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PRIVATE SECTOR HEALTHCARE SERVICES
IN ECUADOR

**A National Survey
of Private Health Facilities**

Executive Summary

Private *Initiatives* for Primary Healthcare Project



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Introduction

Expanding the provision of private sector health services is becoming a priority in many developing countries as Ministries of Health seek ways to improve the availability and quality of healthcare with limited public resources. In Ecuador, the government has expressed an interest in the area of cost recovery and in the development of private sector mechanisms to provide health services not currently offered by the public sector. On a local level, private providers are seeking ways to improve the efficiency and sustainability of their operations in light of the declining demand for their services and the rising cost of delivering quality care.

Currently, little is known about the structure and operations of private health practices, the range of services it offers, the clients it serves, and the operations and management of the numerous private facilities that serve a significant number of the country's urban population, including the poor. Examining these facilities and their major competitors - public sector health facilities - provides useful comparative data on the utilization and efficiency of the entire health sector in urban Ecuador.

To better understand the composition of the formal health sector and how such services are sustained in economically challenging times,

the *Initiatives* Project supported a survey of 300 private and public health facilities in Quito and Guayaquil. Data on public facilities and large private inpatient operations were purchased from the *Instituto Nacional de Estadística y Censos* (INEC) for the years 1984-1993. Data on small private outpatient facilities was collected between January and March 1995 through interviews with 114 physicians in private practices in Quito and Guayaquil. The survey was managed by the International Science and Technology Institute, Inc. (ISTI), Washington, D.C., under sub-contract to *Initiatives*. Data collection and entry were carried out by *Centro de Estudios de Población y Paternidad Responsable* (CEPAR), Quito. The final report was prepared by John Fiedler, Ph.D., and David P. Nelson, Ph.D.

To place the survey in a national and historical context, a longitudinal analysis of the INEC data was undertaken. In addition, a brief analysis of the private health insurance market in Ecuador was carried out based chiefly on a series of the annual reports of the government agency responsible for the regulation and oversight of the industry, the Superintendency of Banks. This analysis was supplemented with in-depth interviews held with representatives of the insurance and prepaid health service organizations. Summaries of this longitudinal analysis and the *Initiatives* survey of private and public health facilities follow.

Evolution of the Ecuadoran Healthcare System, 1984-1993

Service Delivery Performance From Progress to Stagnation

As assessed by (1) the total number of consultations provided (2) the consultation rate and (3) the coverage rate the health care system of Ecuador has made substantial progress over the course of the past decade

(1) After averaging 7.15 million consultations from 1984-1987 the total number of consultations provided jumped by nearly 20 percent before stabilizing at 8.48 million consultations in the 1990-1993 period

(2) Ecuador's consultation rate — the average number of consultations per person — increased from 1984-87 to 1989-93 from 0.78 to 0.81. Although it slipped slightly in 1992-93 the rate is only about 40 percent of the WHO standard of 2.0

(3) The coverage rate — the proportion of the population with at least one consultation — increased between 1984-87 and 1989-93 from about 38 percent to about 44 percent. In 1993 slightly less than half of Ecuadorans had at least one health care consultation

While all three of these indicators testify that the health care system of Ecuador has improved since the mid-1980s they have all been virtually constant since 1990 suggesting that progress has stalled. Moreover the levels at which they have stalled are unacceptably low

Geographic Distribution

There has also been improvement in the geographic distribution of health care in Ecuador since the mid-1980s. The annual distribution of health care services has become more equitably dispersed geographically. Although the average denizen of either Pichincha where the capital city of Quito is located or Guayas where the large port city of Guayaquil is located is much more likely to receive care and to receive more care than the average inhabitant of the other 19 provinces of Ecuador (considered together) the geographic concentration of ser-

vices is dissipating. Geographic differences in both the number of services and the consultation rate have been narrowing since 1989-90. The largest absolute and relative growth in consultations from 1984 to 1993 took place in the 19 provinces in the country other than Guayas and Pichincha.

The Private Sector and Curative Care

About two-thirds of all care provided in Ecuador is curative. In 1991-93, the Ministry of Health (MOH) provided from one-half to two-thirds of curative care, making it by far the most important source of curative care. Annually, the private sector accounts for 12 percent of curative care consultations in Ecuador. However, when the Pichincha and Guayas experiences are subtracted out of the national total, the relative significance of the private sector falls substantially: it accounts for only 9 to 10 percent of curative care consultations, compared to 12 percent for Pichincha and about 18 percent for Guayas. While Ecuador's private health sector is highly concentrated in its two largest cities, it is relatively much more important in Guayas than it is in Pichincha.

Trends in the Number and Composition of Human Resources

Between 1984 and 1992, the number of physician positions in Ecuador increased by 47 percent. Most of this increase was absorbed by the MOH and the Ecuadoran Institute of Social Security (IESS), which operates its own health facilities. Together, these institutions accounted for 58 percent of total physician positions in 1984 and 57 percent in 1992. In terms of relative growth, the private sector posted by far the largest gains, as it went from accounting for 26 percent of total physician positions in 1984 to 31 percent in 1992.

For nearly all of the physician-staffed public sector facilities, 1992 marked the zenith of an historic trend. The following year, there were widespread reductions in the numbers of physician positions in the public sector, as the sector's share of total physicians fell by 12 percent. In the meantime, the private sector continued to grow, and indeed accelerated its pace of growth in 1993.

From INEC data, it appears as though not all of the physicians who were pushed out of the public sector as a result of the downsizing of the MOH and IESS have been able to move into the private sector. In 1993, the number of physician positions in the health sector of Ecuador as a whole fell by five percent. It is more than likely, however, that many of the displaced physicians have been forced to start individual private practices (which are not surveyed by INEC and thus not included in these data) in order to continue practicing medicine.

The number of full-time equivalent physicians fell by ten percent in 1993 roughly twice as fast as the number of physician positions. This suggests that there was an increase in the number of physicians working in part-time positions. In 1993 the average physician position was a 0.64 full-time equivalent, i.e., the average physician had to have 1.57 positions in order to work full-time (40 hours per week).

Staffing ratios throughout the public health sector improved considerably from 1984 to 1993. In 1984 the nurse physician ratio was 0.27:1, roughly the reciprocal of the 4:1 ratio that is a commonly regarded standard for a level of efficiency consistent with acceptable treatment and division of labor norms (but which also depends on case mix and other, more minor considerations). By 1993, this ratio had increased to 0.41:1, substantially better but still well below the standard.

The number of physicians working in the private sector grew significantly in both absolute and relative terms over the decade under study. Private sector health care organizations are, on average, smaller and much more likely to be staffed by physicians with few support staff. The private sector's nurse physician ratio started from an even more abysmal level than that of the public sector, and had risen from 0.10 to only 0.12 by 1993. This low nurse physician ratio points to the considerable room for improving efficiency in the delivery of services — particularly if demand was adequate.

Measuring Excess Capacity and Relative Inefficiency by Subsector

An estimate of physicians' service provision capacity was developed and the percent of their capacity utilization was calculated. The results indicate that Ecuador's physicians are operating at less than one-quarter of their service provision capacity. This finding is alarming. Even if some of the assumptions made in deriving these estimates are altered fairly dramatically, the implied magnitude of inefficiency in Ecuador's health sector remains very high. It appears that the public sector in Ecuador is operating at a higher level of its service provision capacity and more efficiently than the private sector.

The MOH is operating at slightly above the entire sector's average service provision capacity utilization level, and the Ministry of Defense is the least efficient public sector entity. The least efficient private entity is the for-profit sector which appears to be operating at only two percent of its physician service provision capacity, less than one-tenth that of the health sector as a whole.

The very low use of physicians' service provision capacity characterizing the entire health sector suggests that a new strategy for trying to increase access and utilization of health care services is in order. Rather than continuing to simply increase the numbers of physicians, it would be more advisable to investigate how to improve the productivity of physicians throughout the sector.

Assessing the Magnitude of the INEC Survey Biases and Its Implications for the Health Sector Trend Analyses

In eight of the nine years between 1982 and 1990 the number of physician graduates exceeded the number of physician positions, and exceeded it by a substantial amount — nearly threefold — over the entire period. This suggests that the number of physicians who either were forced to enter a solo private practice or did not practice at all, was nearly twice the number that took positions with institutional providers. In short, the private sector and, in particular, private solo practices were the most rapidly expanding portions of the physician market during the 1980s. While the INEC data-based analysis captures this trend, it grossly underestimates its magnitude.

Another important source of data on this atomized subsector is the 1990 census, which contained several detailed questions about the characteristics of physicians' work sites. Of the total of 14,819 physicians reported in the country at that time, only 41 percent worked in the public sector while 59 percent worked in the private sector. In contrast, the INEC annual survey data for 1990 indicate that twice as large a proportion (81 percent) of physicians work in the public sector. While the INEC data reflect the fundamental trend in the changing composition of the health sector — namely the growing relative size of the private vis-a-vis the public health subsector — this finding suggests that INEC data substantially underreport the magnitude of that shift. The 1990 INEC survey captures at most 63 percent of all physicians.¹ This under-reporting of physicians results in an under-reporting of total health sector consultations as well. How much so is difficult to say, although the *Initiatives* survey of private health facilities in Quito and Guayaquil provides some insight in this regard.

According to *Initiatives* survey data, individual physician practices are by far the least productive types of health services in Ecuador. On average they annually provide 495 consultations, just seven percent of the level of the average health care provider/facility. Assuming the productivity levels of the different types of facilities are the same in 1990 as those found in the 1995 *Initiatives* survey, we can estimate that the 5,747 individual physician practices not surveyed by INEC provided (at minimum) 2.84 million consultations in 1990, and that their exclusion had resulted in an under-reporting of 33 percent of all consultations.² This means that the INEC survey reports only 14 percent of private sector consultations. If the 1990 INEC data are supple-

mented with these estimates the private sector's share of total consultations provided in Ecuador is estimated at 29 percent (compared to the INEC-only-data-based estimate of 6 percent). The various changes in the health care market that have occurred in Ecuador since 1990 (already discussed) suggest that the private sector's growth has accelerated since then. At present the private sector probably accounts for about one-third of all consultations.

Taking into account the magnitude of INEC's under-reporting of the entire health sector's performance, means that the performance measures discussed earlier are significantly understated as well. The consultation rate is closer to 1.1 rather than the 0.8 noted. In addition, depending upon trends characterizing this segment of the health care market, it may very well be that the plateauing performance of the Ecuadorian health sector as captured in INEC data since about 1990 might be exaggerated, or may not have occurred.

As already noted, it is likely that the downsizing of the public sector that has occurred since 1992 has accelerated the growth of the private sector. It has most probably resulted in a rapid proliferation in the number of individual private physician practices. Thus what appears from INEC data to have been a plateauing is more likely continued growth in the sector, but of that segment of the sector that is not included in the INEC survey. Rather than plateauing, it is likely that the most important trend characterizing Ecuador's health care system in the last few years has been a type of de facto privatization of the sector — the private sector — and particularly single physician practices — has probably been growing much more rapidly than the rest of the sector. In effect, health care is becoming increasingly privatized in Ecuador. This interpretation is also consistent with the rapid growth in private prepaid health care organizations that has occurred (especially in Quito, but other major cities as well) within the past three years.

¹ At most, only 63 percent because the census data are based on individual physicians, whereas the INEC data are based on physician positions.

² At minimum, because this assumes that all of the physicians not surveyed by INEC are only as productive as those in the outpatient facilities interviewed in the *Initiatives* survey. The *Initiatives* survey found that the average practice in this group provided a mere six percent of the number of consultations that were provided in a public outpatient facility.

THE *Initiatives* SURVEY

Methodology

The study was designed to survey 300 facilities—150 each in Guayaquil and Quito—drawn from both the public and private sectors. Field analysis of the universe of health service providers in Guayaquil and Quito revealed the existence of four ‘domains’ or distinct types of providers to be included in the sample: Domain 1—large, complex, inpatient, public hospitals (MOH, Junta de Beneficencia and Social Security); Domain 2—private hospitals and clinics providing inpatient services; Domain 3—public outpatient facilities (MOH, municipal and Social Security health centers and dispensaries); and Domain 4—private outpatient facilities (comprised principally of small practitioner offices). It was decided that each of these domains should be included in the sample. Data on public facilities and large private, inpatient operations were purchased from the *Instituto Nacional de Estadística y Censos* (INEC) for the years 1984-1993. Data on small private outpatient facilities was collected between January and March, 1995 through interviews with 114 physicians in private practices in Quito and Guayaquil.

A local research firm, the *Centro de Estudios de Población y Paternidad Responsable* (CEPAR) was contracted to conduct the field work and data entry. The draft survey instrument was based on the *Initiatives*-provided survey questionnaire. This draft instrument was translated into Spanish and modified to adapt it to conditions in Ecuador. The modified draft instrument was field-tested in Quito and appropriate changes were made to ensure clarity and compliance with the intent of the *Initiatives* study.

Findings

Characteristics of the surveyed health facilities' physical structure, equipment, and drug and medical supply inventories are examined in detail. In addition, a variety of financing and management-related practices and policies are detailed, including the types, frequency of updating, and uses of each of seven different types of information systems; the price levels of 27 drugs and 25 services; pricing policies and practices; the costs of inputs, including each of 27 drugs; revenue and

cost levels and structures the number of patients with some type of insurance and the amount of revenues derived from insurance coverage Analyses are performed on a national level as well as by domain and city Significant variations were found between domains and cities The key findings follow

Description of Facilities

Three hundred facilities were surveyed 150 in Guayaquil and 150 in Quito Ninety-five were inpatient facilities and 205 were outpatient facilities

Domain		Number in Sample	% of Total
1	large inpatient public hospitals	14	5
2	private hospitals/clinics with inpatient services	81	27
3	public outpatient health centers/dispensaries	91	30
4	private outpatient facilities	114	38
	<i>Total</i>	300	100

Over half of the facilities surveyed were described as general or family practices while 40 percent were described as specialized practices General/family practices are the predominant form in domain 3, while specialized practices comprise half or more of the facilities in domains 1 and 4 General/family and specialized practices are evenly split in domain 2

Getting Established

Since 1990 personal/family financing has partially substituted for commercial bank loan-based financing of the start-up costs of private health facilities This is likely to have been due to the historically high commercial interest rates that have existed since the late 1980s It may be that high commercial interest rates have slowed the growth of the private health sector in the last five years or more relative to what it might otherwise have been

The most frequently cited problems faced when setting up private facilities were taxes and licenses (44 percent of facilities) followed by high interest rates (29 percent) Legal or pricing restrictions were cited as problems by only 15 percent of facilities

Staffing Levels and Patterns

Public facilities are much larger than their private counterparts. As measured by the number of full-time equivalent (FTE) employees, public inpatient facilities are roughly ten times larger than their private counterparts, and public outpatient facilities (depending upon the specific measure under consideration) are from three-to-six times larger than their private counterparts. In addition, physicians constitute about twice as large a percentage of total staff FTEs in private sector facilities, both inpatient and outpatient, as in public sector facilities.

Physicians, particularly in hospitals, are commonly employed only on a part-time basis and are much more likely than other categories of staff to be part-time. Less than one-third of all physicians are employed full-time in a single facility. Domain 4 facilities consist essentially of a single physician providing care with little or no support staff.

Management-related Issues

Market research appears to play a fairly significant role in the sampled facilities. Fifty-one percent of the sample facilities reported that they had conducted some type of patient satisfaction survey in the past three years. Twenty-seven percent reported having undertaken some type of market study of patients' perception of their services. Twenty-four percent conducted a survey about the prices of other facilities in their own geographic area. Twenty-seven percent of the facilities had undertaken some type of survey about the prices charged by other facilities in their geographic area. Eighty-one percent of the facilities that reported having undertaken such a price study said that they had used the survey information to establish their own prices.

Only 69 percent of facilities have accounting systems.

The mean number of hours of service per week is 72.3 and the median is 40.0, but there is great variation by city and domain. Eighty-three percent of the inpatient facilities were reported to be open 24 hours a day, every day of the week. Outpatient domains 3 and 4 average 45 and 31 hours per week, respectively. Guayaquil-based facilities (all types) have a mean number of weekly hours of operation of 104, much higher than the 60.6 that is the mean number of hours of facilities in Quito.

Service Delivery, Physician Productivity and Capacity Utilization

Government hospitals had by far the largest attendance averaging more than 47 000 patients in 1993. These were followed by public outpatient facilities which averaged nearly 8 100 patients and by private inpatient facilities which averaged 3 770 patients during the year. In contrast the average domain 4 facility attended to about 495 persons per year a mere 6 percent of the typical public outpatient facility.

The mean productivity levels of all of the surveyed facilities is 21.5 consultations per week i.e. roughly one consultation for every two physician-hours. The level of productivity ranges from 4 to 71 patients per FTE physician per week. Physicians working in private outpatient facilities have by far the lowest productivity levels, and physicians working in public outpatient facilities have far and away the highest productivity levels. The physician productivity level of public sector facilities is more than 12 times greater than that of private sector facilities. Physicians working in public sector facilities see about 58 patients per FTE physician per week (one every 40 minutes). In sharp contrast physicians working in private sector facilities see an average of just less than five patients per FTE physician per week (one every 8 hours).

These striking findings of markedly different rates of productivity across subsectors and the private sector's poor performance are largely attributable to the extraordinarily low patient attendance levels in private facilities. Productivity is clearly demand-constrained.

An index of the potential level of physician service provision was constructed. The index reveals that the overall average capacity utilization level of the surveyed facilities is a mere 18 percent. By implication there exists a huge amount of excess capacity in each of the four domains. Indeed one may infer that Ecuadoran physicians could increase the number of consultations they provide more than five-fold. To the extent that they are representative of the health sector in Ecuador this finding suggests that Ecuador is wasting a large proportion of the most critical resource of the health sector — its physician manpower.

This finding means that most facilities are operating very inefficiently. Their fixed costs — personnel and infrastructure (the building and most equipment) must be spread over a relatively small number of consultations resulting in high average fixed costs for a consultation. With fixed costs constituting 50-60 percent of total costs high average fixed costs mean the average total costs of a consultation will be high. Hence efficiency (the reciprocal of average total cost) will be low.

The implications of this finding for private sector providers are clear. For a private provider — especially the individual physician in solo practice — the critical issue is to improve efficiency by increasing the number of patients who visit his/her facility. Most of the strategies for doing so require a strong focus on outreach and more generally making their practice structures and operations more patient/consumer oriented: more collaboration with other institutions (such as schools), more evening hours and increased attention to improving the quality of personal interactions between staff and clients, reducing prices and entering into special arrangements with other organizations and institutions to gain preferential access to pools of potential patients, such as through preferred provider-type of arrangements.

Drugs, Supplies, Dispensing, Costs and Prices

Forty-seven percent of facilities provide medicines to their clientele. Inpatient and public facilities are generally much more likely to dispense drugs and to dispense a larger number of drugs. Private outpatient units as a group are an outlier relative to the other three domains. Even when compared to its most similar domain, that of public outpatient facilities, domain 4 is strikingly different.

It appears that drug pricing strategies and policies vary enormously over the reporting surveyed facilities. Sixteen (67 percent) of the minimum price-cost spreads for the drugs are equal to zero, i.e. break-even. Half of the remainder are negative, i.e. losses are incurred and half are positive, i.e. a necessary but not sufficient condition for these sales to generate positive net revenues is fulfilled.

The unit cost-price spreads are divided by the unit cost to provide a net marginal rate of return. The simple, unweighted mean partial rate of return of the 24 drugs for which there are data is 23 percent. This does not appear to be a high rate of return, particularly when it is recalled that this calculation includes only a portion of the costs of the drug sales.

Service Prices and Pricing

The mean price of a consultation reported by 185 of the 229 respondents was 25,346 sucres. Guayaquil's mean price is 15 percent greater than Quito's, while the average consultation price for an outpatient facility is 9 percent greater than that of an inpatient facility.

The mean price of an inpatient day in a general ward (a room having three or more beds) is 28,632 sucres and the median is 25,000 sucres. The price of a semi-private accommodation (two beds) is 60 percent greater. A private room is approximately twice as expensive as a bed in a general ward. The mean price of an inpatient day in a general

ward is about 60 percent higher in Quito than it is in Guayaquil. This is an exception to what has otherwise been the consistent finding of higher prices in Guayaquil.

Forty-five percent of respondents indicated that their facilities did not charge the same price to all patients. When interviewees were asked an open-ended question about how the facility's prices are set, the most common response (66 percent of those charging for care) was that it depended upon the economic situation of the patient. The next most common explanation was that prices were set at the average of the market (17 percent of those charging for care).

Nearly half of the private inpatient facilities estimated that more than half of their clientele are poor, and almost one quarter said that the poor constitute 80 percent or more of all patients. The average (mean) estimate of all private inpatient facilities is 46 percent. The mean estimate of outpatient facilities is a markedly smaller, but still substantial 30 percent.

Guayaquil's health care services prices are, on average, 41 percent higher than those of Quito.

Operating Expenditures, Revenues, Insurance and Profits

Financial data were reported irregularly and even then only by a relatively small proportion of the surveyed facilities. In addition, the highly skewed nature of the distributions across facilities of nearly all of the various financial indicators undermines the usefulness of measures of central tendency as indicators of the typical facility. In short, the nature of the financial data makes it difficult to characterize or understand the financial aspects of the facilities beyond very small groupings.

The sum of the expenditures of the inpatient facilities is 540 million sucres, 8.7 times greater than that of the outpatient facilities, 62 million sucres. In contrast to the marked differences in the magnitude of total expenditures by the two facility groups, the differences in the composition of their expenditures is relatively modest. Expenditures on drugs and medicines constitute an almost identical proportion of total expenditures in both types of facilities. Labor costs represent about 36 percent of inpatient facility expenditures but only 29 percent of those of outpatient facilities. Moreover, on a per facility basis, this difference is dramatically increased because of the much larger expenditure level of the inpatient facilities. The labor costs of the average inpatient facility are more than ten times those of the average outpatient facility.

The monthly revenues of the 70 interviewees who provided such information ranged from zero (there were two such individuals) to 94.8

million sucres. Reflecting this broad range, the standard deviation was 14 million, nearly twice the mean income of 7.6 million.

The total revenues of the 36 inpatient facilities is 476.5 million sucres, more than eight times the 57.8 million sucres total reported by the 34 outpatient facilities. There is a high degree of concentration in the distributions of both inpatient and outpatient facilities' revenues; the single largest facility accounts for roughly 20 percent of total revenues of each of the facility groupings.

One hundred and eight respondents (47 percent) reported that some of their patients had traditional third-party indemnity health insurance that reimbursed them for medical expenditures. Surprisingly, more outpatient facilities than inpatient facilities have some type of insurance affiliation with health insurance companies as well as with prepaid systems.

Insurance affiliation is highly concentrated in Quito. Eighty-nine percent of affiliations with health insurance companies are in Quito facilities, as are 69 percent of prepaid system affiliations. This geographic focus of insurance mechanisms appears to be due in large part to the fact that historically the third-party insurance companies first developed in Quito and most have simply continued to concentrate much of their businesses in Quito, where their central offices are located. The much more recently developed prepaid systems have also been spawned in and to date continue to operate almost exclusively in Quito. Guayaquil's larger and more dynamic economy, coupled with its higher health care prices, provide both the wherewithal and the incentives for consumers to seek out and purchase some type of health insurance. Guayaquil would appear, therefore, to be an opportune site for the development of a prepaid system or a preferred provider network.

Fifty-four percent of the health facilities reporting financial data appear to have generated a profit in the month preceding the interview. The mean level of profits for all facilities was 850,000 sucres. This average was greatly affected by a single facility (an inpatient facility in Guayaquil) which was reported to have lost 29,500,000 sucres that month. The Guayaquil market, with its higher costs and higher prices, also appears to be a riskier environment in which to operate. Thirty-one percent of the facilities operating in Guayaquil had negative profits, compared to just seven percent in Quito. The inpatient facilities interviewed were also more likely to be experiencing financial difficulties. Twenty-six percent of inpatient facilities, compared to 15 percent of outpatient facilities, reported operating losses in the preceding month.

Summary

The combined findings of the *Initiatives* survey and the analyses of the INEC data provide a detailed description of the health sector in Ecuador highlighting important issues concerning client utilization existing management practices profitability and the general efficiency of public and private operations

Disaggregation of the private and public sector data however revealed some surprising findings concerning the size services provided by and over-all efficiency of the private sector While private facilities offer both preventive and curative care and serve a significant number of poor clients relative to their entire client base low patient levels seriously compromise facility efficiency and threaten their long-term sustainability The importance of developing more client-oriented practices reorganizing the private sector from solo to more efficient group practices, and expanding insurance affiliations to urban centers beyond Quito are suggested as ways to improve the viability of private health care in Ecuador

About *Initiatives*...

Private Initiatives for Primary Healthcare (Initiatives), is a demonstration project funded by USAID and managed by the JSI Research & Training Institute. It was designed to test different models of sustainable private sector basic health service delivery systems, and to support local USAID missions' participation in health sector reform efforts. Focusing on Ghana, Nigeria, Ecuador and Guatemala, *Initiatives* provides technical assistance to support the development of local initiative groups (LIGs), which represent different models of private sector healthcare. Technical assistance is also provided to support the development of local management groups (LMGs), which could serve health care providers as a local source of technical assistance in the long term. Documentation and analysis of the experience of these *Initiatives* supported organizations will yield insights into the prerequisites for financially sustainable private basic health services, and will contribute to our understanding of the conditions necessary to establish, maintain, and expand the availability and accessibility of quality healthcare to low income urban populations.

For a copy of the full report of this survey or for more information about *Initiatives*, please contact

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