complaining that they could not get medicines because they had no money, and showed one mother who said she did not have the money to pay for an operation for her child, with the result that the operation was suspended. The hospital director, who was also interviewed, said the MSP budget was not sufficient and the hospital had no choice but to charge fees in order to provide the materials needed for services.

This report is structured as follows. This section, Section 1, is the introduction. Section 2 provides some background on Ecuador. Section 3 describes the study objectives and approach. Section 4 describes the different mechanisms found. Section 5 describes the results of household interviews carried out. The mechanisms and their impact are analyzed and compared in Section 6 and conclusions drawn in Section 7. Finally, some recommendations for Ecuador are made in Section 8.

2. Background on Ecuador

In Ecuador, cost sharing in health must be seen within the political and social context of the country. For many years public policy has been that health care is a free service available to all, but since the early 1980s, severe economic crises have resulted in reduced government spending on health (La Forgia 1993a). Over the period 1981-1991, total government spending dropped by five percent in real terms, but reduced allocations to the MSP meant that real total MSP spending fell by 23 percent. Despite reducing fertility rates, the population has grown by 2.1 percent per year over the period, rising from around eight million to around ten million people (Peabody 1995). The impact of the economic crisis on government health spending has been magnified by this increase in population, with real per capita spending down by 41 percent over the same period.

The ability of the average Ecuadorean to pay for health care out of pocket has also declined over the period, with gross domestic product per capita down from US$1,415 to US$1,355, and real per capita income in 1990 less than in 1978 (La Forgia 1993b). In addition, the distribution of resources is not equal, with 35 percent of the total population existing in poverty and lacking basic sanitation and adequate health care (Palacio 1995). Inability to pay for health care has been cited by the poor as a primary reason for not seeking care when sick (SECAP 1994). The financial burden of paying for health care is not just a problem for the poor, however, since the worsening economic situation has greatly limited the ability of many middle class people in Ecuador to pay for health care.

Despite the declining economic conditions, Ecuador made significant improvements in the general health status of its people during the 1980s (La Forgia 1993b), with declines in infant mortality, maternal mortality, and mortality due to transmissible and infectious diseases. This appears to be due, in part, to government and donor policies to focus spending on extending low-cost basic services to specific populations, such as low-income and rural groups, mothers, and children. The distribution of these health gains is, however, skewed, with much lower health status among rural and indigenous groups, especially those concentrated in the Central Sierra. This reflects the overall poverty and lack of access to basic services of those groups, with significantly higher malnutrition and less access to basic water and sanitation services and maternal health care. Urban areas, while having more available services, are also under pressure, with increasing migration from rural areas. Population growth in urban areas was around 3.7 per year during the 1980s, compared with 0.4 percent in rural areas (Peabody 1995).

Health services are provided by several different types of provider. The public sector consists of four principal government providers: the Ministry of Public Health, Ecuadorean Social Security Institute (IESS), Rural Social Security System (SSC), and the Armed Forces Health Service. In addition, the Welfare Society of Guayaquil (Junta de Beneficiencia de Guayaquil), a large private voluntary organization (PVO) in Guayaquil, provides public services while maintaining autonomy from the government, although it is significantly dependent on government subsidies and the national lottery (La Forgia 1993b). A number of other, smaller PVOs play an important role in health care, including the HCJB-Voz Andes, Catholic Relief Services, Plan International, and the two main family planning PVOs — APROFE and CEMOPLAF.

A national survey of the source of health care indicates that around the end of the 1980s, the most used source for curative care was private for-profit providers (44 percent), followed by MSP (30 percent), IESS/SSC (11 percent) and private non-profit organizations (3 percent) (La Forgia 1993b). The balance

of 11 percent includes the Junta de Beneficiencia de Guayaquil (JBG) facilities. However, data indicate that in rural areas there is greater use of MSP services (40 percent compared with 23 percent in urban areas) and lesser use of private for-profit services (48 percent compared with 61 percent in urban areas).

The MSP has dominated the public sector and is the largest single health provider in the country. In 1991 it had 24,000 employees, 1,521 facilities, and 8,900 hospital beds. It operated 16 specialty, 22 secondary, and 83 primary hospitals, and saw more than half of the public sector hospital inpatients. MSP expanded the number of staff and facilities significantly between 1981 and 1991 and developed the capacity to cover 80 percent of the population. However, as indicated above, only about 30 percent of the population have been using MSP services. Preliminary data from a study of MSP patient characteristics indicate that the majority of patients are women and children with low education levels and from low-income households (CEPAR 1996).

Other government providers serve limited groups of the population. IESS only serves its members, who are people employed in the formal labor sector, and covers only employees, not dependents. IESS by itself only covers around 4 percent or 5 percent of the population, and these are generally urban males and are therefore not the most vulnerable for either poverty or health risk reasons. The SSC covers around 6 percent or 7 percent of the population, mostly rural people enrolled through local organizations, such as cooperatives. Unlike IESS, on which it depends, the SSC also covers family members, and despite service problems, is considered by many Ecuadoreans familiar with rural conditions to be the most functional public institution providing rural health services (La Forgia 1993b).

The supply and quality of care in MSP facilities are generally agreed to be inefficient and poor. Around 80 percent of MSP professional staff are concentrated in urban areas, competing with many other private and public providers. There is an over reliance on physicians vis-a-vis nurses and paramedical staff. Most of the medical equipment is old and much of it is dysfunctional, with many beds unusable due to leaky roofs. Support services are deficient and there are chronic stock-outs of drugs and supplies, with the result that many patients have to purchase those services and supplies from the private sector. Management problems abound, and attempts to improve staff productivity are often hampered by restrictive labor union practices. An almost total lack of management information regarding services, supplies, and finances was noted in 1994 (Couttolenc 1994). While donors have provided assistance to maintain and strengthen special programs for the vulnerable, such as maternal and child care, communicable disease control, and sanitation, other government health services have declined significantly. Public perception of quality confirms the above picture, with few people believing the public sector provides quality services. Persons who choose to use the public sector do so mainly because of location or price (officially free), or because they can get basic services such as vaccinations (La Forgia 1993b).

Demand information and price surveys indicate there is a strong willingness to pay for those health services that are perceived to be of good quality. This is supported by the wide use of private for-profit providers, such as private practitioners, who set fees to recover at least full cost, although fee levels generally appear to be held down by the competition among those providers. Cost sharing is widespread among the PVO service providers, although fees are generally subsidized to varying degrees.

Cost sharing, however, has never been successfully implemented officially in MSP facilities, and co-payments are not officially charged for IESS or SSC services. In 1981 the charging of fees by public sector institutions was banned by the government on the grounds that services should be free. But with

most government funding consumed by personnel costs, the only free service that MSP facilities can generally provide is labor (e.g., consultations). Patients are often referred to the private sector to purchase the necessary drugs, laboratory tests, x-rays, and surgical supplies. Alternatively, some hospitals have developed ad hoc user fee systems to fund the cost of drugs and supplies. Resistance to fees, however, remains strong, principally among hospital trade unions. The introduction by the government of fees in early 1994 met strong social resistance, culminating in a general strike in public hospitals in October of that year, after which a new Minister of Health suspended fees in early December. It is understood that a major reason for the resistance was an over-aggressive fee collection policy in some hospitals, coupled with the absence of appropriate mechanisms to ensure access for the poor and vulnerable.

Access to health services for the poor is therefore provided in principle by the MSP, since all its services are free. However, as noted above, this protection does not exist in practice, as the lack of availability and poor quality of services forces many people to pay for services through private providers or to pay the ad hoc fees charged by many MSP facilities.

3. Study Methodology

The issue of ensuring access to the poor under user fee schemes is simple to resolve, in principle, by having a policy that people only pay what they can afford. This is, however, much easier to say than it is to do. The identification of poor patients and determination of how much they can afford to pay is difficult in any society, and cultural and social variations among and within societies make it even harder. It is probably impossible to have one standard mechanism that works everywhere, and it is therefore important to identify under what circumstances certain mechanisms succeed and others fail, so that elements can be combined or adapted to suit local circumstances.

Under an equitable system, all patients should have access to good quality care and pay what they can afford. Given that a shortage of financial resources is usually the main reason for introducing user fees, the major objective of having them is usually to generate enough revenue to cover that shortage.[1] Depending on the level of external subsidies, the funding shortage can be relatively great (as in the case of a PVO that loses most of its donor funding) or small (as in the case of government facilities that merely cannot cover non-salary costs). The ability to balance the **objective of generating revenue** with the **objective of protecting the poor** depends largely on this level of external subsidy. The option of "making profits" from wealthier patients to cross-subsidize lower fees for poorer patients is always likely to be limited when there is heavy competition for service provision, since no provider can charge much more than cost without risking losing patients to lower-priced competitors.

One of the most critical elements of a good user fee scheme is therefore **balancing the need to generate revenue to cover the cost of good quality services with the need to provide access for the poor at prices they can afford**. Depending on the level, structure, and reliability of subsidies, undercharging may be as important an issue as denying access or overcharging, when that undercharging results in poor quality of care or in patients having to purchase complementary services from the private sector. In any event, both tend to impact heavily on the poor, who are often the bulk of the users of PVO and government health services.

Given the above, the objective of this study was to analyze a range of mechanisms in use for protecting the poor and determine which mechanisms work best and under what circumstances. However, it was not considered possible within the scope of the study to examine the user fee schemes in any broader sense, i.e., to see the appropriateness of fee structures and levels in terms of revenue generation needs. A summary of the general issues covered under the study is as follows:

(1) Do the poor have access to services?
(2) Do people pay what they can afford?
(3) Are the costs of the mechanisms as low as possible?

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[1] Other reasons may include the creation of incentives for people to take more responsibility for their own health or use services in a more cost-effective way (through graduated pricing at different services levels).

To respond to these issues, a set of questions was posed:

- Is there a **policy** to encourage access for the poor?
- Does the **price structure** facilitate access for the poor?
- Are there **automatic exemptions** that benefit those of the poor who are especially vulnerable from a health viewpoint?
- Is there a **waiver system** that ensures people pay what they can afford?
- How **effective** are the mechanisms in ensuring access for the poor?
- Are people protected from **economic hardship**?
- Do mechanisms **prevent undercharging**?
- Are there **targets** for waivers and exemptions?
- Is there an effective system for **recording and reporting** the impact on finances and services?
- What is the relative **cost of administering** the protection mechanism?
- What examples exist in **other social sectors**?

Information on mechanisms was determined through interviews with facility staff and examination of facility records. Additional information was obtained through interviews with patients as they were about to leave the facility. Information on poor people who may decide not to seek treatment because of fees was sought through household interviews. The information from patient and household interviews was sought to complement the information from facility staff and records, not to provide definitive data on service utilization patterns or perceptions.

Health facility staff and records

The team held interviews with the medical director or administrator and social worker or clerk at each health facility. The interviews sought to gather information on the catchment area of the facility, types of services provided, the fee structure for those services, policies and procedures for granting waivers and exemptions, and the types of records kept and reports produced. Attempts also were made to gather data from facility records on the volume and value of services delivered and waivers and exemptions granted, although in some cases data were not available, and in some others, managers were not willing to share financial information. In all hospitals visited, the granting of waivers was a function of social workers, and they were generally a prime source of information.

Patient interviews

To help understand how the system works, patients were interviewed to determine their knowledge and use, or non-use, of the waiver system. Exit interviews were held with ten consecutive patients who had received health care from both the outpatient clinics and the inpatient wards, which included both poor and non-poor patients. The information sought included the distance patients had traveled to receive care; how long they had waited after the onset of illness before seeking care; how much they had paid for services; what waiver or exemption had been received; and where they had obtained the money to pay. Observed factors, such as the education level and appearance of the patient and family members were used to assess whether the family was poor.

Household interviews

To provide information on people who may be deterred from seeking care by the presence of user fees, a small number of household interviews were conducted. Three areas selected for the household surveys were chosen purposively to focus on poor communities in the catchment areas of some facilities included

in the study. All household interviews were held with the mother, as the questionnaire was focused on use of health care services by mothers and children. Interviewers went from house to house, only conducting the interview if the mother was present. The survey ended in each area when 30 interviews were completed. Questions included where they sought care, why they chose a particular provider, how much they paid, and whether a waiver was obtained. Observed factors — such as the appearance and value of the home, property in the home, educational levels, and appearance of the family — were used to assess whether the family was poor.

The sample

In Ecuador, user fees have been in place in PVO and municipal health programs for some years, and ad hoc fees exist in many MSP facilities because of failed attempts to introduce them officially. At the time of the study there was a general strike of MSP facility staff that made it impossible to observe or discuss any of these ad hoc fees and any related waiver mechanisms. It was also not possible to interview staff to get any historical information on the waiver mechanisms that were in place for those months in 1994 when fees were officially being charged. The comments and opinions of some MSP managers who were interviewed informally are included in the study, to the degree that they are appropriate.

The study therefore focused on service providers that currently have official fee collection policies and systems. USAID/Ecuador had particular interest in assessing access for the poor to family planning and reproductive health services, and so clinics from CEMOPLAF and APROFE, the large family planning PVOs, were included in the assessment. The Junta de Beneficiencia de Guayaquil (JBG) which has several hospitals in Guayaquil, was also a major component, as they are similar to public hospitals, but collect fees. The hospital and one of the two health centers run by the Patronato San José (Municipality of Quito) were included because they are important examples of government facilities that have collected fees for a number of years. In addition, some small PVO clinics were included to provide a broader primary health perspective. For-profit facilities were not included as they provide very few waivers, if any.

The study's time frame limited the size of the sample, both in terms of the number of facilities and communities, and the data collected. For cost-effectiveness of study implementation, most of the facilities included in the study were in clusters. This reduced travel time and allowed for greater complementarity between facilities and household surveys. The three clusters were in the main cities of Quito and Guayaquil and the smaller city of Latacunga in the highlands. The household surveys were carried out in one low-income community in each of the three clusters. One was in Barrio Legarda in Quito near to CEMOPLAF's Clínica 21 and the Patronato San José Clínica del Norte. Another was in Mapasingue, a community on the outskirts of Guayaquil within the catchment area of an APROFE clinic, several private clinics, an MSP health center, and the JBG hospitals in the center of Guayaquil. The third was in La Calera, a peri-urban community on the outskirts of the city of Latacunga in a highlands area mostly inhabited by indigenous people. La Calera falls within the catchment area of a CEMOPLAF clinic and the MSP health center and hospital in Latacunga. Rural areas were not included because the main service providers in those areas are MSP and SSC, who were not included in the facility surveys. Unfortunately, with the exclusion of MSP facilities there was little opportunity to look at waivers and exemptions within the context of a vertical referral system, because none of the organizations included in the study has such systems.

Patient exit surveys were conducted at the Patronato Hospital and Clinic, and at the JBG hospitals Enrique Sotomayor and Alexandro Mann. CEMOPLAF and APROFE did not wish to have exit surveys

at their clinics because they did not want to create an increased demand for waivers among patients at this point in time. There were no patients at the Fundación Eugenio Espejo Clinic when the team visited, and there was no time to do exit interviews at the JBG Luis Vernaza Hospital. CARE held exit interviews at the Fundación Pablo Jaramillo Clinic in Cuenca, but complete data were not available at the time this report was prepared.

The facilities chosen represent a variety of characteristics, as shown in Table 1.1. These are:

- catchment population: urban and urban/rural and indigenous and non-indigenous.
- ownership type: municipal or PVO.
- service level: small, medium or large; hospital or clinic.

The table also shows which facility surveys were carried out, and which community they relate to for the household surveys.

Table 3.1: Facilities selected and type of data collected

Institution	Catchment Population	Type	Level	Staff Survey	Patient Survey	Household Survey
CEMOPLAF Centro 21, Quito	Urban, non-indigenous	PVO	Medium Clinic	Yes	No	Barrio Legarda
CEMOPLAF Latacunga	Urban, indigenous	PVO	Medium Clinic	Yes	No	La Calera
CEMOPLAF Otavalo	Urban, indigenous	PVO	Medium Clinic	Yes	No	No
APROFE Mapasingue (Guayaquil)	Urban, non-indigenous	PVO	Small Clinic	Yes	No	Mapasingue
APROFE Clínica Piloto # 1, Guayaquil	Urban, non-indigenous	PVO	Large Clinic	Yes	No	Mapasingue
Patronato San José Sur, Quito	Urban, non-indigenous	Municipal	Small Hospital	Yes	Yes	No
Patronato San José Norte, Quito	Urban, non-indigenous	Municipal	Large Clinic	Yes	Yes	Barrio Legarda
Fundación Eugenio Espejo, Quito	Urban, non-indigenous	PVO	Small Clinic	Yes	No	No
JBG Hospital Alexandro Mann, Guayaquil	Urban/rural, non-indigenous	PVO	Medium Pediatric Hospital	Yes	Yes	Mapasingue
JBG Hospital Gineco-Obstétrico, Guayaquil	Urban/rural, non-indigenous	PVO	Medium Maternity Hospital	Yes	Yes	Mapasingue
JBG Hospital Luis Vernaza, Guayaquil	Urban/rural, non-indigenous	PVO	Medium General Hospital	Yes	No	Mapasingue
Fundación Pablo Jaramillo, Cuenca	Urban, indigenous	PVO	Clinic/ small hospital	CARE	Yes	No

The findings from these surveys and household interviews are presented in Section 4.

4. Description of Mechanisms Encountered

The information gathered from the health facilities is presented by organization and facility. The analysis and comparison of mechanisms are made in Section 6.

4.1 CEMOPLAF

CEMOPLAF is one of the two major non-governmental family planning organizations in Ecuador. It has 21 clinics that provide family planning and reproductive health services. With reductions in donor funding in recent years, CEMOPLAF has been pursuing a goal of financial sustainability and is reported to have increased its level of cost recovery to over 75 percent of direct costs and over 50 percent of total costs (including the cost of donated contraceptives) (Seltzer 1995). This improvement in financial sustainability has partly been achieved at the expense of CEMOPLAF's social objective of providing services to low income families. CEMOPLAF's policy is to not exclude any person who cannot afford to pay, but the number of clinic-based services provided free of charge or at reduced cost to the poor is generally low.

The study team visited three CEMOPLAF clinics: Latacunga, Otavalo, and Clinic 21 in Quito. CEMOPLAF has a fee structure for consultations that is graduated according to the cost of services and the general economic status of the catchment community of the clinic. For example, a general consultation has a fee of S/6,000 in Latacunga, S/7,500 in Otavalo and S/11,000 in Clinic 21.[2] Latacunga, a city in the Andes to the south of Quito, is perceived to be relatively poorer than Otavalo in the North, which has many tourists. Clinic 21 is located in a low-middle income community in Quito, which is perceived to have a higher ability to pay than Latacunga and Otavalo. The fee for laboratory tests is also graduated among clinics, but to a lesser degree than consultations. For example, a *papanicolaou* (cancer) test is S/6,000 in Latacunga and S/9,000 at Clinic 21 in Quito. The fee for family planning methods is also graduated, with S/6,000 for a consultation and S/5,000 for an IUD insertion at Latacunga, compared with S/10,000 and S/10,000 respectively at Clinic 21. Medicines are priced at five percent less than the retail price at private pharmacies — which does not vary much over the country — and are therefore not graduated among clinics.

According to CEMOPLAF, the Latacunga and Otavalo clinics recover all of their local direct costs and some of their central direct costs[3] from fee and sales revenue, but do not recover any indirect costs (currently 17 percent over direct costs). Clinic 21 revenue apparently covers all direct and indirect costs. The cost of a general consultation is estimated by CEMOPLAF at between S/8,000 and S/10,000 across their clinic network. The price of a general consultation is therefore significantly subsidized in Latacunga, slightly subsidized in Otavalo, and more than covers cost in Quito. This graduated price structure offers a degree of protection to poorer communities in general, but the clinics with lower fees are not recovering all costs, and therefore are being subsidized from laboratories, surplus-generating clinics and/or from donor funding.

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2 One US$ was approximately equivalent to sucres (S/) 2,800 at the time of the visit in January 1996.

3 CEMOPLAF clinics have local direct costs (salaries, medicines, laboratory reagents, medical and administrative supplies, rent, and utilities) and central direct costs (staff benefits, training, equipment, and contraceptive supplies).

CEMOPLAF has no automatic exemptions (e.g., for age groups). Poorer individuals can obtain complete or partial waivers for all services. The number of 100 percent waivers granted at the three clinics is very low, less than ten clients per year, and less than one percent of total clients. The number of partial waivers also appears to be very small, and they are only generally granted for laboratory tests as a 20 percent discount. This appears to represent the general picture of CEMOPLAF clinics, although the level of waivers at Cajabamba clinic may be higher (Seltzer 1995). CEMOPLAF staff considers that some of the poorer people in the catchment area do not come to their clinics because they believe they will have to pay.

The process for granting a waiver for consultations begins when the patient arrives at the desk of the receptionist to request a consultation and is told to pay the fee in advance. A patient who cannot pay advises the receptionist and, if the receptionist considers that the patient may be too poor to pay, she recommends a waiver. Since the receptionist is somewhat separated from waiting patients, there is a degree of privacy. No questionnaire is used and criteria are generally informal, such as dress, number of children, occupation, and the patient's expressed ability to pay. A waiver coupon (*cupón gratis*) is prepared in duplicate by the receptionist and one copy is given to the patient to present to the clinic director (one of the doctors). The director gives final approval for the waiver and generally accepts the receptionist's recommendation. Since all regular patients know the fee levels, it is rare that a patient does not bring sufficient money. However, patients do not know in advance if they will need a laboratory test and sometimes do not bring sufficient money. They are asked to pay prior to the test being carried out and if they do not have enough money, they request a partial waiver or a credit. The administrative cost of this system is very low, but the volume of waivers is also very low. If CEMOPLAF sets out to attract more low income patients, it will be necessary to have a more formal system, perhaps using their field workers (*educadoras*) to verify ability to pay via household visits.

This study confirmed the findings of a previous study (Seltzer 1995) that found CEMOPLAF has no established mechanisms to evaluate and track waivers and therefore cannot monitor the impact of price increases on waiver levels. The study team noted that CEMOPLAF also does not have targets for the volume and value of waivers. Although the copies of the waiver coupons provide a record on the number of complete waivers granted, no record is kept of the number of partial waivers or of the value of complete and partial waivers. No information is therefore produced of the volume of services waived or the revenue foregone.[4]

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[4] CEMOPLAF accepted the study team's recommendation that the fee receipts be adapted to show the value of complete and partial waivers granted. The fee revenue account in the accounting books would then show gross revenues (before waiver), and the value of waivers would be posted as an expense to a separate account. If CEMOPLAF sets waiver targets based on the desired target population, it can then monitor performance against those targets. In addition, the reported volume of waivers and revenue foregone could be used by CEMOPLAF as a basis for a system of targeted government or donor subsidies, whereby an amount is paid to the provider to cover the revenue shortfall of treating each poor person.

4.2 APROFE

The Asociación Pro Bienestar de la Familia Ecuatoriana (APROFE) is a non-profit organization that provides family planning and reproductive health services in different locations in Ecuador. It has over 20 clinics and a number of laboratories, the majority being in the coastal region. The head office is in Guayaquil. APROFE's mission is to provide family planning services to lower income groups but, following reductions in donor funding, also aims to achieve a high level of financial cost recovery as part of its financial sustainability strategy. APROFE is actively expanding its upper range of services, such as deliveries and outpatient surgery, and is considering contracting to provide services to large employers. Each clinic proposes its own price list based on local private sector prices, subject to head office approval, which is apparently usually given. The need for a coordinated rational price structure within a local network, e.g., in Guayaquil, is recognized. The overall percentage of total recurrent costs recovered is apparently around 60 percent, but waiver levels are reported to be extremely low (Seltzer et al 1995). The team visited two clinics — Mapasingue and Centro Piloto #1.

Mapasingue Clinic is located in Mapasingue — one of the poorest areas of Guayaquil. The area was invaded by poor families some years ago, but is now a stable, legal community with some electricity and water connections, but with bad roads and inadequate drainage. The clinic is directed by a gynecologist, additional staff being an auxiliary nurse, a counselor, and a receptionist. Only gynecological and family planning consultations and contraceptives are provided; there is no laboratory or pharmacy. In 1995 the clinic is reported to have recovered 77 percent of direct costs and 74 percent of total costs. Prices are lower than at other APROFE clinics, with S/4,000 for a family planning consultation and S/10,000 for a gynecological consultation. The price for a family planning consultation at the private clinic across the street is S/5,000. Prices are increased approximately every year, the last increase being in January 1996. At that time, the price for a family planning consultation increased from S/3,500 to S/4,000.

Clinic staff reported they do not receive financial information about the clinic and did not, until recently, know what level of cost recovery was being achieved. No automatic exemptions are given at the clinic. Full and partial waivers are granted when the patient indicates inability to pay. Waivers are approved by the doctor, on the basis of a recommendation made by the receptionist. Since the clinic is very small, there is no privacy for the patient to discuss the waiver with the receptionist. No formal questionnaire is used — the clinic director and receptionist use their own judgement, based on occupation, dress, and number of children. In most cases, however, **they agree to the amount the patient says she can pay**. Often they know the patients because they mostly come from the surrounding community.

The doctor works for 8.5 hours per day from Monday through Friday and sees on average 35 patients per day (approximately four per hour). The total number and value of waivers are relatively small — 13 patients and S/17,000 in November 1995, all of which were partial waivers. Based on the reported average number of patient visits per month of 770 (35x22), the number of waivers comes to around two percent. The staff indicated that many of the poorer people in the community go to the MSP health center because the consultation is free. The fact that MSP patients often have to purchase laboratory tests and medicines from the private sector probably does not influence their decision because patients cannot get these services at the APROFE clinic.

A waiver is only recorded by writing "waiver" on top of the cash receipt and by showing a reduced fee on the receipt. Neither the volume nor the value of waivers granted is summarized for the clinic or

reported to the head office. Staff indicated they had at one time recorded services with partially waived fees as other services with lower fees so there would not be a big discrepancy between the volume of services and the fees collected. For example, a gynecological consultation valued at S/10,000 with a partial waiver of S/6,000 would have been recorded as a family planning consultation, which has a fee of S/4,000. Staff reported they do not give credit to patients who do not have sufficient cash because it is too time consuming to collect and some patients would not return because they would have to pay the debt. They prefer trying to get the patient to pay the full fee on the next visit and not risk losing the patient.

The **Clínica Piloto 1** is a busy clinic situated in the JBG Maternity Hospital building in the center of Guayaquil. Prices are apparently increased approximately every six months. It has 6,000 patients per month on average and estimates that less 100 per month are waived. There are no automatic exemptions. Patients who cannot pay the full fee are referred to the administrator by the auxiliary nurse for medical patients or the counselor for family planning clients. No formal questionnaire is prepared. The waiver is noted on the patient record. Credit is also sometimes granted and is noted on the patient record. The administrator estimates that approximately half the value of credit granted is recovered. The clinic is using a computerized system to issue receipts and this system is used to produce a monthly report of the value of credit and waivers granted in the month. This information is not, however, entered in the main accounting system. The clinic operates on an appointment and walk-in basis. Time is left between appointments to allow the doctors to see two or three walk-in patients. This system could be used as a form of self-targeting but no additional fee is currently charged for an appointment. The administrator feels that the appointments system does not work well because those patients are often late but demand to be served when they arrive.

Reports indicate 60 percent of the value of waivers granted relate to gynecological consultations. This partly reflects the higher price of that consultation, but is also due to the fact that a waiver on a composite bill that includes other services is shown against the consultation. In December 1995, the value of full and partial waivers granted for contraceptives was S/22,000 out of total contraceptive fee revenue of S/835,000, which comes to 2.5 percent. The total value of waivers for all services for 1995 was S/9,509,700 out of a total of fee revenue earned of S/610,296,200, which comes to 1.5 percent. The balance of credit outstanding at the end of 1995 was S/3,577,950, approximately 0.5 percent of total revenue. Most of the credit sales are for Copper T insertions, which may reflect the higher price of that family planning method compared to other methods.

Although waivers are recorded in computerized receipts system at the larger clinics, they are not recorded in smaller clinics where there are no computers, and they are not recorded at all in the main accounting records. There are no explicit targets for volume or value of waivers, and there is no system for evaluation and tracking of waivers. APROFE cannot determine on a regular basis how many patients received waivers or what the characteristics of those patients were.

4.3 Clínica - Fundación Eugenio Espejo

Fundación Eugenio Espejo, a private non-profit organization, has a small clinic on a hill in a lower-middle income area of Southern Quito. It provides general medical and family planning services and is staffed by a doctor and an auxiliary nurse. The price of a general medical consultation is S/5,000. They sell generic drugs at 40 to 50 percent less than drugs in a commercial pharmacy. Many patients

apparently accept generic drugs because they are cheaper and they believe the quality is satisfactory. The auxiliary nurse is from the community and knows the patients well. She advises the doctor if a family is poor and they then give a waiver or provide drugs that were given to the clinic free of charge. Patients with complications are referred to the MSP Hospital del Sur. The doctor told the team that services at that hospital are free but patients reportedly have to buy their own supplies. The doctor sees about 15 patients per day, but could see up to 40 (five per hour). She thinks that some of the poorer patients do not come to the clinic because they believe they have to pay, and she thinks more promotion is necessary. No waiver targets are set and no formal records of waivers are kept.

4.4 Clínica Fundación Pablo Jaramillo Crespo

The study was carried out at this clinic by Hernan Redroban of CARE as a complementary effort under USAID's APOLO project. This is a small, local PVO clinic in the City of Cuenca. A similar set of data was collected from the clinic, and patient exit interviews were carried out.[5] Household interviews were not carried out. The clinic has outpatient and inpatient services (16 beds), and also offers dentistry, x-rays, laboratory services, and a pharmacy. The total expenditure on services in 1995 was S/816 million, of which S/537 million (66 percent) was covered through fee revenue. The laboratory is the only unit that makes a surplus; the percentage of costs recovered for other units varies between 90 percent for ultrasound and 48 percent for outpatient services. The largest subsidy in sucre terms is for the inpatient department, which has a shortfall of S/156 million, representing 33 percent of costs (all department cost figures included here are comprised of direct and indirect costs, but exclude donated equipment and supplies). The subsidy is proportionally greatest for inpatient services, which probably relates to the higher fee levels for those services.

Based on a small exit survey, 34 percent of the patients are low income, and the balance, 66 percent, are mostly lower-middle income. The price structure used varies considerably according to the patient's ability and willingness to pay, and follows roughly five categories. For outpatient consultations, category A is zero, B is S/3,000, C is S/4,000, D is S/8,000, and E is S/12,000. Of a total of 23,855 patient consultations in 1995, 17,508 (73 percent) paid the "standard" fee of S/4,000; 1,610 (7 percent) paid less than that amount (of which 1,555 paid S/3,000); and 3,816 (16 percent) paid nothing. The balance of 921 persons (4 percent) paid more than the standard fee.

The average unit cost of outpatient consultations has been estimated at S/5,800, compared with an average unit revenue of S/3,500 per consultation. There is therefore a significant subsidy of around 40 percent, with the standard price of S/4,000 lower than the unit cost. The number of patients paying zero (3,816) is very high compared with the number of patients paying between zero and S/3,000 (52), which may indicate that patients are routinely being allowed to pay nothing instead of asking them to pay a little. The number of patients receiving a partial or complete waiver is 23 percent, which is lower than the percentage of patients assessed as poor from the exit interviews (35 percent). However, the poor have some protection through the low level of the standard fee.

Assuming the sliding fee scale is set to recover full cost, it would appear that the amount of unanticipated "waivers" (fees below standard price) is high since the inpatient department only recovers 67 percent of costs. One form of additional protection that is in place relates to high bills resulting from long neonatal

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[5] Data from the interviews were not available at the time this report was written.

care stays. The fees for this care for all patients are reduced by half after 11 days of care. In terms of access, this benefits the poor, but in terms of revenue it hurts the clinic if the reduced rates for better-off patients are lower than cost.

Based on discussions with CARE, the study team considered the hypothetical impact of a fee change. If the standard fee is raised to S/6,000 to reflect full cost recovery, the number of waivers would be expected to rise from 23 to 35 percent. However, the clinic would probably still be better off, with S/35 million more revenue from raising the standard fee (17,508 x S/2,000) less S/5.8 million for extra waivers (2,932 patients who would get a waiver of S/2,000 to stay at current level). This assumes the 35 percent of patients who are "poor" cannot afford S/6,000 and that the rest of the patients can. The 2,932 "new waiver" patients plus the existing 5,426 waiver patients comes to 8,358 — 35 percent of the total of 23,855 patients. However, the percentage of patients needing waivers would probably be higher for inpatient services for which the fees are considerably higher.

Information was not available as to the administrative cost of operating the means testing system, or whether there are any automatic exemptions or waiver targets. However, from the data produced by the CARE team, it would appear that the recording of information is better than at other facilities visited.

4.5 Patronato San José

The Municipality of Quito runs one hospital and two health centers in Quito under the name of the Patronato San José. The team visited the hospital and one of the health centers.

Hospital Patronato San José Sur
The hospital is located in the south of Quito in the area covered by a secondary care facility run by the MSP. The hospital has 33 beds with 80 - 90 percent occupancy. It appears to be a busy facility with outpatient, diagnostic, deliveries, and some specialized services. Patients are often referred to the Patronato hospital, sometimes by MSP hospitals, because it has sufficient supplies. The Municipality provides 60 - 70 percent of the funding, mostly in salaries. Fees are charged for all services, an outpatient consultation being S/6,000. Laboratory and x-ray fees are supposed to cover the cost of materials. Drugs are reportedly cheaper than at private pharmacies.

All patients to be admitted as inpatients are first interviewed by the social worker, and she follows up when she makes ward rounds as part of her normal social work. Patients are interviewed in private in her office or on the ward. She uses an economic investigation form developed by the social worker at the Patronato San José Norte Clinic (*Informe Económico).* She places the patients into category A (full price), which is apparently less than cost, category B (full price less 10 percent) or *Exonerado* (free). For example, the fee for a normal delivery is S/60,000 for category A and S/55,000 for category B. Families with an income level of over S/300,000 per month fall into category A, and those with less fall into category B. However, she also uses her discretion in applying the income levels to the categories. For example, she puts bricklayers who earn slightly over S/300,000 per month as category B because she believes they often spend money on alcohol and the money available for food, etc., is less. Outpatients are only interviewed for waivers if they request them, and most outpatients do not request them because fees are relatively low and patients expect to pay. There are no exemptions — e.g., for preventive services. Waivers are not granted for medicines, laboratory tests, x-ray tests, or blood transfusions.

When the patient is ready to leave, he or she brings the completed bill to the social worker, who applies the discount or total waiver to those items that are discountable (see above) in accordance with the previously determined category on items. The social worker recommends the discount or complete waiver and submits the bill with a waiver request (*Solicitud de Exoneración de Pago)* to the executive director. When credit is granted, an agreement is drawn up by the social worker with the patient and signed by a guarantor. Approval is sought from the hospital director. There are no targets for waivers. There is only one social worker for the facility and her salary is S/683,000 per month including benefits. Each interview takes about 20 minutes and she estimates she has about one per day.

In 1995 the number of outpatient visits was 38,988 and the number of inpatient admissions was 3,956. The social worker could not provide information as to the total budget or total revenue from patient fees, and the administrative director would not provide financial information without prior authorization from the municipality. The social worker has developed a record-keeping system, which shows that 55 patients were granted full waivers and 141 were granted partial waivers (category B) in 1995. Most of these waivers were for inpatient services. Requests were made to other foundations for donations to cover high inpatient bills for 10 patients. Another 54 patients were granted partial waivers as municipal employees, and 17 were granted waivers as Patronato employees. An additional 106 patients were granted credit with a value of S/55 million, and 22 of these 106 loans were not repaid. The credit period granted is three months and there are no finance charges. The social worker supports the idea of credit but feels that collection is often difficult. She sometimes visits patients in their homes to try to collect payment.

Clínica - Patronato San José Norte

This is a busy clinic located next to an open air market in the northern zone of Quito. It has a broad range of outpatient services and also does outpatient surgery. It has a few beds, which are only used for emergencies and sometimes for recuperation. The Patronato clinic has a good reputation and is well staffed. Some of the doctors also work at the prestigious private Hospital Metropolitana. Like the other Patronato facilities, the clinic aims to recover all material costs and some of the maintenance costs of the clinic (the municipality pays salaries and provides a little budgetary support for maintenance). It charges S/6,000 for a general or specialist consultation and S/10,000 for an ophthalmic consultation. The fee for an operation is based on the time spent in theater. If the basic fee for an operation is S/200,000 (based on one hour) and the operation is more complicated than normal and takes two hours, then the fee increases.

For specialist services such as complicated laboratory tests, patients are referred to private facilities with which the Patronato has agreements, and patients who use the private service are granted a discount. For example, any patient (poor or non-poor) referred to the Hospital Metropolitana for a special laboratory test receives a 40 percent discount from that hospital.

The Patronato Norte has three socio-economic categories: category A pay full price; B pay a lower price equivalent to around 80 percent for an operation; and C pay nothing. There are apparently few partial waivers for consultations and medicines, and very few 100 percent waivers. Patients are mostly from the lower-middle[6] economic group. When a patient has a large bill (i.e., for an operation) and cannot pay, the Patronato applies for funds to the INNFA (Instituto Nacional del Nine y Familia) which can pay part

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[6] This term is used to mean the income group between low and middle income levels (equivalent to the second poorest quintile).

or all of the bill. INNFA usually pays within three days. Some patients with private insurance use the facility but the insurance company is only billed at category A, which is apparently less than cost.

A questionnaire is completed by the social worker with details of income, family size, etc., and this information is used to establish socio-economic status, although the social workers apply their own judgment when making the determination of how much the patient can afford to pay. The questionnaire form was designed by the social worker. Patients are interviewed in private in the social worker's office. There is one full-time salaried social worker, one salaried assistant, and one part time volunteer, who all appear to spend less than half their time on determining income levels, granting waivers, and seeking donations (e.g., from INNFA).

The social worker keeps a register of all patients seen by her unit, including both patients seen in connection with waivers and patients seen for other reasons. From the register it appears the majority of patient activities in the unit does not relate to waivers. The register shows when a patient is granted a waiver and this appears to be the only record kept. The waiver is noted on the patient's bill and medical record, but data are not summarized or reported. The value of waivers granted is not recorded in the accounting system. The social worker was not aware of any waiver targets.

Patient interviews

A total of 18 patients were interviewed, ten of whom were at the Clinic Norte and eight at Hospital Sur. As can be seen in Table 4.1, of the 18 patients interviewed, 15 were outpatients and 3 were inpatients; 7 were considered poor by the interviewer and 11 were non-poor (lower-middle income); 7 had come from far away, and 9 had been to another provider first.

All 18 paid for the services, although four received a partial waiver. All partial waivers were for non-poor patients with high bills for surgery. Although these patients were classed as non-poor, they may well have been too poor to pay a high bill, and the partial waivers were probably protection against the high cost of catastrophic illness. Of the 18 who paid, five borrowed some money to pay the bill. These five included three of the four patients with high bills who borrowed money to pay the amount left after the partial waiver was granted.

All of the outpatient bills paid in full by the poor were relatively small (S/8,667 on average). The average outpatient bill for the non-poor was S/82,667. The two outpatient bills for which partial waivers were granted averaged S/300,000 each, and the average amount paid on each was S/266,000, making the average waiver S/34,000 (11 percent of the bills). There was only one inpatient bill for a poor patient, which came to S/170,000 and was paid in full. The two inpatient bills for the non-poor averaged S/500,000 each, and they both had partial waivers. The average amount paid was S/284,500, making the average waiver S/215,500 (43 percent of the bills).

Most patients believed the poor have to pay something, but some patients believed exemptions were available for children under five and prenatal and postnatal care (although this is apparently not the case). Of the patients who knew about waivers, eight knew from staff and two from relatives or friends. Seventeen of the 18 were satisfied with the service, and 16 thought the fees were reasonable.

Table 4.1: Payment data from patient exit interviews — Patronato facilities

	OUTPATIENTS		INPATIENTS	
	Poor	**Non-Poor**	**Poor**	**Non-Poor**
Paid in full	6	7	1	
Partial waiver		2		2
Exempt				
Received credit				
TOTAL	**6**	**9**	**1**	**2**
Paid with own resources	5	7	1	
Borrowed funds from family	1	1		1
Borrowed funds from friends				1
Combination of own and borrowed funds		1		
TOTAL	**6**	**9**	**1**	**2**
Average total bill	8,667	82,667	170,000	500,000
Count	N=6	N=9	N=1	N=2
Average amount paid	8,667	75,111	170,000	284,500
Count	N=6	N=9	N=1	N=2

4.6 JBG Hospital de Niños Alexandro Mann

The JBG runs several hospitals in Guayaquil, including a children's hospital named the Hospital de Niños Alexandro Mann. The JBG has significant revenue from the national lottery, investments, and business enterprises and does not appear to seek to recover much of the hospital costs from patients. The hospital provides inpatient and outpatient services to children up to 12 years old and has 260 beds. The hospital serves mostly lower income groups. Fees are charged for inpatient services and for outpatient investigations and drugs, but not for consultations. There is no fee for emergency surgery, but there is a fee for programmed surgery and patients generally get that money together before they come into the hospital. Fee levels are apparently low compared with cost.

After inpatients are discharged and the bill is calculated, they go to the social worker to determine how much they should pay. Patients are interviewed in private in the social worker's office. A form is completed for all inpatients (*Encuesta Socio Económico)*, with personal, economic, and treatment details. A separate form (*Informe Social*) is then completed by the social worker to request a waiver. Authorization is granted by the hospital director, sub-director, or administrator. The social worker generally accepts what patients say they can afford. Fees for outpatient laboratory and x-ray services are paid before the examination is made, and if the patient cannot pay, she goes to the social worker who authorizes a waiver (authorization from senior management is not sought because of the low value of the fee). Medicines for outpatients are sold at cost and waivers are not usually requested. A special clinic

has been started to provide rapid service for people who come from far away (*Clínica de Faraños*). Patients are received as soon as they arrive and their cards are stamped with a special stamp to ensure they are seen immediately in other departments.

The social workers keep a register of all inpatient discharges showing patient number, name, total bill, and waiver (if any). This appears to be the only complete record of inpatient billings kept at the hospital — the cashier only receives final bills (net after waivers), issues receipts, and sends summary cash reports to the central JBG office. The social workers also keep a register of all outpatient waivers granted. They prepare some summaries but their ability to analyze is limited by not having access to a computer.

Between 30 and 40 percent of consultations are referred to a social worker for a waiver. The social workers' annual report for 1995 shows that out of 13,651 patients seen by the social workers, 4,258 (31 percent) received a partial waiver and 544 (4 percent) received a full waiver. The head social worker reports that until 1995, many other staff were involved in granting waivers and there was much abuse. However, since 1995 only the social workers have been involved, and she believes the number of waivers granted in that year are a fair reflection of what the level should be. Children of JBG staff receive a 50 percent discount at all JBG hospitals. There are no exemptions, although emergency surgery and outpatient consultations are free.

There are 11 social workers, one of whom is full-time in outpatients. The other ten spend only about five percent of their time on waiver determination. The average monthly salary of a social worker is S/500,000 plus S/500,000 in benefits.

The head social worker was not aware of any waiver targets, but believes it would be good to set them for the hospital as a whole and for each social worker. They do not have a system for giving long-term waivers, but she would like to have a process by which a one-year waiver could be stamped on a patient card. This would be shared among JBG hospitals to avoid having to reclassify patients.

4.7 JBG Hospital Gineco-Obstétrico Enrique C. Sotomayor

This maternity hospital has 317 beds, and apparently, a demand for services that exceeds capacity. The fee for a normal delivery is S/40,000, which according to the technical director reflects about 60 to 70 percent of cost (although it seems unlikely the cost is that low). In addition to public wards, the hospital has three types of private wards, which have higher fee levels. Family members of patients who cannot pay are encouraged to donate blood to the hospital instead. Indigent patients are sometimes helped with funds for clothing and transport.

Patients who say they cannot pay the bill for outpatient services are referred to the social worker and are interviewed in private. The social worker generally accepts how much the patient says he or she can pay. As one social worker said, *"If a patient needs to buy drugs with a value of S/75,000 but says she has S/10,000 and needs S/5,000 for market, she will say 'charge me S/5,000,' and we have to accept that."* Social workers are not keeping any statistics of waivers, even though the head social worker stated it is a priority. Even though a computer has recently been provided to the unit, staff do not know how to use it. A sample of the December 1995 waiver records in the social work department showed that for 160 drug sales, 26 patients (16 percent) received full waivers, 107 (67 percent) received partial waivers, and 27 (17

percent) paid the full fee. Of 80 laboratory patients, 10 (12 percent) received full waivers, 40 (50 percent) received partial waivers and 30 (38 percent) paid the full fee. There are 21 social workers who spend on average about 30 percent of their time on waivers. The hospital does not show the amounts waived on the receipts. The social workers are not aware of any waiver targets.

4.8 JBG Hospital Luis Vernaza

The hospital places patients into five categories for determining how much the patients can afford to pay. The categories are A - 100 percent, B - 75 percent, C - 50 percent, D - 25 percent, and E - 0 percent. To determine the appropriate category, the social worker interviews the patient in the hospital and sometimes visits the patient's home. Once the category is decided, the patient is given a card, which is valid for two years.

The hospital has 27 social workers, three of whom work in the outpatient department, which has between 70 and 80 patients per day. In 1995 the hospital saw 121,174 patients: 29,317 inpatients, 30,361 outpatients, and 61,496 emergency patients. Of this number, 82,187 patients (68 percent) paid their full bill, 21,386 (26 percent) received a waiver (partial or full), and the rest (6 percent) were exempt emergency services. The high reported volume of emergency patients may reflect the inclusion of some patients who attend emergency services because they are free.

The waiver system was changed recently to address several problems, which basically emanated from the fact the economic category of the patient (A, B, etc.) was not applied to determine the actual amount to be paid until the patient arrived at the cash office. The social worker recommended the category, and thus the percentage of the bill to be paid, but did not determine the actual amount. The percentage could not be applied by itself since a patient might be able to pay 75 percent of the cost of an outpatient laboratory fee, but not 75 percent of the cost of a serious surgical operation. The determination of how much the patient should pay was therefore made by the cashier in an ad hoc way.

Because the cashiers were determining how much the patient should pay, and patients were unclear what the categories meant, the cashiers were able to charge patients more than they should. For example, it was apparently common for type C patients to be charged according to a type B rate. Because patients did not understand the application of the categories and bills were not reviewed by another staff member, there was no independent check on the amount demanded by the cashier. The same problem existed with relatives and friends of hospital staff, who were often undercharged.

In addition, a group of outside people was operating as middle men (*tramitadores*), approaching a patient when he or she was ready to pay the bill and offering to negotiate a lower price with the hospital and save the patient having to queue to pay. The bill would be marked with the patient category code but the patient would often not know what that meant and how much he or she should pay. The *tramitador* charged the patient a percentage fee and would also pay the hospital less than was collected from the patient. It is likely that these *tramitadores* operated with some collusion from hospital staff, probably the cashiers.

Also, some patients received credit under a category of "provisional waiver," and difficulties of collecting the amounts owed meant revenues were often lost. The granting of credit was finally suspended when the person in charge of collecting the debts disappeared.

The combined effect of these problems was that the weak billing and waiver system sometimes resulted in overcharging of poor patients and undercharging of better-off patients, with negative impact on the poor and possibly to some degree on hospital revenue. After identifying the above problems, the hospital management decided to change the system. Under the new system, the social workers determine the amount of the patient's bill, instead of the cashiers. The categories are used as a guide, and the amount to be paid is discussed with the patient, thus the patient knows how much to pay before going to the cashiers' office.

According to data kept by the social workers, about five percent of the patients are classified as A, five percent as B, 40 percent as C, 40 percent as D, and 10 percent as E. The social workers believe the new system works reasonably well. Although they use a questionnaire, the classification of a patient is generally partly subjective. The value of giving a patient a card that shows the economic classification for two years would appear to be reduced by the fact that the social worker still has to discuss with the patient how much that patient can afford to pay. The social workers' office keeps a register of payments and waivers on a daily basis as evidence of their work, but the information is not used or reported, and the ability to do this is limited by the lack of a computer. The social workers are not aware of the existence of any waiver targets.

Patient interviews

Interviews were held with 20 patients — ten from Hospital Enrique Sotomayor, the maternity hospital, and ten from Hospital Alexandro Mann, the children's hospital. The 20 patients were selected from those who came to see the social workers, some for waivers and others for other reasons. This may not be a representative sample as it is likely to include more poor people. Of the 20 patients, 14 came from far away and eight went to another provider first.

As can be seen from Table 4.2, all ten patients interviewed from the children's hospital were inpatients. Three paid in full, five received a partial waiver, one received a full waiver, and one was granted partial credit. Of the nine that paid something, three used their own resources and six borrowed money from family and friends. For the five patients who provided complete information on bills and payments, the average amount charged was S/132,490 and the average amount paid was S/45,000. The difference relates to two waivers averaging S/218,725 granted on the two largest bills averaging S/268,725 (i.e., each patient only paid S/50,000).

At the maternity hospital, eight of the ten patients were inpatients. Of the ten patients, nine paid in full and one was exempt. Six of the nine paid with their own resources, and three borrowed money from family and friends. The average outpatient bill was S/33,500 and the average inpatient bill was S/39,714. The absence of waivers at the maternity hospital may relate to the fact that most patients at the maternity hospital know well in advance that they will use the services and how much they will have to pay.

At the two hospitals, half the patients interviewed believe the poor have to pay something, some believe waivers are available for children and prenatal and postnatal care. Nobody believed family planning clients or AIDS patients are exempt. Eighteen of the 20 were satisfied with the services, and 15 out of the 18 that paid felt the payment was reasonable.

Table 4.2: Payment data from patient exit interviews - JBG facilities

	Hos. Alexandro Mann		Hos. Enrique Sotomayor	
	Outpatients	Inpatients	Outpatients	Inpatients
	Poor[7]	Poor	Poor	Poor
Paid in full		3	2	7
Partial waiver		5		
Full waiver		1		
Exempt				1
Received credit		1		
TOTAL	**0**	**10**	**2**	**8**
Paid with own resources		3	2	4
Borrowed funds from family		5		2
Borrowed funds from friends				1
Combination of own and borrowed funds		1		
TOTAL	**0**	**9**	**2**	**7**
Average total bill		S/132,490	S/33,500	S/39,714
Count		5	2	7
Average amount paid		S/45,000	S/33,500	S/39,714
Count		5	2	7

4.9 MSP facilities

During the period of the study, all the MSP hospitals and health centers were closed (apart from emergency services) due to a national strike of staff related to salary and budget issues. The following information was obtained from brief interviews with senior managers, complemented by relevant information extracted from the La Forgia study on cost sharing in public hospitals (La Forgia 1993a).

MSP Hospital Eugenio Espejo

Hospital Eugenio Espejo is the large MSP tertiary general hospital in Quito. A senior hospital manager informed the team that patients currently are charged only for the supplies needed for special services such as surgery, ophthalmology, prosthetic devices, and special x-rays. Their fee structure has three levels — A (cost of supplies plus 50 percent), B (cost of supplies), and C (50 percent of cost of supplies). The social workers decide which range patients fit into, although a patient referred by a private doctor to

[7] All patients were classified by the interviewers as poor.

the hospital automatically falls into category A (which probably still results in a loss to the hospital because the 50 percent mark up on supplies is unlikely to cover other costs).

MSP Hospital del Niño de Guayaquil
This pediatric hospital has 356 beds with an 80 percent occupancy rate, and sees around 8,000 inpatients and outpatients per year. During the nine months that cost sharing was officially in place in 1994, about S/800 million was generated in revenue and the funds were managed by the Fundación Icaza Bustamente, a charity operating within the hospital. Patients were classified into five categories (A, B, C, D, and E) and about 500 patients per month paid less than the full fee. Classification was made by the social workers following an interview with the patient, and it was recognized that the process was fairly subjective. The hospital is currently proposing to reintroduce user fees at around 10 to 20 percent of market prices.

MSP Latacunga Health Center
The health center, which is situated in the City of Latacunga, primarily provides family planning, pediatric, and laboratory services. There is a "people's pharmacy" (*farmacia popular*) in the center that operates on a revolving fund basis. About 25 percent of the patients receive a complete waiver for drugs from this pharmacy. The decision to waive is made by the director, as there is no social worker. The center proposed a cost sharing scheme, but it was never implemented for political reasons. The director believes it is easy to identify patients who deserve a waiver in small health centers because staff knows the patients and know what they can afford to pay. He said members of some communities do not want to pay for services, even though they can afford them, and they demand waivers. About 45 percent of the patients who come to the center do not bring funds and do not have funds to pay the bill.

MSP Hospitals in general
In 1993 La Forgia et al. conducted a study on cost recovery in public hospitals (La Forgia 1993a). The study showed that, although hospitals such as the Hospital del Niño Baca Ortiz in Quito and Hospital Eugenio Espejo were charging some fees in 1991, the revenue from those fees only represented about one percent of the cost of services in total, with most of that revenue coming from diagnostics and nothing from outpatient services. Hospital El Suburbio, the general secondary hospital in Guayaquil, was recovering slightly more at 2.3 percent, with fees for all services except for emergency. In 1991 the radiology department generated a small surplus of five percent. Prices were set by facility directors and social workers based on perceived ability to pay. Only for diagnostic services were prices set to recover a significant part of the material costs. Prices were extremely low — the cost of a delivery at the MSP maternity hospital in Quito was less than the round trip taxi fare from a nearby community.

The study found that all facilities had some form of means testing to target the poor and determine their eligibility for a partial or complete waiver. Means testing, as practiced, was found to be ineffective in terms of sorting the poor from the non-poor, but did not discriminate against the poor because few patients paid full price. Formal rules or guidelines did not exist and fee reductions were based on the whim of the social worker or the patient's ability to negotiate. In any event, billing and collection procedures were so lax that many patients paid nothing regardless of means testing. The study showed that of 99 surgical patients at Hospital Baca Ortiz, only 37 percent paid the full fee, four percent received a partial waiver, two percent received a full waiver, and 56 percent evaded payment. The study noted that no records of waivers were kept. It was also noted that patients had to buy some services outside the hospital. For example, inpatients at Eugenio Espejo were having to purchase goods and services from

private pharmacies, laboratories, and even from private hospitals and clinics because of inadequate supplies and deficient equipment. Based on a sample of inpatients, the study determined that most inpatients at Eugenio Espejo could pay the hospital for services if the services were available, because they were already paying substantial fees to purchase the complementary private services.

In terms of the cost of administering means testing, the study found that most of the work was done by the social workers and occupied between 70 and 100 percent of their time. Social workers often prepared the final bill. The administrative cost of the user fee systems in the MSP hospitals was found to be very high compared with the fees collected (75 percent at Baca Ortiz, 217 percent at Eugenio Espejo, 31 percent at the Maternity Hospital, and 64 percent at El Suburbio). Means testing was generally estimated as being between 70 and 90 percent of the administrative costs, and thus was also very high compared with the total revenue collected. At the JBG Enrique Sotomayor and Luis Vernaza Hospitals, the cost of administering fees compared with total fees collected was significantly lower, at 12 and 23 percent respectively. The cost of means testing was also relatively lower. The cost of means testing per beneficiary was between S/11,000 and S/19,000 at the MSP hospitals compared with S/2,500 to S/3,000 at the two JBG hospitals. At the MSP facilities, the high cost of means testing per beneficiary was attributed to the low number of patients who were means tested compared with the number of social workers, and the high cost compared to revenue was mostly due to the low total level of revenue collected. The study noted that the cost of means testing at the National Institute of Hygiene and Tropical Medicine (INHMT) in Guayaquil, which provides laboratory tests, is significantly lower compared with total revenue than at the MSP or JBG hospitals, which is attributed to the requirement that all waivers be authorized by the director. Rather than wait for this authorization, patients who can afford to pay the fee do so.

In summary, the study concluded that means testing was not an issue in terms of protecting the poor, because the entire fee collection system was so weak that few people paid and the level of revenue was very small.

Current ad hoc fees

The extent to which ad hoc fees exist in MSP facilities is shown by the preliminary data from the current CEPAR study (CEPAR 1996). These data indicate that 18.7 percent of persons interviewed in MSP facilities paid something for services. Across service levels this varied from 27 percent in urban sub-centers to 12 percent in hospitals. The amount paid for consultations varied between S/1,000 and S/5,000, with most between S/1,000 and S/3,000. Most of the patients, including those from low-income households, considered the fees to be normal or cheap. Most of the fees were paid with patients' own funds or with family funds, and in the case of low-income patients, the fees were mostly paid with family funds.

4.10 Experiences in other social sectors

In terms of possible experiences from other social sectors, the following information was obtained about education and water schemes.

Education is provided free of charge by the government, with the exception of a registration fee. Other costs relate to books, uniforms, and transport. No information could be found on waivers for any of these costs, and it is believed that all families have to pay the full cost, although the registration fee and in

some areas transport costs are subsidized by the government, and the poor are therefore protected to some degree.

In some of the municipal water schemes in Quito, rates are based on metered consumption and the rate per liter is higher in non-poor areas than in poor areas. Better-off areas pay more than cost and cross-subsidize the poor. However, it should be recognized that the provision of piped water is a monopoly, and charging some patients much more than cost to cross-subsidize poorer patients is likely to be difficult for health services in a competitive environment. No information could be found on any other experiences of protecting the poor for similar services.

5. Public Perceptions Based on Household Surveys

5.1 Characteristics

The household surveys were carried out in one community in each of the three facility clusters. One was in Barrio Legarda in Quito near to CEMOPLAF's Clínica 21 and the Patronato San José Clínica del Norte. Another was in Mapasingue, a poor settlement on the outskirts of Guayaquil within the catchment area of an APROFE clinic, several private clinics, an MSP health center, and the JBG hospitals in the center of Guayaquil. The third was in La Calera, a peri-urban community on the outskirts of the city of Latacunga in a highlands area mostly inhabited by indigenous people. La Calera is in the catchment area of the CEMOPLAF clinic and the MSP health center and hospital, all of which are in Latacunga. In each community a total of 30 household surveys were carried out with mothers who were at home when the interviewers called.

A profile of the survey respondents is shown in Table 5.1. Of the 90 persons interviewed, 72 percent were judged by the interviewers to be poor; the average age of the person interviewed was 33; the average number of children was 2.5; and 41 percent use a family planning method. Eighty-six percent of the persons were judged to be poor in Mapasingue (Guayaquil), versus 60 percent in La Calera (Latacunga), and 70 percent in Barrio Legarda. The relative better-off status in La Calera may be partly because it is an older, settled community where many people are employed in brick-making. The proportion of respondents using family planning also varied — 56 percent in La Calera, 46 percent in Legarda, and only 20 percent in Mapasingue.

Table 5.1: Profile of household survey respondents

	Legarda	Mapasingue	La Calera	Total
Number of respondents	30	30	30	90
Average age	34	31	34	33
Average number of children				2.5
Proportion assessed as poor	70.0 percent	86.7 percent	60.0 percent	72.2 percent
Proportion using family planning	46.7 percent	20.0 percent	56.7 percent	41.1 percent

5.2 Care seeking behavior

Family Planning Providers

Table 5.2 shows details of family planning providers and prices. For the 37 people who used family planning, the overall most common source was CEMOPLAF/APROFE, which was used by 16 people. The most used provider in Barrio Legarda (Quito) was private clinics, in Mapasingue it was APROFE (but not by much), and in La Calera it was CEMOPLAF. The second overall most common source of services was private clinics (but only in Legarda), and the third was government health centers. It must be recognized that these communities may not be representative since they were all recommended by the family planning organizations, although Mapasingue was also recommended by the JBG Hospital del Niño. In terms of prices, it is notable that the average price paid for services at private clinics in Quito was much higher than for any other provider.

Table 5.2: Number of users of family planning services by provider and average price paid

	Legarda		Mapasingue		La Calera		Total	
FACILITY	**Mean**	**Count**	**Mean**	**Count**	**Mean**	**Count**	**Mean**	**Count**
CEMOPLAF/APROFE	6000	4	7167	3	11214	9	8857	16
Others	8000	1	6500	2	7200	6	7125	9
Private Clinic	122500	6	.		.		122500	6
Public Health Center	.	2	5000	1	.	2	5000	5
Public Hospital	.	1	.		.		.	1
TOTAL	**69727**	**14**	**6583**	**6**	**9542**	**17**	**31759**	**37**

Health providers

Details of the use of health providers is shown in Table 5.3. Of the 85 persons who reported having used health services, the majority (24) said they used CEMOPLAF/APROFE. The second highest overall source (18) was private clinics, the third (17) was public health centers and dispensaries, and the fourth was (13) public hospitals. This varied considerably among communities, with public health centers being the single largest source in Legarda, APROFE in Mapasingue, and CEMOPLAF in La Calera. Again, these communities may not be representative since they are all within access of a CEMOPLAF or APROFE clinic. Only one person reported not using any service. The preference for private and PVO facilities was also shown in a study of 4,391 households carried out in 1994 (SECAP 1994). That study indicated that the types of facilities most used by people for their first visit were private and PVO clinics (41 percent of people), followed by public hospitals (14 percent), public health centers (9 percent), and public dispensaries (9 percent). In addition, a significant number of people reported not using any service when they got sick, notably 54 percent of those persons in the poorest quintile who gave the reason as "lack of money."

It is notable that the average price paid was much higher at private clinics, but this time in La Calera (Latacunga), not in Legarda (Quito). The relatively high amounts paid to public hospitals is also interesting and presumably relates to ad hoc fees. The 1994 SECAP study showed that highest average consultation fees were paid at private and PVO facilities (S/25,534 per consultation) with the lowest being at public hospitals (S/9,940), public health centers (S/5,414), and public dispensaries (S/3,901). Since these figures are for consultations, they are not directly comparable with those shown in Table 5.3, which are for all services. Also, the aggregation of private for-profit facilities with PVO facilities in that study may hide the considerable variation in fee levels between the two types of facility found in this study. The data for the SECAP study were presumably collected when fees were officially in place in MSP facilities, because around 50 percent of patients at these three levels of public facilities reportedly paid fees. The SECAP study also showed that the facilities most used by the poorest quintile of people for first visits were private and PVO clinics (25 percent), followed by public health centers (15 percent), public dispensaries (14 percent), and public hospitals (13 percent). The poorest quintile used these three types of public facilities much more than the richest quintile (42 percent of the poorest quintile compared with 24 percent of the richest).

Table 5.3: Numbers of users of health services by provider showing average prices paid

	Legarda		Mapasingue		La Calera		Total	
FACILITY	**Mean**	**Count**	**Mean**	**Count**	**Mean**	**Count**	**Mean**	**Count**
CEMOPLAF/APROFE	6500	4	10927	11	11378	9	10526	24
Private Clinic	91438	9	32000	1	296725	8	184547	18
Health Center or Dispensary	.	10	7625	5	5000	2	7100	17
Public Hospital	9333	5	25000	4	24167	4	18813	13
Mission hospital	.		22000	4	12125	4	17063	8
Pharmacy	90000	1	.	1	18000	1	54000	3
Traditional Healer	.		10000	1	2000	1	6000	2
TOTAL	**57933**	**29**	**14378**	**27**	**97119**	**29**	**58798**	**85**

Services received

Most of the services received were outpatient consultations (37 percent), followed by family planning consultations (21 percent). Inpatient services constituted five percent of total services with surgery being two percent.

5.3 Care seeking alternatives

Most persons interviewed were aware of several options for service provision. More than half the persons interviewed said they knew of a public hospital, a health center, and a CEMOPLAF or APROFE clinic. Slightly less than half the people said they knew of a private clinic. Around one third said they knew of a PVO hospital, and one third said they knew of a pharmacy. Only 15 percent said they knew a traditional healer and only two percent said they knew a community-based distributor for family planning.

5.4 Why people chose certain providers

The reasons given for choosing a provider are shown in Table 5.4. The most common reason was because the service was free or cheap (44 percent of persons). The second reason was good quality service (18 percent) and the third was convenient location (13 percent).

Table 5.4: Prime reason for choosing health service provider

	Legarda	Mapasingue	La Calera	Total	Total percent
Free or cheap	17	12	11	40	44 percent
Good service	5	3	7	15	18 percent
Convenient location	2	5	5	12	13 percent
Other	0	5	2	7	8 percent
Staff attitude	3	1	2	6	7 percent
Not long waiting time	2	1	2	5	5 percent
No reply	1	3	1	5	5 percent
TOTAL	**30**	**30**	**30**	**90**	**100 percent**

The most common reason why people said they did not use public services was because they had to wait a long time, the next was poor quality, and the third was distance. The main reason why people did not use CEMOPLAF in Barrio Legarda was because they do not know the clinic, and in La Calera because of the price (but only three persons). The main reason why people said they did not use APROFE in Mapasingue was poor quality (but only three persons).

However, everybody interviewed in Barrio Legarda and 29 out of 30 people in La Calera said they would use CEMOPLAF services if there were waivers. Of the 30 people interviewed in Mapasingue, only 13 said they would use the APROFE clinic if there were waivers.

5.5 Fees paid and waivers received

Of the 85 services received (Table 5.3), 23 (27 percent) were fully waived and 9 (11 percent) were partially waived. Of the 23 fully waived services, 19 (83 percent) were for persons adjudged by interviewers as poor. Of the nine partially waived services, six (67 percent) were for persons adjudged as poor. Most of the complete waivers were for outpatient services at public health centers and hospitals (which either means that the service is free and was marked as a full waiver, or there was a fee that was waived). Of the six persons who were hospitalized, two received partial waivers and two received full waivers. Of the three persons who had surgery (three of the six hospitalized), one received a complete waiver.

The average fees paid according to the respondents are shown in Table 5.5. There was considerable variation by community, but with the small size of the sample, this cannot necessarily be taken as indicating price differences among communities. Nevertheless, some interesting figures can be seen. For example, the average payment reported for family planning consultations was highest in Legarda at S/33,929 and lowest in Mapasingue at S/5,457, with the payment for La Calera also low at S/7,929. The average fee paid for a general consultation was also highest in Legarda at S/23,000 and lowest in Mapasingue at S/7,308 in Guayaquil, but the figure for La Calera was relatively high at S/17,900. In general, the figures indicate fees may be lower in Mapasingue, which may relate to the large number of competing providers noted by the team in Mapasingue.

Table 5.5: Average fees paid per service by community

	LEGARDA		MAPASINGUE		LA CALERA		TOTAL	
	Sucres	No.	Sucres	No.	Sucres	No.	Sucres	No.
Family planning consultation	33,929	7	5,457	7	7,929	7	15,771	21
Family planning method	3,500	1	8,333	3	7,267	3	7,186	7
Medical consultation	23,000	5	7,308	13	17,900	10	13,893	28
Hospitalization	15,000	1	45,000	1	100,833	3	72,500	5
Lab or x-ray examination		0	10,417	12	54,520	4	21,375	16
Surgery	45,000	1		0	1,800,000	1	112,500	2
Medicines	31,000	3	2,500	1	9,280	5	15,767	9

The number of responses in Table 5.5 is more than that shown in Table 5.3 because some respondents reported having used more than one service.

5.6 Knowledge about waivers

The main way by which people knew about waivers was through friends and relatives. This is understandable given that the facilities themselves do not publicize the availability of waivers and, in the absence of an official government user fee policy, there has been no public information campaign.

5.7 Summary

The household surveys indicate that poor people use PVOs (such as CEMOPLAF and APROFE), private clinics, and public facilities fairly evenly where they are all available. The reasons for the poor choosing one facility over another are low price, good quality, and convenient location. About 40 percent of those interviewed received free services (mainly at public facilities) or were granted partial waivers. Excluding free outpatient services at public facilities, waivers were granted more for inpatient than outpatient services.

6. Analysis and Comparison of Mechanisms

In this section, the various mechanisms encountered are analyzed and compared, using the questions set out in Section 3 as a basis. MSP hospitals are not included in all elements of the analysis because the ad hoc systems they use were not assessed.

6.1 Is there a policy to encourage access for the poor?

At the CEMOPLAF and APROFE clinics, there is a policy to grant waivers to the poor, but the policy is not advertised because, with reductions in donor funding, emphasis has been on financial sustainability. Poor patients are not turned away, but they are also not encouraged. At the Clínica Fundación Eugenio Espejo, the policy appears to be to encourage poor patients to attend, but public knowledge of the availability of waivers is apparently limited. There appears to be more encouragement at the Clínica Fundación Pablo Jaramillo, which is substantiated by the high proportion of patients identified as low income (34 percent). The Patronato facilities do not discourage access by the poor, but appear to be relatively strict with the application of fees, with few partial and full waivers being granted. The JBG hospitals would seem to more actively encourage the poor, with no charge, for example, for consultations at the Hospital del Niño and no charge for emergency services.

6.2 Does the price structure facilitate access for the poor?

All of the facilities visited were subsidized to some degree and their prices were in general much lower than those in the private sector (S/20,000 to S/40,000 minimum per consultation in Quito).

CEMOPLAF and APROFE have the smallest rates of subsidies, but they are able to maintain quite low prices, partly because they are fairly cost efficient and partly because they have some external funding. In addition, lower consultation fees are maintained at clinics in poorer locations, partly due to lower costs and partly due to the allocation of more subsidy. For example, the CEMOPLAF services at Latacunga are subsidized by about 25 percent, whereas services at Clinic 21 are not subsidized. Services at the Clínica Fundación Eugenio Espejo are also subsidized, although the amount is not known. Services at Clínica Fundación Pablo Jaramillo are heavily subsidized at around 40 percent of outpatient service cost and 33 percent of inpatient service cost.

The Patronato San José is subsidized by the Municipality of Quito in the sense that it provides funds for salaries and some maintenance costs. This probably represents a subsidy of around 70 percent. Since fees are set to recover material costs, general consultations probably carry a lower subsidy than laboratory and x-ray services and drugs.

The JBG hospitals appear to have a high level of subsidy for most services. For example, no fee for consultation is charged at the Hospital de Niños, and Hospital Sotomayor staff stated that the fee for a normal delivery is around 60 percent of cost (it was not clear what inputs were included in the cost figure and it is likely, given the low fee level, that it is much lower that 60 percent).

When fees were in place in MSP hospitals, they were apparently heavily subsidized and aimed mainly at recovering only non-salary costs. However, the absence of a central fee policy meant that fee levels varied across facilities. Currently, many poor people use the MSP facilities because services are either

free or have low ad hoc fees, but in many cases people have to purchase some goods and supplies from the private sector.

There are two ways in which the above price structures facilitate access to the poor. First, fees are low, mostly because they are subsidized from other sources: local and international donor funding, other business activities (JBG), the central government (MSP), and local government (Patronato San José). In the case of CEMOPLAF and APROFE, the subsidy is smaller than at other facilities, but they are able to maintain low prices because services are quite cost efficient. Second, with the CEMOPLAF and APROFE system of differential pricing by geographic location, poor communities benefit from lower prices.

In addition, within some facilities, there is some differential application of subsidies across services. For example, some CEMOPLAF laboratories make a profit even though the clinics to which they are attached do not. Similarly, most facilities attempt to recover the full cost of medicines while consultations may be subsidized (e.g., Patronato). While there is no reason to believe this benefits the poor more than any other kind of patient, it may be helpful to the poor in terms of reducing the cost of access to a medical practitioner. It is not clear if there is any differential application of subsidies between essential and non-essential services that might benefit the poor (e.g., when an essential service has more subsidy). An interesting additional mechanism that probably helps the poor is the rapid service clinic at JBG Hospital de Niños Alexandro Mann, which provides streamlined service to children who travel a significant distance to the hospital.

6.3 Do the poor benefit from exemptions?

No information could be found on automatic exemptions for age, preventive service, or disease type, etc., at the CEMOPLAF or APROFE clinics, the Clínica Eugenio Espejo, or the Clínica Pablo Jaramillo.[8] The JBG pediatric hospital Alexandro Mann does not charge for emergency surgery, and since the majority of children appear to be from low or lower-middle income families, this exemption should benefit a highly vulnerable group. Likewise, not charging a fee for outpatient consultations at Alexandro Mann also benefits the most vulnerable group (children from poor families) in general. The JBG Hospital Luis Vernaza also does not charge for emergency services, but since this is a general hospital, these services do not specifically relate to a vulnerable group and this exemption is therefore more related to protection from the cost of catastrophic illness. It is also not known what proportion of these emergency patients are poor, although most patients are believed to be from low or low-middle income families.

When fees were in place at MSP facilities, apparently the absence of clear guidelines meant the application of automatic exemptions, for vaccinations for example, was inconsistent. The degree to which the poor benefit from the currently "free" MSP services is questionable, since the quality is poor and many patients have to pay the private sector for services not available at MSP facilities or pay the ad hoc fees at MSP facilities.

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[8] Although free promotional and other services may be provided outside the clinic setting.

6.4 Is there a waiver system that ensures people pay what they can afford?

All the facilities included in the study had waiver systems. They tended to be more informal at the smaller facilities and more formal at the larger ones. At the small APROFE clinic and at the Clínica Fundación Eugenio Espejo, where there were only two to four staff, the system was that the receptionist or nurse recommended a waiver based on her knowledge of the patient, and the clinic director (the doctor) approved. Interviews with the receptionist were not conducted in private. At the CEMOPLAF clinics the system was a little more formal, with a waiver coupon used to record the waiver. However, no formal socio-economic history was taken and the waiver was granted on the basis of the receptionist's perception of the patient combined with the patient's stated ability to pay, and the approval by the clinic director was almost automatic. Some privacy was afforded by the distance between the reception and waiting areas. Partial waivers are not usually granted except for a 20 percent discount for laboratory tests.

At the large APROFE clinic, patients who request a waiver are referred by the auxiliary nurse or family planning counselor to the clinic administrator, who makes the decision based on her judgment and the patient's stated ability to pay. Interviews are conducted in some privacy. The waiver is noted on the patient record for future consideration. Credit is also given at the large APROFE clinic, but apparently only half of the total granted in the year is recovered. Despite the informality of the systems at these clinics, the volume and value of waivers is very low because staff is aware of the need for revenue and does not encourage waivers, and patients generally expect to pay.

The Clínica Pablo Jaramillo has five listed fee levels for each service and has a social worker who determines at which level a patient will pay. Even though the clinic is located in an area where there are many poor people, the relatively large volume of patients who paid little or nothing may indicate the system is weak. The wide range of outpatient fee levels actually paid (well beyond the five set fee levels) indicates a likely tendency to set the price according to the patient's stated ability to pay.

At the Patronato facilities, systems are more formal and include the use of a socio-economic questionnaire developed by one of the social workers. All inpatients are interviewed when admitted and are classified in one of three categories: A - full price, B - full price less a small discount (10 to 20 percent), or C - free. Outpatients are only interviewed if they say they cannot pay the fee. Interviews are conducted in private. The social workers use the questionnaire as a guide when selecting the category and use their own judgment to complement the information provided by the patient. The social worker uses the socio-economic category to calculate the amount to be paid on the bill. The bill is then approved by the facility director. Patronato policy is that all laboratory tests, x-rays, medicines, and blood transfusions must be charged at full price. When a patient cannot pay a large bill (e.g., for surgery), a request is made to INNFA, which generally covers part or all of the bill. Credit is also granted on occasions. The number of waivers and credit transactions was quite small in 1995, and most of them were for inpatient care.

JBG hospitals also have formal systems. Social workers hold private interviews with inpatients when they are discharged and with those outpatients who request a waiver. A socio-economic questionnaire is used to help determine how much they should pay, although the social worker generally accepts the patient's statement as to how much he or she can pay. For inpatients, the social worker completes the waiver request and the bill, which are sent to the hospital director, sub-director, or administrator for

approval. For outpatients, the social worker authorizes the waiver and bill herself because the amount is generally small. Prior to 1995, systems were weak at both the Hospital del Niño and Luis Vernaza, and there was apparently considerable under-collection from some patients and overcharging of others. At Luis Vernaza patients are classified in one of five economic categories relating to the percentage of the bill the patient should pay. In the past, application of percentages without discretion to bills in accordance with the economic categories has been a problem, because a fixed percentage of a large bill may be more than the patient can pay, whereas the same percentage of a small bill may be affordable. To solve this problem, the social workers now determine the amount to be paid, not just the percentage. The volume of waivers granted is generally high: 35 percent at Hospital del Niño and 18 percent at Hospital Luis Vernaza. When patients cannot pay the bill, the hospital requests family members to donate blood to the hospital.

It was not possible to get much information on current MSP systems. However, systems have probably not changed much from 1993, when the La Forgia study was carried out. This study showed that social workers were using means testing systems and that they were ineffective in terms of sorting the poor from the non-poor, but that few people paid full price anyway and many absconded without paying anything.

6.5 How effective are the mechanisms in ensuring access for the poor to services?

Accurately determining which mechanisms are the most effective in ensuring access (avoiding undercoverage) requires much wider and more detailed information of patients and households than was feasible under this study, especially since some facilities used combinations of mechanisms. It is difficult to assess how the poor respond to the many different alternatives, such as (1) higher fees and more waivers, or lower fees and fewer waivers; (2) equal subsidies on consultations and drugs, or no consultation fees and full cost recovery on drugs; (3) exemptions for children or waivers for poor children; (4) sliding scale fees or "negotiated" waivers; and (5) interviews with all inpatients or only those who request a waiver. The following findings are therefore somewhat impressionistic.

It appears that some poor people are dissuaded from seeking services at CEMOPLAF and APROFE because prices are not very low and people generally expect to have to pay. The household survey indicated that many more poor people would use these facilities if they could get waivers. Even though prices are very low at the Clínica Fundación Eugenio Espejo, the doctor believes that some poor people do not use this service because they do not know they can get a waiver.

The high proportion of poor people using the Clínica Pablo Jaramillo indicates that the poor are not dissuaded from using their services, probably because fees are very low and people know that they can get partial or full waivers.

From the exit interviews at Patronato facilities, it appears that most of the patients are poor and the balance tend to be lower-middle income. These families use the Patronato because outpatient fees are very low and waivers are given to protect patients against large bills for inpatient services.

Exit interviews and visual observation at the JBG facilities indicate that many of the patients are low income and lower-middle income. Again, these patients use JBG facilities because fees are low, and in some cases free, and waivers are easily available.

6.6 Are people protected from financial hardship?

The issue of financial hardship from overcharging relates mainly to large bills for outpatient surgery or inpatient care, and therefore mainly relates to the Clínica Pablo Jaramillo, Patronato, and JBG facilities. Four different types of protection were encountered. First, as stated previously, fees are generally low because they are subsidized by donors or government or through non-health activities. Second, at Clínica Pablo Jaramillo an element of protection is provided by the reduction in the daily fee rate for neonatal care after a certain number of days. Third, income criteria are used to choose either one of a range of fixed fees, as at Clínica Pablo Jaramillo, or to grant partial or complete waivers (with considerable patient negotiation), as at Patronato and JBG facilities. Fourth, patients who could not afford to pay high bills at Patronato facilities could get assistance from INNFA. Despite these mechanisms, a significant number of patients at JBG and some patients at Patronato facilities borrowed money from family or friends to pay high bills, mainly for inpatient services. Without investigation into individual circumstances, it is hard to judge the effect of such loans on patients and their families since loans within extended families are common.

6.7 Do the mechanisms prevent undercharging?

At CEMOPLAF and APROFE, the low number of waivers makes it unlikely there is much undercharging. The small size of the clinics, the personal control exercised by staff over waivers, and the emphasis on financial sustainability are all factors that limit undercharging. Similarly, the small size of the Clínica Fundación Eugenio Espejo makes it easy to control for undercharging, although it was not possible to determine if there is any. At the Clínica Fundación Pablo Jaramillo, the financial data indicate there may be some undercharging, which probably relates to less emphasis on financial sustainability at that clinic.

It is harder to tell if there is undercharging at the Patronato facilities because, although the number of waivers is low, the value of some the waivers is high. Nevertheless, the two tier recommendation and approval system makes it unlikely there is any significant undercharging. At two of the JBG hospitals, weak systems in the past apparently resulted in some undercharging. In particular, allowing different staff members to recommend waivers and having the cashiers calculate the amounts to be paid apparently resulted in significant abuse. Concentrating the waiver process and bill preparation in the hands of the social workers and using a two tier authorization process seems to have addressed this problem, as evidenced by the low number of waivers in 1995. According to the La Forgia study, undercharging used to be a significant problem in MSP hospitals because of general weaknesses with the fee and waiver systems.

Undercharging is easier to control at smaller facilities, where staff members tend to know what other staff members are doing. The greatest problem is with larger facilities when there is an absence of good internal controls, such as a two tier recommendation and approval system. However, a critical weakness in all of the systems is the absence of effective recording, accounting, reporting, and monitoring systems.

6.8 Are there targets for waivers?

In none of the facilities assessed was there any indication of forecasts or targets for the volume or value of waivers, which means managers and staff cannot assess easily if the balance of revenues and waivers is appropriate for the volume and mix of patients using the facility.

6.9 Is there an effective system for recording and reporting waivers?

With the exception of possibly the Clínica Fundación Pablo Jaramillo, no effective systems were encountered for recording and reporting waivers. Waivers were not recorded in the accounting systems and no complete reports are made of volume and values of waivers. This effectively means that fees also are not properly accounted for. Some of the social workers keep their own records but they are not standardized or reported to management.

6.10 What is the relative cost of administering protection mechanisms?

Measurement issues
One issue with comparing cost-effectiveness of different protection mechanisms is deciding what to use as the effectiveness measure. Comparing the cost with revenue collected makes those facilities that grant fewer waivers appear more cost-effective. However, comparing the cost with the number or value of waivers granted makes those facilities that grant more waivers (as a proportion of patients interviewed for waivers) appear more cost-effective. Neither of these measures is appropriate by itself.

In order to arrive at appropriate measures it is necessary to define the purpose of user fees, which includes the role of protection mechanisms. A useful definition may be "collecting enough revenue from users, in accordance with their individual ability to pay, to provide good quality, efficient services to the target population." Within that general definition, an effective waiver mechanism is one that ensures everyone pays what they can afford, which therefore combines the two "conflicting" objectives of (a) generating revenue and (b) protecting the poor.

It is therefore probably necessary to look at the user fee system as a whole in order to measure the effectiveness of means testing and other components. If targets are set for service volume and revenue, and waiver volume and value based on the characteristics of the catchment population, then one way to define the most cost effective system is that which achieves those targets for the least cost. Given the complexity of this measurement, it is probably best to use a series of indicators to measure cost effectiveness, each of which provides a different perspective. For the waiver system, these could include system cost compared with number of waiver interviews, number of waivers granted, and value of waivers granted. For the user fee system, this could be user fee system cost compared with total gross revenue earned and net revenue received after waivers.

The comparison of facility-based waiver systems with other mechanisms (exemptions or differential subsidies) may be even more complicated. For example, the indicator of cost per patient interviewed is a useful one for comparing different waiver mechanisms, but it is not clear how useful that indicator is for comparing such systems with mechanisms that do not use interviews but rely more on graduated fees or unemployment certificates.

Findings

Data for most of these indicators, such as fee revenue, were not available at JBG and Patronato facilities, and the following comments only reflect part of the picture and are somewhat impressionistic.

At the smaller, community-based clinics, the system appears to be relatively cost-effective because general staff is used (e.g., receptionists or nurses) and numbers of waivers are low. If the number of waivers were to increase greatly, a more formal mechanism of identification.

At Hospital Patronato San José Sur, there is only one social worker, who probably spends less than one hour per day on waivers and credit, given that the volume of these is low. The rest of her time is spent doing general social work. With a total salary package of S/683,000 per month, the cost of the social worker's time in administering the system is less than S/85,375 per month. If we assume around 4,000 interviews (all inpatient admissions and a few outpatient requests), that comes to S/256 per interview. With 312 patients per year granted waivers or credit, the cost per waiver or credit granted comes to S/3,283 each. At the Clínica Norte, the cost is slightly more because the social worker has an assistant.

At the JBG hospitals, there are many more social workers. Hospital Alexandro Mann has 11, Enrique Sotomayor has 21, and Luis Vernaza has 27. At the Hospital Alexandro Mann each of the social workers sees on average 103 patients per month for various reasons (not only regarding waivers), of which 36 are granted a waiver. At a total salary package of around S/1,000,000 per month, this comes to S/9,708 per interview, and S/27,777 per waiver. At Luis Vernaza, each social worker processes on average 66 waiver patients per month, at a cost of around S/15,000 per waiver.

Since the Patronato facilities and JBG hospitals have social workers for regular social work activities, and since the amount of time spent on waivers appears to relatively small (around 10 percent and 30 percent respectively), this represents no additional financial cost but does represent some opportunity cost. Given the large numbers of social workers at the JBG hospitals and the striking difference in cost per interview and per waiver compared with Patronato facilities, some savings might be achieved by reorganizing the waiver system.

The effective use of staff time is important, especially since improvements in the management of waivers and exemptions would require extra time. For example, it may be appropriate to have the social workers approve all outpatient waivers because of the small value of waivers involved, but to have a senior manager approve all inpatient waivers because the value of the bill in question is generally much higher. Efficiency savings could probably also be made by having complete billing and waiver details kept by the accounting department instead of the social workers, and the use of a computer would relieve some of the record keeping and monitoring burden.

Within the context of each facility, the mechanisms seem to be reasonable in terms of cost. In none of the facilities does it appear likely that the cost of granting waivers exceeds the net revenue collected, which would be an obvious indication of an inappropriate system. However, without better data on revenue and administrative cost of the fee systems, it is not possible to look at overall cost effectiveness.

6.11 What examples exist in other social sectors?

No information could be found on waiver mechanisms in other social sectors. A differential fee system is in use for water systems, whereby better-off areas pay more per liter than poorer areas. This does not appear to be a very relevant example for the health sector because the provider has a monopoly on distribution and thus can charge the better-off areas much more than cost.

6.12 What public information exists about waivers and exemptions?

In the absence of an official government user fee policy, there is no national information about waivers and exemptions because services are officially free. The providers included in this study did not generally provide public information about waivers and exemptions. In the case of the Patronato and JBG, patients learn about the existence of waivers and exemptions through staff, friends, relatives, and notices in facilities.

6.13 Summary

The experience of the various providers is summarized in Table 6.1.

The CEMOPLAF and APROFE clinics have relatively small numbers of waivers — less than three percent of all patient visits. Their clinics tend to share the same characteristics — small, community-based, highly fee dependent and sustainability oriented — and have somewhat informal waiver systems. They have few waivers because most poor people believe they have to pay to use these services and therefore seek free (or cheaper) services elsewhere. The clinics are able to control both undercharging and overcharging because internal control is easier and staff knows the community. Partial waivers tend to be a discount, for example, of 20 percent. The Clínica Fundación Eugenio Espejo is similar to CEMOPLAF and APROFE, although perhaps less fee dependent. The main reason for the low number of poor patients is apparently that the community does not know waivers are available.

Table 6.1: Summary of fee and waiver relationships

Institution	Type	Dependency on user fees	Fee levels	Cost recovery rate	Exemptions	Fee types	Waiver levels
CEMOPLAF	PVO clinics	High	Low	High	None	Fixed	Very low
APROFE	PVO clinics	High	Low	High	None	Fixed	Very low
Patronato San José	Municipal hospital and clinic	Medium	Very low	Medium	Municipal and Patronato staff	3 levels: full, small discount, and free	Very low
Fundación Eugenio Espejo, Quito	PVO clinic	Low	Very low	N/A	None	Fixed	N/A
JBG Hospital Alexandro Mann, Guayaquil	PVO hospital	Low	Very low, free outpatient consultations	N/A	Staff discount	OP fixed, IP means tested	High
JBG Hospital Gineco-Obstetrico, Guayaquil	PVO hospital	Low	Very low	N/A	Staff discount	Means tested	High
JBG Hospital Luis Vernaza, Guayaquil	PVO hospital	Low	Very low, free emergency care	N/A	Staff discount	5 patient categories	High
Fundación Pablo Jaramillo, Cuenca	PVO clinic	Medium	Very low	High	None	5 fee categories	High

N/A means not available.

The Fundación Pablo Jaramillo clinic is also small and community-based, but appears to be less fee dependent or sustainability oriented. It appears to be more open to treating the poor and less concerned about undercharging. The clinic has five categories of set fees, including zero, and the top two categories appear to include a margin of profit for some services. It has a much higher rate of waivers than the above clinics — 23 percent of outpatient visits and around 33 percent of inpatient fees — but has a relatively high level of cost recovery at 66 percent. The volume of outpatient waivers may be appropriate because although 35 percent of patients were adjudged to be poor, the standard consultation fee of S/4,000 is very low.

The Patronato hospital and clinic are larger than the above clinics and less community-based. They are dependent on fees to cover non-salary costs and are sustainability oriented. Their cost recovery rate should be around 20 to 30 percent, given that staff costs are covered by the municipality. The number of waivers is very low. Most waivers are granted to reduce high bills for inpatient services and day surgery. They have formal waiver systems, under which patients are put into one of three economic categories: full price, full price less 10 to 20 percent, or free. Social workers use some discretion when deciding which category to use.

The JBG hospitals are larger facilities serving a wide catchment area. They also appear to be less concerned about fee collection, probably because the JBG has funds from other sources. Waiver levels are significant, with about 17 percent of all patients receiving waivers at Luis Vernaza and 35 percent at Alexandro Mann. Formal systems are in place with five economic categories for patients.

7. Conclusions

Based on the analysis and comparison of the various mechanisms in use in Ecuador, the following conclusions can be reached.

7.1 Fee structures

All of the providers included in the study deliver services mainly to low income and lower-middle income groups, and the use of these services by these groups represents a degree of self-targeting.

Some protection is therefore provided to lower income groups through the fee structure and characteristic targeting. The mechanisms used are as follows:

Low overall fee levels: Patients at most of the facilities benefit from low prices resulting from subsidies, and in some cases, from lower costs due to efficiencies.

Differential prices for geographic areas: Some providers (CEMOPLAF and APROFE) have lower prices in poorer areas, partly from lower costs and partly from the allocation of more subsidy.

Differential prices for services: In some facilities, the poor may benefit in terms of access to outpatient services by the fact that outpatient consultations are more heavily subsidized than other services. For example, the absence of a consultation fee at the JBG children's hospital helps the poor to have access to a medical practitioner. Similarly, the poor may benefit from access to free emergency services at JBG hospitals.

Protection against financial hardship: There are two examples of protection from the high cost of illness. One is the free emergency services at JBG hospitals mentioned above. The other is the 50 percent reduction in neonatal care fees after 11 days at Clínica Fundación Pablo Jaramillo.

Automatic exemptions: Few examples of exemptions were found among the PVO and Patronato facility-based services, which generally tend to charge for all services and use pricing structures or waiver mechanisms to make those services affordable. Examples of "political exemptions" were found at Patronato facilities, where municipal and Patronato employees receive free service, and at JBG Alexandro Mann hospital, where children of JBG employees receive a 50 percent discount. No examples of age exemptions were found, other than the exemptions found at the JBG Alexandro Mann hospital, where all services are for children.

Fast track services: Patients who come from far away to the JBG Alexandro Mann Hospital benefit from the fast track clinic, which may help reduce the cost of travel or staying at the hospital by reducing the time taken for diagnosis and treatment.

7.2 Waiver mechanisms

In addition to the protection given through characteristic targeting and the fee structure, all of the facilities visited have some sort of waiver policy through which poor patients can receive free or discounted services. However, these policies are applied in different ways.

JBG Luis Vernaza Hospital has the most structured means testing policy, whereby patients are assigned one of five economic categories based on a formal socio-economic interview. The category determines what percentage of the bill the patient will pay, although the percentage is used as a guide and not as a rule. The Clínica Pablo Jaramillo has a sliding scale model where each service has five different set prices. Each patient is also assigned one of five economic categories, but the category is used to determine which of the different prices is applied.

The Patronato has a more limited means testing model, in which a patient is assigned one of three categories, also based on a formal interview. The categories are used to determine if the patient will pay the full price, full price less a small discount (10 to 20 percent), or nothing. This model seems to be aimed at getting most people to pay the full fee and only granting a discount or a full waiver as an exception.

The least structured means testing model is that used by the JBG Alexandro Mann and Enrique Sotomayor hospitals, where waivers seem to be easily obtained, no fixed categories or differential prices are used, and the amount charged is based principally on the patient's stated ability to pay. CEMOPLAF, APROFE, and Clínica Eugenio Espejo have a similar model but most patients are expected to pay and waivers tend to be more by exception.

The above policies seem to fall into two main types that probably depend on the financial sustainability goals of the organizations. At the JBG facilities and the Clínica Pablo Jaramillo, the emphasis appears to be that patients should pay what they can afford, and the means testing policies, with broad ranges of categories, reflect that emphasis. In many cases the amount to be paid is based on how much the patient says he or she is willing to pay. At the Patronato, CEMOPLAF, and APROFE facilities, however, the emphasis is more on financial sustainability, and policies are aimed at having most patients pay a standard fee, with waivers being granted by exception.

Waiver policies tend to cover both initial access to primary services and relief of the financial burden of high price bills due to catastrophic illness. However, the degree to which they are emphasized varies across the organizations. For example, at the Clínica Pablo Jaramillo, a significant number of waivers are granted both for outpatient consultations and hospitalization. At the Patronato facilities, however, there are few waivers for outpatient consultation because the expectation is that fees are low enough to be affordable to almost everybody. The waiver service is instead focused on patients who use higher priced services: inpatients and surgery outpatients. One interesting mechanism is that used by the Patronato of requesting INNFA to pay all or part of a high bill that is beyond the means of a patient.

The effectiveness of the waiver mechanisms depends to a great degree on the decision-making processes and internal controls, which tend to vary with the size of the facility. The smaller clinics are able to manage with less formal methods of determining ability to pay because the staffs are more familiar with the community. In those clinics the initial assessment is generally made by a receptionist because small

clinics cannot afford a full-time social worker. These clinics can also manage with less formal internal control systems because the manager can exercise approval authority over all waivers and thus can know the volume and value of waivers without needing formal record systems. In addition, the manager can personally monitor what staff is doing, and staff tends to monitor each other. At clinics with a strong emphasis on revenue generation (e.g., CEMOPLAF and APROFE), it is also easier to control undercharging because most patients expect to pay and therefore the volume of waivers requested is low. Patients may also be discouraged from requesting waivers by the lack of privacy in smaller clinics.

The hospitals and large clinics generally have somewhat more formal systems because staff cannot know everyone in the catchment area and managers cannot monitor personally and informally. Formal means testing interviews, with questionnaires, are used to collect socio-economic information, which helps standardize the approach among social workers and provides a record basis for supervisory and evaluation purposes. In addition, the use of more formal interviews may help reduce the number of patients who unnecessarily request a waiver. However, the questionnaires appear to be of limited effectiveness in determining how much a patient should pay, and many social workers state that they have to supplement the formal information with their judgment about aspects such as dress, way of speaking, etc. In many cases the social workers admit the final decision on what to charge depends on how much a patient says that he or she can pay. The private nature of the interviews may reduce embarrassment for patients who request waivers but may also make patients feel more free to bargain.

Combinations of characteristic and direct targeting, as used in most facilities, seem to make more sense than focusing on one or the other. For example, it appears to be better to have low consultation fees and only grant outpatient waivers by exception for indigents (as at Patronato facilities). Means testing is then only used for more expensive care such as surgery or hospital stays. The use of different economic categories seems to be a reasonable method for means testing, but it is probably better to use those categories to assign the patient a fee category on a sliding scale to avoid having to negotiate with the patient (as Clínica Pablo Jaramillo does, but more strictly). The experience of using the categories to assign a percentage of the fee has been problematic (Luis Vernaza), because it cannot be applied to all fees when there is a big variation in fee levels (e.g., 25 percent of a consultation fee of S/6,000 is very different from 25 percent of a surgical intervention fee of S/100,000). Use of a sliding scale also should eliminate the need for social workers to operate as billing clerks. The policy of interviewing all inpatients upon admission (Patronato) makes sense when there is a likelihood many patients will not be able to afford the full fees. The use of a fee card valid for one or two years (Luis Vernaza) is also appropriate, but is probably best used with a sliding scale system so that the actual amount to be paid does not have to be negotiated each time the patient uses a facility. Such a card could also be used across a network of facilities. The use of exemptions for types of illness, service, or age group may also be appropriate, especially in public primary care facilities, but this depends on factors such as the volume and mix of patients and should be decided within the context of the overall user fee scheme.

Although more formal decision-making and control systems are needed in larger and more complex facilities, care has to be taken that these systems are not too costly. It is noteworthy, for example, that the La Forgia study at Hospital Eugenio Espejo found the administrative cost of the user fee system, of which means testing was a major cost component, was more than twice the value of the fees collected (La Forgia 1993a). The determination of how many patients need to be interviewed is a critical factor. For example, a system in which every patient must be interviewed to determine the economic or fee category (e.g., Clínica Pablo Jaramillo) is likely to be more expensive than a system under which only inpatients are routinely interviewed (e.g., Patronato San José) or one in which only patients who request

a waiver are interviewed. It is also important to use staff effectively by having different authority mechanisms for small and large waivers. For example, as at the JBG Hospital Alexandro Mann, it is appropriate to have a system in which a senior manager approves all inpatient waivers because the value of the bill in question is generally much higher, and to have the social workers approve all outpatient waivers because the value of the waivers involved is small.

Some of the providers (APROFE and Patronato) grant credit to patients. While the volume and value of such credit is relatively low in such cases, there are concerns about the difficulty and cost of collecting such debts. Staff reported they do not like to give credit to patients who do not have sufficient cash because it is too time-consuming to collect, and some patients would not return because they would have to pay the debt. These staff prefers trying to get the patient to pay the full fee on the next visit and not risk losing the patient. Extra control and careful monitoring should be used with any credit system to ensure that it is not used as a way of undercharging, or that needy patients cease to attend because they owe money.

7.3 Setting targets and reporting

The most important deficiency encountered during the study was the consistent lack of proper management information on the impact of the various mechanisms on service utilization and finances. There was little evidence of any planning, management and monitoring of waivers and exemptions, or of any targets or information systems upon which such functions could be based.[9]

In addition, no formal records or reports were found of the volume and value of waivers granted or the characteristics of patients receiving the waivers. Those records that were encountered were prepared by the social workers on their own initiative, and reports were not provided to managers. In none of the facilities is the value of waivers recorded in the accounting system: fee revenues are all recorded net (after deduction of waivers), and if no fee is paid there is no accounting record. The accounting records do not therefore reflect the total fees earned or the revenue foregone due to exemptions or waivers, which makes it hard to reconcile revenue with services and identify the financial impact of waiver policies and procedures.

7.4 General reflections

It is clear from the study that the protection of access to services under user fee schemes by the poor and other vulnerable groups depends to a great degree on the goal of the organization and the availability of external subsidies. Every provider, whether government or non-government, must generate the funding necessary to provide good quality services to its target population. If the organization has a mission to provide care to the poor, and the poor are not able to cover the cost of the service, the funding shortfall must be covered from external subsidies or profits made from providing services to better-off people. In a competitive environment, the latter option is limited because patients will change providers if profit margins become too high. The availability of funding for services to the poor is therefore highly dependent on the amount of external subsidy. However, the efficient and effective use of resources is

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[9] With the possible exception of the Clínica Pablo Jaramillo.

also critical, since the unrecovered cost of services needed by the poor and vulnerable is generally much higher than the amount of external subsidies available.

Each provider must perform the difficult exercise of assessing health needs, planning service capacity and mix, and determining price, exemption, and waiver policies. The cost of services, based on service types and volumes, must be capable of being covered by the revenue from subsidies and fees, which are also based on service types and volumes, but additionally take into account fee, waiver, and exemption levels. The setting of fee levels is a critical factor in this exercise. If fees are on the high side, this may result in low service utilization in general, little use of services by the poor, or a high number of waivers. On the other hand, if some services are free or fee levels are too low, insufficient revenue may be generated and service quality may suffer. This may result in higher costs to patients if they have to seek elements such as tests and drugs outside the facility, if they have to visit another provider, and/or if recovery from illness is delayed. The problem of undercharging is therefore not just an equity issue, because when the lack of revenue results in bad or incomplete quality of care, it is the poor who suffer.

To successfully determine service and financing objectives, providers must have clear goals about whom they aim to serve, and plans must reflect both the organization's mission and financial circumstances. Determining the optimal combination of services, fees and waivers is complex and may be facilitated through spreadsheet modeling. In addition, systems must be in place to monitor closely the financial results and impact on the poor.

It was apparent that none of the providers visited in Ecuador had all the above elements in place. In particular, there was no evidence of plans or targets for waivers and exemptions at the facilities, and information and monitoring systems were weak or nonexistent. While different mechanisms, such as low fees, automatic exemptions, differential fees and means tested waivers, exist in different facilities, and sometimes in the same facility, there was no evidence that these mechanisms formed part of a well thought out financial plan.

From the analysis of providers in Ecuador, it is clear that the volume and value of waivers vary with the financial needs of the provider. In the main, the organizations included in the study do not have policies in place to exempt vulnerable groups, and instead tend to charge for all services and use pricing structures or waiver mechanisms to make those services affordable. CEMOPLAF and APROFE, who rely heavily on fee revenue to keep operating, maintain some access for the poor through low prices made feasible by low costs and some element of external subsidy. However, fees are not low enough to attract the poor who do not use the services much, and the volume and value of waivers is very small. The Patronato San José relies heavily on fee revenue to fund non-staff costs and maintains access through very low prices made feasible by the large municipal subsidy. The volume and value of waivers is small and focused on high priced bills. The JBG hospitals appear to rely much less on fee revenue because they have a large, reliable subsidy and maintain access through very low prices, some free services, and a significant volume of waivers. Problems of undercharging are most likely to exist in the JBG hospitals and, to some degree in the Clínica Pablo Jaramillo, where the waiver systems seem to be used rather liberally. The use of an external fund, such as INNFA, to cover the cost of expensive services that patients cannot afford is a good mechanism.

The Patronato model of setting outpatient consultation fees on the low side and only granting waivers by exception for indigents is likely to be the most cost-effective system for general outpatients. Means testing is then only used for more expensive care such as surgery or hospital stays. The use of different

economic categories seems to be a reasonable method for means testing, but it is probably better to use those categories to assign the patient a fee category on a sliding scale to avoid having to negotiate with the patient. The policy of interviewing all inpatients upon admission (Patronato) makes sense when there is a likelihood that many patients will not be able to afford the full fees. The use of a fee card valid for one or two years (Luis Vernaza) is also appropriate, but is probably best used with a sliding scale system so that the actual amount to be paid does not have to be negotiated each time the patient uses a facility. Such a card could also be used across a network of facilities.

In terms of the administrative cost of the different mechanisms, it would appear that, at the clinic level, it is appropriate to use receptionists and other general staff to handle waivers and the decision-making processes do not need to be that formal. At the larger facilities, it is appropriate to use social workers to handle waivers, since they carry out other tasks. It is important, however, to have an efficient decision-making process and not to use expensive staff to make decisions on low value waivers. In general, issues of cost-effectiveness should be looked at within the context of the overall user fee system, because the waiver system's elements cannot be isolated.

There was not enough time for the study to look in depth at the cost-effectiveness of different protection mechanisms, which would involve a much more detailed look at user and non-user characteristics and preferences and waiver and revenue data. This is a fairly complex exercise, especially when different mechanisms are combined, such as in Patronato or JBG facilities, and would need to be carried out by providers and the government on a continuous basis. The principle constraint at this stage remains the absence of standard planning and monitoring systems that would allow facilities to make appropriate policies and procedures and measure the impact. This weakness is particularly apparent in the absence of accounting records and reports.

The absence of government policies to guide both government and non-government providers is an obstacle to achieving a more rational, effective, and uniform system that protects the poor in any consistent way. It is important for the government to recognize that ad hoc fees are widely charged in MSP facilities and produce an official user fee policy that provides clear guidance on protecting the poor. The government also needs to establish reporting requirements and monitoring systems to ensure both government and non-government policies and procedures are achieving the desired goals.

Identifying effective mechanisms for targeting the poor will remain a priority for a long time to come. It is clear from this study that there are limitations on the lessons that can be learned from one-time comparisons among providers within a country because of different institutional goals and policies and different cultural, social and economic environments. Additional valuable information can be obtained measuring the impact of different mechanisms as they are tried out over time within selected countries. For example, much could be learned from working with selected providers to establish proper planning and monitoring systems and then assessing the overall impact of current and modified fee and exemption structures and waiver systems.

8. Recommendations

Based on the study, a number of recommendations are provided for health care providers in Ecuador.

8.1 General requirements

Protection of access to services and protection from hardship: There are two levels of protection for the poor that need to be in place. One is that of access to services — e.g., primary consultation and diagnosis. The second is that of protection against the cost of catastrophic illness, which is impossible for a poor person to pay and can make a non-poor person become poor (e.g., through having to sell land or borrow funds).

Balance revenue needs with protection needs: There is little or no benefit to the poor from a free but underfunded health service when the quality of care is bad or patients have to purchase supplies or services elsewhere. It is therefore as important to generate the revenue needed to provide the necessary quality and coverage as it is to subsidize services to the poor.

Systems will vary: The choice and mix of mechanisms (fee structure, exemptions, and waivers) to generate fee revenue and protect the poor depends on the circumstances of the catchment population and target group and on the revenue needs. When services are defined and costs and external subsidies are known, an optimal configuration of fees, exemptions, and waivers can be determined.

8.2 Fee structure

Using characteristic targeting via the fee structure can be a cost-effective way to protect the poor because it requires no means testing. However, an element of undercharging (leakage) is inevitable because some people who benefit from a subsidized fee would be able to pay more. Appropriate fee and exemption mechanisms include the following:

Differentiation by location: Fees should be differentiated according to the general ability to pay in the catchment area — e.g., a consultation fee may be lower in a poor area than in a rich one.

Graduation by level: Consultation fees should be graduated according to facility level to provide easier access to lower level services (and opportunity for self-selection) — e.g., lower consultation fees at a health center than a hospital. Graduated consultation fees also encourage more cost-effective use of services.

Exemptions for the vulnerable: Automatic exemptions or very low fees should be in place for vulnerable categories, especially at primary care levels — e.g., under fives, malnutrition, preventive services such as vaccinations, pre and post natal check ups.

8.3 Means testing

Means test in the facility: In the absence of a reliable external mechanism such as national identification cards,[10] it is probably best to continue to do means testing in the facility. As long as the facility has the responsibility for funding services to the poor (i.e., from a fixed budget), the authority to grant waivers must rest with the institution best able to balance the need to fund services with the need to serve all members of the public. At community-based facilities it may be appropriate to involve a local organization such as a health committee.

Who recommends a waiver: The level of person who is authorized to recommend a waiver should depend on the level of service. In a small clinic this would be the receptionist, in a medium clinic it might be a nurse or counselor, in a large clinic it might be a social worker, and in a hospital it would be one of several social workers. The marginal cost will be low when this system uses existing staff.

Who approves a waiver: The level of person authorized to approve a waiver should depend on the financial value of the waiver. At the small clinic level it should be approved by the person in charge. At medium and large clinics it should be approved by the director or the administrator. At hospitals (or large clinics) a two tier approval system should be used when approval for a waiver up to a certain value can be given by the social worker herself, perhaps with countersignature by another social worker. However, approval for a waiver over that amount should be approved by the head of the social work department and/or the hospital administrator. This process can be simplified by having all outpatient waivers approved at the lower level and all inpatient waivers at the higher level.

Standard questionnaires: A standard questionnaire should be used to determine ability to pay at all levels in order to reduce undercharging and make the patient aware of a more formal structure. The use of a standard form will avoid confusing patients who may attend different facilities and will assist in the comparison of data within and across facilities. However, recommenders should be allowed to use some discretion, providing the reason is written on the form.

Low, fixed fees for outpatients: A low, fixed fee should be used for outpatient consultations so that the majority of patients will not require a waiver. Charges for drugs and investigations should be close to full cost recovery, depending on the cost recovery policy, but subsidies may be applied to certain items — e.g., public health benefits.

Means testing for high-priced services: For high fee services (e.g., inpatient or surgery), patients should be categorized, but the number of categories should not exceed five. A sliding fee scale is preferable to categories that only set percentages, because it helps avoid negotiation with patients. The means testing

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[10] An alternative identified by La Forgia et al. (La Forgia 1993a) would be to have local authorities or other government bodies determine which households are indigent. Although Ecuador does not have a national social assistance program, the MSP's FONIN programs distribute food and other commodities to the poor, who are identified through places of residence. Through its regional offices, FONIN could facilitate the certification of patients. La Forgia et al. point out that one disadvantage would be the lack of incentives for the means testing agency to filter out the non-poor and the fact that, if the mechanisms do not exist, the system would be costly to set up.

process should occur upon admission or before the outpatient procedure is performed, so that the patient knows the likely price in advance.

Long-term certification: Once a patient has been interviewed and given a category, that category should be valid for a predetermined period of time — perhaps one or two years. During that time the patient would not need to be re-interviewed, and the category could be automatically applied to another member of the immediate family. Certification works best with sliding fee scales because the patient does not need to be re-interviewed for subsequent treatments with different prices.

Public information: Information must be provided to patients and the public about the fee structure, automatic exemptions, and the availability of waivers via a means testing system. However, the information must attempt to dissuade people from seeking waivers to pay less than they can afford.

Referral waivers: Consideration should be given to the applicability of categories within a network of facilities, such as MSP. In other words, if a waiver level is determined at a health center, then it may be possible to take this determination into account at a hospital. However, the hospital must monitor such referral waivers closely, as they could be subject to abuse.

Credit: The use of credit should be tightly controlled to make sure it is more cost-effective than granting a waiver. The negative aspects of credit include the time spent in trying to collect the amounts due and the risk that some patients would not return because they would have to pay the debt. It may be preferable to waive the fee and get the patient to pay the full fee on the next visit than risk losing the patient.

Fast flow: The use of fast patient flow systems for patients who travel from far away can help protect the poor from non-fee costs (lodging, food, transport, etc.) and should be explored.

8.4 Planning and setting targets

Determining fees and exemptions and establishing waiver procedures: Planning procedures should be established for determining facility-level fee, exemption, and waiver policies. This will include forecasting the likely volume and value of waivers based on the expected volume and economic mix of patients by service and the epidemiological and economic profile of the catchment population.

Setting targets: The above forecasts should then be used to set targets against which performance can be measured. Volume and value targets should be set at the level of the facility, the service (department), and by recommender when there is more than one. These targets should be used as a basis for comparison of the actual volume and value of waivers delivered on a monthly basis. The standardization of such forecasting and target setting procedures will facilitate regional and national policy making and monitoring.

8.5 Monitoring and evaluation

Continuous monitoring: Mechanisms will need to be adjusted after installation and changed over time as the environment changes. No waiver system can be foolproof, and continuous close monitoring will be necessary to ensure that goals are adjusted as necessary and achieved.

Accounting for exemptions and waivers: The gross fees by service must be shown on the bill (or receipt) and the value of the exemption or waiver should be shown separately as a deduction from the bill.[11] The gross fees must be entered in accounting records, also by service or department, and the value of waivers should be entered as an expense and posted to a "waivers" expense account. For accounting control (i.e., reconciling revenue with services), it is better and easier to enter gross fees and waivers than to enter fees according to categories, which requires extra coding. Private fees should be recorded separately, again to facilitate control.

Patient characteristics: Regular reviews should be made of the characteristics of patients who receive waivers and those who do not. Reviews will be necessary for monitoring the effectiveness of the waiver system in terms of appropriate selection and also for monitoring the impact of fee and system changes. Particular attention should be paid to patients who borrow money to pay the bill because of the risk of causing financial hardship.

Indicator districts: In addition to the routine facility-based data, it is necessary to collect data from a limited number of representative catchment areas to determine shifts in health care seeking behavior and other reactions to fees, exemptions, and waivers.

Cost-effectiveness: Cost-effectiveness of mechanisms for protecting the poor should be monitored in the context of overall cost-effectiveness of both the user fee system and the work of the social workers, because means testing is closely integrated with both.

Computerization: To facilitate the record keeping and reporting of waivers in larger facilities, computers should be installed in social work departments, appropriate systems established, and staff trained.

8.6 Standardization

Official policies: It is important for the government to recognize that ad hoc fees are widely charged in MSP facilities and to produce an official user fee policy that provides clear guidance on protecting the poor. The government also needs to establish reporting requirements and monitoring systems to ensure that both government and non-government policies and procedures are achieving the desired goals. The standardization of systems, to the degree possible, will reduce confusion for patients and facilitate the collection and comparison of data, which will help in reviewing policies.

8.7 Targeted subsidies

Pre-approved subsidy levels: It would be useful to explore the possibility of having government bodies or donors provide targeted subsidies for organizations like CEMOPLAF and APROFE based on the number and value of services delivered to the poor.

Financial hardship subsidies: It would also be useful to explore expanding access to government bodies for funding for poor patients faced with large bills — e.g., through INNFA.

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[11] This recommendation was made to all providers visited by the team. CEMOPLAF management immediately stated that it would be implemented when receipts are next re-printed.

Private providers: Agreements should be sought with private providers of services not available at the public or PVO facility for the provision of services to referred patients at a discounted price and for the provision of an agreed number of free services to referred poor patients.

8.8 Priority for follow-up

Development of planning and monitoring systems: The development of an effective planning and monitoring system is a priority for both individual providers and the Government of Ecuador. Such development should be combined with a more detailed look at the cost-effectiveness of different protection mechanisms, which would involve a more comprehensive look at user and non-user characteristics and preferences and waiver and revenue data. This fairly complex exercise should be focused on providers that operate the most critical and numerous types of facilities (hospitals and large health centers), such as the Patronato San José and JBG, and should be used to establish systems for national replication in both government and PVO facilities. This would include the development of guidelines on means testing criteria and on the design and implementation of systems for monitoring and reporting.

Appendices

Appendix A

Appendix A. Additional Recommendations Regarding the Reintroduction of User Fees into MSP Facilities

With regard to the likely reintroduction of user fees in MSP facilities, it may be useful to add some recommendations based on the information obtained in Ecuador and on experiences in other countries.[12] Some of these recommendations have been made previously (Vallejo undated) but are well worth repeating. The main priority when introducing a new user fee program, especially when there is likely opposition, must be on **acceptability** and not on revenue. A program must be acceptable to all parties — the public, the politicians, the providers and the patients. When new fees are introduced, the following aspects should be considered:

Budgetary agreement: There must be a clear agreement between each facility and the MSP, and between the MSP and the Ministry of Finance, that budgetary allocations will not be reduced to reflect user fee revenue. Otherwise there will be little incentive to collect fees.

Reduce exemptions over time: Automatic exemptions should be initially liberal to protect the vulnerable (under 5s, preventive services, malnutrition, etc.) and these can be reduced slowly over time, if necessary.

Primary level exemptions: Certain services, such as for under 5s, can be exempt at the primary level but charged at the tertiary levels, so that speciality hospitals can also generate revenue.

Tighten waivers over time: The waiver system should also be initially liberal — waivers should be granted whenever there is some doubt of the patients ability to pay — and can be tightened over time.

Low fee levels initially: Fee levels initially should be on the low side; they can be raised slowly over time to the desired level.

Graduated fees: Fees may be graduated among different levels of services, with lower fees at lower level facilities. Graduated fees encourage first use of primary level services and facilitate access to primary care services for the poor. An alternative is to have a bypass fee for patients who go to higher level facilities without a referral.

Acceptable fee types: Fees should be put in place first for services that are most closely related with current patient expenses — e.g., medicines, laboratory tests. Consultation fees should be left until later, allowing the MSP to say that free services are still provided and facilitating access for the poor.

Revenue targets: The goal should be to recover non-salary costs, and fees should be set accordingly, which should make the average fee less than half the private sector fee. However, unless there are separate budgetary funds to subsidize automatic exemptions and waivers for the poor, the standard fee levels should be set higher to allow for internal cross-subsidies. Initially, fees may be set just to cover

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[12] Detailed guidelines on the introduction of user fees can be found in *Guidelines for Cost Sharing in Government Health Programmes* (Management Sciences for Health 1995) and information on experiences similar to those undergone in Ecuador in recent years can be found in *Health Financing Reform in Kenya: The Fall and Rise of Cost Sharing, 1989-94* (Collins 1996).

medicines and supplies, and maintenance can be covered once the fees are increased. At the larger health center and hospital level, this fee setting is best carried out with some basic modeling using spreadsheets.

Quality improvements: Quality improvements must be started immediately when fees are introduced and must be highly visible to the patients, e.g., painting the waiting area. Queuing and waiting times must be minimized, especially since the process of paying may tend to increase these times.

Public information: A public information campaign is important to advise the public, patients and providers about how the scheme will work. Posters with fees, exemptions and waiver information should be displayed. Information about "how your fees are being used" should be displayed prominently in the facilities.

Revenue retention: Revenue should be retained at the facility, and a share of the revenue should be used back in the departments where it is collected so that staff is motivated to encourage payment of fees and patients are motivated to pay.

Collection and accounting systems: Good collection and accounting systems must be established in order to control revenue and expenditures.

Revenue and waiver targets: Revenue and waiver targets must be set and actual performance should be monitored on a monthly basis through the accounting records.

Monitoring and evaluation: An effective monitoring and evaluation system should be put into place, with regular review of financial and service statistics, patient characteristics and exit interviews, and occasional household surveys in selected catchment areas.

Appendix B

Appendix B. List of Principal Persons Met

APROFE	Dr Paolo Marangoni (Executive Director)
	Abg. Eduardo Landivar (Operations Director)
CARE Ecuador	Econ Hernan Redroban (APOLO Project)
	Dr Ivan Palacios (APOLO Project)
CEMOPLAF Head Office	Lic Teresa de Vargas (Director)
CEPAR	Lic Francisco Vallejo (Coord. Health Projects)
Clínica-Fundación Eugenio Espejo	Dr Alexandra Torres (Doctor)
JBG Hospital de Niños A. Mann	Dr Martinez (Medical Director)
	Head of Social Work Dept
JBG Hospital G/O E. Sotomayor	Dr Luis Torres Garcez (Medical Director)
	Lic Alicia Castillo (Head of Social Work Dept)
JBG Hospital Luis Vernaza	Lic Sonia Penafiel (Head of Social Work Dept)
MSP Headquarters	Dr Patricio Espinoza del Pozo (Sub-Secretary General)
MSP Hospital Eugenio Espejo	Dr Honoria Bejerano de Mora (Admin Sub Director)
MSP Hospital del Niño Guayaquil	Dr Macias Alvarado (Director)
Patronato San José - Hospital Sur	Dr Fernando Villacrez (Director Médico)
	Lic Margarita Pinto (Social Worker)
Patronato San José - Clínica Norte	Lic Julia Santa Cruz (Social Worker)

Appendix C

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