

PA-NEE-514
1/1/86

HEALTH CARE FINANCING IN LATIN AMERICA AND THE CARIBBEAN
USAID Contract #LAC-0632-C-00-5137-00

Exploratory Report: Options for Health Care
Financing Studies in Bolivia

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Submitted to:

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March, 1986

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ANNEX B

COUNTRY STUDY OPPORTUNITIES IN BOLIVIA

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March, 1986

The State University of New York at Stony Brook has been awarded a contract by USAID to undertake up to twelve health care financing studies in nine Latin American countries, in a period of four years. It is intended that these country studies be as directly supportive of AID Health Officer's ongoing sector work as possible. The studies should also increase our knowledge generally about health care costs, demand for health care and alternate financing mechanisms within the LAC region. One of the objectives of this consultant's work in Bolivia was to tentatively identify country study opportunities to be carried out under the project.

After only two days of reviewing general orientation documents and reports of specific studies undertaken in Bolivia and of exchanging information and ideas with G. Bowers and R. Indaburu of USAID-Bolivia, some tentative conclusions are proposed for discussion. The areas of study proposed below respond to an initial interpretation of the country, its health situation and the policies and programs of the main health sector organizations. These are also highly tentative.

Health Sector Background

Bolivia is the poorest country in South America in terms of per capita income. In 1985 its estimated population was 6.4 million. Of these, 2/3 live in rural areas, dispersed or in

communities of fewer than 2,000. As of 1978, over 60% of the population 15 years of age and older were illiterate. Ethnicity, culture and language divide the country into several groups: 60% of the population is native, mainly of the Aymara tribe (in the Highland of La Paz), of the Quechuas (in the Elanos) and of numerous, lesser important tribes in the eastern lowlands; 30% are mestizos and the remaining 10% are whites of European origin. The predominant language is Spanish, although it is common, particularly among female Indians, that only the native language (aymara, quechua, others) can be spoken. Other major barriers in Bolivia's socio-economic development have been its geography and climate. The country has three main regions: the arid highlands (3,000 to 6,000 mts. over sea level); the fertile and mineral rich midlands (2,000) and the fertile extensions and tropical forests of the eastern lowlands. High mountains, flooding rivers and dense tropical forests have made the development of a land-base transportation network difficult. Also, communication has not developed and thus, the rural population has little access to the goods and services of society.

Health Status of the Bolivian population reflects the low level of socio-economic development. As of 1978, the last year for which we could obtain official information, the most important mortality indicators were as follows:

Crude Death Rate, 19 per thousand;

Infant Mortality Rate, 154 per thousand live births;

Life Expectancy at Birth, 46 years.

Official vital statistics are not reliable and thus, these figures may not reflect accurately the depressed health status of

the Bolivian population. As expected, fertility is high and thus, the proportion of total population being 15 years or younger is near 50%. As a result, health problems among young age groups are a large proportion of the total ill-health picture. Among children, malnutrition, infectious and parasitic diseases, particularly gastro-intestinal and respiratory are the most common problems with rates as high as 50-60% in some rural and marginal urban communities.

Health services are provided by a large number of institutions with little inter-coordination. Probably the largest network of facilities and services, both in urban and rural areas is the Ministry of Social Welfare and Public Health (MOH), although its services appear to be oriented mostly toward hospital and medical care, delivered at fixed facilities, mainly hospitals in urban areas. The MOH also has supervising authority over several (more than 10) social security organizations (SSO's) that provide income maintenance and health care services to about 20% of the population. These are workers or employees, actively employed in modern sectors of the economy. These institutions are urban based, for the most part manage their own facilities and provide almost exclusively hospital and medical care to their beneficiaries. A third group of providers are the non-governmental organizations (NGO's), mostly of religious orientation, that provide a mixture of hospital and medical care as well as, lately, primary care services to the urban and rural poor. These organizations pursue somewhat different objectives and are not effectively coordinated by the MOH. Thus, some

"functional" gaps (as well as geographic ones) may be left in the coverage of the population with basic health services. The fourth component is the private sector composed of hospitals, physicians, pharmacies and others of which very little information is available with the exception of private drug consumption. All household surveys performed in Bolivia have identified expenditures in drugs as the most important "out of pocket" expenditure related to health. All these organizations constitute the formal health system, oriented toward a modern, western approach to health problems. It is stated that it covers effectively less than 50% of the Bolivian population. It is also argued that the remainder, particularly in rural areas where the population is widely dispersed, gets health care mainly from traditional healers. Although this has not been consistently found by household surveys in rural and marginal urban areas, the existence and work of traditional healers is widely recognized. Among them, two deserve special mention: the practical midwives who attend deliveries on a fee for service basis and the itinerant native doctors, the Callahuayas, a highly prestigious tribe who handles herbal medicines and dispenses services and medicines on an ambulatory basis among the native population.

Bolivia is a country ideally suited for a primary care strategy with the basic components agreed on in the Alma Ata conference. In effect, its level of socio-economic development, its geographical, cultural and linguistic barriers, the volume and nature of health problems and the scarcity of health resources, all call for a strategy that maximizes the impact of services upon the health status of the population. It seems,

however, that the GOB and particularly its MOH have not been able to adopt and effectively implement a clear, sector-wide health policy that addresses the basic health needs of the rural and marginal urban populations. On the contrary, judging by public sector expenditures (about 85% of the MOH's budget goes for hospital and medical, curative services), an ad hoc health policy appears to have been adopted which does not give priority to basic health services.

As in other developing countries, the MOH carries little political power and it is, therefore, a weak organization. This results in its inability to provide effective leadership, direction and coordination to the organizations, both public and private, which are actively engaged in the health field. Furthermore, the MOH does not appear to have consistent, accurate information on health indicators, human resources, production and cost of services and health care expenditures, either of its own network of facilities and/or those of other organizations. This lack of information weakens the definition of a policy that stresses primary care strategy.

It seems from the review of available documents that the MOH's network of Health Posts (Puestos Sanitarios) and Health Centres (Puestos Medicos Perifericos) is insufficient and ineffective to satisfy the basic health needs of the rural and marginal urban Bolivian population. Both the responses obtained by surveys in relation to sources of care as well as the census of health providers in these areas do not identify the MOH as the main organization delivering effectively primary care services to

the rural and urban poor. Instead, there is an informal, maybe incoherent network of primary care providers, mostly NGO's each with its own emphasis, strategies and policies. According to survey results, there are segments of these populations that lack any effective access to health services.

AID-Bolivia has tried unsuccessfully to obtain from the MOH a real commitment--expressed in reallocation of resources--to primary health care. Several projects supported by AID apparently failed to induce that policy decision in the MOH, in a wider scheme, in the GOH. As a result, a decision was made by AID-Bolivia, about three years ago, to change its policy and promote the effective delivery of primary care services, not through the network of the MOH, but through private organizations. Thus, at least two important efforts are currently under way, to organize the delivery of these services by private organizations and to finance their operation, at least partially, from revenue obtained from the consumers. However, AID would be prepared, provided the MOH demonstrates its commitment, to reconsider its policy decision and support the efforts of the MOH to implement projects in the PHC field. Less drastically, maybe AID-Bolivia should be prepared to induce such a change, by doing, with the GOH (including the Ministry of Planning and Coordination as well as the MOH) health care financing studies whose results will be valuable to support and implement such a policy shift. Of the seven studies identified as potentially useful, the first two are directed towards re-establishing a policy dialogue between USAID and GOB in relation to public sector primary care services. The next three try to

strengthen primary care under present circumstances; therefore, they relate to problems of organization and financing of private services. Finally, the last two studies are related to whose results will be valuable to support and implement such a policy shift. Of the seven studies identified as potentially useful, the first two are directed towards re-establishing a policy dialogue between USAID and GOB in relation to public sector primary care services. The next three try to strengthen primary care under present circumstances; therefore, they relate to problems of organization and financing of private services. Finally, the last two studies are related to specific issues-- drugs supply and family planning--that are relevant to the present health situation.

Tentative H.C.F. Studies in Bolivia

A.P. 1980-1981 Study on Health Expenditure.

This study would identify, with rigorous methodology, the following items:

- health expenditure as share of GNP and of total Central Government and Social Security expenditures and its trend over the past ten years;
- levels and composition of ²sources of health sector financing, including household expenditures from several available surveys;
- levels and disposition (uses) of expenditures by sub-sectors (public, social security, non-governmental, private medicine and traditional healer), by budget categories when feasible (personnel, services, medical and hospital supplies, drugs, etc.) and programs (hospital and medical care vs.

primary care).

The object of this study is to provide information to GOB decision-makers (Presidency, Ministry of Planning and MOH) who will be supportive of a political decision to reallocate public sector funds toward primary care in rural and marginal urban areas.

It was argued that more accurate and complete information evidencing inequalities or current misallocations does not, by itself, ensure a policy decision. There is no recognition of the problem by MOH authorities and information already available regarding budget allocation within the MOH--clearly prioritizing hospital and medical care--is not interpreted by MOH authorities as indicative of a wrong policy. However ~~time~~ ^{time} this may be, it should also be taken into consideration that the present administration of the GOB has shown a willingness to address some of the long-term bottlenecks the country has suffered in the economic areas.

After several years of continuous and increasing chaos, Bolivia seems to be prepared for some major reforms. In this light, it is feasible that economic and planning authorities would recognize that an effective improvement in the health status of the population--a social development that provides a substantive base for economic growth and political stability--can only be achieved, given the amount of resources being spent, by reallocating them to more efficient, primary care programs. Pressure from the

economic and planning sector of the GOB and the possibility of getting strong financial support from AID to improve primary care may be the effective combination that seems to be needed for the MOH to change its overall policy to a reasonable extent.

It should be mentioned that two studies of this type have been done in Bolivia: one by an AID Mission in conjunction with the MOH in 1976 and another by PAHO together with the MOH in 1983. This consultant had an opportunity to review only the first (on a superficial basis) and has concluded that methodological failures prevent it to be of use for policy-making. The two major errors are in the estimation of private, out of pocket expenditures and in the lack of accurate information about expenditures by program, by different organizations. We did not have a chance to review the PAHO study. However, it is interesting to note that the authorities of the MOH, in late 1985, have requested support from the international community to undertake a study of this type.

B. Cost and Productivity Studies of Primary Care Services.

This study would measure the costs (capital and operating) and output (different types of activities) of primary health care units organized and administered by the major organizations active in this area: namely the MOH, the SSS and the NGOs. The objective of the study is to provide information about the current effectiveness of different providers and of different units within a provider, to

several levels of decision-making, planning and management. In particular, it is hoped that this information, at the level of the GOB and of the MOH, would help to reallocate resources towards primary care activities and to improve the productivity and efficiency of this type of service. By uncovering deficiencies, bottlenecks and lack of resources that are responsible for the low effectiveness of MOH's primary care centres, this study would help the Ministry's authorities to allocate needed resources for this program. In this sense, the arguments and counter-arguments of political will, expressed in relation to study (A), apply here as well.

A second, more limited objective of this study would be to help managers of primary care programs, in whatever organization they are included, to identify specific aspects responsible for low levels of productivity, and thus motivate them to introduce practical changes that may result in marginal improvements in productivity and/or reduction of costs. It is assumed that some units would be more effective than others, that variables related to higher effectiveness could be identified and measured, and moreover, that these variables could be manipulated by primary care managers in order to improve productivity.

It was argued against this proposal, besides the general point already mentioned in No. 1, that there are always hypothetical ways of organizing more efficient primary care

services. Therefore, empirical data, as the one provided by this study, could be lost or rendered ineffectual in a theoretical discussion about ways of improving productivity or reducing costs. Moreover, it was also argued that this type of study may reinforce the notion, already held by MOH officers, that performance of primary care services should be interpreted in relation to available physical facilities, although it was recognized that this was a function of the design of the study. In this sense, it would be advisable to include, among the output indicators, not only activities by program (ORT, prenatal visits, well baby care, etc.) but also some indexes of coverage like immunization levels, proportion of pregnant women included in prenatal program, etc. The usefulness of the results are dependent upon the active support of the Ministries of Economics and Planning and Coordination, as well as upon a clear understanding by MOH authorities of the ultimate aim of the study and a commitment that their results would be incorporated in the planning/management effort.

It should be mentioned that no previous work has been done in this area in Bolivia and that USAID has identified the ineffectiveness of the MOH primary care network as an important roadblock. The interest/commitment of several levels of the GOH and, eventually of the NGO's to participate has not been indicated so far, and thus, should be explored prior to any decision.

C. Direct Expenditures and Willingness to Pay Under Alternate Financing System of Primary Care Services.

Three household surveys have been undertaken in Bolivia to obtain, among other items, information about direct, out of pocket health care expenditures. The first was done in relation to the Montero Project in late 1977, on a combined urban and rural population in the Department of Santa Cruz. The second was done in late 1984, in two urban and two rural areas, also in Santa Cruz. Regrettably, the applicability of the results of this survey is limited for two reasons: sampling was not done at random because a particular population was being targeted, and second, there were some methodological problems in the questionnaire. The third survey was done in 1985, in two rural areas in the State de Cochabamba. This consultant had very limited access to this third survey, and thus cannot comment on its quality and the usefulness of its results. The study would perform an in depth analysis of the survey data already existing and, if needed would conduct another survey. The question that has not been satisfactorily answered so far is twofold: what are the variables that influence the behavior of rural and urban poor Bolivians in demanding and paying for health care services when ill, and second, what "packages" and "prices" are they prepared to demand, provided an effective delivery organization would assure them good quality, continuous care.

The objective of this study ^{is to} ~~would~~ facilitate the design and

implementation of private, primary care organizations financed directly by consumers. There are already two projects of this type being implemented with AID support in Bolivia: one in Santa Cruz (PROSALUD-MSH) and another in Cochabamba (IMSS-PRICOR). Not only they would benefit from a deeper analysis of the data already available but they may need additional information which cannot be obtained from the existing surveys. Furthermore, the replication of these two projects in other parts of the country may well face different attitudes/constraints so that PROSALUD and IMSS experience, valuable as it would be, would not suffice.

D. Development of a Simplified Model to Evaluate the Effectiveness and Efficiency of Primary Health Care Services.

Somewhat similar to study (B), this one proposes the development of a health information system to be implemented by private (for profit or from NGO's) primary care units, on a permanent basis. The information system would provide data needed by nurse auxiliaries or health promoters about their own activities and health impact, as well as their cost on different items to maintain a high level of effectiveness and efficiency. This simplified monitoring model would yield indicators that would enable the primary care worker, or its immediate supervisor or program manager, to identify problem areas and thus to take corrective action. Most considerations about political will are

appropriate here if the monitoring ~~system~~ ^{is} is intended not only for private organizations but ~~the~~ public providers as well. However, if widely adopted by, let's say, all NGO's, it will provide a strong data base from which coordination of activities could be undertaken to avoid geographical and/or functional gaps. The development of a model of this type is not within the specific terms of reference of the HCF-LAC project, although it falls within its more general purpose. Finally, the considerations made about Study (C) and public sector policy are applicable to this proposal.

E. Alternate Financing System: Payment in Kind.

This study, on the form of a household survey, would explore the feasibility and willingness of potential consumers of primary care services, to pay for these services in kind through the production of their crops. This is an attractive proposition in Bolivia, as in other underdeveloped countries with extended rural population, for mainly two reasons:

- high rates of inflation make it difficult to administer any pricing system.
- A great proportion of the target population, particularly in the rural areas, does not receive money as the main expression of income.

Furthermore, AID Bolivia already has a project in a rural area (water and sanitation) in which payment by beneficiaries is made in kind. A key element of this type

of payment seems to be the possibility of reducing to very few (one or two) the number of goods with which payment could be made. Otherwise, administration, storage and marketing of products becomes so complex that it constitutes a project by itself.

The objective of the study, which is closely related to Study (C), would be to facilitate the implementation of alternate primary care delivery systems in specific rural areas where payment with money is not feasible.

F. Social Costs Associated With High Fertility.

As other developing countries in the Latin American Region, Bolivia experiences high fertility rates, particularly among its poor. Associated with this there are several phenomena that have cost implications in terms of direct expenditures as well as in terms of income foregone. The most obvious ones are: infant mortality and morbidity, maternal mortality and morbidity, etc. However, because of cultural and religious reasons, the GOB and the MOH have a "hands off" policy regarding family planning. Besides other effects, this makes illegal abortions one of practical and more widely used means of regulating fertility with its negative effect in terms of both direct and indirect costs.

The objective of the study will be to open up the policy dialogue with the GOB and the MOH around this topic, which will become even more urgent, once infant mortality starts to fall.

The usefulness of the study is subject to practically the same considerations as Study (A). In addition, it does not enter into the specific terms of reference of the HCF-LAC project.

G. Drug Policy: Supply and Pricing.

The supply of drugs for the rural population in Bolivia has been approached during the past few years through Popular Pharmacies. These have gotten their supply of drugs through two mechanisms that are inherently unstable in the long-term: provision at cost by drug manufacturers established in the country and donations received predominantly from eastern European countries.

Besides the channel of popular pharmacies, drugs manufacturers are allowed to commercialize their products ~~products~~ through commercial pharmacies, but at administered prices. However, it appears that price administration in this second channel is not very strict. Thus, an unstable equilibrium is reached between "profits" in the commercial channel and "losses" in the popular channel.

Besides being unstable, this arrangement may be excessively costly for Bolivian society. Price levels have apparently not been compared with international sources and international tender of essential drugs has not been tried. Moreover, every survey has identified expenditures in drugs as the most important item in terms of direct health care expenditures.

The study will address several aspects of pricing and supply of essential drugs for the rural and urban poor of the Bolivian population. Specifically, it would identify price differentials for similar products, both internally and internationally, levels of consumption by different channels for given prices, and it would explore the feasibility of recovering some of its cost through charges directed toward the consumers. It would also analyze the methods used in administering prices in both channels. Its objective would be to provide the necessary information to design a more stable and reliable supply of essential drugs.

This study, as the previous one, does not fall into the specific terms of reference of the project. However, due to their relevance and because they fall into the general aim of the HCF-LAC project, they are included in this report.

Relevance and Feasibility of Proposed Studies

USAID/Bolivia Health Officer, Mr. Gerald Bowers, reviewed the studies proposed in the previous section in terms of their relevance and feasibility. As a result, two areas of study were identified as those more relevant to the health situation in Bolivia and current USAID policy: the study of National Health Expenditures ("A") and the study on Direct Expenditures and Willingness to Pay Under Alternative Financing Systems for PHC services ("C"). In his opinion, although both areas are relevant, the "C" study would serve current USAID policy more directly, and thus it is his first choice.

From the methodological point of view, the "C" study requires not only an analysis of the data available as previously indicated but also the collection of fresh data through a new survey of attitudes toward PHC services financing and delivery mechanisms. In effect, the existing data is not representative of the target population and does not provide information about the conditions of financing, organization, health education, etc., that may enhance the acceptance of self-financed PHC services. It is recognized from previous surveys that rural and marginal urban populations are willing to pay for curative services but it is not known under which circumstances they would be willing to pay for primary care. Therefore, besides the analysis of existing data, it is recommended that a new survey, on a national scale, be undertaken to explore these research questions. Because of USAID policy considerations, the new survey may be limited to the most densely populated areas of the country, namely the Departments of La Paz, Cochabamba and Santa Cruz.

The practical feasibility of undertaking these two studies is also more favorable to the "C" one. In effect, it does not involve the coordination of different government agencies and there are, in Bolivia, locally based research groups that are technically capable of being the counterpart to the HCF-LAC project. In effect, USAID has had experience and/or has good references of at least four organizations that have this capability: the Consultora Boliviana de Reproduccion Humana

(COBREH), the Centro de Investigaciones Sociales (CIS) - both in the private sector, the Instituto Nacional de Estadística (INE) and the Consejo Nacional de Población (CONAPO), in the public sector.

Despite these considerations about relevance and feasibility, USAID/Bolivia would be prepared to sponsor study "A", if the HCF-LAC project decides it has a higher priority and makes a definitive decision to do it. The HHR-USAID office would approach the MDH and other government agencies that may be involved in the study, once the project has made a firm decision in relation to its implementation. In effect, although this study is also possible, it presents considerably greater difficulties than study "C". Several government agencies have to "open up" their accounting information and their authorities could be reluctant to share this information. Besides, the financial data may be organized along lines different from those required by the study. Therefore, a strong political commitment of the GOB will be needed to ensure its implementation. This type of commitment could be obtained, but requires a firm previous decision by the project.

It is the opinion of this consultant that both projects could be done through the life of the HCF-LAC project. Moreover, study "C" should precede study "A" since it would be the only source of reliable information on direct expenditures. These, for some concepts like professional fees and private care in general, could not be obtained from currently available sources. Thus, study "A" without a representative survey on expenditures

would produce an incomplete picture of the total amount of resources spent in health services by the Bolivian population.