

PN-ACC-557

Case Study of GUATESALUD

*A Rural Health Maintenance Organization in
Guatemala*

A Summary

Private *Initiatives* for Primary Healthcare Project



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This document was produced by the Private Initiatives for Primary Healthcare Project under Cooperative Agreement No. HRN-5974 A-00 2053-00 with the U.S. Agency for International Development Global Bureau Office of Health and Nutrition September 1997

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FORWARD

As populations increase and competition for shrinking public resources becomes more fierce, governments around the world are urgently seeking ways to maximize quality health care delivery while reducing costs. Ministries of Health in many developing countries are exploring how the private sector can meet health needs of their growing populations. Though the private health sector operates in most developing countries, little is known about who it serves, its efficiency and effectiveness in service delivery, and the quality of the services it provides. The Private Initiatives for Primary Health Care project (Initiatives) was designed to examine how private providers can deliver quality basic health services to low-income urban residents and remain financially viable.

Initiatives prepared case studies of five organizations in Africa and Latin America to better understand the factors influencing their success. Case studies are an appropriate approach to documenting and disseminating the organizational and development process. By recording an organization's genes and development, case studies allow insights into how and why the private provision of basic health services is a viable approach for reaching low-income urban populations.

The subject of each case study is a social enterprise, or a private organization that is dedicated to providing social services to largely disadvantaged populations that are not adequately served by public agencies or private markets. Social enterprises maintain or improve social conditions in a way that goes beyond the financial benefits created for the organizations, funders, managers, or employees. Concurrently, such enterprises must find effective ways to address financial pressures, including decreasing dependence on donors, as they develop ways to continue meeting their social objectives.

These case studies focus on the effectiveness, sustainability, and replicability of each enterprise. In looking at effectiveness, the studies place emphasis on service

delivery specifically on the enterprises' ability to remain focused on the target population, blend health needs with client demands, and merge technical quality with superior service. In examining sustainability or the capacity of the enterprise to continue to provide services, the studies explore factors including efficient enterprise management and operation, financial viability, adaptability, and community support. Replicability, determining whether or not the initiative group models can be transplanted, is both a function of effectiveness and sustainability as well as external factors that include markets, the policy environment in which the groups operate, external assistance in terms of technical and financial aid, and the presence or degree of the government support or opposition.

The case studies integrated both quantitative and qualitative data analysis and utilized multiple data collection methods such as facility studies, focus groups, medical records, participatory research, observation, interviews, market surveys, and project documents.

Initiatives is making the series of five case study summaries available. This case study of GUATESALUD Guatemala was prepared by Catherine Overholt. A synopsis of the study was prepared by Catherine Overholt and Lisa R. Van Wagner. The summary contained in this booklet was based on the report synopsis and edited by Raisa Scriabine.

INTRODUCTION

GUATESALUD is a private not-for-profit organization launched in August 1991 to deliver high quality low cost primary health services to the rural poor — farm workers and their families in Guatemala. It was envisioned as a social enterprise that relies on the goodwill of people who contribute their time, skills and money but uses business practices to accomplish its objectives.

GUATESALUD is an initiative of two doctors, one American and one Guatemalan, who created the enterprise to be self-financing, sustainable and replicable. GUATESALUD delivers health services to farm workers largely through trained farm-based promoters who are supervised by GUATESALUD physicians.

COUNTRY CONTEXT

Guatemala ranks as the fifth poorest and the second least-urbanized country in Latin America. Poverty is concentrated in rural areas where 60 percent of the population lives. Extreme poverty afflicts 71 percent of rural residents. With a growth rate of 2.8 percent, Guatemala has the fastest growing population in Latin America. Nearly half of the Guatemalan adult population and more than half of all adult women are considered illiterate. Forty percent of children aged 7 to 14 do not attend school. Forty-six percent of the children fail to complete primary education.

The health status for Guatemala reflects a situation that compares poorly with other countries in Latin America with a life expectancy at birth of 64 years. In Guatemala, 34 percent of children under five are considered malnourished. For every 1,000 Guatemalan children that survive their first year of life, 39 die before reaching age five. Guatemala shows the worst performance among all countries in the Americas for the percentage of children who are underweight. Diarrhea, respiratory ailments, malnutrition, and infectious diseases represent the main causes of death for all age groups.

The intense internal social and political conflict which enveloped Guatemala during the past 35 years has contributed to the precarious economic situation. Peace accords were signed at the end of 1996.

Health services in Guatemala are predominantly public and urban. The Ministry of Public Health and Social Assistance (MSPAS) and the Institute for Social Security (IGSS) are the two main government agencies that offer health services to the general population. MSPAS and IGSS dispense roughly 90 percent of all the delivered health services. It is estimated that 46 percent of Guatemalans lack coverage for any health services.

Until recently, the government's posture and policies have been antagonistic towards the development of private

health care service delivery. During the early 1990s, the government began to address health sector reform. In 1991, the country's health policy focused on ways to achieve greater efficiency in publicly provided health services. The strategy was to use the budget and the operating capacity of existing facilities and human resources more effectively. In 1993, a paper prepared by the Inter-American Development Bank (IDB) identified the low participation of the private sector in financing and providing health services as a principal health sector problem. When Guatemala concluded loan negotiations with the IDB in 1995 to finance a health sector reform program, loan funds were directed towards strengthening and restructuring the MSPAS and helping the government establish an institutional and regulatory framework for private sector involvement in providing health services. Loan funds were provided to incorporate strategies to privatize areas of public health.

Guatemala currently has a thriving private sector delivering health services, but these too are concentrated in urban areas - largely in Guatemala City and to a lesser extent in secondary cities. Traditional healers dominate the rural areas, and non-government organizations (NGO) have a presence in some rural communities.

The vast majority of private outpatient facilities are small clinics. About three-quarters of them are located in Guatemala City. NGOs and other private providers operate 74 percent of the total outpatient establishments and 18 percent of hospital beds. Forty-five percent of the private hospital bed capacity is located in Guatemala City. Private hospitals tend to be small, averaging 10 beds or less per facility, but four or five elite institutions have more than 100 beds. Private providers deliver services to an estimated 14 percent of the population. Demand for services at private hospitals is high, even among lower income groups.

While healthcare is concentrated in urban areas, Guatemala's economy is based predominantly in agriculture. Fifty percent of the economically active population works in

activities related to farming in rural areas. Each year over 35 percent of the total rural population— an estimated 900 000 people— migrate from the highlands to the large farms along the southern coast during the harvest season in search of paid work. These migrating people often do not receive health care in their places of origin nor do they receive it on the farms where they are hired.

Several organizations were established to help meet the health care needs of rural residents. ANACAFE, the national coffee growers association that includes all coffee producers as members, created a social action program twenty-five years ago that provides partial funding for delivering health services to rural populations through associations, cooperatives, and municipal centers. AGROSALUD is an insurance system financed by plantation owners with support from ANACAFE that provides agricultural laborers employed on coffee plantations in the coastal and central regions of the country and their family members with outpatient health care services. AGROSALUD covers 26 500 persons on 31 plantations and emphasizes public health and primary care activities.

Private insurance covers approximately six percent of the population. Two prepayment health insurance plans, eight traditional indemnity insurers, and three Preferred Provider Organizations operate in Guatemala. These insurance plans and HMOs market to upper-level management personnel in large and prestigious firms and middle class families not covered by traditional insurance.

FOUNDERS

GUATESALUD was founded by Drs. Glenn Lopez and Carmen Cerezo. Dr. Lopez, a U.S. citizen, grew up in Guatemala and completed his medical education at Cornell University. He completed his family practice residency at Chicago's Cook County Hospital.

During his medical residency in 1986, Dr. Lopez served for two months as a volunteer at AGROSALUD, an organization which provides basic out-patient health services to farm workers and their families by relying on a worker from the farm known as a promoter. The promoters are trained in health care delivery by the Behrhorst Clinic in Chimaltenango, Guatemala. The Behrhorst Clinic also provides hospital services in rural Guatemala.

Lopez identified aspects of both the Behrhorst Clinic and the AGROSALUD programs that he felt needed to be improved. Overall medical supervision by a doctor was inadequate in both programs, and promoters supervised the work of other promoters. At the Behrhorst Clinic, there were strong incentives for promoters to purchase and sell medications as a source of income since they were not supposed to charge for their services. At AGROSALUD, Lopez felt that the promoter training program lacked structure. The package of services promoters provided were related more to the health needs that the farm owner deemed important than to the epidemiological reality of the on-farm population. Lopez developed a proposal to improve AGROSALUD's services and presented it to the IDB for funding. Although IDB approved a three-year grant of US\$150,000 to AGROSALUD to implement the proposed program, the AGROSALUD Board turned down the grant. Dr. Behrhorst, medical director at AGROSALUD, suggested that Lopez was on the right track and recommended that he try to set something up on his own.

After completing his residency, Lopez joined CIGNA Healthplan, a major health maintenance organization in Los Angeles, California, as a family practitioner. His strong

attachment to Guatemala and his desire to be involved with social change motivated him to arrange a unique work schedule with CIGNA. For three years Dr. Lopez worked six weeks at CIGNA and then spent two weeks in Guatemala pursuing his idea to deliver health services to the rural poor. In 1989 CIGNA asked Dr. Lopez to be chief of staff for its West Los Angeles Health Care Center. His management responsibilities curtailed his travels to Guatemala, but he continued to pursue his vision of establishing a program that would deliver health services to low-income populations. In addition, he began a masters program at UCLA in Health Systems Administration.

Dr. Carmen Cerezo was born and raised in Guatemala. She studied medicine at the University of San Carlos and completed her pediatric internship at Roosevelt Hospital, one of two large public hospitals located in Guatemala City. To complete her pediatric training, she secured fellowships for several months of study in pediatrics and blood diseases of children at teaching hospitals in Florida and in Pennsylvania. During her internship and medical training, Dr. Cerezo was frustrated by the magnitude of the health problems she encountered, the lack of resources to deal with them, and the disorganization and indifference of the public health system. She knew that many of the health problems she saw were preventable.

Dr. Cerezo and Lopez remained in contact after their high-school days. While he was working for AGROSALUD, Lopez visited Cerezo to discuss his idea for delivering basic primary health services to rural areas patterned on the AGROSALUD model. She thought the idea had merit and was motivated to stay in touch to develop it further.

In 1987, Dr. Lopez and Dr. Cerezo visited the Alaska Community Health Aide Practitioners Program (CHAPS) to study its promoter training program. CHAPS began operations in the 1950s as a way to provide TB medications to native Americans living in rural, isolated areas. It uses lay health workers to deliver health services. Promoters solve

problems in areas that were out of reach for doctors. Doctors support promoters by radio.

The observations that Lopez and Cerezo made cemented their commitment to start their own program in Guatemala. After the Alaska trip, Cerezo returned to Guatemala to work in the emergency room of a private hospital. Lopez returned to CIGNA in Los Angeles. They coordinated plans to build GUATESALUD.

OBTAINING LEGAL RECOGNITION

Dr. Cerezo and Dr. Lopez worked from 1986-1989 to obtain legal recognition for GUATESALUD in Guatemala as a non-profit tax-exempt organization. Dr. Lopez was informed by GUATESALUD's legal advisor that the Guatemalan Institute for Social Security (IGSS) opposed the establishment of the clinic because it viewed the concept of an employer-based prepaid primary health care program as a direct threat to its existence.

Farm owners employing more than six people, either permanently or on a temporary basis, must contribute to IGSS, which in rural areas offered only accident coverage and not the general health coverage available in urban centers. IGSS pressed members of the government committee who were considering GUATESALUD's petition for legal status to block its approval as a not-for-profit organization.

Finally, in September 1989, Dr. Lopez and Dr. Cerezo prevailed upon the former president of the National Lawyers Organization (the equivalent of the Guatemalan Bar) to help them. He succeeded in obtaining all the necessary ministry approvals to create GUATESALUD as a tax-exempt organization. The final decree was quickly signed in December 1989 by Guatemala's President Vinicio Cerezo. Carmen Cerezo was named as GUATESALUD's legal representative.

FINANCING

Dr. Lopez sought funding for the development of GUATESALUD by creating Employee Healthplans International (EHI), a U.S.-based 501C-3 organization that allowed him to solicit funds from U.S. donors. He provided all of the start-up funds from his savings, put together a five-

year budget and organized a fundraising campaign. He contacted over 100 U.S. corporations that had business activities in Guatemala, submitted proposals to several large U.S. foundations, and wrote an article describing the organization that appeared in the Cornell Medical School alumni magazine.

Despite these efforts, EHI raised very little money. The foundations never responded, and EHI was unable to raise any funds through its multiple proposal-writing efforts. A few corporations expressed interest in providing support after the organization was up and running, and medical school friends contributed \$6,000. However, these funds were inadequate to finance a U.S. office and the Guatemalan operation. The long delay to legally establish GUATESALUD combined with the serious financial problems inherent in footing the bills for two organizations caused the U.S. supporters to lose interest. Before GUATESALUD was able to open its doors, EHI ceased to be a significant player in the organization's development.

GETTING STARTED

Early in 1991, Cerezo left her work at a private hospital and established a private pediatric practice in San Lucas Sacatepeque, a small rural town thirty kilometers from Guatemala City. She recruited and trained the first promoter, relying on her own private practice to provide the basic setting for training and practical experience. She recruited GUATESALUD's first farm client, her father-in-law, who was a coffee farmer with a plantation on Guatemala's south coast. He allowed Lopez and Cerezo to pilot the GUATESALUD concept on his farm. This first support was decisive because it opened the door for meeting with a larger group of coffee farm owners.

Lopez left Los Angeles for good in May 1991 and joined Cerezo in Guatemala to open GUATESALUD's door officially. The newly trained promoter provided health

services to the workers and their families on the pilot coffee farm during June and July 1991 under Cerezo's supervision. This test provided a reasonable demonstration of the concept. The experience helped to identify more concretely what health and medical care farm workers and their families would require and how to adjust the promoter training and supervision accordingly.

DEVELOPING A CLIENT BASE

To make GUATESALUD a self-sustaining operation within three years, the founders needed to secure client contracts quickly. Coffee farms were a logical choice for a target market because they require intensive labor inputs and have large permanent on-farm populations that are supplemented during the peak labor demand season by large numbers of migrant workers.

During the coffee harvest season, a farm owner could hire upwards of 200 migrant workers, depending on the size of the farm. Migrant workers frequently travel with the whole family and all but the very small children in the family work harvesting the coffee.

Dr. Cerezo organized a group meeting to discuss GUATESALUD's concepts and plans with five coffee farm owners whom she knew well and who did not participate in AGROSALUD's program. In reviewing Dr. Lopez's and Dr. Cerezo's plans, plantation owners (*finqueros*) pointed out that the assumptions about the distances that doctors would be able to travel to visit the farm clinics were too optimistic. Dr. Lopez and Dr. Cerezo made changes to accommodate more realistic travel times, but these changes also increased the service costs. However, this meeting resulted in four more *finqueros* agreeing to sign on for GUATESALUD's service. With Dr. Cerezo's father-in-law, these five coffee-farm owners became GUATESALUD's first clients.

In late August 1991 GUATESALUD began its operations in earnest delivering health services to coffee farm workers and their families. Dr. Lopez and Dr. Cerezo recruited promoters from within the worker community on each of the farms and prepared them for their duties in a one-month training program. By the end of 1991 three additional coffee farms were added to the enterprise.

DEFINING THE SERVICE PACKAGE

GUATESALUD's service package and its target clientele are unique in the Guatemalan context. The target clientele—farm owners and employers—have had few options for health services for workers. Clinics run by either the MSPAS or the IGSS are not well distributed in rural areas and clinics run by NGOs tend to be limited to a particular rural community. Organizations such as ANACAFE, the national coffee growers association, have until recently focused their efforts on providing a limited range of services to communities within a restricted geographical area. While some farm owners have hired a doctor part-time to provide farm clinic services, solo practicing doctors have not provided reliable services when they work for more than two or three farms. Furthermore, doctors who offer their medical services on this basis do not offer pharmaceuticals as part of their service contract.

At the time GUATESALUD was founded, most coffee farms had no existing system of health service delivery nor had they had any prior services. This gave GUATESALUD the opportunity to design and implement a low-cost program for delivering basic primary health care services with little interference.

GUATESALUD's preventive and primary care activities were to include the universal standard package for targeting and improving maternal and child health. Services include nutrition and prenatal support consultations, well-child growth monitoring, deparasitization, vitamin A

administration family planning and school health GUATESALUD is committed to incorporating prevention activities and services. The Ministry of Health (MOH) handles immunizations. When promoters are informed by the MOH of a scheduled immunization day in their area they notify the farm population and motivate them to attend.

SETTING PRICES FOR SERVICES

Dr. Cerezo and Dr. Lopez established the price of the basic service package in 1991 through discussions with several coffee-farm owners. In these conversations they learned that plantation owners would be willing to pay a monthly charge of about Quetzales 900 (US\$170) for managing the provision of health services to the farm population of up to 500 people. Most plantation owners also favored Dr. Lopez's and Dr. Cerezo's proposal that patients share in the cost of providing curative services.

The financial structure was grounded in monthly payments by client-sponsors (the farm owner) to GUATESALUD and collection of co-payments from patients by GUATESALUD which it would turn over to the client-sponsor. Client-sponsors with more than 500 workers and dependents are required to set up additional service units each with a monthly fee of about Q900 (US\$170).

GUATESALUD charges client-sponsors two start-up levies: Q1 100 (US\$209) for the one-month promoter training course and Q5 000 (US\$952) for an initial stock of medications and equipment to supply one service unit. GUATESALUD also charges the client-sponsor for the replacement stocks of medications at the time they are delivered, usually once a month. This charge in principle is recovered by the client-sponsor from medicine charges paid by patients.

Patients pay for their medical visits and their medications. The charge for a visit to the promoter is Q1

(US\$ 19) and a consultation with the doctor is Q5 000 (US\$1 14) The promoter is allowed to keep the fees charged for promoter consultations at most clinics Fees for visits to the doctor are turned over to the client-sponsor GUATESALUD charges patients for all medications Most owners allow farm workers to pay for their consultations and medications with a credit voucher which then is deducted from their salary by the farm administrative office

Before beginning its operations GUATESALUD requires the client-sponsor to provide it with a room on the farm to be used as a clinic It must be supplied with running water a safe place to store medications a place for privacy during examinations and adequate waiting space for patients GUATESALUD requires the client-sponsor to employ the promoter as a full-time worker It recommends but does not set salary levels for promoters

Originally the agreements with client-sponsors were not always formalized into a written contract as Dr Cerezo and Dr Lopez believed a contract represented a breach in the personal relationship they had cultivated However after a few unfortunate experiences with farm owners who did not live up to the terms of their verbal agreements by 1994 most agreements to provide services were formalized through written contracts prepared by a local lawyer Dr Cerezo is the legal signatory on all GUATESALUD s contracts with sponsors

GROWING THE BUSINESS

Dr Lopez and Dr Cerezo originally directed their client-sponsor marketing and recruiting efforts to the coffee industry. They developed a brochure and a slide-lecture presentation and secured invitations to attend the meetings of coffee growers associations and make their presentations.

Their initial efforts were successful with several farms signing on for services in late 1992 and early 1993. However, the commitment of coffee-farm owners to deliver health services to their workers was only as strong as coffee prices. Several farms stopped making their payments to GUATESALUD during 1992-93 when world coffee prices were low and others terminated GUATESALUD's services completely.

The situation with coffee farms persuaded Dr Lopez and Dr Cerezo to diversify their client-sponsor base and they responded to invitations from other types of agribusiness to provide health services to their workers and families.

DIVERSIFYING THE CLIENT BASE

Simpson Forestal

Simpson Forestal, a U.S. based forestry company, was the first non-coffee business to sign a contract with GUATESALUD. By late 1995, GUATESALUD was operating in four villages within the Simpson forestry area. Today, Simpson is GUATESALUD's largest client-sponsor.

COBIGUA

In late 1992, COBIGUA, the independently owned Guatemalan affiliate of Chiquita Brands, Inc., asked GUATESALUD to take over the delivery of outpatient health services to its 5,000 workers and their families. However, Chiquita Brands had a history of problems

between workers government owners and unions that continues in COBIGUA s present-day operations

Dr Lopez and Dr Cerezo realized that accepting a contract with COBIGUA would push them into a different operating milieu and they worried about their ability to deliver health services without the clinic becoming a pawn between the unions and the owners

However due to the loss of several coffee farm clients Drs Cerezo and Lopez believed that financial survival rested on accepting the contract They were confident they could make adaptations to their GUATESALUD model and grow the business to meet the COBIGUA challenge

GUATESALUD began delivering services to twelve COBIGUA clinic sites in March 1993 By mid-1994 the contracts coordinator left COBIGUA leaving GUATESALUD s services operating in a state of limbo After facing an increasing number of problems GUATESALUD terminated the COBIGUA contract on September 15 1995 COBIGUA at the time represented 70 percent of GUATESALUD s income

The COBIGUA contract helped GUATESALUD survive at a time when its financial future was in question The loss of the COBIGUA business had a significant financial impact on GUATESALUD The experience illustrated both the advantages and disadvantages of a single large client

Chulac Cooperative

In 1994 a three-party agreement was worked out between the Fund for Social Investment (FIS) the Chulac cooperative of small coffee growers and GUATESALUD for GUATESALUD to operate a clinic at the Chulac cooperative FIS agreed to fund the promoter s training and the initial stock of medications and equipment It also agreed to pay one-half of the monthly service-unit fee and the promoter salary for a period of a year The Chulac

cooperative agreed to pay the other half of the monthly service-unit fee and provide an appropriate room in which the clinic could operate. The expectation was that after a year the clinic would generate sufficient funds to cover the operating costs without FIS resources. The Chulac clinic began to operate as a GUATESALUD clinic in November 1994. FIS funding ended in November 1995.

GUATESALUD continued to operate the clinic but with acute financial problems. The cooperative did not pay its share of the monthly service-unit fee during the first year of operations. Later when patient payments to the cooperative were not accounted for, GUATESALUD began having the promoter deposit the money directly into GUATESALUD's bank account. The financial situation with Chulac continues to be a drain on GUATESALUD and remains unresolved.

Other FIS Projects

In 1995, FIS asked GUATESALUD to administer transfer of funds to three communities for a program to equip and train 50 midwives. GUATESALUD accepted the request although the project had little to do with GUATESALUD's business efforts at the time. By agreeing, GUATESALUD gained access to FIS' other health sector initiatives.

FIS and GUATESALUD struck an agreement during the latter half of 1995 that FIS would assume the financial role of the client-sponsor according to the GUATESALUD model on behalf of several small villages in Alta Vera Paz. FIS agreed to pay for capital investment to train promoters and provide for six months' salary as well as to buy equipment and drug supplies. FIS later agreed to extend the financial arrangements for operating costs to one year. The community was to provide an adequate and secure facility to serve as the clinic site. In October, MSPAS gave approval for Drs. Lopez and Cerezo to visit and explain the program to 10 communities in Alta Vera Paz that had no nearby health services. Promoters were recruited with the help of the communities selected and were trained in November 1995.

In March, 1996 Dr Lopez and Dr Cerezo believed they would open the FIS-sponsored clinics within one to two months. Multiple delays however plagued the startup. GUATESALUD had the promise of a signed agreement with FIS but no money to begin operations. FIS needed a letter of support from the MSPAS but the senior management of the Ministry opposed the FIS/GUATESALUD arrangement because of heavy opposition from the unions. GUATESALUD however had strong support from the local communities. When Dr Lopez and Dr Cerezo agreed in writing that GUATESALUD would operate only in areas where there were no MSPAS facilities these barriers to move forward were eliminated. FIS however required GUATESALUD to order and deliver medications to the village clinics before it would disburse any payments to GUATESALUD.

The delays took their toll. GUATESALUD waited to hire a new doctor and begin the clinic operations until it had received the FIS funds. By then two promoters had taken other employment opportunities while waiting for the clinics to open and the others had to be retrained. GUATESALUD began operating seven FIS-sponsored clinics in November 1996.

NEW PRODUCTS

In mid-1996 three more coffee-farm owners asked GUATESALUD to establish clinic services for their workers. GUATESALUD also opened a clinic for a nursery owner who had heard about GUATESALUD from other producers and expanded its health services for Simpson Forestal to an additional village. These clinics became operational during October and November 1996.

Given the risk of work-related accidents in its logging operations Simpson asked GUATESALUD to provide basic training in first aid and life support for its foremen. Dr

Cerezo developed seven one-week training modules covering life support fractures bleeding, and stabilization and transport procedures. With the assistance of a U.S. medical student volunteer, she began to implement training for 35 foremen in March 1996. GUATESALUD charges Simpson Q1 800 (US\$342) per month over seven months for this educational program.

GUATESALUD also trained several promoters for FEDICOVERA, a federation of small coffee-growers' cooperatives. FEDICOVERA operates health clinics for cooperative members with financial assistance from ANACAFE. GUATESALUD hoped to contract with FEDICOVERA to supervise the promoters to manage the clinics as usual, but the group felt GUATESALUD's prices were too high.

DECISION MAKING

GUATESALUD's by-laws require that it have a governing board of six members. Dr. Cerezo and Dr. Lopez named themselves as two board members and they chose two coffee farm owners who subscribe to GUATESALUD's services to fill two additional positions. No other Board members have been appointed. Meetings of the Board are infrequent. Dr. Cerezo notes that the Board's responsibility is minimal and because the owners are very busy they are rarely contacted for consulting or advice. However, when contacted, Board members have been responsive to GUATESALUD's requests.

In 1994, the GUATESALUD enterprise came to the attention of the USAID-funded Private Initiatives for Primary Healthcare Project (*Initiatives*) managed by the JSI Research and Training Institute. The Project offered Drs. Lopez and Cerezo technical assistance to build their enterprise. A local consulting firm, Consult Centroamericana, was contracted to conduct an assessment and make recommendations. Its report, completed in August 1994, provided Drs. Cerezo and Lopez with basic guidance in a number of areas including changing GUATESALUD's organizational structure to conform to the needs of a growing and expanding business.

The major recommendation was to divide and separate responsibilities more definitively between Drs. Cerezo and Lopez. Although GUATESALUD was growing and becoming more complex, each found it troublesome not to be involved in all aspects and decisions about the business. They held detailed discussions on both small and large aspects of running the GUATESALUD operation on an almost daily basis, and these discussions were time-consuming. When one of them was not available, decision-making was postponed.

At the suggestion of Consult Centroamericana, they became co-directors, dividing responsibilities for

administration and medical oversight and creating job titles that reflected this separation of roles. Dr. Cerezo became the Medical Director and Dr. Lopez the Administrative Director. Purchasing, inventory, accounting, finance, statistics, and epidemiology were assigned to the jurisdiction of the Administrative Director. Training, supervision, and evaluation of promoters and doctors, program development, medical protocols, and quality assurance fell to the authority of the Medical Director.

Drs. Cerezo and Lopez remain unclear about their roles and about what authority for independent decision-making each has for their areas of responsibility. A counselor and the Board have been required to mediate between them. Sorting out their distinct responsibilities and areas of authority continues to be an ongoing task.

Decision-making remains unsystematic and unplanned. Important decisions may be made tomorrow or next week or not until next month. Management's responses continue to be reactive, in part due to their absorption with operating issues. No time has been allocated for forward planning. The other board members could be helpful here in providing a more informed business perspective, but they have not stepped forward to provide this leadership, nor has the management requested this assistance.

STAFF

Doctors

During 1994 to mid-1995, GUATESALUD employed six full-time male doctors. Male doctors were hired because traveling around rural Guatemala alone was regarded as somewhat unsafe for a woman. Three doctors were dismissed when GUATESALUD terminated the COBIGUA contract in mid-1995.

GUATESALUD doctors train promoters, ensure quality control for promoter's work by reviewing patient

charts and daily reports making appropriate corrections and checking prescriptions for medication treat patients on the days they visit the clinics distribute medications to clinics and help promoters control the medication inventory

GUATESALUD doctors also provide continuing education to promoters at clinics within their jurisdiction Promoters are the front line for delivering quality medical services Promoters make decisions regarding a patient Doctors reinforce and support these activities The doctors work is reviewed and monitored by Dr Lopez and Dr Cerezo Doctors medical records are usually reviewed about once a year and in conjunction with a site visit to a clinic

Doctors are recruited through newspaper advertisements Drs Cerezo and Lopez both interview all the candidates and check references although both admit that references are not as thoroughly checked as they should be An orientation program for newly-hired doctors has not been formalized yet

Doctors are paid a base salary of Q2 500 (US\$476) Doctors using their own vehicle are paid a minimum of Q4 000 (US\$761) Overnight expenses are paid by GUATESALUD when a clinic-visit schedule dictates that they stay in the field Doctors also receive Q100 (US\$19) compensation for each night that they must remain away from home

Promoters

Promoter candidates must know how to read write and do simple math Completion of any number of years of formal schooling is not compulsory Promoters are recruited by either Dr Lopez or Dr Cerezo who visit a farm or community to explain the program and seek candidates for the position They interview and select candidates with the concurrence of the client-sponsor

The promoter is the a key factor as to why a clinic does or does not work. The community's input is vital in determining who the promoter will be if the clinic is to succeed.

Each promoter is directly employed by the client-sponsor and the salary varies from clinic to clinic. Average salary earned in 1995 was approximately Q656 (US\$124) per month. Salary ranged however from Q360 (US\$68) to Q940 (US\$179). Supplementary income from patient fees ranged up to Q180 (US\$34) per month with promoters earning on average Q50 (US\$9.50) from patient income each month.

Basic Promoter Training Course The GUATESALUD promoter training program provides a solid grounding in the basics of anatomy and physiology and builds diagnostic and problem-solving abilities around this basic knowledge. Drs. Cerezo and Lopez believe this approach will enable the promoter to make basic medical decisions. Training methods rely on lectures, discussions, and hands-on skill development. Trainees take written and oral exams which test their proficiency and assimilation of the material.

Drs. Cerezo and Lopez formalized the first promoter training experience into a month-long course for the first group of promoters. At first, they had planned to rely on the Behrhorst Clinic for GUATESALUD's promoter training. They later decided to develop and conduct training themselves to better ensure its quality. They used the book *Where There Is No Doctor* (supplemented with handouts) as the basic text for the program until September, 1995, when a public health student intern consolidated and computerized the training materials, creating a rough draft text for the course. Dr. Cerezo now has overall responsibility for the promoter training program. Both Dr. Cerezo and Dr. Lopez teach courses. They are assisted by the staff doctors and other organizations that conduct training for special topics. APROFAM, Guatemala's family planning agency, provides

training in the use of family planning methods and on the importance of birth spacing during each four-week training course

GUATESALUD holds an annual one-week refresher course for promoters. Promoters are required to attend. Client-sponsors are charged for the cost of food, lodging, and transportation.

Other Staff

GUATESALUD expanded its central office staff during the period of the COBIGUA contract to a total of five (in addition to Drs. Cerezo and Lopez). An accountant/bookkeeper was hired, enabling a more systematic and routine approach to be developed for billing procedures. GUATESALUD was then able to generate monthly balance sheets and profit and loss statements.

While the increase in staff became necessary to accommodate the growth in complexity of the organization and the numbers of independent clinic sites, the loss of the COBIGUA revenue created financial stress on the organization's ability to support these positions.

HUMAN RESOURCE MANAGEMENT ISSUES

GUATESALUD also encountered problems with staff integrity. A receptionist and an accountant were fired for forging checks. While the funds were recovered in both instances, the experience alerted Dr. Lopez to the need for more vigilant financial oversight. Two doctors who worked in the COBIGUA area were dismissed because they did not fulfill the standards for completing the work, and one was found to be dishonest in the management of the medication inventory. Some doctors left because they were dissatisfied with the rigor of rural work. Better background checks on prospective doctors could help address such problems in the future. Doctors will also be required to have rural work experience and be accustomed to driving long distances.

MARKETING AND BUSINESS DEVELOPMENT. NEED FOR PLANNING

GUATESALUD operates in two distinct marketplaces: the third-party payment market composed of owners/employers in rural-based agribusinesses who purchase GUATESALUD's services on behalf of their employees, and primary health care on a fee-for-service basis market focusing on consumers in rural villages.

Its management however lacks a solid base of knowledge about either market. There is no concrete strategy or plan to guide expansion nor the development of a stable client base. Priorities need to be elaborated. A sound business plan needs to be developed showing how alternative assumptions/scenarios would change financial outcomes and a more strategic approach needs to be taken in regard to marketing. To date, agribusiness client-sponsors have been acquired through personal networks and word-of-mouth. Questions such as what is being sold, to whom, at what price and against what competition have not been addressed.

Diversification of the client-sponsor base will be needed. The two co-directors have concentrated their efforts almost exclusively within the coffee growing industry, drawing primarily on their personal relationships and links with coffee-growers. They recruited two coffee growers to serve on the Board of Directors, in part to gain better access to other coffee growers and to be seen as reliable and trustworthy to that industry. The contacts and networks of GUATESALUD's two coffee-grower board members have aided them in extending its services to additional coffee farms.

However, the lack of diversity in GUATESALUD's farmer-client base has presented financial problems when coffee growers terminate the service or delay payments when international coffee prices are low. The founders have invested little time and effort in understanding the potential for selling services to a wider group of agribusinesses. They

are not familiar with who the producers/employers are particularly among the nontraditional agribusiness such as growers of flowers and vegetables where they are located how these businesses look at the need for health services for their employees or how to direct marketing efforts to them

GUATESALUD management also lacks sufficient knowledge about the agro-industry sector to allow for adequate pricing and promotion of GUATESALUD's product. Among the coffee-grower clients, the co-directors have been reluctant to raise the price of the service package out of a fear that owners are extremely price-sensitive and will terminate the service. The assumption that the price of the service is the driving feature sustaining GUATESALUD's client contracts remains unexamined and unsubstantiated. Management does not know to what extent other characteristics of its services are valued by the client. A better understanding of these issues is fundamental to financial viability, particularly as GUATESALUD enters the more financially risky fee-for-service market in rural villages.

GUATESALUD's management has at best only limited knowledge of what people in the fee-for-service market want to consume and for what they are willing and able to pay. Dr. Lopez and Dr. Cerezo have not performed a market survey in the villages where GUATESALUD will expand with FIS support, and the assumptions they have made about what consumers can and will pay for are unsubstantiated and untested. There is no written business plan to guide and monitor the progress of this venture, and management responses have been fairly ad hoc.

OTHER MANAGEMENT ISSUES

Consult Centioamericana found that serious weaknesses existed in the organization and structure of the enterprise, the accounting system, financial management, the storage and

retrieval of information and purchasing and inventory procedures Delta a computer engineering firm was later contracted with funds provided by the *Initiatives Project* Delta helped design computer systems and programs to handle GUATESALUD's storage retrieval and processing of information Systems were designed for purchasing inventory accounting financial and epidemiological/statistical data They were put into place in mid-1995

The computerized data system however is still not able to produce summary reports of epidemiological data Information is printed out by discrete categories and then must be reassembled into a summary report by hand Dr Cerezo spends a significant amount of time each month assembling these reports A new program must be designed to accommodate a summary format Similarly monthly reports which can assist financial management tasks have not been designed nor implemented

QUALITY CONTROL

The promoter maintains a medical history for each patient seen These records are reviewed by the staff doctor at each fortnightly visit to the clinic for their completeness and accuracy for correctness of the diagnosis and for appropriateness of the treatment or other actions taken Doctors and promoters discuss them and the promoter makes corrections as they are indicated by the doctors Frequently when a promoter is uncertain about a diagnosis or treatment the promoter will ask the patient to come to the clinic on the day of the doctor's visit Drs Lopez and Cerezo also review these records as a way to monitor the work of the staff doctors

PROCUREMENT AND INVENTORY

GUATESALUD's medication list numbers about 100 pharmaceutical products and it buys from 36 suppliers. It purchases brand name products rather than generics because that is what the patients at the farm level are used to and prefer. Dr. Cerezo decides what products are to be used at the clinics.

Fifteen suppliers form a core group from whom GUATESALUD regularly purchases. Average monthly purchases of medications run about Q45,000 (US\$7,500). GUATESALUD tends to keep less than one month's supply in stock.

GUATESALUD has no refrigeration at its headquarters office or at any of the clinic sites. Purchasing inventory and pricing are now computerized even though inventory purchasing and financial management still are not well integrated.

GUATESALUD aims for an average markup of around 20 percent and tries to keep its final price to the patient lower than the retail price suggested by the wholesaler. Price revisions have not been systematic and routine.

FINANCIAL MANAGEMENT

Payment Structure

GUATESALUD has benefited from its creative revenue flow structure. During its first five years, GUATESALUD relied on cash payments from clients in advance for the services it delivered to the clients' employees. While GUATESALUD had collection problems with some of its clients, this approach considerably reduced capital requirements and financial exposure. Revenue flow was also facilitated by the client assuming the risk and

financial burden for carrying the pharmaceutical inventory. On-site health workers were also supported by an adequate salary paid by the client. These features of the revenue flows were key to GUATESALUD's financial sustainability during the early years.

Short term loans covered the organization's cash flow needs. Some 20 loans were made for periods of four days to two weeks at four percent interest with no collateral. GUATESALUD borrowed and paid off bank loans for the purchase of two vehicles when it was operating the COBIGUA clinics. GUATESALUD was forced to obtain a three-year bank loan of US\$10,000 at an annual interest rate of 25 percent in early 1996 because of the deficit in operating costs caused by the termination of the COBIGUA contract. Obtaining this loan was facilitated by a Board member who also sits on the Board of the bank.

Securing timely payments from all client-sponsors has been difficult. When clients have been past-due in their monthly fee and payments for restocks of medications, Dr. Lopez and Dr. Cerezo have been overly tolerant in not demanding payment. The nature of their main client base, coffee farmers who experience fluctuations in the price of their product and ensuing cash flow difficulties, is part of the problem. Familiarity with clients has also been a problem as many were carried for too long before GUATESALUD was forced to terminate services and write off losses.

The Chulac clinic experience is a debt situation that is still unresolved.

Pricing Services

Although GUATESALUD has become more systematic about reviewing and changing its prices for medications, the contribution that the sale of medications makes to overall revenue has not been examined in any systematic way. GUATESALUD also has not changed its service price to

client-sponsors since it began full-scale operations in August 1991

Dr Lopez and Dr Cerezo are resistant to increasing service fees even though expenses have risen. GUATESALUD raised doctors' salaries in 1996 but the co-founders fear that if they increase the service fee they will lose clients. They reason that an increase in revenue from each service unit will be more than offset by the losses from client-sponsors who terminate GUATESALUD's services. They assume that the delinquency in payment by many of their coffee-producer clients is associated with price sensitivity. However, these assumptions have not been analyzed nor have projections been made of potential gains and losses that might result from an increase in the monthly service fee.

GUATESALUD built on the strengths of other approaches in developing its model for delivering preventive and primary health services to rural populations

SERVICE DELIVERY AND UTILIZATION

The package of preventive health services is appropriate and responds well to the health needs of participating communities

GUATESALUD's performance record for preventive activities shows continual improvement since 1994. In 1994, the number of preventive visits was small. Family planning, child health, prenatal, and nutrition support consultations accounted for fewer than 6,500 visits for all the clinics, and the COBIGUA clinics accounted for over half of these visits. If only the independent and Simpson clinics that have remained in the GUATESALUD system since 1994 are considered, then a striking increase is seen in the number of average monthly visits for birth spacing, prenatal visits, well child and growth monitoring, and vitamin A administration. However, if compared with other organizations such as AGROSALUD, GUATESALUD appears to do less well in delivering prenatal, family planning, and immunization services.

With regard to curative services, the total number of visits in 1994 was 83,233 and the COBIGUA patient load accounted for 83 percent of this total. Again, if only the independent and Simpson clinics remaining in the GUATESALUD system since 1994 are considered, then it is seen that there was a small number of total curative visits for 1994, but by 1996, the average number of monthly visits to these clinics doubled. If compared to AGROSALUD, GUATESALUD's activities seem to be focused on a more comprehensive approach to delivering primary care.

services. Half of AGROSALUD's adult and child consultations for example are for deparasitization while GUATESALUD's patient record-keeping reveals that it is addressing the major infectious disease problems of the community.

FINANCIAL PERFORMANCE

The COBIGUA contract helped GUATESALUD survive at a time when its financial future was in question. It provided the resources to build systems, develop staff and develop organizational capacity. The termination of the contract had a significant financial impact in mid-1985. GUATESALUD generated a cumulative net income as of July 1995 of US\$17,566. Between August and the end of the year, operations without COBIGUA only generated an additional US\$23,428 in gross margin which was inadequate to cover the US\$40,761 of overhead expenses incurred during this period. The difference of US\$17,333 ate up almost all the net profits that had been earned during the first half of the year.

During 1995, accounts receivable as a percentage of product sales overall for all the clinics were only three percent for pharmaceuticals and nine percent for services. The percentages are low but attributable to the fact that GUATESALUD's largest client was a prompt payor. GUATESALUD also paid more attention to invoicing its largest client more quickly than it did smaller clients.

GUATESALUD's slow invoicing procedures may have contributed to collection problems with the Simpson clinics in 1995. By 1996, collection problems with the Simpson clinics were resolved. Only two of the clinics presented accounts receivable problems and only for pharmaceutical products.

In 1995, independent clinics remitted payment for pharmaceuticals more promptly than they did for medical services. Accounts receivable as a percentage of

pharmaceutical sales was almost 10 percent, but for services it was nearly 20 percent. The El Pacayal clinic had the poorest payment performance for both services and pharmaceuticals. GUATESALUD carried the clinic for several months before finally suspending services in December 1995. The US\$3,047 it owed became a financial loss for GUATESALUD though it appears not to have been recognized as a bad debt by the accounting system.

In 1996, the accounts receivable as a percentage of sales for services was reduced to a third of the previous year's level as a result of GUATESALUD's more forceful stand on payment issues. GUATESALUD began to threaten service suspension when a client was more than a month behind in its service payments. The situation with accounts receivable for pharmaceuticals, however, deteriorated. Six of the 15 independent clinics are running an accounts receivable balance that is greater than 20 percent of pharmaceutical sales. This poses difficulties for GUATESALUD's cash flow.

CONCLUSION

EFFECTIVENESS

GUATESALUD has drawn together an appropriate package of preventive health activities that respond well to the health needs of the communities in which it functions. GUATESALUD's affiliation with ANACAFE, which began in 1995, has strengthened its knowledge and orientation in public health practice and promoted GUATESALUD's connection to the public health community.

Promoters are well-trained, supervised by a doctor, and well-compensated. The promoter training program is well conceived, thorough, and rigorous. More importantly, training is regularly supplemented with further supervision by the GUATESALUD doctors, and with annual continuing education workshops that update and hone promoter skills.

The availability of qualified physicians who are motivated to work in rural areas is another factor contributing to program effectiveness. Guatemala has a large supply of physicians, and GUATESALUD pays as well as, and in many cases better than, other available employment opportunities. Compensation for doctors and promoters is sufficient to call forth well-qualified people and to avoid frequent turnover in staff. The fact that GUATESALUD's headquarters is not located in the capital city but in a small town, some distance from Guatemala City, keeps the founders grounded in rural reality and sends an important message to client-sponsors and staff as well.

SUSTAINABILITY

One of GUATESALUD's great strengths is the involvement, commitment, and perseverance of its founders. The co-directors have invested their savings and made the organization their livelihood. They therefore have a great stake in the outcome of the venture and are motivated to spend extraordinary time and effort on details and aspects of the business that may contribute to the organization's success.

GUATESALUD however, continues to operate under conditions of financial stress and crisis. The co-directors see expansion as essential to financial survival. However, they have not planned how they will expand. The financial analysis of the enterprise has been ad hoc and unsystematic. The key issues that will determine GUATESALUD's future financial viability and that need to be examined and scrutinized include prices, costs, volume, product mix, marketing and collection.

For financial sustainability, GUATESALUD must have profit margins that are sufficient to cover its overhead costs. GUATESALUD's overall margins are insufficient to cover overhead, thereby producing deficits. Given this situation, expansion is not necessarily a solution to GUATESALUD's financial woes. Without a re-examination of prices, particularly in relation to their impact on volume and overhead costs, expansion could mean that GUATESALUD will lose more money as it tries to expand. The revenue stream would be enhanced by an increase, to the extent possible, in the price of medical services. It would also be increased if more medical services can be provided at higher profit margins — such as increasing the productivity of doctors by having them cover more clinics.

While management does not seem to be concerned about competition, competitors do represent a problem for marketing GUATESALUD's services. Competition comes from doctors seeking to create or expand their solo practices and from other organizations — both governmental and NGO — who deliver health services to rural populations. Another competitive threat comes from organizational providers that offer services in areas where GUATESALUD operates, such as the IGSS. In some areas of the country, dependents are eligible to receive services from IGSS, and clinic consultations and medicines are free of charge.

If GUATESALUD is to survive, Dr. Lopez, Dr. Cerezo, and committed board members need to set aside time to analyze the business and work out a short-term survival

strategy and a longer term financial plan. Without some careful analysis of how their sources of revenue are contributing to their bottom line, they stand to lose more money if they expand. If the business is to grow, much of how they presently operate will have to change. They need to develop a strategy that will help them to be more focused and organized in their approach to operating the enterprise.

ABOUT INITIATIVES

Private Initiatives for Primary Healthcare (*Initiatives*) is a project funded by the U.S. Agency for International Development (USAID) and managed through a cooperative agreement with JSI Research & Training Institute. The project promotes access to quality basic health services in developing countries by strengthening local private groups' abilities to provide basic health services. The project specifically targets low-income residents of urban and peri-urban areas.

Working in Ecuador, Guatemala, Nigeria and Ghana, *Initiatives* strengthens the financial and institutional capabilities of local provider groups. In these countries, the local groups encompass a range of service models including independent physicians and nurses, networks of providers and traditional and non-traditional insurance schemes. *Initiatives* provides technical assistance through business development workshops and individual consulting in the areas of strategic, business and financial planning, marketing assistance and capital acquisition.