

**MIDTERM EVALUATION OF THE
SELF-FINANCING PRIMARY
HEALTH CARE II PROJECT
(PROSALUD)
(511-0607)**

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by

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ABBREVIATIONS

ADN-MIR	Accion Democrata Nacional/Movimiento de la Izquierda Revolucionario
CAIS	Health Information Analysis Committee
EOPS	end of project status
FIS	Fondo de Inversion Social (Social Investment Fund)
GOB	government of Bolivia
MCH	maternal and child health
MNR	Movimiento Nacional Revolucionario
MOH	Ministry of Health
MSU	management support unit
NSH	National Secretariat of Health
PHC	primary health care
POPTECH	Population Technical Assistance Project
PROA	Pro-El Alto
PROISS	Programa de Intergracion de Sistemas de Salud (Integrated Health Care Systems Project)
PVO	private voluntary organization
SNIS	National Health Information System
SOMARC	Social Marketing for Change Project
SOW	scope of work
SRS	Secretaria Regional de Salud
UDP	Union Democrata Popular
USAID	United States Agency for International Development

EXECUTIVE SUMMARY

Background

USAID/Bolivia requested that POPTECH conduct an evaluation of the Self-financing Primary Health Care II/PROSALUD Project. The evaluation was conducted in Bolivia between March 19 and April 5, 1995. Additional analysis of documents and data and writing was carried out through the first week of May 1995 in the United States. The team consisted of John L. Fiedler, Ph.D., a health economist and financial expert, and Lee R. Hougen, Dr.P.H., a health management and primary care expert.

The Scope of Work, prepared by USAID/BOLIVIA, called for the evaluators to undertake the following:

1. Review the stated purposes of the project.
2. Assess progress toward outputs.
3. Identify constraints to project implementation.
4. Identify lessons learned.
5. Assess progress toward sustainability.
6. Make recommendations for adjustments in project design and the implementation strategies.

Project Goal and Outputs

The overall goal of the Self-Financing Primary Health Care II Project is to improve the health status of low-income urban and peri-urban areas of Bolivia.

The major outputs of the project are the following:

1. The establishment of PROSALUD systems for a private sector, cost-recoverable, primary health care network in El Alto and La Paz.
2. The establishment of reference hospital services in Santa Cruz and El Alto (if deemed appropriate).
3. The creation of a PROSALUD National Board of Directors to plan and develop the expansion of the PROSALUD model in other Departments of Bolivia.
4. Increased demand and participation by community members for the provision of health care services in the project areas of El Alto, La Paz, and Santa Cruz.

History

The Self-Financing Primary Health Care Project was initiated in Santa Cruz, Bolivia in 1983 with support from the United States Agency for International Development (USAID). The original intent was to establish a network of primary health care clinics to serve three

cooperatives located in and near the city of Santa Cruz. The original project design underwent major revisions in its first two years, eventually evolving into a network of community-sponsored health centers, directed by a management support unit (MSU). A fundamentally important element of the original project, which was not altered and which plays an important role in shaping the organization's philosophy and behavior, is the goal of self-financing; i.e., recovering 100 percent of its costs. PROSALUD, as this evaluation will point out, is unique among primary care providers in that it provides high-quality/low-cost care to underserved and low-income populations and recovers a high percentage of its costs.

In 1985, the PROSALUD network numbered three rural health posts, two rural health centers, and three urban health centers. By 1990, at the end of the first Self-Financing Primary Health Care Project, the organization had added seven additional urban health centers, provided health care coverage to a population of 90,000, and provided more than 80,000 services (encounters with clients). In 1991, the organization embarked on a new five-year USAID project designed to replicate the Santa Cruz experience-based model in the La Paz/EI Alto area and add a referral hospital to the Santa Cruz network. By the end of the first quarter of 1995, the La Paz/EI Alto regional office of PROSALUD had developed a network of nine health centers that provide coverage to a population of 127,350 and had provided (in 1994) 217,536 services (two-thirds of them preventive services provided free of charge).

In addition to its 22 clinics, PROSALUD consists of a 25-bed referral hospital in Santa Cruz; two regional offices (MSUs), one in Santa Cruz and one in La Paz, each in charge of the day-to-day operations of its clinic network; and a National Office, located in Santa Cruz that oversees all operations. In addition, PROSALUD has a National Board of Directors, comprised of prominent civic and business leaders of Santa Cruz.

Today, the nationwide PROSALUD system, with 269 employees and 49 risk-sharing adjunct staff, provides health care to a service population of nearly a quarter million persons (nearly four percent of the population of Bolivia). In 1994, the national system provided a total of 442,108 services in its Santa Cruz, EI Alto, and La Paz-based facilities. The volume and composition of the services presented by each regional office and the national totals are presented in Table 1. In 1994, PROSALUD's health centers nationwide were recovering 68 percent of their direct costs and 33 percent of the sum of the costs of operating these facilities and the two regional MSUs (exclusive of the PROSALUD/Santa Cruz hospital and the National Executive Director's salary).

As detailed in the chronology of events presented in Appendix B, the project is behind schedule for establishing the network of facilities in La Paz/EI Alto. Instead of the planned 19 facilities on-line or nearing completion by the second quarter of 1995, the project has only nine facilities currently operating, with another four health centers under construction and scheduled to begin delivering services in June 1995.

TABLE 1

Insert

The delay in establishing the full network of health centers has seriously affected the financial performance of the PROSALUD/La Paz network. In the first quarter of 1995, only 61 percent of the nine clinics' service delivery costs, excluding the La Paz MSU, had been recouped. It is highly unlikely that the network will be able to raise this level of cost recuperation to the end-of-project goal of 100 percent by May 1996 when the current project is scheduled to terminate.

Project Design and Evolution

The project design had two major shortcomings:

1. Essential inputs were made exogenous to the project. The health centers that were to form the PROSALUD/La Paz network were to be provided by third parties that were outside of the control of the grantee. Project implementation delays were due in large part to PROSALUD/La Paz receiving its infrastructure substantially later than had been planned. Moreover, PROSALUD had little say in the selection of the specific clinic sites.
2. Selection of El Alto as the major PHC delivery site jeopardizes the cost-recovery goal of the project.

The El Alto experience has not been difficult simply because of poverty. El Alto has also meant reaching clients with different preferences and demands, resulting in different revenue structures, service mix, and cost structures, all of which together required a variety of modifications in the original model developed in Santa Cruz.

The project design has evolved over time and continues to evolve in an effort to overcome the limitations that have resulted from these two design shortcomings. Most significantly, (1) project funds are being used to construct health centers and (2) these centers are being constructed on new, more promising locations in La Paz. The current strategy calls for opening up more clinics in mid-1995. Three of these clinics will be in more affluent neighborhoods of La Paz enabling the cross-subsidization of the relatively poorly performing, high-risk sites in El Alto. This is wise, but will not be enough. Consideration and support should also be given to establishing other well-situated health centers in order to offset the major liability that the El Alto site represents for achieving the project's self-financing goals. Alternatively, or perhaps simultaneously, the self-financing goals of the project need to be more realistically reconciled with the project site that was, for the most part, dictated to PROSALUD.

Another flaw of the project design is that it overlooks the importance of the impact that PROSALUD has had through the market on (1) the price of care charged by other, especially private, for-profit providers and (2) the practice patterns of all other providers—but most notably public and non-profit providers. Not having considered these indirect effects on the health care market of La Paz/El Alto and Santa Cruz and on the national market, the project has not attempted to identify or measure (let alone maximize) these impacts, possibly the most important and enduring effects of the project.

PROSALUD's Level and Composition of Services

PROSALUD began providing services in its seven El Alto health centers in January 1992. Although the level of the clinic network's service delivery has been decisively upward, the total number of services has stagnated around 55,000 for the past year and a half (quarter 3, 1993 through quarter 4, 1994), which is not necessarily attributed to PROSALUD. The El Alto site of the project has proven to be much more challenging than had been anticipated.

In 1991, El Alto was clearly underserved in terms of health care. Having high rates of infant and maternal mortality, USAID considered it a community in need of a primary health care (PHC) program. Thus, it appears that the need for the project to deliver services to an underserved area was put on the same level of concern as the project's need to become self-financing, or to, at least, exhibit a high degree of cost recovery.

Since its inception, each year roughly 70 percent of all care provided by the PROSALUD/La Paz network has been preventive (*vis-à-vis* curative) in nature. PROSALUD provides all preventive care free-of-charge. Sixty-five percent of preventive services have been vaccinations, the supplies for which (vaccines and syringes) PROSALUD has received from the National Secretariat of Health (NSH). Erratic NSH supplies have been the principal cause of the stagnating PROSALUD total service provision record in the past year. When vaccinations are subtracted, the service provision performance of PROSALUD follows a much more pronounced upward trend. Curative care consultations, the base of PROSALUD's cost recovery efforts, grew by 90 percent between 1992 and 1993 and by 25 percent from 1993 to 1994.

The pace of expansion in the volume of services delivered by PROSALUD has been slower than anticipated. In part, this has been due to the slow start of the project. Not only did PROSALUD have relatively little say in which communities its clinics would be located, but furthermore, nearly all of PROSALUD's current delivery sites were assigned to it by either the NSH or the municipal governments.

In addition, there has been rapid growth in the number of other providers in PROSALUD/La Paz's market, especially in El Alto, constituting competition for PROSALUD. In 1993, PROSALUD accounted for 35 percent of all of the outpatient consultations provided throughout the El Alto and La Paz health districts.¹ In 1994, despite the fact that PROSALUD clinics' posted a major increase in the number of outpatient consultations provided—expanding by 40 percent—PROSALUD's share in these combined markets fell to 29 percent. The vast majority of the expansion in the size of the market occurred in the El Alto area.

Despite increasing numbers of providers in La Paz/El Alto, PROSALUD remains one of the principal providers of family planning and women's reproductive health services in the region.

¹ Note: These data are not for all services but only outpatient consultations, as this is the only indicator for which comparable data for the entire sector is available.

Among the 12 non-vaccination services provided by PROSALUD/La Paz clinics, the fastest growing have been deliveries and family planning services. Births in PROSALUD/La Paz grew more than 11-fold between quarter 1, 1992 and quarter 4, 1994. Family planning services, which were first offered at PROSALUD clinics in La Paz in quarter 3, 1992, grew just under 11-fold from that time to quarter 4, 1994.

In 1993 PROSALUD clinics serviced 95 percent of the new users of family planning methods in the El Alto and La Paz health districts. In 1994, PROSALUD clinics increased the number of new family planning users they served in El Alto and La Paz by 159 percent.

The fact that increasing numbers of women in El Alto have been delivering their babies in PROSALUD clinics is significant for several reasons. First, the proportion of women which has historically had institutional births in El Alto has been very low. PROSALUD is helping to change long held, high-risk patterns of behavior. Second, this change reflects the growing confidence and trust with which the community holds PROSALUD.

Service delivery statistics show that PROSALUD is much more maternal and child health- (MCH-) oriented than the other providers operating in El Alto and La Paz health districts, including the NSH. The PROSALUD clinics provided 42 percent of all the outpatient consultations that were provided to children under age five in 1993 and 38 percent of the 1994 total.

In terms of women's health care, PROSALUD's preeminent position in the market is again evident. PROSALUD staff attended half of the 1,790 births in the La Paz/El Alto health districts, a disproportionately large number given PROSALUD's share of outpatient visits or its share of the total number of facilities in the two districts.

Progress Toward Self-financing

The PROSALUD/La Paz clinic network's cost recovery performance peaked at 65 percent in the second quarter of 1993, and thereafter slid downward each quarter until bottoming out at 48 percent in quarter 2, 1994. Since then it has recovered and has now stabilized at roughly 60 percent.

PROSALUD is substantially behind in its efforts to achieve self-financing because of (1) the delays and non-compliance of other actors with their agreements with PROSALUD and providing PROSALUD with facilities in a timely manner, (2) the rapid growth of the non-PROSALUD health care infrastructure in La Paz/El Alto, and (3) the very different circumstances of the La Paz/El Alto area compared to Santa Cruz. Even under the most propitious of circumstances, it is highly unlikely that the La Paz regional office clinic network will be able to achieve its end of project goal of 100 percent self-financing (exclusive of the MSU) by May 1996.

Trading off Revenue Generation/Cost Recovery for Other Public Health and Social Goals

PROSALUD has made a very conscious and deliberate decision to trade off revenue generation/cost recovery in order to better achieve other goals. To promote what PROSALUD regards as a more socially desirable mix of services, it provides preventive care free-of-charge. To promote greater continuity and a higher quality of health care, it does not charge for follow-up visits. Two-thirds of the services provided by PROSALUD/La Paz are preventive services and 35 percent of curative care visits are follow-up visits. Hence, more than 75 percent of the services provided by PROSALUD are free-of-charge.

Financial Performance of PROSALUD/La Paz: Variation in the PROSALUD Model Required by the Different Socioeconomic Conditions of La Paz/EI Alto

Lower Prices. The average price of most services is substantially higher in the Santa Cruz PROSALUD network than in that of La Paz. For example, the price of a general medical consultation ranges from 10 to 12 Bolivianos in the Santa Cruz health centers, whereas its modal price in La Paz/EI Alto is only 5 Bolivianos (this level was made effective March 1, 1995). This significant price difference means that a medical consultation in La Paz/EI Alto generates at most about half the gross revenue of a consultation provided in Santa Cruz.²

Even though the physicians of the PROSALUD/La Paz clinics have productivity levels that are about 85 percent of those of the PROSALUD/Santa Cruz physicians, they (directly) generate less than 40 percent of the gross revenue compared to their Santa Cruz counterparts.

- (1) General Inability to Implement Fee-splitting/Risk-sharing Arrangement in La Paz/EI Alto. The low price of consultations, coupled with the lower volume of curative care consultations, precludes being able to rely as extensively on the risk-sharing arrangement that has been such an important generator of net revenues in the Santa Cruz experience. Under this arrangement, specialty physicians (gynecologists and pediatricians) and dentists are not paid directly by PROSALUD. Instead, in return for the right to practice in a PROSALUD facility, they agree to split their fee-based revenues with PROSALUD (50-50 and 80-20, respectively). The general non-viability of the fee-splitting arrangement in La Paz/EI Alto results in lower net revenues due primarily to higher personnel costs.
- (2) Less Free Care is Provided in La Paz/EI Alto. A special, sample-based study conducted as part of this evaluation found that in June 1993, 97 percent of all patients paid the full regular price of care for which there was a charge, and that in June 1994, this proportion edged up to 99 percent. In light of the abject poverty characterizing the bulk of the catchment areas of the PROSALUD La Paz/EI Alto health centers, one cannot help wondering if PROSALUD is not being pushed too hard, and too fast to achieve 100 percent self-financing by May 1996, at the

² One Boliviano equaled 0.21 US dollars in March 1995, and there has been little inflation in the past year.

expense of providing access to care. This is also the perception of various prominent actors in the health sector.

Efforts to Reduce the Major Element of Costs: Personnel. One of the hallmarks of the PROSALUD model has long been its ability to minimize personnel costs by (1) paring down staffing patterns to what must be regarded as "bare-bones" minimum numbers, (2) substituting multi-function positions for those more traditional and unnecessarily specialized, and (3) entering into risk-sharing/fee-splitting arrangements with specialty physicians and dentists. PROSALUD/La Paz has found two additional measures to further lower its costs: (1) reducing the level of physicians' salaries to make them the equivalent of those paid by the NSH (in 1990 they were 25 percent greater) and (2) eliminating the incentive system in 1993 (based on a type of fee-sharing rebate of revenues collected when a health center's performance goals were exceeded) and replacing it with a fee-sharing arrangement for providing emergency services which effectively increases the hours of operation of PROSALUD clinics at no cost to the organization.

MSU Costs, Start-up Costs, and PROSALUD/La Paz's Level of Total Cost Recovery

The costs of operating the La Paz MSU are substantial, more than twice as much as the costs of operating the nine health centers. Thus when the MSU costs are included in the cost recovery performance measure, the level of self-financing of PROSALUD/La Paz falls precipitously. Whereas 55 percent of the clinics' expenditures were recovered in 1994, only 17 percent of the **total** costs of the La Paz operations were recovered.

The MSU proportion of total costs, however, has been falling. This is a positive development and one that should continue throughout the next few years. It is reflective of what should be considered a normal pattern of start-up costs, owing to the substantial number of one-time or limited activities as the MSU sets up the regional office and its clinic network.

The size of the La Paz MSU appears to be in direct response to the tasks it performs together with the PROSALUD National Office to meet demands placed on the organization by USAID reporting, documentation, and accounting requirements. Donor coordination, community relations, and working with the NSH are big consumers of staff time. Carrying out these functions are, in most cases, clearly routine for the MSU and is the rationale for the MSU's existence; however, hosting visitors, contributing to grant applications, managing complementary grants, and responding to opportunities for program expansion make a well-staffed MSU essential at this point in time.

Furthermore, the selection of El Alto as the site for the first seven health centers out of the nine clinics in operation to date, and the difficulties that PROSALUD has had in obtaining its complement of health centers has made the structural limitations of the original project design self-evident. PROSALUD's response has been to search for new methods and activities—beyond those contained in the project paper—to enable it to achieve a higher level of self-financing. As a result of this still unfolding re-strategizing and redesigning of the project, PROSALUD/La Paz's MSU remains disproportionately large and overly expensive because it has yet to enter a consolidation phase.

Given that MSU costs still constitute 70 percent of total operating costs, it is imperative that they become the focus of attention in the development of a new, longer-term financing strategy to increase the level of cost recovery of the PROSALUD/La Paz network. It is essential to spread the MSU costs over a larger number of facilities and/or other activities, thereby enhancing the sustainability of the entire PROSALUD organization. These activities may include the development of additional health centers, but there are other activities that PROSALUD could pursue as well.

The Santa Cruz Network's Performance

The 1991-1994 period was generally marked by continued improvement in the service delivery performance of the Santa Cruz clinic network. Its level of self-financing, however, has decreased. Disaggregated analysis of the sources of revenue reveals that the "projects assistance" revenue line item has accounted for a critically important 20-30 percent of total PROSALUD/Santa Cruz gross revenues between 1991 and 1994. In 1994, when the revenues from this source fell by 410,000 Bolivianos, the combined revenues garnered from all other sources of revenues increased but could not completely offset the drop of this single category. As a result, PROSALUD/Santa Cruz's level of self-financing fell from 94 to 75 percent excluding MSU costs, and from 67 to 55 percent, inclusive of MSU costs. PROSALUD/Santa Cruz is not likely to achieve its end of project goal of 100 percent self-financing, inclusive of MSU expenditures. (If the hospital is included in the calculations, the 75 percent figure falls to 62 percent.)

The magnitude and variability of the "projects assistance" revenue source suggest that PROSALUD/Santa Cruz's financial performance has been less stable than apparent at first glance and thus is a cause for concern. About half of the revenues in this line item were earned from the technical assistance the Santa Cruz regional office provided to the La Paz regional office during its development. The other half of these revenues were earned by Santa Cruz office personnel providing other national and international technical assistance services. With the revenues received for assisting in the La Paz replication drying up, PROSALUD/Santa Cruz needs to pursue the development of additional and preferably more stable sources of revenues.

The Cost Recovery Performance of the National PROSALUD System

Graph 1 presents the cost recovery performance of the two regional offices and of the national PROSALUD system. In 1993, PROSALUD recovered 84 percent of its clinics' expenditures and 40 percent of total expenditures (i.e., those of its clinics and MSUs, but exclusive of the hospital). In 1994, these percentages fell to 68 and 33 percent, respectively. The drop in PROSALUD's performance in 1994—by both measures—is due to the slipping performances of both regional offices.

GRAPH 1

insert

Which Way Out? More Compromises or More Health Centers and Other New Product Lines/Activities?

It is obvious that PROSALUD could choose to strike trade-offs in a more self-serving manner than it has chosen to do to date. If it did so, there would be little question but that it would be successful and sustainable. Doing so, however, would entail altering the terms of the compromises it currently strikes:

- Between maintaining access to care and raising its prices to some level above their current very low, near-NSH-equivalent levels.
- Between providing free preventive and follow-up care, a socially responsible and desirable mix of services, and redirecting the focus of its services to curative care.
- Between maintaining commitments to the neighborhoods and communities it currently serves and eliminating the less productive clinics which are a net drain on the system.

Indeed, PROSALUD has already been forced to strike these trade-offs in La Paz/EI Alto operations. The alternative to further compromising its philosophy and general model is for PROSALUD to develop new means of generating net revenues. The opening of three more clinics in mid-1995 in more affluent neighborhoods of La Paz will contribute to the cross-subsidization of the relatively poorly performing, high-risks sites but will probably not be enough. Consideration and support should be given to establishing other well-situated health centers in order to try to offset the major liability that the EI Alto site constitutes for achieving the project's self-financing goals. The Santa Cruz system could consider the same strategy.

Fortunately, the decentralization initiative of the government of Bolivia and the recent rapid growth in municipal government-sponsored health systems is creating an ideal situation replete with opportunities for PROSALUD to spread its overhead costs and increase the efficiency of its MSUs and National Office. While it is not yet clear what shape the national reform will take, there is already considerable demand from mayors for PROSALUD services. Plans have already been developed to extend the current project to support PROSALUD in at least the early stages of this endeavor, specifically in Tarija and Riberalta. The evaluation team heartily endorses this extension.

Conclusions and Recommendations

PROSALUD is a patient-focused, primary health care-centered delivery system distinguished by its unique capability to provide a high volume of high-quality services with high levels of efficiency, self-financing, and patient satisfaction. The two foremost critical elements of PROSALUD's well-documented and institutionalized management system are its development and reliance upon a data-driven, monitoring, evaluation, and planning system and its personnel recruitment criteria and process.

At all levels of the organization there is a high level of understanding and appreciation of the very close relationship between service delivery and financial performance. The PROSALUD monitoring, evaluation, and planning system emphasizes and makes transparent the relationship between service delivery and financial performance. The organization's reliance on such a system and the way in which PROSALUD has made monitoring, evaluation, and planning participatory processes through a series of public meetings has nurtured a level of consciousness about the business aspects of health care that are conspicuously lacking in other systems—be they in the Third World or the First World.

First developed in Santa Cruz, the PROSALUD model has been successfully replicated in La Paz/EI Alto. However, the financial performance of both regional offices has not yet achieved the expected levels, and it is unlikely that they will achieve their end of project goals of 100 percent self-financing, exclusive of the MSU in the case of La Paz and inclusive of the MSU in the case of Santa Cruz, by May 1996. Given that this shortfall has been due to a constellation of extenuating circumstances—the most significant being outside of the direct control of PROSALUD—the project, to date, must be regarded as a success.

In the opinion of the evaluation team, the end of project status (EOPS) is fundamentally flawed and the degree of self-financing should not be the singular yardstick used to assess PROSALUD's performance. The end of project status focuses far too narrowly on the financial aspects of PROSALUD operations. Yet, clearly, self-financing is not the goal.

PROSALUD is having an ever-growing impact on the entire health sector of Bolivia by virtue of its providing a best-practice model of a well-managed, consumer-focused provider of high-quality care elements. Health care providers throughout Bolivia are emulating this model in increasing numbers.

PROSALUD is currently at a critical juncture. The financial performance of PROSALUD/La Paz has been lagging and only now, with the opening of the three new health centers in La Paz, is it starting to enter a phase in which it will be much better positioned to begin to substantially improve its service delivery and its cost recovery performances. Moreover, the National Office is launching its first major undertaking, with the relatively modestly sized replication efforts in Tarija and Riberalta. USAID should extend the current project to ensure the adequate support of the organization as it passes through these critical next phases.

Other recommendations for USAID/Bolivia and PROSALUD include the following:

1. PROSALUD should not undertake the development of a referral hospital as part of the La Paz regional office network (a detailed, seven-point justification for this recommendation is provided in the main body of the report). Instead it should pursue discussions with representatives of hospitals in the La Paz/EI Alto area to establish a formal referral system agreement. The PROSALUD/Santa Cruz Hospital (which has been working on the development of such a system for the past year) should be involved in this process.

2. By virtue of the knowledge and credibility it brings to the effort (due to its recent experience) the La Paz regional office MSU staff should be involved in the replication efforts in Tarija and Riberalta.
3. Support should be provided to PROSALUD for opening one or more clinics (in addition to those currently planned) in relatively affluent neighborhoods of La Paz.
4. The indirect effects of PROSALUD—its competitive impact and its demonstration effect—should be identified and, to the extent possible, quantified.
5. To aid it in its effort to identify additional net revenue-generating activities over which to spread its MSUs and National Office fixed overhead costs, technical assistance should be provided to PROSALUD to conduct pre-feasibility analyses for (a) the development of preferred provider organizations and (b) the development of capitated systems. PROSALUD should also begin exploratory discussions with (a) the private health insurance industry to investigate the possibility of developing a joint venture to establish a special provider-based plan (e.g., prepaid or preferred provider organization) that could be marketed like a traditional third party indemnity plan to clients of lower socioeconomic strata and (b) some of the social security systems to investigate the possibility of selling them services.
6. PROSALUD should ensure that its new accounting system (currently being developed with technical assistance) establishes each of PROSALUD's major health care service activities as a cost center such that the system will be capable of identifying the level of net revenues generated by of each major activity.
7. PROSALUD should establish a formal process (market analyses) whereby it identifies and monitors the characteristics of all other providers in and around its health centers' catchment areas. These provider profiles should include information about the number and types of physical, personnel, and financial resources, the prices of services, the hours of service, types of equipment available, and types of services provided.
8. PROSALUD should address the shortcomings identified in the report, which include developing a National Board; developing a replication strategy (in addition to the replication plan); and developing franchising guidelines.

FINAL CONCLUSIONS AND RECOMMENDATIONS

PROSALUD is a patient-focused, primary health care-centered delivery system distinguished by its unique capability to provide a large volume of high-quality services with high levels of efficiency, self-financing, and patient satisfaction. The two foremost critical elements of PROSALUD's well documented and institutionalized management system are its development and reliance upon a data-driven, monitoring, evaluation, and planning system and its personnel recruitment criteria and process.

First developed in Santa Cruz, the PROSALUD model has been successfully replicated in La Paz/EI Alto. However, the financial performance of both regional offices has not yet achieved the levels that had been hoped for, and it is unlikely that they will achieve their end of project goals of 100 percent self-financing, exclusive of the MSU in the case of La Paz and inclusive of the MSU in the case of Santa Cruz, by March 1996. Given that this shortfall has been due to a constellation of extenuating circumstances—the most significant being outside of the direct control of PROSALUD—the project, to date, must be regarded as a success. PROSALUD is currently at a critical juncture. The financial performance of PROSALUD/La Paz has been lagging and only presently, with the opening of three new health centers in La Paz, is it entering a phase in which it is much better positioned to substantially improve its cost-recovery performance. Moreover, the National Office is launching its first major undertaking with the relatively modestly-sized replication efforts in Tarija and Riberalta. USAID should extend the current project to ensure the adequate support of the organization as it passes through these critical next phases.

Additional recommendations for USAID/Bolivia and PROSALUD include the following:

1. PROSALUD should not undertake the development of a referral hospital as part of the La Paz regional office network (a detailed, seven-point justification for this recommendation is provided in Chapter 5). Instead it should pursue discussions with representatives of hospitals in the La Paz/EI Alto area to establish a formal referral system agreement. The PROSALUD/Santa Cruz hospital (which has been working on the development of such a system for the past year) should be involved in this process.
2. By virtue of the knowledge and credibility it brings to the effort the La Paz regional office MSU staff should be involved in the replication efforts in Tarija and Riberalta.
3. In order to give greater national prominence to PROSALUD and its indirect effects, while providing additional sites for PROSALUD/La Paz that will prove capable of generating net revenues that can cross-subsidize some of the poorer clinic sites in EI Alto, support should be provided to PROSALUD for opening one or more clinics (additional to those currently planned) in relatively affluent neighborhoods of La Paz.

4. The indirect effects of PROSALUD—its competitive impact and its demonstration effect—should be identified, and to the extent possible, quantified.
5. To aid it in its effort to identify additional net revenue-generating activities over which to spread its MSU and National Office fixed overhead costs, technical assistance should be provided to PROSALUD to conduct pre-feasibility analyses for PROSALUD's to pursue the development of preferred provider organizations and the development of capitated systems. PROSALUD should also begin exploratory discussions with (a) the private health insurance industry to investigate the possibility of developing a joint venture to establish a special provider-based plan (e.g., prepaid or preferred provider organization) that could be marketed like a traditional third party indemnity plan to clients of lower socioeconomic strata, and (b) some of the social security systems to investigate the possibility of selling these services.
6. PROSALUD should ensure that its new accounting system (currently being developed with technical assistance) establishes each of PROSALUD's major health care service activities as a cost center in order for the system to identify the level of net revenues generated by of each major activity. By the same token, PROSALUD should begin development of a cost-based rate of service delivery or per capita fee for specified services to prepare for negotiations with municipalities and other potential funding sources.
7. PROSALUD should establish a formal process whereby it identifies and monitors the characteristics of all other providers in and around its health centers' catchment areas. These provider profiles should include information about the number and types of physical, personnel, and financial resources; prices of services; hours of service; types of equipment available; and types of services provided.

PROSALUD should address the shortcomings identified in the report which include developing a National Board; developing a replication strategy (in addition to the replication plan); and developing franchising guidelines.

1 SCOPE OF WORK

The Scope of Work for the Self-financing Primary Health Care II/PROSALUD Project evaluation was prepared by USAID/Bolivia and directed the evaluators to review and comment on the following topics:

1. Review stated purposes of the project.
2. Asses progress toward outputs.
3. Identify constraints to project implementation.
4. Identify lessons learned.
5. Asses progress toward sustainability.
6. Make recommendations for adjustments in project design and the implementation of different strategies to achieve project goals, if appropriate.

The full Scope of Work (SOW), presented in Appendix A, was detailed and extensive presupposing that three persons would conduct the evaluation in roughly two and one-half weeks. Because of limited funding, only two persons were contracted for the evaluation and neither the SOW nor the amount of time granted for the evaluation were changed, causing the Mission evaluation officer to propose a modification of the SOW at the last minute to concentrate on the issues most important to the Mission. The evaluation team did, nevertheless, attempt to address the main issues in the original SOW.

2 TEAM AND EVALUATION METHODOLOGY

The evaluation was conducted between March 20 and April 4, 1995, in the cities of Santa Cruz, La Paz, and El Alto, Bolivia. The team consisted of John L. Fiedler, PhD, an economist and financial expert, and Lee R. Hougen, DrPH, a health management and primary care expert. Dr. Fiedler participated in the final evaluation of the Self-financing Primary Health Care Project (511-0569), which took place September/October 1988. Dr. Hougen served as the chief of the Health and Human Resources Division of USAID/Bolivia between August 1979 and July 1984, during which time he participated in the design of the original Self-financing Primary Health Care Project; however, he was no longer in-country when the project was substantially redesigned nor when PROSALUD, the grantee of the current project, was formed. By having background knowledge of the current project and health care in general in Bolivia, the evaluators were able to maximize their time in completing the SOW.

In preparation for the evaluation, team members read background documents related to the project, including former evaluations, market studies, and progress reports. A list of these documents is contained in the bibliography (see Appendix I). Contacts were made with other consultants and USAID/Washington staff familiar with the project. USAID/Bolivia and PROSALUD staff sent to each evaluator updated information on the status of the project as well as new Bolivian laws that established new opportunities for PROSALUD in the health sector.

Once in-country, initial briefings were held with the USAID Mission in La Paz. Subsequently, individual and group meetings were held with PROSALUD staff of the newly created National Office in Santa Cruz, the Management Support Unit (MSU) staff in Santa Cruz and the MSU staff in La Paz. Several PROSALUD health centers were visited in La Paz and Santa Cruz, including the Reference Hospital in Santa Cruz. To gain information from persons not affiliated with PROSALUD, interviews were held with the USAID current and former project officers and with the regional secretaries of three Regional Secretariats of Health (formerly Unidades Sanitarias of the MOH) in La Paz, El Alto, and Santa Cruz. Likewise, the presidents of the National and local Colegio Medico in La Paz and Santa Cruz were interviewed for their view on the impact of PROSALUD's work on the private providers in the health sector. In the closing days of the in-country work, the team met with the sub-secretary of the National Secretariat of Health, Dr. Javier Torres Goitia, hijo. (See Appendix H for a complete list of contacts.)

Debriefings to share the team's initial findings were held with PROSALUD staff in Santa Cruz and La Paz, followed by two debriefings with USAID, with the staff of the Health and Human Resources Division, and at a Mission-wide presentation with members of PROSALUD present.

3 BACKGROUND

3.1 Project Goal, Purpose, and End of Project Status

The project goal is to improve the health status of populations within the poor urban and peri-urban areas of Bolivia, with particular emphasis on reducing maternal, infant (0-1 years) and child (1-5 years) mortality rates within the project area.

To accomplish this goal, the project purpose is to improve the access, quality, coverage, and sustainability of health care services by (1) replicating the PROSALUD model in the project area of El Alto and La Paz, and (2) by expanding the PROSALUD Santa Cruz system by, among other things, establishing a referral hospital.

3.2 End of Project Status

- The PROSALUD primary health care system in Santa Cruz will be successfully replicated in selected areas of La Paz and El Alto and strengthened and expanded in project areas of Santa Cruz; approximately 160,000 people in La Paz and El Alto and 180,000 people in Santa Cruz will have access to the health care services of improved quality and broader coverage.
- PROSALUD in La Paz/El Alto will cover 100 percent of its operational costs, excluding the cost of the management support unit (MSU).
- PROSALUD in Santa Cruz will recover 100 percent of all costs, including its MSU.
- PROSALUD La Paz/El Alto will be fully established as a viable institution (i.e., the MSU and the primary health care network are operational and meeting the health care needs of the project's target population).

3.3 Chronology of Events

The current project builds upon and extends the accomplishments achieved in the Self-financing Health Care Project (511-0569) that concluded in May 1991, with PROSALUD providing primary health care in the peri-urban areas of Santa Cruz through a network of 15 health facilities (health centers and rural health posts), 90 service delivery staff persons, and a MSU of 19 persons involved in management and quality control operations.

The chronology of the project is presented in Appendix B.

3.4 Project Design and Evolution

As seen in the chronology for establishing the network of facilities in La Paz/El Alto, the project is behind schedule. Instead of having the planned 19 facilities on-line or nearing completion by the second quarter of 1995, including a possible reference hospital, the project has only nine facilities operating with four additional health centers under construction. The delay in establishing the full network of health centers has seriously affected the financial performance of the PROSALUD/La Paz network. In the first quarter of 1995, only 61 percent of the nine clinics' service delivery costs, excluding the La Paz MSU, had been recouped. It is highly unlikely that the network will be able to raise this level to the end of project goal of 100 percent by March 1996 when the current project is currently scheduled to terminate.

3.4.1 Two Major Project Design Shortcomings

1. The selection of health center sites and the provision of the health centers—essential inputs into the project—were exogenous to the project and outside of the control of the grantee.

The health centers that were to form the PROSALUD/La Paz network were to be provided by third parties that were outside of the control of the grantee. Project implementation delays were due in large part to PROSALUD/La Paz receiving its infrastructure substantially later than had been planned. Moreover, PROSALUD had little say in the selection of the specific clinic sites.

The delay in establishing the planned network of health centers is due to the unwillingness of several complementary projects to contribute infrastructure to PROSALUD as planned. The design of the project, as set forth in the Project Paper, attempted to take advantage of the presence of the numerous institutions already working in, or planned to work in, the project area of El Alto and La Paz. These institutions had agreed to make specific, what in hindsight were to be critically important, contributions to the goals of the project. Planning the participation of these organizations was a laudable goal. Coordination meant that PROSALUD would not have to spend project resources on inputs that could be supplied from these complementary projects. Furthermore, the coordination effort sought to coordinate donors and other actors and to obviate duplication, thereby addressing two of the principle causes of inefficiency in the health sector.

The price, however, proved ultimately to be a high one, for it meant that PROSALUD did not have control over inputs that were vital to its achieving the planned outputs of the project. This potential liability was recognized in the project's Logical Framework where the project's outputs were made contingent on the assumption that collaborating organizations would participate as planned. They did not.

The Project Paper called for the collaborating organizations, including the Ministry of Health (MOH), to provide staff and selected "newly built or remodeled" facilities for PROSALUD, with the aim of enabling PROSALUD to quickly establish its service delivery network in La Paz. The municipalities of El Alto and La Paz were also to provide health facilities in key locations. Both the ministry's and the municipalities' facilities were to be remodeled and refurbished by

the World Bank's Integrated Health Care Systems Project or Programa de Integracion de Sistemas de Salud (PROISS) and/or by the government of Bolivia (GOB) Social Investment Fund (Fondo de Inversion Social, FIS). The USAID-funded community development project Pro-El Alto (PROA) was expected to mobilize community support for the project on behalf of PROSALUD and provide feedback to PROSALUD on the communities' reactions to its services.

As it turned out, the relationships between these organizations and PROSALUD became to be competitive, rather than the collaborative arrangement that had been hoped and planned for in the Project Paper. PROISS was the major source of infrastructure costs for the project. While PROISS did refurbish a few selected facilities, it did not do so in a timely manner, and it withdrew its support for the construction of the health centers needed to expand services in the city of La Paz. Consequently, at PROSALUD's request, USAID authorized the construction of five health centers at project expense, drawing on other project budget categories that were underspent.

Given the preparation and background discussions held with PROISS during the PROSALUD replication project design, it was logical to assume its participation. However, once it was known that it would no longer collaborate, USAID and PROSALUD should have moved more expeditiously to an alternate source of funding for clinic construction to keep the project on schedule. The development of a contingency plan identifying an alternative source of funding would have aided all parties to recognize when non-fulfillment of the terms of the agreement could be identified as such and would have been a helpful aid in knowing how to proceed once it was evident that PROISS would not live up to its agreement.

2. Selection of El Alto as the major primary health care (PHC) delivery site jeopardizes the cost-recovery goal of the project.

Nothing heightened the inherent dichotomy of purposes of the project more than the selection of the city of El Alto as the major service delivery site in a project whose very title emphasizes financial sustainability. El Alto is a very poor community, even by Bolivian standards.

The September 1990 Integrated Survey of Households conducted by the National Institute of Statistics found that of the people living in the four major cities of Bolivia, those of El Alto, on average, spend less than half of what people of the other communities spend. But the poverty of El Alto is not the only reason it is so difficult to recover costs in El Alto. Further complicating the effort is the fact that health is a low priority of its inhabitants. Inhabitants of El Alto spend one-fifth as much on health care as do the persons living in the other three communities, and a significantly larger proportion of their expenditures are on pharmaceutical products as opposed to professional health care services. Hence, while the average household in El Alto has total expenditures (a proxy for income) of only half the level of households in La Paz, Cochabamba, or Santa Cruz, El Alto households devote an even smaller share of their much smaller total expenditures on health, 2.0 percent relative to the 4.3, 4.4, and 4.9 percent spent by households of Santa Cruz, La Paz, and Cochabamba, respectively (Morales, 1995, p. 12). In other words, health is a lower priority in the budget of households in El Alto.

Data from the same survey provided additional corroborative evidence of this different priority ranking by also providing insight into the people of El Alto's culturally different approach to health care. The survey found that among persons living in Bolivia's 10 largest cities who reported themselves as having been ill or having had an accident in the two weeks prior to being interviewed, the denizens of El Alto were the most likely to have self-treated or to have sought care in the informal health sector and the least likely to have sought care in the formal health sector (Cuadro #2, Pooley & Murillo, 1993). This is reflective of the fact that El Alto is home to recent immigrant populations from the more remote areas of the altiplano and to displaced families from the city of La Paz. Composed largely of Aymara rural families, this population is still accustomed to delivering most births at home with the assistance of husbands. (Only 17 percent of births are attended by traditional midwives according to PROSALUD's baseline survey.) Selecting El Alto as the site of this project meant not only overcoming massive poverty but also a different cultural concept of the role and importance of health care, and formal health care in particular.

At the initiation of the project in 1991, El Alto was clearly underserved in terms of health care. With high rates of infant and maternal mortality, USAID considered the community in need of a primary health care program. Thus, it appears that the need for the project to deliver services to an underserved area was put on the same level of concern as the project's need to become self-financing, or to, at least, exhibit a high degree of cost recovery. There was inadequate appreciation for the difficulty of bringing a new concept of health care to a very poor population and, at the same time, inducing this same population to pay for the care.

The original design of the Project Paper identified El Alto as the primary project site. PROSALUD had no alternative but to accept it as such. It is noteworthy that the executive director of PROSALUD participated on the Project Paper team and, after a pre-feasibility study of the El Alto area, he insisted that the original plan (contained in the Project Identification Document that called for all clinic sites to be located in El Alto) be revised to allow for some clinic sites to be located in La Paz. (The chief means by which PROSALUD has traditionally been able to provide care to the poor has been by cross-subsidizing clinics located in poor neighborhoods with excess revenues generated in more affluent neighborhoods.)

Not only did PROSALUD have relatively little say in that communities the clinics would be located, but furthermore, nearly all of PROSALUD's current delivery sites were assigned to it by either the MOH or the municipal governments. With the long delays PROSALUD experienced in obtaining access to a physical infrastructure, it was not in a position, given the project's timetable and goals and its poor political position, to be able to negotiate for particular sites or even to comfortably turn down some of the sites which were eventually preferred by the MOH or the municipal governments, even though several of them—the Alto Lima III, Villa Ingenio, Chuquiaguillo, and to a lesser extent Huayna Potosi health centers—were, at best, marginal. (Annually each of these health centers has posted cost recovery rates that have been about 15 percent below the network average.)

The PROSALUD model includes a formal site selection process that includes site selection analytic tools and site selection criteria. Had PROSALUD been given the liberty to apply the PROSALUD model in its entirety, these sites would in all likelihood never have been selected. However, given the original project design, coupled with the complex, politically charged

environment of the early implementation effort, PROSALUD could not but accept these sites. In all likelihood, PROSALUD will be saddled with these less than desirable clinic sites throughout the foreseeable future, which has already, and will continue to, severely compromise the organization's ability to achieve a high level of cost recovery in its La Paz/EI Alto operations. The current strategy calls for opening up four more clinics in mid-1995 in much more affluent neighborhoods of La Paz to enable the cross-subsidization of these relatively poorly performing, high-risks sites. This is wise, but may not be enough. Consideration and support should be given to establishing other well-situated health centers in order to try to offset the major liability that the EI Alto site constitutes for achieving the project's self-financing goals. Alternatively, or perhaps simultaneously, the self-financing goals of the project need to be realistically reconciled with the project site.

4 ACHIEVEMENT OF OUTPUTS, CONSTRAINTS, AND LESSONS LEARNED

4.1 Establishment of the Management Support Unit in La Paz

The impetus for PROSALUD's wholehearted involvement in the project came at the beginning when USAID decided to make PROSALUD the grantee of the Cooperative Agreement and included PROSALUD's executive director on the Project Paper team. With PROSALUD as the direct and sole grantee, there would be no contracted long-term technical assistant firm to second guess PROSALUD's management decisions nor would there be a scapegoat should the replication fall apart in La Paz. The success of the project was squarely in the shoulders of PROSALUD with involvement from USAID in the substantive areas of project oversight specified in the Cooperative Agreement. The project was launched with a sense of urgency to hire the best staff persons for the La Paz MSU who, in turn, would make the project operational.

In the context of the PROSALUD delivery model, the MSU is responsible for hiring, training, and firing staff; establishing working relationships with other providers in the area including the MOH; maintaining relations with the community; maintaining the fiscal structures; procuring and distributing medications and supplies; and overseeing the delivery of services and controlling quality. The evolution of the management sub-systems took years to develop based on the experience of delivering services in Santa Cruz. The way PROSALUD wanted to relate to its clients and the definition of its corporate image was also the product of years of experimentation in Santa Cruz.

To make sure the experience in Santa Cruz would carry over to La Paz, USAID requested that PROSALUD's executive director, Dr. Carlos Cuellar, move to La Paz for at least two years. Dr. Cuellar was accompanied by Santa Cruz's MSU training coordinator, Lic. Pilar Sebastian, whose dynamic working style helped the La Paz staff visualize the implementation of the program's components.

Dr. Cuellar admits there was a naive notion about the potential difficulties that would be encountered in carrying out the replication process. The difficulty of transmitting the management system and program values to the newly hired La Paz MSU staff was underestimated. The La Paz staff members considered themselves professionals in their own right; they surely had first-hand knowledge of the regional culture, and they had life long contacts with officials and community leaders in the area. They were resistant to implementing a delivery model unfamiliar to them and which was developed in another, culturally different area of Bolivia. The efforts to redo, adjust, and adopt the Santa Cruz model to La Paz were endless until Dr. Cuellar explained to the La Paz staff that he was there to "implement a program, not reinvent a program."

As per the replication plan, the La Paz staff traveled to Santa Cruz to see first-hand the various management systems, their rationale, and how they worked. Visits to Santa Cruz were reinforced by visits of Santa Cruz staff to La Paz to work with counterparts to hammer out implementation details. But the resistance continued. The Santa Cruz staff claimed that the

La Paz MSU altered established procedures without even trying to understand them or apply them. When the Santa Cruz staff offered comments and suggestions, the La Paz MSU would reject them out of hand. As a consequence, the Santa Cruz staff nearly stopped all communications with La Paz. To the La Paz staff, the presence of Lic. Pilar Sebastian as coordinator of marketing was important to its sense of autonomy. One La Paz staff member commented: "With Pilar here, we had the secrets of Santa Cruz in our midst." The Santa Cruz MSU staff was concerned that two different PROSALUD programs would emerge from the rift between the offices, a situation that did not happen in the end.

The project confronted the problem faced by most diffusion of innovation efforts, whereby the innovator tries to control the process so as to ensure its being relatively homogeneous (thereby ensuring the integrity of the model), while allowing adequate autonomy to the replicators to adapt the systems and processes to local circumstances, both to ensure its effectiveness and promote a sense of ownership. The objective of this strategy is to achieve support for a common model which allows the project to go forward with a high degree of uniformity between the services offered in Santa Cruz and La Paz so as to ensure comparability and quality control. This is a delicate balancing act.

In the first 18 months of replication, nearly all difficulties were attributed to regional differences and the different perceptions of the La Paz vis-à-vis the Santa Cruz staff. With the passage of time, three mechanisms were introduced to resolve conflict: (1) the introduction of regional and inter-regional staff meetings, (2) the establishment of the National Office, and (3) the documentation of all major management systems (which in most cases consisted of updating already existing documentation).

Staff Meetings: A Forum for Communication and Conflict Resolution. Staff meetings are now held weekly at each MSU for senior staff, and the staff meetings are opened to all regional staff on a monthly basis. Also, monthly staff meetings are held with representation of both MSUs, at which time differences of opinions are aired and resolutions are reached. Regular staff meetings are supplemented with visits between managers involved in the same functional areas to work on implementation details.

Establishment of the National Office. The creation of the National Office changed the dynamics of the relationship between the two regional offices by reducing the polarization between the two groups. The National Office, established in 1964, now plays the role of mediator and quality control for all services performed by PROSALUD.

Documentation of Management Systems. Perhaps the greatest factor in promoting uniformity in the quality of services is the documentation of the major management systems in PROSALUD. PROSALUD has had a number of operational and personnel management manuals since at least 1989, but one outgrowth of the replication has been a comprehensive review and updating of these manuals. The final drafts of the revised manuals were presented to PROSALUD in March 1995 and are planned to be released in final form in May 1995. The manuals cover a number of topics, and the main manuals are summarized in Appendix C.

It is noteworthy that there are two administrative procedures manuals, one for La Paz and one for Santa Cruz. While these two manuals are largely the same, there are some differences,

which reflect the different conditions of the two networks' sites. The existence of the two manuals also manifests the compromise struck between, and the mutual respect now characterizing the relationship between, the Santa Cruz, La Paz, and National Offices.

Another important indicator of the effective establishment of the La Paz MSU is that it has had its own independent, local medical supplies procurement system functioning for more than two years.

Based on assessments of both MSUs, including a review of the various manuals, the evaluation team believes the MSU in La Paz is fully operational. Moreover, its members are willing to participate in further replications of the PROSALUD service delivery model in other parts of Bolivia, suggesting that they feel that they have progressed sufficiently along the learning curve to feel comfortable and confident enough with sufficient time to participate in the replications, and, furthermore, that they have something to contribute to such a process.

4.2 Establishment of the Primary Care Network in La Paz/EI Alto

PROSALUD's relationship with EI Alto and La Paz began in 1989 when it provided technical assistance on services and cost recovery to the Villa Bolivar "D" health center. As part of the research that went into the current project, PROSALUD conducted a market study for the sites that PROSALUD expected to receive from the MOH. It assisted the World Bank PROISS Project gather information on the communities for each of the health center sites that PROISS planned to upgrade as its contribution to the project. Despite this level of preparation, the unforeseen difficulties of replicating the Santa Cruz PROSALUD model were considerable.

After consulting with PROSALUD and MOH staff, the evaluation team has categorized the range of obstacles under the headings listed below. Most of the events described below are presented in chronological order and took place in the first two years of the project. The events clearly delayed the establishment of the delivery network of facilities.

4.2.1 Unanticipated Events that Adversely Affected Implementation of the La Paz Clinic Network

The implementation plan based on the Santa Cruz experience needed significant adjustment given the interest groups that emerged in EI Alto. The implementation plan developed in Santa Cruz and reflected in the Project Paper proposed a gradual expansion of the health centers following a series of steps identified in Figure 1. The following unexpected events were encountered:

Changes in the Institutional Vehicles for Community Involvement. According to the Project Paper, the La Paz MSU staff was to have initially worked with PROA to reach and communicate with community organizations nearest to the assigned health centers. These organizations included mother's clubs and Clinic Patronatos that were originally believed to be the most relevant organization in the health sector. In fact, many of these organizations were either inactive or were less representative of the community than the larger and more powerful

Community Committees (Juntas Vecinales). Once it was recognized that the health-related organizations were too weak or did not fully represent the community, the MSU began working with the Juntas. In most cases, the Juntas had political affiliations and leaders with personal interests which had to be dealt with. Also, PROSALUD found that it was ineffective to be represented by PROA in community organization activities. Often, PROA was not altogether familiar with the PROSALUD program nor the services it planned to offer.

The MSU took an inordinate amount of time informing, placating, and negotiating with the Juntas in order to gain entry to the assigned clinic sites. Table 2 lists the existing nine clinic sites in the project as of April 1995. (Four additional health centers are under construction in La Paz.) The table shows the affiliation of each center: MOH, municipality, or neighborhood organization. In most cases, negotiations were conducted with all of the related parties and as many as three individual Letters of Agreement had to be signed with each of the organizations before PROSALUD could work with the assigned center.

Changes in the Implementation Schedule: The December 1991 "Clinic Blitz" and Potential Colleagues become Enemies. MOH medical staff members assigned to centers to be managed by PROSALUD were expected to continue working at those sites. However, soon after work with the communities had begun to show signs of community interest and support, the medical staff of the MOH working in the project area began a heated attack against the project mainly due to the higher work standards and longer working hours required by PROSALUD. Working with the Unidad Sanitaria of El Alto, which was short of staff for other programs, it was agreed that all MOH staff members would exit the clinics assigned to PROSALUD during the 1991 Christmas holidays and PROSALUD staff would enter the five clinics simultaneously. As one La Paz MSU staff member reported:

We moved all their [MOH] furniture and equipment out and the next day we started to operate the clinic ourselves with only a broken chair in the waiting room, but at least the clinic was ours. We now could control our environment and apply our standards to the care we offered.

Approximately 360 Persons Applied for 54 PROSALUD Service Delivery Positions. While the MSU/La Paz expected interest in the project, the number of applicants was more than expected, necessitating a selection system that could deal with the volume of applicants, provide the best employees and not create a negative climate toward the project from those not selected.

FIGURE 1

PROCESO DE IMPLEMENTACION DE UN CENTRO DE SALUD

- Reconocimiento de zona geográfica.
- Condiciones físicas y de accesibilidad.
- Conteo de vivienda.
- Obs. de Competencia.
- Poder adquisitivo de pobladores.
- Poder de Convocatoria de los líderes.

menos de 1,000 viviendas → Fin del prodeso. ó excesiva competencia.

1,000 viviendas o más.

↓
Obs. de Instituciones.
Competencia.
Mercado Potencial.

↓
Estudio de Pre-mercadeo o pirámide poblacional.

↓
Conformación del Comité de Salud.

↓
Autorización de la U. Sanitaria.

↓
Autorización del Plan Regulador.

↓
Construcción o refacción del Centro.

↓
Procedimiento de adquisición de insumos y equipos.

↓
Reclutamiento y capacitación del Personal.

↓
Promoción.

↓
Implementación e inauguración del Centro.

↓
Promoción y Publicidad.

↓
Punto de equilibrio.

↓
Autofinanciamiento.

TABLE 2

**PROSALUD - LA PAZ/EL ALTO
BUILDING SERVICE DELIVERY CAPACITY
(As of January 1995)**

CENTER (Date Built)	LOCATION 1995 pop.	FACILITY OWNER	DATE ASSIGNED TO PROSALUD	START DATE OF SERVICE DELIVERY	
				REGULAR	BIRTHS
16 July Est'd: 1981	El Alto 15,600	HAM/IBRD	Nov. 91	Feb. 92	Apr. 92
V. Brasil Est'd 1989	El Alto 13,750	MOH/EA	Nov. 91	Aug. 92	Dec. 92
V. Ingenio Est'd 1992	El Alto 12,600	Junta	Jan. 92	Mar. 93	Jan. 93
H. Potosi Est'd 1990	El Alto 13,500	Junta	Nov. 91	Sept. 93	Jun. 93
A. Lima III Est'd 1989	El Alto 12,400	HAM/MOH	Nov. 91	Aug. 92	Oct. 92
A. Lima I Est'd 1986	El Alto 18,400	HAM/MOH	Nov. 91	Sept. 93	Mar. 92
V. Bolivar Est'd 1987	El Alto 15,800	HAM/MOH	Aug. 91	Sept. 94	Aug. 91
Chuquiaguillo Est'd 1986	La Paz 8,500	MOH	Nov. 92	Jan. 93	Oct. 93
A. Miramiraf. Est'd 1992	La Paz 16,000	MOH/Junta	Nov. 92	Mar. 93	Mar. 93

El Alto, Dist. I, target pop.	86,250
El Alto, Dist. II, target pop.	15,800
El Alto total	102,050
<u>La Paz, Dist II, target pop.</u>	<u>25,300</u>
Total 1994 target pop	127,350

Conflicting Expectations. Despite PROSALUD's efforts to clarify the intent of the project, overwhelming confusion and misinformation reigned in El Alto as to what the project was all about. Different private voluntary organizations (PVOs) and government agencies working in El Alto created different and conflicting expectations from the project. In addition to the MOH presence in El Alto, the World Bank-funded PROISS Project, health providers affiliated with the Roman Catholic Church, a Dutch health project, and a small hospital managed by the Italians were in operation. Each provider had a different mix of services and referral systems, pricing policies, community outreach methods, and employee salary structures. The Dutch

paid its staff high wages and offered "sobre sueldos" to the MOH medical staff, even at the district level; PROSALUD did not. Some groups provided totally free services; PROSALUD did not. Some projects provided vehicles to the MOH; PROSALUD did not. Yet, PROSALUD provided the most complete mix of PHC services including family planning; other providers did not. Competition rather than collaboration between providers was the daily routine. The man or woman on the street was confused and so were most of the health workers.

There were fundamental differences in the way the MOH and PROSALUD approached the delivery of services to the public. As described in the Chapter 1, the services of the MOH vacillate between those that are offered within the clinic setting and those offered door-to-door as with vaccination campaigns. Thus, the MOH tends to shower health activities on the target population of a health center. These actions often have conflicting purposes and inconsistencies in the minds of the users. For example, PHC services require regular and consistent open clinic hours to attract users; however, frequently MOH clinics were closed and disappointed clients rarely returned. On the other hand, PROSALUD believed its clinic schedule was "untouchable" and must be honored by all staff daily, to the extent that even staff training activities were held on Saturday afternoons so as not to remove staff members from their clinic duties during the week.

On repeated occasions, the MOH demanded that PROSALUD participate in door-to-door vaccination campaigns or "epidemiological control" activities, thus taking key staff members out of the clinics. When PROSALUD refused to participate and explained that it was already vaccinating a high percentage of the children in its clinics, the MOH claimed it was uncooperative.

4.2.2 Some Positive, Spontaneous PROSALUD Responses to the Situation

Just as there were several negative events that delayed replication, there were also several unexpected, very positive events that began to turn the tide of public opinion in favor of PROSALUD. Two events are mentioned as examples of activities that PROSALUD initiated and would be well-advised in future replication efforts to initiate early on in order to enhance the public's understanding of the organization's work, promote its acceptance, and foster its goodwill toward the program.

The School Education Program. The School Education Program taught teenagers living near the PROSALUD health centers in El Alto to recognize and manage several PHC illnesses and then assigned each student to work with five low-income families. The students visited their assigned families to explain the importance of breastfeeding, prenatal care, and childhood immunizations. When a student detected a malnourished child or a pregnant woman, they helped the family attend the clinic to get the attention they needed. The program lasted less than two years before it was dropped due to a lack of funds; however, while it lasted it was very popular with the teenagers as well as with the families they visited. The program created a positive following for PROSALUD, nullified much of the local criticism, and increased clinic attendance.

Other Important and Successful Marketing Activities. Under the heading of "marketing" falls the not only the social marketing of contraceptive assisted by the Social Marketing for Change Project (SOMARC) but also the activities to promote the use of the clinic network. Therefore, marketing activities also include the building of basketball courts and play areas near the clinics, lighting in the parks, providing small gifts to children at Christmas, and making sure the clinic facilities are well maintained.

One of the La Paz MSU staff members referred to these various unplanned aspects of the replication effort as "shocks" to the replication system. The evaluation team feels that many of the unanticipated events could have been predicted given the information the staff had on the area. Nevertheless, the events appear to have been handled as well as could be expected.

In future replication efforts, and in the opening of the new clinics later this year, it is recommended that more publicity be given to PROSALUD's philosophy, the way in which it operates, and its accomplishments. A "question and answer" format could be used in the newspaper or in a publicity pamphlet to explain the program, using the very questions that are most asked of the program during the initial market surveys. Marketing events such as those designed during the El Alto roll out and known for their positive effect can also be scheduled early in future replications.

While the system is now well on its way to being permanently established in La Paz, it remains handicapped because all of the originally planned health centers are still not functioning. It is assumed that the centers in construction will be completed as scheduled and a polyclinic may be added to the network in lieu of the reference hospital; but even with the addition of these facilities, however, the network will remain considerably smaller than had been planned—one-third smaller. This means that the MSU costs are spread over a smaller number of facilities and services, resulting in higher overhead costs and, more generally, higher unit costs for all the services provided. A smaller service delivery capability, coupled with less than optimal clinic locations, renders PROSALUD/La Paz, as it is currently structured and planned, unlikely to ever recover 100 percent of its costs (inclusive of the MSU). This suggests that additional sources of revenues must be pursued more than the currently planned 13 clinics or more alternative types of net revenue-generating activities. The discussion returns to this important theme below.

4.3 Establishment of the National Office and Project Monitoring

In the first quarter of 1994, PROSALUD inaugurated its National Office. All but one of its eight staff members were drawn from the Santa Cruz MSU. The establishment of the National Office was a logical step for a growing organization with two regional offices and ample new targets of opportunity to expand services. The National Office has removed itself from the day-to-day management of the regional delivery programs. Using the management information system, the National Office can concentrate on monitoring the performance and control of quality. More importantly, the National Office can respond to new business opportunities in and outside of Bolivia, activities that were difficult to carry out when the staff was assigned to the Santa Cruz MSU.

The functions of the National Office and its relationship to the regional MSUs are well documented in the recently developed manual on management procedures. The sections dealing with the delegation of decision-making are particularly well defined whereby the decision-making powers of each of the regional offices are classified as follows:

- Decisions that regional offices can make following established procedures and require no prior approval from the National Office and require only routine reporting;
- Decisions that can be taken following established procedures but do require notification to the National Office
- Decisions that cannot be made without formal approval from the National Office

For the Santa Cruz and La Paz MSUs, most of their decision-making falls into the first category of delegated authority, but for a new MSU with less experience, its delegated authority is planned to be limited initially to the second and third categories of decision-making. Clearly, these management procedures reflect a mature organization that is preparing for the demands and consequences of further replication within a decentralized management system environment.

4.4 Critical Elements of the PROSALUD Model: The Personnel Selection Criteria and Process and the Monitoring, Evaluation, and Planning System

The two most critical elements of PROSALUD's management systems contributing to its success are (1) its development and reliance upon a data-driven, monitoring, evaluation, and planning system and (2) the organization's personnel recruitment criteria, process, and procedures.

These two aspects of PROSALUD's management systems complement one another in a synergistic fashion. The personnel recruitment system ensures that the persons hired by the organization are well-qualified technically, and, of equal importance, that they share the philosophy and goals of an organization dedicated to primary health care and public service. Furthermore, the system ensures that they are persons with desirable personality traits; that they are pleasant, friendly, and easy to get along with, yet self-confident and independent. Upon entering any PROSALUD facility, one cannot help but be struck by the deportment and character of the staff. Patients are met and made to feel welcome by a staff that is caring, outgoing, and engaging.

In addition to filling out a detailed application form, prospective staff persons are interviewed by several persons with whom they will be expected to work, as well as persons further up the organizational ladder for whom they will work. Persons who pass the initial screening and are selected have a two-month probation period. At the conclusion of the probation, the person's performance is evaluated, the person is re-interviewed, and the interviewers meet to discuss the hiring decision. The specific steps and the criteria used in the process are described in detail in one of the PROSALUD management manuals. PROSALUD's skill and success in applying the established criteria, selecting its staff, and in administering its personnel system are testified to by the very low turnover rate of its staff and the staff's high productivity, which is a hallmark of the system.

The other critical element in the PROSALUD management model—its monitoring, evaluation, and planning system—builds on the product of the personnel system, taking advantage of the organization's motivated, dedicated and technically capable staff. The monitoring, evaluation, and planning system is implemented, and is constantly being refined, via employee participation in a series of regularly scheduled, formal, and well-structured meetings at all levels of the organization.

There are three distinct sets of monitoring, evaluation, and planning indicators. The most fundamental set consists of the 17 specific types of health services provided by PROSALUD during a particular time period (a month, a quarter, semi-annually, or annually), the equivalent of that presented in Table 1. This set of indicators is used as a basic planning tool to establish and monitor service provision goals that are set for each individual facility by its own staff (see further discussed below). These indicators are used primarily to provide basic information about the general level of service provision of each health center by type of service and to monitor progress toward established goals.

Two additional lists were constructed and first used in 1989 and have evolved since then (see Appendix B). These additional lists use the same basic structure as the first, but both introduce additional information that transforms the list either into a more useful tool, in one instance, for assessing the productivity and adequacy of care provided by PROSALUD staff or, in the other instance, for measuring and monitoring the epidemiological profile and health care utilization level of the center's service population. The first of these augmented lists, for example, contains additional information about whether it was the first visit for a particular ailment or a follow-up visit, what type of staff person provided the care, and for several particular types of services some basic information about the patient (e.g., age, sex, vaccination dose number, and health risk status). These augmented indicators add information reflecting treatment protocols and quality of care goals and provide a monitoring tool that combines quantitative measures with (primarily process indicators of the) quality of care measures.

The second of these augmented basic services lists ties the service statistics to the target population of each specific service and the population coverage rate for each planned volume, or actually delivered number, of services. These indicators generate population-based service delivery measures.

There are two other distinct sets of indicators that form the complement of the monitoring, evaluation, and planning system and that both use the quantitative measures of the basic services as inputs. The first of these translates the basic services list (planned or actual) into the inputs—personnel types and numbers, medicines, and other supplies—that can or should be required in order to be provided (based on PROSALUD experience and norms). The second of the complement systems combines the basic service quantities with costs of the required inputs and the prices of PROSALUD services to generate estimates of the financial flows associated with the anticipated or actual service delivery levels.

These three related sets of indicators are used on both an *ex ante* and an *ex post* basis to review any individual PROSALUD health center's financial performance or that of the entire

organization, as well as to predict financing requirements and cash flows for the coming month, quarter, or year, based on an anticipated service provision level and composition.

One very distinctive characteristic of PROSALUD personnel at all levels of the organization is the high level of understanding of and appreciation for the very close relationship between service delivery and financial performance. The PROSALUD monitoring, evaluation, and planning system emphasizes and makes transparent the relationship between service delivery and financial performance. The organization's reliance on such a system and the way in which PROSALUD has made monitoring, evaluation, and planning participatory processes through a series of public meetings has nurtured a level of consciousness about the business aspects of health care that are conspicuously lacking in other systems—be they in the Third World or the First World. (Table 3 provides a summary listing and brief description of PROSALUD's regularly scheduled, management-related meetings.) These indicators and this participatory process serve to integrate the service delivery and financial requirements and goals of each clinic, regional network, and the organization as a whole and serves to keep all employees cognizant of, and constantly relating, the services delivery and financing aspects of their work.

In order to keep the medical directors of each clinic abreast of their progress toward the goals they developed in the annual planning exercise, each health center tallies its service statistics and forwards them to the MSU where the information is crossed-checked. The information is then returned to the clinics on computer-generated graphs—one for each service—plotting the planned and actual service provision levels for the past month, as well as their year-to-date cumulative totals. A graph plotting the center's planned and actual monthly income by month and cumulative totals is also sent each month. An example of one of the financial graphs (reporting the entire 1993 experience) is presented in Figure 2.

Quarterly, the medical directors and head nurses of each health center in the region meet with the regional office's executive committee to discuss progress toward achieving the planned service provision goals. Both service delivery and financial performances are reviewed. A combination of self-evaluation and peer-evaluation are used in an open, minimally structured forum that employs a constructive (non-threatening, problem-solving oriented) approach. The discussion is centered around service indicators for each of the 17 health services.

It should be emphasized that—just as with its monitoring and evaluation indicators, so with its series of regular meetings—not all of PROSALUD's monitoring and evaluation activities are focused on quantitative service delivery and financial performance issues. There are also monthly meetings of the medical directors of the health centers and a separate set of monthly meetings of the head nurses of the health centers to discuss medical audits, extraordinary medical cases (analogous to weekly "grand rounds" in a hospital), and more generally to review general operations and troubleshoot. The separate meetings of head nurses are held only in the La Paz network. They were initiated there because the head nurses wanted a separate forum to better ensure that their different issues and needs would be more adequately discussed and addressed.

Insert Table 3

Insert Figure 2

Which used to be Figure 1

In late November of each year, the year-to-date service and financial data by clinic and activity type are sent to the clinics. The clinics work throughout the next six weeks with their director of Medical Services and other regional office personnel to develop their service delivery goals for the coming year. Their draft goals are reviewed, discussed, and finalized at the annual planning and evaluation meeting that is generally held in early January. (As noted above, it is these annual plans which provide the performance benchmarks used in evaluating each clinic in the coming months.)

Once a year, the members of the regional MSUs and the National Office attend a retreat and develop a three-year plan. This exercise is a three-step process. First, the internal workings of the organization—its chief problems, accomplishments, and goals—are identified reviewed and assessed. Second, the context of PROSALUD—how it has influenced the organization and how it is likely to affect it in the future—is considered. This involves identifying and reviewing the economic, social, political, health status, and health care-related developments of the PROSALUD clinic sites, as well as of the cities and regions in which they are located, and the country as a whole. The second step also seeks to understand how contextual factors have affected the organization and how they are likely to affect it in the future. The third step involves putting these two pieces together and developing a three-year plan that becomes the context within which the annual operating plans of the organization are developed.

4.5 The PROSALUD/La Paz Service Provision Record

4.5.1 Levels and Trends

PROSALUD began providing services in its seven El Alto health centers in January 1992. As Graph 2 shows, although the level of the clinic network's general service delivery has been decisively upward, the total number of services has stagnated around 55,000 for the past year and a half (quarter 3, 1993 through quarter 4, 1994). In the first year of operations, the centers together provided a total of 99,000 services. The following year two additional centers were opened in La Paz and the total number of services provided by the network increased by 100 percent to 197,000. Excluding the two new centers from the analysis, service provision by the seven El Alto centers expanded by 57 percent in 1993.

In 1994, the pace of expansion slowed markedly as the nine-clinic network recorded nine percent growth in the volume of services it delivered. The original seven El Alto centers posted a 12 percent increase that year, while the two centers located in La Paz had a combined service provision growth rate of only seven percent; the much larger Alto Miraflores center actually experienced a two percent reduction in the number of services it provided.

Given that the network is in its infancy and that its service area has been a medically highly underserved area, the slow start in PROSALUD clinics' service provision—particularly after the long delays already experienced in simply obtaining many of the facilities—is troubling and warrants further analysis to understand the nature and causes of this slow start, and, more generally, to learn how PROSALUD/La Paz has been developing.

Graph 2

4.5.2 *Service Composition I: Preventive Versus Curative Care*

Since its inception, the overwhelming majority of all care provided by the PROSALUD/La Paz network has been preventive (*vis-à-vis* curative) in nature. Annually, curative care has constituted only about 30 percent of all services. Graph 3 depicts the curative care share of all services provided each quarter from 1992 through 1994. The 1993 total of curative care services was 90 percent greater than that of 1992, and 1994 was 25 percent greater than 1993.

The principle source of variation in PROSALUD's service delivery record is the preventive services component. As seen in Graph 4, curative care has mapped out an uninterrupted and slowly rising level of service provision over this three-year period, while preventive care provision has oscillated, although still mapping out a generally increasing trend line. One can readily see in Graph 5 that the shape of the total service provision trend line has mirrored that of the numerically relatively, more significant preventive care component and that the total preventive services trend line mirrors that of vaccinations. This is to say, quarterly oscillations in the numbers of vaccinations have been chiefly responsible for oscillating numbers of all preventive services, as well as oscillating numbers of all services provided by PROSALUD. These relationships reflect the quantitative importance of vaccinations in the PROSALUD delivery system service statistics: over this three-year period, vaccinations accounted for 45 percent of total activities and 65 percent of preventive services.

What accounts for the marked fluctuations in the number of vaccinations provided by PROSALUD/La Paz clinics? PROSALUD obtains its vaccination supplies (as well as the syringes used to administer them) from the National Secretariat of Health (NSH). PROSALUD personnel note that vaccination supplies have been erratic throughout the past few years, have been in particularly short supply for much of the last year, and shortages persist to date. In an interview during a visit to a NSH health center in La Paz made during this consultancy, it was learned that the Secretariat has only very recently re-established an adequate and regular source of vaccination supplies in NSH-operated facilities. It is anticipated that those provided to PROSALUD will reach similar levels shortly—for the time being.

This situation—PROSALUD's dependence on the Secretariat for vaccinations—demonstrates the price of (1) cultivating the acceptance and support of third parties and (2) coordinating with third parties; *viz.*, it jeopardizes PROSALUD operations. Making PROSALUD activities dependent on namely the actions of others puts PROSALUD at greater risk of failure. While it may well be that this is a political price that is essential to pay, it should be recognized that it constitutes a trade-off in terms of PROSALUD's image and its performance.

To a certain extent PROSALUD has noted that it is willing to continue to rely on the Secretariat for vaccination supplies because of the cost savings it realizes by doing so. In this instance the trade-off is between pushing PROSALUD to be more self-financing and accept a lower proportion of children and women of childbearing age being vaccinated or at least being vaccinated in as optimal (timely) a manner as might otherwise have been the case. At the very least, this trade-off, too, must be recognized. The discussion returns to the issue of the trade-offs resulting from pursuit of the self-financing goal.

graph 3

graph 4

graph 5

4.5.3 Service Composition II: The Fastest Growing Types of Services

Among the 12 non-vaccination services provided by PROSALUD/La Paz clinics, the fastest growing have been births/deliveries and family planning services. Births grew by more than 11-fold between quarter 1, 1992 and quarter 4, 1994. Family planning services, which were first offered at PROSALUD clinics in quarter 3, 1992, grew by just under 11-fold from that time to quarter 4, 1994.

The fact that increasing numbers of women in El Alto have been delivering their babies in PROSALUD clinics is significant for several reasons. First, the proportion of women who have historically had institutional births in El Alto has been very low. PROSALUD is helping to change long held, high-risk patterns of behavior. Second, this change reflects the growing confidence and trust with which the community holds PROSALUD. Third, delivery is a single service that is perhaps the most significant of a number of other obstetric-related and infant and child health-related services, because of the technical skills involved and, from the patient's perspective, the emotional aspects. If a woman is going to have her baby at a PROSALUD clinic, there is a good chance she is going to obtain her prenatal and postpartum care, and at least some of her infant's well-baby care (vaccinations and growth and development monitoring), from the same source. Thus growing numbers of deliveries in PROSALUD clinics are likely to precede growing numbers of services being provided by PROSALUD centers as these women come to develop a more permanent relationship with the centers. This is manifested (though not unequivocally proven) by the fact that two birth-related services, postpartum check-ups and tetanus toxoid vaccinations, were (after deliveries and family planning) the next most rapidly growing (non-vaccination) services.

PROSALUD staff is aware of the significance of these trends. Indeed, the organization has adopted a pricing strategy that encourages pregnant women to enter into this longer-term, more permanent relationship with their PROSALUD health center. It has done so by providing a package discount price for births which includes any medications required, a postpartum check-up, and a well-baby visit. This is an astute strategy, for in the long run, PROSALUD must seek to develop a large base of "customers" who regularly turn to PROSALUD facilities for their health care needs. The changes in the mix of PROSALUD services due to the much more rapid relative rates of growth of deliveries and family planning services bode well for the future.

4.5.4 An Important Conditioning Contextual Consideration: The Rapid Change in the El Alto and La Paz Health Care Markets

In 1993, PROSALUD provided 35 percent of all of the outpatient consultations provided in the El Alto and La Paz health districts. In 1994, PROSALUD's share in these combined markets fell to 29 percent. Although PROSALUD clinics' posted a major increase in the number of outpatient consultations provided—expanding by 40 percent in just one year—the pace of expansion reported by all other providers was more than twice as great: 90 percent. The vast majority of the expansion in the size of the market occurred in the El Alto area. The number of outpatient consultations provided in El Alto in 1994 was 107 percent greater than in 1993. In contrast, the La Paz market expanded by only nine percent. Whereas the La Paz market

constituted 35 percent of the combined outpatient market in these two Unidades Sanitarias in 1993, despite the fact that the absolute size of the La Paz market expanded in 1994, its share in this combined market fell dramatically to 22 percent.

Outpatient consultations, however, have constituted only about 30 percent of all PROSALUD service delivery activities. Thus, this may not be the best measure by which to assess the place and performance of PROSALUD in the market. Unfortunately, however, it is the best measure available, and in terms of the other principle PROSALUD goal—namely, becoming self-financing—it is the most important.

Why the rapid growth in the number of outpatient consultations in these two health regions and its particularly rapid growth in El Alto? It has been due in large part to the 1994 opening of three new health facilities in El Alto and two in La Paz. These are just the latest of the major expansions that have occurred in the health care infrastructure in these two health districts in the past few years. Beyond the addition of these five new facilities in 1994—which constituted a substantial 16 percent increase in the total number of facilities in these two health districts—the following have also taken place in the past three years:

- The opening of the two new PROSALUD facilities in La Paz facilities in January 1993
- The construction and opening of seven facilities by the World Bank PROISS Project
- The rapid expansion in the number of church-sponsored centers in El Alto (there are now five just in district one)

This rapid expansion of infrastructure was not fully anticipated by USAID or PROSALUD in the design and early implementation of the PROSALUD replication project. While the service area of PROSALUD/La Paz remains a relatively underserved one, the pace at which this new PROSALUD regional network has been able to capture a substantial segment of the market—and commensurately its cost recovery efforts—has been slowed by the considerable competition that this new influx of health care facilities and providers into the immediate area has brought with it. Moreover, the pace of this expansion is about to accelerate. According to The PROISS Project agreement, 15 more facilities are to be built in the next year.

Given this rapidly changing situation, effective marketing takes on added importance to bring notice to the public of the existence of PROSALUD clinics and to inform people of the nature of PROSALUD services and the availability of the services. This is a very different environment than that which has characterized the Santa Cruz market for most of the past decade. To its credit, PROSALUD has been able to recognize the fundamentally different nature of this situation and has revised elements of the basic model to accord greater visibility, importance, and resources to marketing within the La Paz/El Alto Regional Office. This is most evident in the hiring of a person with significant private sector experience to be the director of administration and to head marketing efforts.

4.5.5 PROSALUD'S Niche and Significance Within the La Paz/El Alto Health Care Market

Table 4 presents data obtained from the NSH's National Health Information System (SNIS) which was compiled by the El Alto and La Paz health districts' Health Information Analysis

Committee (CAIS). The information available from this system is not all inclusive, but because it is reported by health facilities, it provides an opportunity to take a closer look at PROSALUD's role within each of these health districts. (Additional tables presenting annual data by health district are provided in Appendix E.)

As these service delivery statistics testify, PROSALUD is much more maternal and child health- (MCH-) oriented than are the other providers operating in the same two health districts, including the NSH. The PROSALUD clinics together provided 42 percent of all of the outpatient consultations that were provided to children under age five in 1993 and 38 percent of the 1994 total. In 1993, 41 percent of all PROSALUD outpatient consultations were provided to children less than age 5, compared to 31 percent for all other providers in the two health districts. In 1994, these shares fell to 40 and 26 percent, respectively, implying that the PROSALUD network became more specialized relative to the rest of providers in terms of the proportion of its patients that came from this age group.

In terms of women's health care, PROSALUD's preeminent position in the market is again evident. PROSALUD health center providers attended half of the 1,790 births in the two health districts, a disproportionately large number given their share of outpatient visits or their share of the total number of facilities in the two districts. Forty-one percent of all women with at least one prenatal care visit received that care from PROSALUD. The fact that PROSALUD's share of births is substantially greater than its share of women who obtained some prenatal care is not easily reconciled with existing information. It is likely that a significant number of women who have institutional births (at any health care facility, including those of PROSALUD) do not obtain any prenatal care. It might also, or alternatively, be that women who deliver at PROSALUD clinics obtain their prenatal care from other, non-PROSALUD providers. Given the importance of births (as a life event and because they appear to influence the selection of a regular source of care), this is an issue that merits further investigation and monitoring (via periodic market analyses) by PROSALUD.

Looking more closely at two of the very few available indicators of the appropriateness and adequacy of the care provided, 49 percent of the women with at least one prenatal care visit to a PROSALUD health center had their first such visit before the fifth month of their pregnancy, compared with 43 percent of the women visiting other providers in the two health districts. The women who obtained their prenatal care at a PROSALUD facility had, on average, 2.6 visits, 44 percent more than the average 1.8 visits of women visiting other providers.

In 1993 PROSALUD clinics served 95 percent of the new users of family planning methods in the El Alto and La Paz health districts. In 1994, PROSALUD clinics increased the number of new family planning users it served by 159 percent. Nevertheless, the proportion of all new users it served fell to 69 percent as other providers rapidly expanded their activities in this segment of the market. This, as already noted, was a common pattern in the La Paz/El Alto health districts in 1994; i.e., although PROSALUD service delivery expanded significantly, that of all other providers expanded much more dramatically, resulting in PROSALUD's market share declining. This was the case for each one of the 17 different service delivery statistics presented in Table 4. While PROSALUD's service delivery of these 17 indicators of service provision grew 45 percent, other providers' service delivery grew more than twice this rate (97 percent). Over the course of this two-year period, the number of PROSALUD facilities

remained fixed, while the number of other providers' facilities increased from 18 to 23 (28 percent). It should be noted, however, that two PROSALUD facilities had just opened at the beginning of this period and they accounted for part of the expansion in PROSALUD service provision over the period as they became fully functional, slowly increasing their level of activities.

TABLE 4
insert

5 HOSPITAL ISSUES

The Project Paper requested PROSALUD to study the feasibility of setting up a referral hospital in La Paz as was completed in Santa Cruz. The evaluation team was requested to review and comment on the La Paz hospital development in terms of its potential income generations as well as the feasibility of receiving referrals from the El Alto and La Paz health centers. Discussions were held with the La Paz MSU director, Dr. Jack Antelo; medical director, Dr. Federico Gomez-Sanchez; and PROSALUD national director, Dr. Cuellar. The operations and financial performance of the Santa Cruz reference hospital was also reviewed, and Dr. Wilson Rodriguez of the hospital was interviewed.

5.1 A Brief Review of the Performance of the PROSALUD/Santa Cruz Hospital

Since its inception, PROSALUD has been subject to charges of "cream-skimming;" i.e., providing care to only the relatively simple, non-complex cases, and referring the difficult ones to other providers. Similarly, some critics claimed that the PROSALUD model was not really a health care delivery model because it focused exclusively on primary health care, the least technologically and skill-intensive level of care. Both of these groups of detractors disparaged the PROSALUD model by pointing out that the PROSALUD formula of success included off-loading the more technically and financially demanding patients to hospitals run by other organizations. As long as PROSALUD did not have a hospital it would be subject to this criticism.

In part for political reasons—specifically, to rebuff these critics—but motivated also by the lure of operating a hospital and the desire to more clearly identify the limits of the self-financing approach, PROSALUD set out to revise the model by incorporating a hospital into the service delivery network. In the second quarter of 1992, PROSALUD purchased the privately owned and operated San Carlos Hospital in Santa Cruz. It was more than one year later, after extensive renovations and a considerable amount of preparatory work, before the hospital was inaugurated and opened its doors for business.

In the first months business slowly increased and then seemed to prematurely reach a plateau at levels of service provision well below the capacity of the different service departments. Beginning about July, however, the number of services delivered each month resumed an increasing trend, and most continued to do so through the end of the year. By the end of the year, the following changes had taken place:

- The number of outpatient visits per month was twice as high as it had been in the beginning of the first months of the year
- The number of surgeries had increased nearly four-fold
- Having registered only seven or eight births per month, the number of deliveries started increasing, and in December—the busiest month ever—45 babies were delivered.

As a result of these increases, the level of revenues increased and the level of cost recovery increased (see Graph 6).

Increasing service provision levels was not the only reason that the level of cost recovery increased. Changes in the way in which the hospital was organized and its increased integration within the PROSALUD system were other important contributing factors as well. After conducting a survey and review of the referral practices of PROSALUD health center physicians, it was learned that the addition of the hospital to the PROSALUD system had not prompted many of them to change their behavior. Many still referred their patients to other hospitals. To encourage the health center physicians to keep their referrals "in-house," the hospital introduced the practice of giving PROSALUD referring physicians 10 percent of the fee their referral patients pay to the hospital (for the physician's honorarium only). The impact was pronounced.

Owing to this practice and other fee-splitting arrangements, only 48 percent of the gross revenues of the hospital actual stay with the hospital. The strategy of holding down the otherwise always high fixed costs of personnel has resulted in widespread reliance on fee-splitting arrangements throughout the hospital. The X-ray service is contracted out in a manner analogous to the dental services arrangements in the health centers: the X-ray technicians are responsible for providing all necessary equipment, are not paid a salary, and are required to split the revenues they collect with the hospital. The percentage split, however, is slightly more favorable for the X-ray team, 85-15, compared to dentistry's 80-20. The electrocardiogram machine is operated under a similar arrangement as well, with an 80-20 split.

The PROSALUD clinics' physicians have been instructed not to refer indigents to the PROSALUD hospital. The clinics and, less frequently, the hospital itself refer them to other hospitals—generally those of the NSH. This has resulted in PROSALUD's being charged with "dumping" indigents and has marred the organization's reputation in some circles.

Talking with the hospital director about two specific, very recent cases that were cited by the Secretary of the Santa Cruz Regional Secretariat of Health, the director explained that both cases required tertiary care. The PROSALUD hospital, a secondary level facility, was not able to provide the necessary care, and rather than risk the health of the patient, referred them both to a NSH hospital. Hence, one of the principle reasons the organization felt compelled to establish a hospital—namely, to defuse the criticism that it was "cream-skimming"—persists, although it probably has abated. Thus, the only way in which PROSALUD could hope to completely eschew such politically charged criticisms would be to have its own tertiary care facility. While that might solve this problem it would exact another high toll: it would exponentially compound the financing problems the organization currently confronts due to the hospital.

Insert
graph 6

To provide more insight into the magnitude of the risk involved in running the current hospital, it is useful to juxtapose the total revenues and expenditures of the hospital to those of PROSALUD/La Paz. From January through November 1994, the hospital had expenditures of 1.17 million Bolivianos, compared to 1.62 million for the entire nine-clinic network in La Paz for all of 1994. During that same period, the Santa Cruz hospital lost nearly one-half million Bolivianos, the equivalent of 66 percent of the losses suffered by the entire nine-clinic network in La Paz.

The hospital's level of cost recovery has remained around 60 percent for several months. It is still early in its organizational development, however, and the hospital has considerable potential to increase its service delivery levels and concomitantly its financial performance. The general practitioners, for example, have had a consistently low level of productivity, averaging only about one consultation per hour. Furthermore, the director has several good ideas that he is trying to introduce to further improve the facility's financial status, including establishing a slightly higher priced fixed appointment time consultation service and introducing some additional specialties (at no risk to PROSALUD).

5.2 PROSALUD/La Paz Should not Establish a Hospital

While it is very early in the experience of the PROSALUD/Santa Cruz hospital, indications are that it will be exceedingly difficult for the hospital to achieve 100 percent self-financing. On the basis of its performance to date, it would be ill advised to replicate this portion of the Santa Cruz model in the La Paz/EI Alto region. In addition to financial considerations, the inordinate amount of time and energy the regional office staff has had to devote to this new enterprise, particularly when considered in combination with PROSALUD's current plans to expand into new markets (further discussed below), militate against adding a hospital to the La Paz network. There are also other reasons—specific to the conditions of the La Paz/EI Alto market—which underscore this position and are discussed below.

The decision not to pursue the opening of a reference hospital in La Paz at this time is supported by the evaluation team and most members of PROSALUD for the following reasons:

1. The income of the vast majority of potential patients in the principle market area of the PROSALUD/La Paz network, EI Alto, is not adequate to support a hospital that is intended to be (at least) largely self-financing. The PROSALUD/La Paz clinics are having a very hard time trying to achieve a high level of cost recovery. A hospital—as the Santa Cruz experience has demonstrated—would further aggravate the situation.
2. The PROSALUD La Paz/EI Alto health centers are located in three different geographic neighborhoods that are comprised of distinct socioeconomic and cultural classes of potential users. It is doubtful if a single hospital site could prove acceptable to and effectively accommodate such a diverse user population.

3. The three different geographic neighborhoods in which the PROSALUD La Paz/EI Alto health centers are located are relatively distant from one another, and there is no equidistant point from all three where the hospital could be located. Hence, transportation would be an obstacle to access and utilization of the hospital by one or more of the neighborhoods, thereby compromising the effectiveness of the hospital as a referral center.
4. The occupancy rate of hospitals in La Paz has remained around 35-45 percent throughout the past five years. (International standards identify 80-85 percent as the minimal acceptable range.) Thus, there is a massive surplus of hospital beds in La Paz. This situation makes it likely that PROSALUD will be able to negotiate an attractive agreement with one or more existing hospitals to establish a referral system or, to the extent that PROSALUD feels it needs to have more direct control, to rent hospital beds (or an entire floor of a hospital) while avoiding the uncertainties and risks that building and operating its own hospital would inevitably entail.
5. Unlike Santa Cruz where PROSALUD felt no hospital was available that (a) had an adequate physical infrastructure, (b) could confidently be relied on to provide an acceptably high quality of care, and (c) would be willing to enter into an agreement with PROSALUD to provide referral services, in the La Paz/EI Alto area there are several potential candidates that meet these conditions.
6. Another reason cited as justification for a La Paz hospital is that referral systems with other organizational entities require an investment of an inordinate amount of time and still do not function well. However, the experience of the PROSALUD/Santa Cruz hospital, again, demonstrates that simply having the facility "in-house" is not a solution. The director of the Santa Cruz hospital reports that the referral system between PROSALUD clinics and the hospital leaves much to be desired. He estimates that only about 30 percent of the referral caseloads are handled appropriately (i.e., as established by the PROSALUD protocol).

PROSALUD has already started to explore formal arrangements with three referral hospitals. Hospital Los Andes in EI Alto already has an agreement with PROSALUD and currently serves as a referral facility in EI Alto. For the centers located in northern La Paz, the hospital of the Fundacion San Gabriel is being considered, and for southern La Paz, a working relationship with the Methodist Hospital in Obrajes is being considered. In each of these cases, cost-sharing schemes will be explored. To better ensure that the referral system is functioning as intended and referred patients are well attended, consideration should be given to the possibility of locating a PROSALUD "client coordinator" in each facility. This multi-faceted alternative would be much more cost effective than PROSALUD establishing its own hospital. In the event that such referral agreements cannot be worked out with these hospitals or that the arrangements prove unacceptable (for whatever reason), consideration should be given to renting beds or a floor in one or more of the many highly underutilized hospitals.

The decision not to open a reference hospital in La Paz at this time does not preclude exploring the possibility of establishing a polyclinic that would house the most requested and needed medical specialists. These physicians could be non-salaried and could work under a

fee-splitting arrangement, just as most do in the Santa Cruz hospital. The polyclinic could also house a more sophisticated reference laboratory to support the entire delivery network, which would likely be an income generator for the system. Because only ambulatory services will be offered at this facility, its location would be less of a concern to the users than would be the case with a hospital facility. The location of the polyclinic is under study and the San Pedro health center site is being considered. This site looks promising: it is located in one of the most densely populated zones of La Paz and near a major marketplace with access to good urban transportation. This alternative is more promising than a hospital that carries much greater financial risk.

6 PROGRESS TOWARD SELF-FINANCING

Graph 7 shows the evolution of the La Paz clinic network's cost recovery performance. As the graph shows, the performance peaked at 65 percent in the second quarter of 1993 and thereafter slid downward each quarter until bottoming out at 48 percent in quarter 2, 1994. In each of the final two quarters of 1994 the level of self-financing increased, but at year's end the 64 percent mark attained still did not exceed the former peak achieved one and one-half years ago. Moreover, preliminary data for the first quarter of 1995 suggest that the level has dipped slightly to 61 percent.

The combination of (1) the delays and non-compliance of other actors fulfilling agreements with PROSALUD, whereby they were to provide PROSALUD with facilities to manage, (2) the rapid growth of non-PROSALUD health care infrastructure in the project site—and with it competition for PROSALUD clients, and (3) the very different circumstances of the La Paz/EI Alto area compared to Santa Cruz, have resulted in PROSALUD's being substantially behind in its efforts to achieve self-financing. Even under the most propitious of circumstances, it is highly unlikely that the La Paz regional office clinic network will be able to achieve its end of project goal of 100 percent self-financing (exclusive of the MSU) by March of 1996. The following discussion includes a financial analysis of the operations of the La Paz regional network to elucidate the bases of this conclusion and better understand how PROSALUD, and in particular, PROSALUD/La Paz, has performed financially.

6.1 Variations in the PROSALUD Model Required by the Different Socio-economic Conditions of La Paz/EI Alto

6.1.1 *Lower Prices*

The average price of most services is substantially higher in the PROSALUD clinic network of Santa Cruz than in La Paz. For example, the price of a general medical consultation ranges from 10 to 12 Bolivianos in Santa Cruz health centers, whereas its modal price in La Paz/EI Alto is only five Bolivianos (and this level was made effective March 1, 1995). This significant price difference means that a medical consultation in La Paz/EI Alto generates at most about half the gross revenue of one provided in Santa Cruz.

Even though the physicians of the PROSALUD/La Paz clinics have productivity levels that are about 85 percent of those of the PROSALUD/Santa Cruz physicians, they (directly) generate less than 40 percent of the gross revenue compared to their Santa Cruz counterparts.

INSERT
GRAPH 7

General Inability to Implement Fee-splitting/Risk-sharing Arrangements in La Paz/EI Alto. The difference in the price of medical consultations between La Paz/EI Alto and Santa Cruz is significant not only because it means that a medical consultation in La Paz/EI Alto generates only half the gross revenue of one in Santa Cruz, but also because this very low price precludes PROSALUD's from relying extensively on the risk-sharing arrangement that has proven to be such an important generator of net revenues in the Santa Cruz experience. In the case of Santa Cruz, this arrangement characterizes PROSALUD's relationship with all three medical specialists working in its clinics—pediatricians, gynecologists, and dentists—all of whom work on a fee-sharing basis, splitting the revenues they generate through their consultations with the PROSALUD organization. In the case of the pediatricians and gynecologists, the split is 50/50. Dentists, who must provide their own equipment, are allowed to retain 80 percent of what they gross in fee collections. (PROSALUD provides the equipment required by pediatricians and gynecologists.)

The 1989 evaluation of PROSALUD/Santa Cruz found that the only net revenue-generating services in the system were, in order of significance: (1) pediatrician services, (2) laboratory services, (3) gynecologist services, (4) pharmacy, and (5) dental services. Thus, two of the three largest net revenue generators in the PROSALUD model are largely non-functional in La Paz/EI Alto. (Unfortunately, due to changes in PROSALUD's accounting system introduced in 1990, it is no longer possible to ascertain the net revenues produced by any particular activity. More on the loss of this important management tool is discussed below.)

It has been possible to entice dentists to work at PROSALUD/La Paz health centers using the same 80/20 split as in Santa Cruz and similarly requiring them to supply their own equipment. During a visit to one of the EI Alto centers during this consultancy, however, the dentist at the facility complained vehemently that he needed to change his arrangement with PROSALUD—at least increase his prices—if he was to continue working with PROSALUD, as the combination of increasing input prices, low fees, and fee-splitting was making the arrangement economically non-viable.

Other than dentists, the only risk-sharing/fee-splitting arrangements in the nine PROSALUD/La Paz regional network centers are with two pediatricians. Physicians are exceedingly reluctant to enter into such an arrangement when fee levels are so low. If the network were staffed using such arrangements at a level similar to the facilities in Santa Cruz, another 16 specialists would be working in the nine PROSALUD/La Paz clinics.

Another result of the low fee structure of La Paz/EI Alto (which is a derivative of the non-viability of the fee-splitting arrangement) is that the costs of operating a PROSALUD health center are considerably greater in La Paz/EI Alto due primarily to higher personnel costs. The mean annual expenditures of a facility in Santa Cruz is 145,000 Bolivianos, compared to 180,000 in La Paz/EI Alto, reflecting primarily differences in personnel costs. (It should be noted that three of Santa Cruz's facilities are rural centers that do not have physicians. This difference, however, only accounts for 1.0 of the 3.8 person per facility difference and for only the three posts of the network's 13 facilities, i.e., nine percent of the staffing difference.)

Less Free Care is Provided in La Paz/EI Alto. Yet another result of the combination of (1) the low fee structure in La Paz/EI Alto and (2) the project goal of achieving 100 percent self-

financing of the clinics by March 1996 has been the tendency for PROSALUD clinics to provide substantially less care at discounted prices or totally free-of-charge to indigents. The PROSALUD/La Paz administrative system requires that each health center maintain a daily log identifying the payment status of all patients. These logs are submitted to the regional office monthly. The purpose of the log is to enable cross-checking and reconciling total service provision statistics with the total receipts of the center. The regional office accounting staff, however, does not have the time to tally these data. It implicitly assumes that the mere existence of such a system—coupled with the health center staff's assumption that these data are being reviewed—adequately achieves the end of ensuring the integrity of this cash accounting system.

A special analysis was conducted as part of this consultancy to investigate the proportion of non-paying patients and their impact on the self-financing status of PROSALUD/La Paz. Since time limitations did not permit undertaking a comprehensive, longitudinal assessment, the analysis was based on the patient payment status daily logs of a sample of two facilities in La Paz and two in El Alto. In order to enable the examination of a systematic variation by size of facility, one large, relatively more productive and one smaller, less busy center were selected in each health district, and the monthly logs for what was deemed (by the PROSALUD/La Paz financial director) to be a representative month (June) were selected. The monthly logs for the same month in 1993 and 1994 were reviewed in order to examine whether there had been any systematic change in the granting of price discounts over time. The results are reported in Table 5.

The 1989 evaluation found that approximately eight percent of PROSALUD/Santa Cruz's patients were totally exonerated from payment. The number usually cited in the case of PROSALUD/La Paz is 13 percent, although the source of this statistic could not be identified during this consultancy. The information presented in Table 5, however, reveals a significantly different reality. The most liberal granting of price discounts and fee exemptions was found in Chuquiaguillo (in both years), which it was just under 13 percent in June 1993 and less than four percent in June 1994. In June 1993 in four facilities (i.e., nearly half of the nine PROSALUD/La Paz centers), 97 percent of all patients paid the full regular price of care. In June 1994, the proportion edged upward to 99 percent. In light of the abject poverty characterizing the bulk of the catchment areas of the PROSALUD La Paz/El Alto health centers, one cannot help wondering if PROSALUD is not being pushed too hard, too fast to achieve 100 percent self-financing by March 1996. Is this end of project goal encouraging PROSALUD to pursue self-financing too vigorously at the expense of access to care? This is the perception of various prominent actors in the health sector.

6.1.2 Replacement of the Former Incentive System by Fee-sharing for Providing Emergency Services

Former Incentive System Based on Fee-sharing When Performance Goals were Exceeded.
One very innovative aspect of the original PROSALUD/Santa Cruz model (introduced in 1988) was the employee incentive system. The system was devised to (1) encourage PROSALUD personnel (especially physicians) to expand the clientele of their clinics and improve the financial condition of the system by tying wages to the financial performance of their clinic and

(2) avoid institutionalizing the practice of awarding annual pay increases totally untied to productivity or any other performance indicator.

The system consisted of a base salary that all employees were guaranteed regardless of the performance of their clinic and a variable bonus/incentive scheme that was dependent on the clinic surpassing an average of its previous performance levels. With the exception of the pharmacy, revenues generated by all of PROSALUD's service delivery activities were used to determine whether or not the clinic's performance qualified for a bonus. Pharmacy was intentionally excluded so as not to create any incentives for PROSALUD providers to prescribe medicines or to practice polypharmacy. Lab examinations and the revenues generated by lab exams were, however, included.

To complete the description of the bonus system, 30 percent of all of the monies left in the revenue "pot" after subtracting the minimum performance benchmark were set aside for distribution to personnel. Of this 30 percent, 30 percent was awarded to the full-time physician. The remaining 70 percent was split among all other clinic employees, in direct proportion to the share that their salary comprised in the clinic's total salary package. The bonus generally constituted about 10 percent of the employees' total compensation. This innovative system was discarded in June 1992, primarily because of new tax laws that discouraged such incentives.

The New Incentive System. On August 1, 1993, a new incentive program based on fee-sharing and the provision of emergency services was introduced. The new, emergency care-based system is exclusively for physicians. Other PROSALUD personnel no longer have the opportunity to benefit monetarily from exemplary performances. In the new, emergency care-based system physicians are entitled to retain 80 percent of the consultation fee revenues they generate providing care during non-regular hours, i.e., after 6:30 PM and before 8:30 am Monday through Friday or at any time on weekends.

Is the new system effective? One cannot help wondering if the introduction of this system has not created some resentment among non-physician staff members who now—by virtue of being left out of the system—have probably been made to feel less important than physicians. In terms of altering physician behavior, the fact that PROSALUD/La Paz physicians earn 50 percent of their PROSALUD-derived income from this scheme suggests that it has indeed been effective.

Additional evidence about the effectiveness of the program comes from its impact on the type of staff delivering babies in PROSALUD/La Paz clinics. Physicians now are motivated to come to their clinic in the middle of the night to deliver a baby. Physicians are entitled to 80 percent of the 100 Bolivianos delivery fee. As Graph 8 shows, the composition of birth attendants has changed significantly between 1993 and 1994, which in large part is due to the introduction of this scheme. The share of births attended by physicians increased 49 percent over these two years, growing from 59 to 88 percent of all deliveries.

PROSALUD's management team personnel maintain that the fee-sharing, emergency care scheme was prompted by quality of care and access considerations foremost, and only secondarily as a mechanism for holding down costs and providing monetary incentives for staff

physicians. PROSALUD personnel also mentioned the non-monetary incentives that are available to all staff, not only physicians. These include the status associated with working for an organization of the stature of PROSALUD, and, more personally, the friendly competition the PROSALUD system fosters through its public, organization-wide performance reviews and opportunities for continuing education and training.

6.2 The Composition of Costs and Revenues, the Financial Performance, and the Cost-Recovery Strategies of PROSALUD/La Paz

The only two PROSALUD/Santa Cruz facilities that recover more than 100 percent of their costs have substantially higher costs than the typical PROSALUD health center—50 percent greater in the best cost recovering clinic (which recovered 119 percent of its costs in 1994). This is also true of the best cost recovering facilities in La Paz/EI Alto (see Table 6). Villa Bolivar, Alto Lima I, 16 de julio, Villa Brasil, and Alto Miraflores are the only facilities in the La Paz/EI Alto network that have ever (on a quarterly basis) outperformed the network as a whole since the first quarter of 1992 (as shown in Table 7a), and they have all consistently had higher costs than the rest of the facilities.

This situation is largely due to the cost of personnel, which is the largest component of clinic operating costs (representing 60–70 percent of total operating costs, up from 55–60 percent in 1989). The staffing patterns of all of the clinics is nearly identical. Thus, the only way in which costs vary substantially is the extent to which a clinic treats more patients and thereby incurs higher variable costs for drugs and other medical supplies and lab exams. The clinics serving more patients have higher revenues that more than offset the increased variable costs of treating the additional patients. The higher variable costs are more than offset by the revenue generated because the personnel costs are fixed and personnel are operating at below the capacity number of services they could be providing (if demand were greater), and because the pricing policies used to establish the fee levels of lab exams, drugs, and nursing services are net revenue generating, thereby serving to defray fixed personnel costs. For example, medicines, which constitute 23 percent of the total operating costs of the La Paz/EI Alto clinics, are marked up a uniform 25 percent above cost and generate 53 percent of gross revenues in La Paz (see Graph 9).

As shown in Graph 10, the sources of revenues in the PROSALUD/La Paz clinic network have not changed appreciably since 1992, despite the fact that resources have quadrupled in absolute terms since then. Similarly the structure of costs has changed very little since 1992, though (nominal) costs were 2.6 times greater in 1994 than in 1992 (see Graph 11).

Table 5

Table 6

Table 7a

Relative Measures of Cost Recovery by the PROSALUD/LP Centers...

Graph 8

Graph 9

Graph 10

Graph 11

6.2.1 Options for Improving the cost Recovery Performance of PROSALUD/La Paz

As already noted, the end of project status indicators for the PROSALUD/La Paz clinic network to be 100 percent self-financing (by March 1996) will not be met, but how close can PROSALUD be expected to get to this goal? The level of self-financing is measured by the quotient of gross revenues divided by total costs. A more common and more intuitive way of assessing financial performance is using the more traditional concept of profitability. The end of project status (EOPS) calls for PROSALUD/La Paz to achieve zero profits, i.e., to reach its so-called "break-even" point where gross revenues equal costs. Profits equal (gross) revenues minus costs. Thus there are distinct strategies to reach the break-even point and become self-financing: by increasing revenues or reducing costs, or, of course, by some combination of the two. PROSALUD's options to increase its clinic network's financial performance are discussed below, first by exploring possible means to reduce costs and then by exploring possible avenues for increasing revenues.

Exploring Possibilities for Reducing Costs. With personnel constituting the single most important component of costs, an immediate concern is if personnel costs can be reduced. Although time did not permit undertaking an analysis of this issue as part of this consultancy, given the characteristics of the basic PROSALUD model, this is not likely to be a particularly fruitful avenue to pursue for several reasons. First, some of the highest cost personnel working in PROSALUD/La Paz clinics, namely, the two pediatricians, are not even earning a salary. They are sharing the fees they generate. As already noted, the low prices of PROSALUD/La Paz consultations has precluded the organization's ability to establish this arrangement on the same scale as Santa Cruz.

Second, the remaining PROSALUD/La Paz physicians (the vast majority) who earn a base salary are not earning large salaries (even by Bolivian standards). The base salary that the typical physician earns is the equivalent of his/her colleague working for the NSH. Most PROSALUD physicians earn an additional 50 percent of their base salary by providing a combination of (1) emergency care in a fee-sharing scheme whereby the physician and PROSALUD split the gross revenues generated 80-20, (2) working on Saturdays, when a 70-30 fee-splitting arrangement is in effect, and (3) providing reproductive health services for which a similar 70-30 split is made (the latter financed by family planning funding provided by another USAID project).

The difference between the total earnings of a PROSALUD and an NSH physician may be regarded as sizable, but it is necessary to recognize the important differences in these positions in order to make more meaningful comparisons:

- PROSALUD employees work longer days than their NSH colleagues. PROSALUD service providers work 8:00 am to noon and 2:30 PM to 6:30 PM five days a week, whereas NSH providers are officially scheduled to work 8:30 to 2:30, five days a week (and are commonly reported to work considerably less than this). NSH providers able to go to another job—perhaps their private consultancy—in the afternoon.

- PROSALUD employees are expected to do a substantial amount of work—especially related to supervision, monitoring, and evaluation—on their own time, generally Saturdays.

Similarly, other PROSALUD positions pay base salaries that are virtually identical to those paid by the NSH. Thus, reducing base salaries of PROSALUD staff does not appear to be a viable option for reducing PROSALUD costs and thereby increasing its cost recovery performance. It is noteworthy that when the 1989 evaluation was performed, the base salary of a PROSALUD physicians was 25 percent greater than that of an NSH (then Ministry of Health) physician. PROSALUD's efforts to achieve higher levels of self-financing have already resulted in its eliminating this variation while introducing other innovative schemes to "stretch" personnel expenditures. Base salaries therefore, must, be regarded as "bare bones" minimums and not realistic candidates for further reductions, at least not significant reductions.

If the price of PROSALUD labor cannot be appreciably reduced, the other alternative to reduce labor (personnel) costs is cutting staff. Is this a viable option for PROSALUD/La Paz? One of the hallmarks of the PROSALUD model identified in the 1989 evaluation was the organization's use of a variety of techniques to minimize and control personnel costs. At that time the organization had just completed a process of paring down staffing patterns to what were regarded as minimum numbers. This process included substituting multi-function positions for the more traditional and unnecessarily specialized ones. For instance, PROSALUD replaced night watchmen who simply provided security services with nurse auxiliaries who provided security services but also provided limited health care services beyond routine clinic hours, thereby making services more accessible and increasing utilization. The resulting staffing patterns, in terms of both numbers and types, were identified as the optimal configuration and became PROSALUD's standardized clinic staffing pattern. Deviations from this standard are permitted on a case-by-case, clinic-by-clinic basis, depending on the level and composition of services demanded. While time constraints did not permit assessing the staffing patterns of the La Paz/EI Alto clinics, casual observation from visits to several facilities suggested that there is very little room, if any, for reducing the numbers of PROSALUD/La Paz clinic staff persons, in order to enhance the profitability of the network. It should also be pointed out that PROSALUD's practice of operating a single laboratory for every three clinics may be regarded as a technique for economizing personnel (as well as equipment and supplies).

PROSALUD has continued to rely on the NHS for vaccinations, syringes, medicines used in the treatment of tuberculosis, and vaccination and child growth monitoring cards in order to hold down its costs and make its policy of providing free preventive services less painful in terms of eschewing costs.

In conclusion, while there may exist some possibilities for reducing costs within the PROSALUD/La Paz network, opportunities for cost cutting appear to be relatively limited and are not likely to have a significant impact on the cost recovery status of the La Paz/EI Alto network.

Exploring Possibilities for Increasing Revenues. The other half of the profit equation is revenues. What might PROSALUD/La Paz do to increase its revenues? It is important to bear in mind that the goal is not simply to increase revenues per se, but rather net revenues; i.e., revenues minus the costs of generating those revenues. An alternative approach to reducing (the absolute level of) costs would be to improve the efficiency of use of other inputs. Based on the proportion of total costs which inputs constitute (see Graph 12), the most important inputs would be medicines, other medical supplies, and lab exams. Patients pay directly for some of these inputs, namely medicines and lab exams, and both of these types of inputs appear to be net generators of revenues for PROSALUD, although this cannot be definitively stated since neither, individually, constitutes a PROSALUD accounting system cost center. Hence, it is not possible to quantify the total costs associated with these activities, most importantly labor but also the costs of acquisition and storage. This must be borne in mind in the following discussion.

In 1994, pharmacy costs were 365,599 Bolivianos, compared to revenues of 471,510 Bolivianos, while laboratory costs were 7,857 Bolivians, well below its 56,243 Bolivianos in revenues. These imperfect measures suggest that pharmacy and laboratory operations accounted for roughly 106,000 Bolivianos and 48,000 Bolivianos, or 12 and five percent, respectively, of the total net revenues of PROSALUD/La Paz.

The relative importance of these support services in generating the gross revenues of La Paz is in sharp contrast to the much smaller, but nevertheless significant, role they play in the Santa Cruz network. These differences, which are attributable to differences in the mix of services demanded and provided and different tariff structures, are readily evident in Table 7b.

TABLE 7b

DIFFERENCES IN THE FINANCIAL SIGNIFICANCE OF PHARMACY AND LABORATORY REVENUES AND COSTS IN THE PROSALUD LA PAZ AND SANTA CRUZ CLINIC NETWORKS		
SERVICE/SITE	GROSS REVENUES	COSTS
PHARMACY		
1. Santa Cruz	16	11
2. La Paz	53	23
LABORATORY		
1. Santa Cruz	14	2
2. La Paz	6	1

Graph 12

Although there are no data available by which to assess the appropriateness of the amount of drugs dispensed by PROSALUD/La Paz providers, PROSALUD's list of service indicators does contain a measure for laboratory services, the number of lab exams per first curative consultation. Although this indicator has followed a generally upward trend since the inception of the La Paz network, the number of lab exams per new consultation continues to be less than that of the Santa Cruz clinics. Hypothesizing that lab tests, generally a diagnostic tool, would be more common in the La Paz system because of the presumed backlog of health ailments in a population long without adequate access to care, this finding is somewhat surprising. The number of tests per new consultation in La Paz in 1993 was 0.15, less than half of the Santa Cruz number 0.34. In 1994, the magnitude of this variation decreased substantially to 0.28 and 0.36, respectively. Are PROSALUD/La Paz physicians sensitive to the income limitations of their patients and do not order as many lab exams as may be needed? Or are they more careful and conservative in ordering such tests? Or is it simply that the epidemiological profile of the La Paz is sufficiently different from that of Santa Cruz to account for this difference? (The Santa Cruz rate has been relatively constant around 0.35 for several years now, suggesting some type of stable, long-term utilization rate.) For whatever reason, it is clear that PROSALUD/La Paz physicians are not ordering large numbers of unnecessary lab exams in order to increase the cost recovery performance of the network. (PROSALUD should undertake, however, an investigation of these substantial regional differences.)

Looking at the remaining sources of revenue identified in the accounting system, dental consultations are a net revenue generator for PROSALUD, since all recurrent costs are assumed by the dentist. While no information is available on the costs associated with births, there is no reason to believe that the technology of PROSALUD's births has changed much since 1989, and, to the extent that associated costs have increased, they have done so primarily due to increasing labor costs. It is likely, therefore, that the 1989 evaluation finding that births were the single largest net revenue-generating service provided by PROSALUD is still pertinent.

The evaluation team had virtually no additional information with which to examine the nature, role, or significance of the two remaining unanalyzed principal categories of revenue sources, medical consultations and nursing services, in the net revenue generation of PROSALUD/La Paz.

Pricing Policies and Practices. Revenues are equal to the price at which services are sold multiplied by number of services. The relatively low level of prices in La Paz/EI Alto and the relatively short period of time that the organization has been given for the clinic network to become 100 percent self-financing (exclusive of the MSU) by March 1996 have encouraged the La Paz regional office to devote considerable time and attention to the issue of pricing.

PROSALUD closely monitors its costs and prices on an ongoing basis. PROSALUD/La Paz regional office staff feels that it has pushed prices up as rapidly as feasible given the political and economic realities of La Paz/EI Alto. A review of the history of its efforts and a review of the prices of its competitors suggest that is indeed the case. PROSALUD prices are slightly higher than most (but not all) of those of the NSH and some other competitors. The Dutch-sponsored system of five centers, for instance, pursues cost recovery, but its goal is only to

recoup the recurrent cost of supplies, perhaps one-third of the costs of its clinics' operations. This puts PROSALUD at a competitive disadvantage. PROSALUD already covers nearly twice this proportion of costs, but, according to its agreement with USAID, this is substantially inadequate.

When PROSALUD first began operations in the La Paz/EI Alto facilities the price of a consultation was a uniform three Bolivianos in all facilities. Starting in February 1992 PROSALUD revised its price schedule and began to differentiate prices by health center. It implemented a new policy charging the patients of other physicians (who were referred to a PROSALUD center for medicines, lab exams, or to obtain a particular service—but not simply to obtain a medical consultation) a higher price. Initially only two of the facilities, 16 de julio and Villa Bolivar, had higher prices; 3.5 Bolivianos for a medical consultation and 10 Bolivianos for stitches, compared to three and eight Bolivianos, respectively. When the two La Paz-based centers were opened they charged four Bolivianos for a consultation. In March 1992, the price of a dental consultation in all centers was reduced from five to three Bolivianos.

Thereafter, the prices of services have been changed only three times: August 1, 1993, August 1, 1994, and March 1, 1995. Table 8 presents the evolution of price changes made in the highest priced health center of the PROSALUD/La Paz network, Centro Villa Bolivar. With each price revision prices became increasingly differentiated by health center. Table 9 contains the current price structure in each PROSALUD/La Paz health center. The Table has three parts: Part A contains the prices charged PROSALUD patients for services provided during regular working hours (8:00 am to noon and 2:00 PM to 6:00 PM). Part consists of two sections. The top portion contains the fee charged non-PROSALUD patients (i.e., persons referred by other providers) and the bottom portion contains special emergency services fees. Table 10 contains the evolution of prices charged both PROSALUD patients (in the upper portion of the table) and those charged referral patients (in the lower portion) for laboratory examinations.

Referrals are charged higher prices which, depending on the particular service or lab exam, are from 14 to 200 percent greater than the fee a PROSALUD patient pays. Emergency fees are charged for services provided outside regular hours. The prices of emergency services are roughly 50 percent higher than regular fees. Table 9 indicates that the differences in the prices charged PROSALUD patients and referred patients have narrowed over time.

The prices of medicines have been changed two to three times more often than those of either consultation services or lab exams. Generally new medicine prices are issued every three to four months, reflecting their greater variability and probably the generally greater public willingness to accept higher drug prices, with the understanding that the higher prices are a reflection of higher costs simply being passed on to the consumer.

Another means to increase revenues is altering the structure of PROSALUD prices by charging for some services that have been provided free of charge to date.

Trading Revenue Generation/Cost Recovery for Other Public Health and Social Goals.
PROSALUD has made a very conscious and deliberate decision to trade revenue generation/cost recovery for better achievement of other important goals. As discussed

Table 8

Table 9

Table 10

previously, two-thirds of the services provided by PROSALUD/La Paz are provided free-of-charge. PROSALUD could charge something for these services and generate additional revenues, but not without reducing access to and utilization of its services. Part of the PROSALUD model is its commitment to public health goals and promoting health care by not charging for preventive services. In the context of the EL Alto market, this commitment may also be of practical usefulness as an effective marketing strategy. Free preventive care can first entice persons not accustomed to using Western medicine or formal health care providers into PROSALUD clinics. This may provide the basis for these (and other) persons to develop confidence and trust in the PROSALUD providers and system, and thereby be instrumental in spawning a more regular and permanent clientele. This, however, is a longer-term process and an impact that is difficult to quantify in the absence of periodic market studies of the knowledge, attitudes, and practices of PROSALUD patients and other persons residing in the PROSALUD clinic catchment areas.

Similarly, PROSALUD does not charge for follow-up visits in the treatment of a particular ailment. In 1994, 25 percent of all of the curative care visits of children and 31 percent of those of adults were follow-up visits. The proportion of follow-up visits is 40 percent higher in La Paz compared to Santa Cruz as Table 11 reveals. This policy—like the provision of free preventive care—has more significant implications for La Paz than Santa Cruz.

Had PROSALUD, and especially PROSALUD/La Paz, decided to charge for these visits, undoubtedly it could have generated more revenues. Another aspect of the PROSALUD model, however, is to trade such potential revenue generated by fees for follow-up visits for the social goals of greater continuity of care and higher quality of care which it feels is the result of its no-charge policy. This policy, too, can be an important marketing tool; it virtually elevates the health of the client and the patient's satisfaction with the health care provided to a position of importance above the much narrower concern of the organization's financial considerations.

Because PROSALUD has almost exhausted the price variable mechanism as a means of revenue generation, the only remaining strategy by which to increase revenues and cost recovery is to increase the quantity of services provided. Given the relatively nascent character of the La Paz regional network, this may be the most promising approach. It appears that the PROSALUD/La Paz regional network clinics have some excess capacity and they could increase their delivery of services without greatly increasing costs. More specifically, it appears that most of them could increase the number of patients they serve without needing to hire additional staff, thereby spreading fixed personnel costs over a larger number of services, and thus driving down their unit costs (i.e., increasing their efficiency). In the same vein, the new fee-sharing scheme for providing emergency care and care on Saturdays may be viewed as a clever means of stretching existing physician manpower without incurring additional direct personnel costs. This approach, however, has been more difficult than had been anticipated because of the proliferation of health providers and infrastructure in the area. This has encouraged PROSALUD to take a keener interest in marketing and hire a private sector marketing specialist, which is an appropriate first response. The Deferred Payment Program (which will be discussed in greater detail in the next section) is designed to generate additional demand to utilize some of this excess capacity.

TABLE 11

6.3 A More Disaggregated Look at the Cost Recovery Performance of PROSALUD/La Paz

All of the PROSALUD/La Paz clinics have followed remarkably similar paths of self-financing, reflecting the facts that (1) the cost and revenue structures of each facility are very similar and (2) cost and revenue levels are largely determined by forces outside the individual clinics. Despite the aforementioned efforts to introduce different prices into the network, the structure of revenues remains largely the same (refer to Graph 10). The structure of costs, too, has remained largely static. With the structure of both costs and revenues largely determined by the nature of the PROSALUD model, and particularly its staffing pattern, variations in the level of revenues and the level of costs—and thereby the level of cost recovery attained—are determined chiefly by the level and mix of demand.

The similarities in the shape of the cost recovery curves of the individual clinics is striking (see Graph 13), and suggests that most of the changes in their costs and revenues over time have been the result of system-wide factors, rather than attributable to particular practices or behaviors of individual clinics. Whether these system-wide factors are, however, characteristics of the PROSALUD system or the La Paz/El Alto health sector "system" (including changes in demand) or some combination thereof is not readily evident. As noted earlier, some of the variation in the utilization of PROSALUD clinics has been the result of erratic NSH supplies of vaccines. While this variation is not directly reflected in the cost recovery performance of the clinics—because preventive services are free-of-charge—it may be indirectly manifested here, to the extent that persons not obtaining preventive services may have been discouraged from coming to the clinic where some proportion of them no doubt obtained fee-generating curative care during the same visit that they obtained some free preventive care.

Another reason for the similarity in the shape of clinics' cost recovery curves is that the outlays for their most important cost, (personnel), have been marked by the same changes introduced at the same time in all of the clinics. PROSALUD has generally tied increases in the level of salaries it pays its physicians to the increases annually granted the NSH physicians.

For the past several years, government increases have been tied to the general rate of inflation, adjusted for changes in the exchange rate (specifically the value of the U.S. dollar). PROSALUD's salary increases, however, must also be reviewed by USAID. USAID usually undertakes this review in May and makes the changes retroactive to January. These annual first quarter increases in salaries are one of the principle causes of the fluctuations in the cost recovery performance of PROSALUD. More specifically, they are one of the causes of the generally lagging first quarter and, to a lesser extent, second quarter self-financing performance.

Graph 13

The impact of this increase in costs is exacerbated in the first quarter by seasonal variation in the demand for medical care. January and, to a lesser extent, February are characterized by low levels of utilization that result in lower than average (gross) revenues. Increased costs and dampened revenues create a depressing effect on the proportion of costs that are recovered in the first quarter of most years. In quarter 1, 1993, cost recovery efforts increased only two percent over the previous stagnant quarter. The first quarter of 1994 was the largest quarter decline in the level of cost recovery in the history of PROSALUD/La Paz when it fell from 59 to 50 percent. Similarly, in quarter 1, 1995, the proportion of costs recovered was 61 percent, down three percent from quarter 4, 1994.

6.3.1 MSU Costs, Start-Up Costs, and PROSALUD/La Paz's Level of Total Cost Recovery

The previous discussions of self-financing of PROSALUD/La Paz have considered only the costs of operating the clinics and have not considered the MSU costs. Graph 14 shows the annual evolution of total PROSALUD/La Paz costs,—i.e., the costs of operating the MSU plus the health centers. As is evident from the graph, the costs of operating the La Paz MSU are substantial, more than twice as much as the costs of operating the nine health centers. When relatively high MSU costs are included in the cost recovery performance measure, the level of self-financing of PROSALUD/La Paz falls precipitously as is seen in Graph 15. Whereas 55 percent of the clinics' expenditures were recovered in 1994, only 17 percent of the total costs of the La Paz operations were recovered. Moreover, one should add a prorated portion of the National Office expenditures to the La Paz MSU and clinic expenditures for a more accurate picture of the financial performance of the La Paz network because a substantial portion of National Office resources has been devoted to establishing and improving the La Paz operations. Unfortunately, this calculation cannot be performed because the National Office officially established in mid-1993, and (with the exception of the salary of the national executive director) its costs were never isolated from those of the Santa Cruz office until January 1995. (Note: this means the MSU costs of Santa Cruz are somewhat inflated.)

PROSALUD/La Paz's level of self-financing exclusive of the MSU dipped from 58 percent in 1993 to 55 percent in 1994, while its level inclusive of the MSU moved in the opposite direction, increasing from 14 percent to 17 percent during the same two years. This reflects the fact that the size of MSU expenditures relative to the clinics' expenditures decreased in 1994, even though MSU expenditures increased in absolute terms by 19 percent that year. Clinic expenditures increased in relative terms because they grew at a pace nearly three times as fast as the MSU expenditures, by 52 percent in 1994. The declining importance of MSU costs in total PROSALUD/La Paz costs is the result of MSU costs spread over more health centers and more services.

The fall in the proportion of total costs attributed to the MSU is a positive development and should continue throughout the next few years. It is reflective of what should be considered a normal pattern of start-up costs. Starting up the La Paz network has involved a substantial number of one-time or limited duration activities. Protracted discussions and negotiations to obtain the facilities and their subsequent remodeling; development of initial inventories of drugs and medical supplies; development of La Paz-specific forms; interviewing, hiring, and training of staff; wasted time and other inefficiencies that characterize work patterns until the

staff develops and becomes accustomed to regular work routines are all examples of start-up activities that result in higher than normal operating costs. As start up activities are completed, the responsibilities of the MSU decrease with corresponding decreases in the expenditures of the MSU.

Another reason for expected high rates of increase in costs, apart from the costs of the MSU, during the start-up phase of operations and their subsequent decline is the rapid growth in service provision levels during the initial phase. The use of consumable supplies that increase with increasing service provision levels (so-called "variable costs")—such as the cost of additional supplies of medicines, cotton, bandages, gauze, alcohol, laboratory test reagents and biologicals, syringes, and so on—result in rapidly increasing costs during the start-up phase. Eventually, as the health center network becomes established, start-up costs diminish, and, as the service provision level of the network starts to stabilize, the rate of increase of variable costs decreases.

These two phenomena—the behavior of MSU costs and the variable costs of service provision—act to cause initial rapid increases in costs and thereafter cause the disproportionately high costs of a new project to eventually fall and approach a more stable, longer-run level during the consolidation phase of the project.

A third reason higher start-up costs are expected in this particular project is because the PROSALUD model gives priority ranking in the first phase of replication (according to the national executive director) to effectiveness; i.e., to implementing the system and starting to provide quality health care. Once that has been reasonably well accomplished, greater attention focuses on strengthening operations (i.e., lowering unit costs).

The cost structure of PROSALUD/La Paz does not yet adhere to this pattern as closely as one might expect. Its cost structure is different than expected in the beginning of the fourth year of this project: start-up costs have been higher, while MSU costs as a proportion of total costs have been higher (due to having fewer health centers in operation), at the same time that revenues have been lower. Higher costs and lower revenues mean that PROSALUD/La Paz is considerably behind in its quest to make its clinics 100 percent self-financing.

How much greater MSU costs are relative to what they would be in a more stable, longer-term situation is difficult to say. The selection of El Alto as the site for the first seven health centers, accounting for seven of the nine clinics in operation to date, and the difficulties that PROSALUD has had in obtaining its planned complement of health centers has made the structural limitations of the original project design self-evident. PROSALUD's response has been to search for new methods and activities, beyond those contained in the project paper, to enable it to achieve a higher level of self-financing. This project restructing and redesigning is still unfolding and therefore PROSALUD/La Paz's MSU remains disproportionately large and expensive. The continuing search for a more economically viable structural base of operations means that PROSALUD/La Paz has not entered the consolidation phase. Without entering the consolidation phase, it is difficult to predict what the long-run costs of the MSU should be, but a general idea can be obtained by looking at the experience of PROSALUD/Santa Cruz. This will be part of a review of the cost-recovery efforts of the Santa Cruz-based operations discussion in the following section.

Given that they still constitute 70 percent of total operating costs, it is imperative that MSU costs become the focus of attention in the development of a new, longer-term financing strategy in order to increase the level of cost recovery of the PROSALUD/La Paz network and enhance the sustainability of the entire PROSALUD organization. These activities may include the development of additional health centers, but PROSALUD could pursue other activities, as well. Some possibilities are explored in the next chapter.

6.4 The Santa Cruz Network's Performance

For the most part, the 1991-1994 period was marked by continued improvement in the service delivery performance of the Santa Cruz clinic network, and relatively minor fluctuations in the curative vis-à-vis preventive composition of the services provided (see Graph 16). Massive increases, annually averaging 22 percent, were posted in the number of services provided in both 1991 and 1992. 1993 saw the rate of growth slip to three percent, and in 1994 the number of services provided contracted by four percent. Both the slowdown in 1993 and the decrease of 1994 were largely attributable to PROSALUD's August 1993 loss of two rural health facilities (Puesto de Salud El Pailon and Hospital Cotoca). PROSALUD personnel reported that political jockeying on the part of the Secretaria Regional de Salud (SRS) led to its insistence that the facilities be returned. (Time did not permit independent verification of the cause of this reversal in public policy.)

Although the loss of these facilities contributed to the reduced number of services provided by PROSALUD/Santa Cruz, it also led to the improved financial performance of the network, because both of these rural-based facilities had persistently been net drains on the financial position of the organization.

The proportion of the total expenditures accounted for by the MSU remained relatively constant throughout this four-year period (see Graph 17). The MSU accounted for 26 percent of total PROSALUD/Santa Cruz expenditures in 1994, a mere 37 percent of the La Paz MSU's proportionate share of PROSALUD/La Paz's expenditures.

Graph 18 shows the cost recovery performance of the Santa Cruz regional office with and without the MSU. As noted earlier, the Santa Cruz MSU costs reported during this period are inflated somewhat because they include costs of the National Office and other higher than "normal" costs owing to the MSU's participation in the La Paz replication effort and the addition of the referral hospital. Some unknown proportion of the higher costs incurred as a result of the replication have been defrayed by payments received from the USAID project for those services (although there is no way to know if the full costs of these activities were covered by these revenues). This approach to reimbursing Santa Cruz's technical assistance in the replication effort was adopted to enable a more clean withdrawal of USAID assistance under this project from all PROSALUD/Santa Cruz activities, with the exception of the referral hospital.

graph 14

graph 15

graph 16

graph 17

graph 18

The payments made to PROSALUD (and the National Office) are reported in the accounting line item "projects assistance," which also includes payments received by the Santa Cruz and National Officer personnel for technical assistance provided to other projects, including several international consultancies. (See Appendix F.) PROSALUD's cost recovery performance has traditionally been measured by considering all revenues as being earned by the clinics—as they mostly have been until the development of this technical assistance activity, and to divide revenues by either (1) the total expenditures of the clinics—to obtain the proportion of cost recovery, exclusive of the MSU, or by (2) the sum of total expenditures of the clinics and the MSU—to obtain the proportion of cost recovery, inclusive of the MSU. Traditionally, PROSALUD has reported its level of self-financing using the clinics expenditures as a base for the indicator. This is understandable because it provides a more positive result. Presently, however, with several years' ascent to a position of considerable budgetary significance, it is essential to change this practice in order to be more consistent and provide a more accurate indication of the level of self-financing of the clinics. There is now a need to net these revenues out of the clinics' revenues, as they are the result of technical assistance provided by MSU personnel, and establish separate revenue accounts for the MSU and National Office (completely analogous to the way in which treatment expenditures have historically been treated) in order to provide better understanding of what the level of PROSALUD's self-financing is measuring.

The "projects assistance" revenue line item has accounted for a critically important proportion of total PROSALUD/Santa Cruz revenues during this period: 20 percent of total gross revenues in 1991, 27 percent in 1992, 31 percent in 1993, and 18 percent in 1994. In 1994, when the revenues from this source fell by 410,000 Bolivianos, the combined revenues garnered from all other sources of revenues increased but could not completely offset the drop of this single category, and total PROSALUD/Santa Cruz revenues fell by 365,000 Bolivianos.

The variability and magnitude of this revenue source suggest that PROSALUD/Santa Cruz's financial performance has been less stable than would appear at first glance and is a cause for concern. PROSALUD/Santa Cruz needs to pursue the development of a more stable source of revenues. As a result of this slippage (between 1993 and 1994), the cost recovery performance of the Santa Cruz regional office dropped substantially from 94 percent to 75 percent of clinic expenditures and from 67 percent to 55 percent of total (MSU plus clinics') expenditures. This is troubling. This is the lowest level of self-financing that PROSALUD/Santa Cruz has attained since 1988. Moreover, if the hospital is included in the calculations, the 75 percent figure for clinics only falls to 62 percent, while the total regional office system's percent, of course, remains unchanged. PROSALUD/Santa Cruz is not likely to achieve its end of project goal of 100 percent self-financing, inclusive of MSU expenditures.

6.5 The Cost Recovery Performance of the National PROSALUD System

Graph 19 presents the MSU versus clinics' expenditure composition of PROSALUD nationwide. Over half of the total expenditures of the organization are accounted for by the two MSUs (which, in the data reported in the graph, include the National Office's costs, with the exception of the executive director's salary).

Graph 20 further disaggregates the MSU-clinics' dichotomy to reveal the regional office origin of the same two types of expenditures for 1994. Although the expenditures of the health centers in the Santa Cruz network approach twice the level of those in the La Paz network, the Santa Cruz MSU spends only 28 percent as much as La Paz. Again, this is evidence of the high cost start-up phase of the La Paz regional office.

Graph 21 shows PROSALUD's total national expenditures (exclusive of the hospital) for 1992-1994. The 1994 levels of self-financing are 68 percent of clinic expenditures (actually just less than 60 percent due to the "projects assistance" revenues distortion noted above) and 33 percent of total (clinics and MSUs) expenditures. The drop in PROSALUD's performance in 1994—by both measures—is due to the slipping performance of both regional offices (for reasons already detailed).

graph 19

graph 20

graph 21

7 SUSTAINABILITY, THE POLITICAL ENVIRONMENT, AND EXPANSION/ REPLICATION ISSUES

7.1 Sustainability

Sustainability involves at least two dimensions—institutional development and financial independence. PROSALUD has made significant strides in terms of its institutional development, as evidenced by its success and the evolution of its structure and performance as an institution.

The critical factors contributing to PROSALUD's successes in Santa Cruz and La Paz include the following:

- Outstanding leadership
- Long-term continuity of nearly the entire core management team that initiated the project 10 years ago
- The existence throughout the organization of a teamwork ethos based on a sense of partnership, mutual respect, and a shared sense of social responsibility and shared commitment to public health and public service
- A monitoring, evaluation, and planning system that cultivates individual employees feeling of responsibility for the performance of the organization
- Criteria and procedures used in the personnel recruitment, training, and evaluation system
- Openness to suggestions and new ideas, coupled with a willingness and ability to change
- The existence of a large surplus of physicians in Santa Cruz and La Paz which facilitates recruiting and retaining motivated and technically competent personnel while charging relatively low rates of remuneration and the using risk-sharing/fee-splitting arrangements
- A "shared community of interests" approach to working with other actors in the health sector that entails avoiding zero-sum games and actively seeking out and constructing ways to generate positive-sum gains for all involved parties
- A proven track record, which, when coupled with an earnest commitment to public health, has (ultimately) proven able to disarm opposition

The last half of this list in particular consists of characteristics and operating systems of the institution that have been institutionalized and thus are major reasons why the organization is sustainable.

In addition, analysis of the evolution of the institution-reveals a number of characteristics and developments that are indicative of a mature, well-integrated, sustainable institution. These indicators (1) testify to the organization's ability to shape and fine tune its structure and operating systems in order to undertake new activities and better enable it to address ever-changing market and political conditions and (2) provide evidence of an increasingly sophisticated level of operations. These indicators include the following:

- A second regional office structure has been developed and is functioning relatively independently of Santa Cruz.
- The basic model has been adapted to meet the exigencies of providing care to a much poorer, culturally distinct population that is relatively unaccustomed to providers of western medicine. The model has achieved a 55 percent level of self-financing exclusive of the MSU and 17 percent inclusive of the MSU.
- A National Office has been developed.
- Many of the new Santa Cruz regional office staff members are persons who have long been employees of PROSALUD and have been promoted within the organization, bringing with them experience and other points of view.
- A secondary level reference hospital has been added to the infrastructure in Santa Cruz. Although its service mix and costs are much more difficult to predict and control relative to primary health care, the hospital is nearly 70 percent self-financing.
- Personnel turnover is low.
- Detailed manuals specifying rules, regulations, processes, and procedures for each of the critical components of the management system have been revised, expanded, and recently published.
- The service delivery package continues to evolve, as reproductive health services have been added. (The particular approach to these services, contraceptive social marketing, is a natural addition to the PROSALUD package because (1) it is an MCH service, that is at the heart of the PROSALUD model, (2) it is commercially oriented, like the PROSALUD model, in general, and (3) PROSALUD is already a

leader in reproductive health services in the relatively short time these services have been available in Bolivia).

- PROSALUD undertakes continued refinement of service provision measures, including the development of process indicators of the quality of care and population-based tools for constructing epidemiological profiles of communities.
- The La Paz regional office has demonstrated considerable sophistication in its close monitoring of prices and costs and in the evolution of its increasingly differentiated price structure.
- In recognition of the need to compete with the rapidly growing number of alternative providers in La Paz, advertising and other elements of marketing have been accorded increasing importance within the model.
- The La Paz regional office has developed a deferred payment program to boost the capacity utilization of the La Paz clinic network which will be rolled-out in June 1995.
- The organization has developed an increasingly important role as a provider of technical assistance, both nationally and internationally.
- The organization has had an important impact on the entire health care sector by virtue of its high-profile, high-quality, low cost, consumer-oriented model. Competitors have felt compelled by the market to copy various aspects of the model.
- PROSALUD continued increasing the level of service provision in the Santa Cruz regional office health centers even while the management team was preoccupied working with the La Paz Regional Office and operationalizing the hospital.
- PROSALUD developed and applied the first patient satisfaction survey in November 1994. This survey is now planned to be institutionalized and routinely undertaken (every six months or once a year).

7.1.1 PROSALUD's Conflictive Goals and the Inevitability of Trade-offs

It should be readily evident that PROSALUD could choose to strike the series of trade-offs it makes in a more self-serving manner than it has to chosen to do. If it did so, there would be little question that it would be successful and sustainable. Doing so, however, would entail altering the terms of the compromises it currently strikes:

- Between maintaining access to care and raising its prices to some level above their current very low, near-NSH-equivalent levels.
- Between providing a more socially responsible and socially desirable mix of services—in particular, continuing to provide a great deal of free preventive care and free follow-up care—and redirecting the focus of its services to curative care, which is net revenue generating and has much greater potential for increasing the level of revenues it generates
- Between maintaining commitments to neighborhoods and communities it currently serves and eliminating the less productive clinics that are a net drain on system resources (such as the rural sites in Santa Cruz and the entire the El Alto site, or at least dropping the four El Alto health centers that are consistently the biggest financial liabilities).

Indeed, PROSALUD has already been forced to strike these trade-offs at different points than it had anticipated in the case of its La Paz/El Alto operations as evidenced by fewer persons receiving care at discounted prices or free-of-charge; prices now beginning to depart noticeably from those of the MOH/NSH; and the various required modifications of the model (detailed earlier). Still, PROSALUD has not abandoned its philosophy. It is due to the inherent difficulties of trying to pursue a self-financing strategy in a place like El Alto, where the population is so poor and is generally unaccustomed to relying on Western medicine, that brought about these compromises in the original PROSALUD model.

Are these deviations desirable? It depends on the model's goals. If the goal is to provide access and care, then these deviations are not desirable. If the goal is to achieve self-financing, then, they are. If the goal is the development of a sustainable Bolivian institution, then the situation becomes ambivalent. What is expected of Bolivian institutions? Are they required to be 100 percent self-financing?

Assessing whether or not the goals established for PROSALUD are reasonable and whether or not the organization's accomplishments are adequate, is not a simple task. When considering if the EOPS will be fulfilled by March 1996, the answer is probably "No." If the issue is approached from the USAID perspective, or a public health portfolio manager's perspective, it becomes more complex. It seems to make little sense to transferring millions of dollars to other organizations (such as the NSH or PVOs) that have little cost recovery interest or potential and are structurally plagued with effete management. Would not the funds go much further in terms of having an impact on health status and in an enduring impact on the health sector of Bolivia if they were channeled instead to PROSALUD? A 1992 evaluation that compared two MOH/NSH health centers in Santa Cruz to two PROSALUD centers in the same city determined the funds would definitely be better utilized by PROSALUD (Richardson, et al., 1992).

7.1.2 The Simplistic and Mechanistic Approach of the EOPS

In the opinion of the evaluation team, the EOPS is fundamentally flawed and should not be the singular yardstick used to assess PROSALUD's performance. The EOPS focuses far too narrowly on the financial aspects of PROSALUD operations. Yet, clearly, self-financing is not the goal. It is but a means by which to achieve the goal of improving the health status of Bolivians. Moreover, the EOPS views PROSALUD as an entity whose sole contribution—both to the health sector of Bolivia and to the health status of Bolivians—is the provision of health care services. This is a contribution, but it is only one of PROSALUD's contributions and may not be the most significant. PROSALUD is having an ever-growing impact on the entire health sector of Bolivia by providing a best-practice model of a well-managed, consumer-focused provider of high-quality care elements. Health care providers throughout Bolivia are emulating these elements in increasing numbers.

This important impact is transmitted through the market by competition. It may be useful to point out that competition occurs on various bases, not just price. The constructive, motivating forces of professional and institutional pride are also at work. PROSALUD has impacted the market through both of these competitive forces. The for-profit private sector has been most markedly, though not exclusively, affected by PROSALUD's price competition. The public sector and non-profit organizations have been most affected by PROSALUD's "demonstration effect"—whereby, as a result of its best practice patterns it becomes a model, demonstrating to other actors in the health care arena how to improve the structure, organization, effectiveness, and efficiency of health care delivery.³

7.1.3 The Indirect Impact of PROSALUD on the Functioning of the Health Care Market.

It would be exceedingly difficult to definitively prove that PROSALUD was the causal agent effecting these changes, but from discussions with other key actors in the health sector there is sufficient evidence to indicate that these accounts—while largely anecdotal in nature—accurately attribute a causal role to PROSALUD.⁴ Given the current dynamics of the health sector in Bolivia, PROSALUD may have had the good fortune to be in the right place at the

³ A second concern about the EOPS: Why is self-financing a project goal for the La Paz/EI Alto network when the location of most of the facilities is in a poor community where the achievement of the goal requires clients to pay a larger absolute amount and a much larger proportionate amount (as a percent of their income) compared to a client in Santa Cruz for the same service? The evaluators question whether this situation is equitable, desirable, and the best way to provide increased access to and use of health care services. Perhaps Santa Cruz facilities could be used to cross-subsidize La Paz/EI Alto operations.

⁴ Some key actors in the health sector grudgingly credited PROSALUD with a particular impact and others (blinded by self-interest) characterized its social contributions as adverse development for which PROSALUD is to blame.

right time and was less a causal agent than a facilitator or an expediter of changes that were bound to occur. PROSALUD, nonetheless, deserves credit for its contributory role. Some of PROSALUD's most important impacts include the following:

- In 1991 there were no deliveries in El Alto in health centers. PROSALUD introduced delivery services in 1992. Since 1992, 3,237 births (through February 1995) have taken place at PROSALUD facilities. Today the regional secretary of health and other PVOs in El Alto offer delivery services in most of their health centers.
- PROSALUD introduced cost recovery charging the same prices as the Secretariat of Health. As a result, the Secretariat of Health strengthened its own cost recovery efforts which resulted in a significant increase in the amount of funds collected.
- PROSALUD introduced clean, well-lighted, "user-friendly" facilities. The Secretariat of Health and several other PVOs soon followed with improvements to their facilities.
- PROSALUD's health centers in El Alto were the first facilities in the region to offer 24-hour service. Shortly after it opened, the SRS/El Alto established 24-hour service in all its facilities.
- The Secretariat of Health introduced several cost-avoiding and fee-sharing arrangements to offer dental and other specialty services in its own clinics, imitating the PROSALUD model.
- Largely due to PROSALUD's initiative and insistence, the health providers of El Alto meet monthly to compare service statistics for their respective institutions; organize the market to ensure greater uniformity of service provision statistics; and coordinate providers in the region by assigning each a geographically defined catchment area population.
- Private providers are beginning to reduce their prices well below the Colegio Medico-recommended levels in order to compete with PROSALUD.

A more complete listing of the indirect effects, prepared by PROSALUD staff is contained in Appendix G. The evaluation team believes that the indirect effects of the project need to be verified and documented. Indirect effects are multiplier effects; they multiply the direct effects a project achieves by transmitting them to the larger environment of providers, including the government, via the market. The fact that the project has this kind of indirect impact suggests USAID's perspective PROSALUD's role in the delivery of health care in Bolivia should be re-evaluated. How should the indirect effects be evaluated relative to PROSALUD's service provision and its level of self-financing goals? This depends in part on the importance of these

effects. The effects alone, however, warrant USAID's continued support of PROSALUD, at the very least, by extending the current project.

7.2 The Political Environment and the Bolivian Health Sector

Since the elections of 1982, Bolivia has been ruled by democratic governments with relatively peaceful transitions of power. There has been a slow but steady movement to reduce the size of the national government and decentralize social services, including health and education. In the health sector, the trend to decentralize is evident, although there have been reversals in some important policy issues concerning how decentralization is to be implemented and the configuration of the new system. For example, initially decentralization was designed to favor outreach activities and included campaigns to deliver health services to people in their homes. This approach was later abandoned, returning to the health infrastructure as the source of care, and thus resulted in strengthening the network of rural health posts and urban health centers. PROSALUD weathered these changes and carved out a mode of delivery in tune with the needs of its clients, despite the latest programmatic thrusts of the MOH. It has not been easy to counter to the MOH's concept of services delivery.

For example, following the Union Democrata Popular (UDP) regime, the Movimiento Nacional Revolucionario (MNR) party of Victor Paz Estensoro (1985-1989) worked to bring financial stability to the country and imposed some of the tightest fiscal restraint measures the country has ever experienced. Fortunately, the hyperinflation of the mid-1980s began to slow, but the health sector lacked resources to pay staff, maintain its facilities, and buy medicines. As a health policy, the MNR stressed social mobilization of Ministry staff to reach families in their homes. Health promoters were hired to work with the communities, but when they wanted to form unions and demanded benefits from the MOH, they were disbanded. The extramural focus of the MOH meant that hospitals and health care facilities received little attention and began to show major signs of deterioration.

Under the coalition government of the Accion Democrata Nacional and Movimiento de la Izquierda Revolucionario (ADN-MIR) parties under President Jaime Paz Zamora (1989-1993), the MOH stressed the improvement of its institutional-based service delivery capacity and, as an outreach effort, inaugurated the Plan de Supervivencia Infantil (Child Survival Plan). Efforts to decentralize the MOH sought to strengthen the Regional Health Units (Unidades Sanitarias) and the districts, the focal points for delivering services to the people. PROSALUD took advantage of these decentralization efforts by working more closely with the Unidad Sanitaria in Santa Cruz to set up its health center network.

7.3 The Popular Participation Law and The Future of PROSALUD

The MNR returned to power in August 1993 with Lic. Gonzalo Sanchez de Lozada as president. This government is currently in the process of further decentralizing the services of the national government and reducing its overall size. Two national laws that provide the general framework for decentralization and have important implications for the organization and functioning of the health sector have been issued. First, the law on the Reform of the Executive Branch (Reforma del Poder Ejecutivo), has issued in 1994 to reduce the number of ministries to four, converting the former MOH to a National Secretariat of Public Health under the Ministry of Human Development.

Also issued in 1994 was the Law on Popular Participation (number 1551). This law transferred the entire MOH/NSH health infrastructure, exclusive of the tertiary care specialty hospitals, to the municipalities with the understanding that they would be responsible for all maintenance. The municipalities have begun to receive funds from the national government (the amount determined by a fixed per capita allocation) to pay for these services at the local level. The law states that 90 percent of these funds must be dedicated to "investment," leaving only 10 percent for the recurrent operating costs for system that has been long starved for operating funds. At the time of the evaluation, this law was still unclear and subject to significantly varying interpretations.

The "investment" category of the Law of Popular Participation has been subject to important differences in interpretation. On the one hand, the mayors have a relatively loose interpretation of investment. They and others believe the 90 percent requirement is intended to prevent municipalities from using the funds they are allocated from the central government to simply increase the number and/or wages of personnel, and they contend that "investment" includes contracting out for services. On the other hand, the NSH, attempting to resist the erosion of its authority implied by the law, has a narrower interpretation of investment, that focuses on bricks and mortar and some equipment.

Along with this position, the NSH declared that the medical staff of all facilities must continue to report to the NSH and it will continue to pay salaries of the professional staff directly to the staff. By virtue of the high proportion of the total budget that is expended on personnel and the different nature of incentive structures that exist within a highly centralized, hierarchical national system (which is likely to develop at the more personal and accountable local level), this will be the decisive issue determining the future of the public health system of Bolivia. He who controls personnel, controls the system.

The goal of the Popular Participation Law is to provide a new structural framework to foster a more responsive, smaller, and less costly bureaucracy. Depending on the final outcome of the political battle concerning the interpretation of the new law, the law is likely to give organizations like PROSALUD an opportunity to expand their service delivery capacity in other regions of the country. This is in response to mayors who want to provide streamlined health

services to their constituents and do not have (and do not want to develop) in-house capacity to manage these services, but, instead, will opt to contract out for them. PROSALUD has mastered the mechanics of delivering and managing basic health services and has proven able to recover a relatively high portion of its operating costs. On the other hand, PROSALUD does not have the capital to build the infrastructure that is presently available through the municipalities. This is a unique opportunity for PROSALUD to expand its program to other areas of Bolivia. It has already received several inquiries and requests from municipalities to do so.

Even if the municipalities are not given the freedom to use their central government allocations to contract out for services, PROSALUD will still expand through its working relationships with mayors. Bolivia's severe financial crisis of the 1980s resulted in serious erosion of the role and importance of the NSH (then the MOH) in the public health care system, particularly its financing role. By 1993, the real expenditure level of the NSH had not recovered its 1980 level. In response to this public health care financing crisis, Bolivians undertook major local initiatives to augment the now greatly diminished role of the central government. The most important of these initiatives were the development of local user fee systems, which quickly accounted for 50 percent of the financial resources of the public system, and the development of municipal health care systems, independent of the MOH/NSH. As seen in Graph 22, in 1993 municipal governments spent US\$32.6 million on health care, the equivalent of 10 percent of total expenditures on health that year, and just 10 percent less than the US\$36.3 million spent by the government of Bolivia.

graph 22

Hence, even if the municipal governments are not granted much flexibility in the use of the monies they receive from the central government, they will still play an important role, and PROSALUD, by virtue of its recently acquired national status, philosophy, and track record, will continue to play an important role in these systems. Moreover, these systems are changing most rapidly and are the face of the future. The NSH may prove able to maintain much of its control over public health sector resources for now, but this is a temporary victory and will soon prove evanescent.

The decentralization of most of the rest of government, in particular the social services (which account for 40 percent of total central government expenditures), is already proceeding. In 1994, 600 million Bolivianos (US\$135 million) was budgeted for transfers to the municipalities in the first step of implementation (Cardenas and Darras, 1994, p. 6). The general decentralization movement will bring with it changes in attitudes and expectations and the distribution of political power that together will create a momentum the health sector will not be able to forestall for long. The mayors' offices' high demand for PROSALUD's services manifests Bolivians' recognition and acceptance of the PROSALUD model, its quality of care, effectiveness, and efficiency.

Well on its way to replicating the Santa Cruz model in La Paz/EI Alto, and searching for new activities to spread the overhead costs and increase the efficiency of its La Paz MSU and National Office, PROSALUD is poised to take advantage of this timely opportunity and thereby improve the financial sustainability of the organization.

7.4 Increasing the Cost Recovery Performance of PROSALUD

Entering into contracts with municipalities will substantially alter the conditions under which PROSALUD currently functions. PROSALUD will negotiate with individual mayors to establish a fee level and an expected or desired level of coverage. PROSALUD must be concerned with discussing how the municipality will pay for the care of indigents. The fee level should be negotiated to include some excess revenues beyond the cost of providing the anticipated level of care to help defray the costs of the regional office MSU and the National Office. If it has not already done so, PROSALUD should begin work on the development of a cost-based level of service delivery or per capita fee (inclusive of the overhead mark-up) to prepare for its negotiations.

It will be necessary for PROSALUD to develop other means to increase its cost recovery performance. The deferred payment program (Programa de Pago-Deferido, PPD), slated to be rolled out in June 1995, is an important effort that seeks to improve PROSALUD/La Paz's financial position by expanding its market and spreading the significant fixed and overhead

costs of both the clinic network and particularly the MSU over a larger number of patients, thereby improving the organization's self-financing status.⁵

Particularly with the considerable competition that has developed in the El Alto portion of the La Paz regional office market, this program has great promise for helping the organization expand its market significantly and rapidly.

There is great need for other innovative programs that can accomplish this same fundamental aim. Consideration should be given, for instance, to reifying the prepaid system that was so short-lived early on in the development of the Santa Cruz system (1986-1987). In addition, it appears as though PROSALUD is well positioned to begin forming a preferred provider organization in La Paz. This would be desirable not only to spread the overhead of the MSU and National Office but also to provide another channel for introducing and/or invigorating competition in the health care market; i.e., for fostering more indirect impacts of the PROSALUD model on the health sector.

PROSALUD needs to manage a service delivery system to remain a credible provider of services and have access to a "laboratory" to experiment with different mixes of services, marketing methods, client responses, and cost recovery techniques. The proposed expansion into Tarija and Riberalta will give PROSALUD access to other markets to experiment with new products.

After opening the remaining health centers in La Paz and expanding into Tarija and Riberalta, PROSALUD's staff will grow to approximately 330 persons. The maintenance of perhaps 30 facilities in the future and meeting the payroll for over 300 employees will be a taxing undertaking. The demonstration effect of the program could be put in jeopardy if PROSALUD, including its National Office, is consumed with the daily tasks required to keep a rapidly growing organization functioning.

PROSALUD's equally important, or perhaps most important, role is in advising other private and public entities how to follow its example of innovation in PHC delivery and cost recovery. Offering consulting and technical assistance to Bolivian institutions interested in the replication

⁵ The program is intended to attract and recruit employers, who would still have to pay their social security contributions. It is believed employers would still opt to participate because PROSALUD would guarantee them that workers would work significantly less time than the current one to three days reported for most social security utilization experiences. In addition, the PROSALUD PPD would require far less paperwork than the social security system, there would be no need for cash payments for services on an ongoing basis, and the system of care and expenditures could be easily monitored by the employer. The program has been designed with a highly flexible structure, with provisions for most cases—from simply providing a one-time bonus voucher to a worker for an exemplary performance to establishing a single-provider alternative to the social security for all of a firm's employees health care needs.

of part or the entire delivery model is a potential income-producing activity for the National Office as well as the two regional MSUs.

USAID must be careful not to overburden PROSALUD by making it the implementation vehicle for too many of its new goals and/or initiatives. It is imperative to be cognizant of this potential, particularly because, while the service provision performance of PROSALUD is important and laudable, the indirect effects are as valuable as the service provision record, and—particularly in the longer run—are likely to be relatively more valuable. It would be a pity to squander this larger and potentially more enduring impact on the health care market of La Paz, Santa Cruz, and the entire country of Bolivia as a result of over zealousness in the pursuit of higher annual service provision statistics.

8 CONCLUSIONS AND RECOMMENDATIONS

8.1 Shortcomings in PROSALUD's Performance

Despite the generally very positive findings concerning the performance of PROSALUD (both its direct and indirect effects) a number of shortcomings—mostly minor—should also be noted:

- The organization failed to document the lessons learned from its La Paz/EI Alto replication experience and thus is in jeopardy of not adequately appreciating them and making the same mistakes again.
- While PROSALUD has an implementation plan for replication (developed specifically for the USAID replication sites), it does not have a replication strategy (strategy was also absent from the La Paz/EI Alto replication plan).
- PROSALUD has not developed franchising guidelines as it was charged to do in the Project Paper.
- PROSALUD devotes too few resources to undertaking market studies and has inadequately documented the size, nature, and evolution of the supply side of the market. Its lack of appreciation of the supply side was a major reason it knew little about the incipient burgeoning of providers in EI Alto as the project started and was one important reason it has had trouble becoming established in that market.
- PROSALUD has yet to develop a National Board of Directors which the Project Paper stated should participate in the development of the replication plan (although the plan has already been developed).
- The accounting system (revised in 1990) no longer supports analysis of the net revenue generation of specific health care activities. The revision of this system, currently under way, needs to restore this capability and, with it, an important management tool.
- The level of self-financing of both regional offices appears to have reached a maximum (given the current number of clinics in each of the networks) at levels considerably below the goals established in the Project Paper's EOPS. (Other opportunities exist for PROSALUD to increase its self-financing performance, including adding additional health centers and one or more polyclinics to each regional network.

A final concern about PROSALUD's performance is that it has not devoted enough attention to cultivating its public image. PROSALUD has long been, and continues to be, a lightning rod for criticism. To a significant extent this is the price of success. The most commonly heard criticisms and concerns include the following:

- The inconsistency and incompatibility of PROSALUD's stated service provision mission/objective and the degree to which it pursues cost-recovery
- The view that a recipient of international assistance should provide care free-of-charge
- The argument that not paying a physician and putting the physician at risk (via a fee-sharing arrangement) undermines the quality of care provided

The organization needs to be more concerned about these criticisms and the misinformation that most of the most vociferous and visible critics have about the model. PROSALUD needs to develop a more systematic approach to advertising to correct these misperceptions (e.g., publishing pamphlets using a question/answer format). To a significant extent many of these views are expressed principally by persons who feel particularly threatened by PROSALUD. Still, the battle to become established in La Paz/EI Alto was in large part a battle to win the minds and hearts of the community and dispel malicious rumors and misinformation. Now that PROSALUD is on the national stage, there is all the more reason, and it will be easier, to explain and demonstrate the organization's goals and objectives.

It should be pointed out that PROSALUD has sought to disarm and/or coop some of its critics. In Santa Cruz, PROSALUD has been successful in its bid to obtain one of the four "voices" (vocales) on the Board of Directors of the Colegio Medico (of the department of Santa Cruz). Similarly, the national executive director of PROSALUD is presently considering seeking the presidency of the Public Health Association of Bolivia. (The PROSALUD/La Paz regional executive director recently published two articles in the journal of this association.) These are commendable efforts. More of the same is needed.

8.2 Final Conclusions and Recommendations

PROSALUD is a patient-focused, primary health care-centered delivery system distinguished by its unique capability to provide a large volume of high-quality services with high levels of efficiency, self-financing, and patient satisfaction. The two foremost critical elements of PROSALUD's well documented and institutionalized management system are its development and reliance upon a data-driven, monitoring, evaluation, and planning system and its personnel recruitment criteria and process.

First developed in Santa Cruz, the PROSALUD model has been successfully replicated in La Paz/EI Alto. However, the financial performance of both regional offices has not yet achieved the levels that had been hoped for, and it is unlikely that they will achieve their end of project goals of 100 percent self-financing, exclusive of the MSU in the case of La Paz and inclusive of the MSU in the case of Santa Cruz, by March 1996. Given that this shortfall has been due to a constellation of extenuating circumstances—the most significant being outside of the direct control of PROSALUD—the project, to date, must be regarded as a success. PROSALUD is currently at a critical juncture. The performance of PROSALUD/La Paz has been lagging and only presently, with the opening of three new health centers in La Paz, is it entering a phase in which it is much better positioned to substantially improve its service

delivery and its cost recovery performances. Moreover, the National Office is launching its first major undertaking with the relatively modestly-sized replication efforts in Tarija and Riberalta. USAID should extend the current project to ensure the adequate support of the organization as it passes through these critical next phases.

Additional recommendations for USAID/Bolivia and PROSALUD include the following:

1. PROSALUD should not undertake the development of a referral hospital as part of the La Paz regional office network (a detailed, seven-point justification for this recommendation is provided in Chapter 5). Instead it should pursue discussions with representatives of hospitals in the La Paz/El Alto area to establish a formal referral system agreement. The PROSALUD/Santa Cruz hospital (which has been working on the development of such a system for the past year) should be involved in this process.
2. By virtue of the knowledge and credibility it brings to the effort the La Paz regional office MSU staff should be involved in the replication efforts in Tarija and Riberalta.
3. In order to give greater national prominence to PROSALUD and its indirect effects, while providing additional sites for PROSALUD/La Paz that will prove capable of generating net revenues that can cross-subsidize some of the poorer clinic sites in El Alto, support should be provided to PROSALUD for opening one or more clinics (additional to those currently planned) in relatively affluent neighborhoods of La Paz.
4. The indirect effects of PROSALUD—its competitive impact and its demonstration effect—should be identified, and to the extent possible, quantified.
5. To aid it in its effort to identify additional net revenue-generating activities over which to spread its MSU and National Office fixed overhead costs, technical assistance should be provided to PROSALUD to conduct pre-feasibility analyses for PROSALUD's to pursue the development of preferred provider organizations and the development of capitated systems. PROSALUD should also begin exploratory discussions with (a) the private health insurance industry to investigate the possibility of developing a joint venture to establish a special provider-based plan (e.g., prepaid or preferred provider organization) that could be marketed like a traditional third party indemnity plan to clients of lower socioeconomic strata, and (b) some of the social security systems to investigate the possibility of selling these services.
6. PROSALUD should ensure that its new accounting system (currently being developed with technical assistance) establishes each of PROSALUD's major health care service activities as a cost center in order for the system to identify the level of net revenues generated by of each major activity. By the same token, PROSALUD should begin development of a cost-based rate of service delivery or per capita fee for specified services to prepare for negotiations with municipalities and other potential funding sources.

7. PROSALUD should establish a formal process whereby it identifies and monitors the characteristics of all other providers in and around its health centers' catchment areas. These provider profiles should include information about the number and types of physical, personnel, and financial resources; prices of services; hours of service; types of equipment available; and types of services provided.
8. PROSALUD should address the shortcomings identified in the report which include developing a National Board; developing a replication strategy (in addition to the replication plan); and developing franchising guidelines.