



EXECUTIVE SUMMARY

**Funded by the United States Agency for International Development,
the Pan American Health Organization/World Health Organization,
the World Bank, and the Inter-American Development Bank**

May 1994



***HEALTH SECTOR
REFORM
IN EL SALVADOR:
TOWARDS EQUITY
AND EFFICIENCY***

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LIST OF ACRONYMS

ADD	Acute Diarrheal Disease
ANDA	Administración Nacional de Acueductos y Alcantarillados (National Administration of Aqueducts and Sewers)
ANSAL	Análisis del Sector Salud de El Salvador (Health Sector Assessment of El Salvador)
ANTEL	Administración Nacional de Telecomunicaciones (National Telecommunications Administration)
ARI	Acute Respiratory Infection
CCS	Consejo Consultivo de Salud (Health Advisory Board)
CEL	Comisión Hidroeléctrica del Río Lempa (Lempa River Hydroelectric Commission)
COMURES	Corporación de Municipalidades de El Salvador (Municipalities Corporation of El Salvador)
CSSP	Consejo Superior de Salud Pública (Public Health Council)
EDUCO	Educación con Participación de la Comunidad (Education with Community Participation)
FIS	Fondo de Inversión Social (Social Investment Fund)
FONASA	Fondo Nacional de Salud (National Health Fund)
GAES	Grupo Asesor Económico y Social (Economic and Social Advisory Group)
GNP	Gross National Product
GOES	Government of El Salvador
ISDEM	Instituto Salvadoreño de Desarrollo Municipal (Salvadoran Institute for Municipal Development)
ISSS	Instituto Salvadoreño del Seguro Social (Salvadoran Social Security Institute)
MASICA	Medio Ambiente y Salud en el Istmo Centroamericano (Environment and Health in the Central American Isthmus)
MASS	Metropolitan Area of San Salvador
MEA	Municipalidades en Acción (Municipalities in Action Program)
MI	Materno Infantil (Maternal and Child Care)
MINED	Ministry of Education

MOH	Ministry of Health
NGO	Non Governmental Organization
PAHO	Pan American Health Organization
PHC	Primary Health Care
SALUCO	Sistema de Salud Comunitario (Community Health System)
SEMA	Secretaría Ejecutiva del Medio Ambiente (Executive Secretariat of the Environment)
SHC	Specialized and Hospital Care
SILOS	Sistema Local de Salud (Local Health System)
STD	Sexually Transmitted Disease
USAID	United States Agency for International Development
WHO	World Health Organization

I. OVERVIEW

If changes are not made in El Salvador's health system, in the future one of every two children will experience poverty-related health problems which will limit physical and mental development.

The above statement summarizes the main conclusion of the Health Sector Assessment of El Salvador (ANSAL). Profound changes are needed in the health system in order to prevent such a vision from becoming a reality. This executive summary presents the background and reasoning behind the changes recommended, the general approach to sectoral reform, and an outline of the four reform components.

Women of childbearing age and children under fifteen years constitute almost 65 percent of the total population of El Salvador. Though this group has major health problems, it receives relatively little attention compared to other population groups. The main health problems of women and children require prompt primary health care; if not prevented or treated promptly, these problems can become more serious. The prevalent health problems and their timely treatment require: 1) focus on preventive, educational, and basic curative services; 2) easy access to basic health care services, particularly in the rural and marginal urban areas; 3) an integrated health system which provides for efficient referral of high risk cases; and 4) an increase in the availability of potable water as well as an increase in environmental protection.

Over the past five years, important efforts made by the Government of El Salvador (GOES) have resulted in an improvement in the overall health situation. In spite of this, however, the health system currently faces major difficulties: 1) limited access to health services for the rural poor; 2) basic inefficiencies in the system; 3) concentration of health services in the metropolitan area of San Salvador; and 4) a mainly curative focus which is inappropriate given the epidemiological profile of the population. The MOH's ability to develop, implement, and supervise health sector policies suffered during the civil war as the state focussed its limited resources on the direct delivery of services. Delivery of public health care became centralized, inefficient, and scattered in terms of the services provided and the population covered.

Other factors play a part in the functioning of the health system. In spite of an increase in government spending over the past four years, health sector financing remains inadequate and heavily dependent on foreign sources, while significant budgetary inequities exist within the system. In addition, the GOES lacks effective human resource policies and there has been minimal coordination with the institutions responsible for the education of health personnel. The centralized management of personnel and the ineffective incentive system have also contributed to inefficiencies that have resulted in an imbalance between the supply and demand of health personnel.

If the current state continues, El Salvador will face:

- a general deterioration of the health situation;
- the preservation of the existing inequities in the health services;
- the financial collapse of the system;
- a reduction in the quality of health services; and
- increased cost of bringing about future changes.

ANSAL's review of the performance of the health system prompted its team to develop specific recommendations dealing with the problems identified. In each area specific recommendations were developed; these are included in Appendix 1 of this document.

Using the sector analysis and the set of recommendations for specific changes as its base, the ANSAL team looked for alternative development models for the health sector in El Salvador. The exercise included an

extensive process of consultation with representatives of public and private sector health organizations, community leaders, users of the health system, politicians from a variety of political parties, and representatives of international organizations. The process led to a consensus between Salvadorans and the ANSAL team regarding both the importance of reforming the health sector and the basic approach of the proposed reform. The major international organizations that were consulted—World Bank, Interamerican Development Bank, Pan American Health Organization (PAHO)/World Health Organization (WHO), and the United States Agency for International Development (USAID)—expressed their general support for the approach developed by ANSAL.

The principal problems of the health sector, as determined by the ANSAL team, are: insufficient health services and coverage; a lack of efficiency; inequities; and a lack of financial sustainability. To solve these problems, ANSAL proposes a strategy based on the following measures:

- redefine the role of the state in the health sector, transforming it from a direct provider of health services to a facilitator for services provided by private organizations;
- focus the attention of the state on the poorest members of the population and on primary health care;
- strengthen the programs directed towards ten priority health problems;
- focus on health promotion and preventive care;
- gradually increase the level of financing and diversify the sources of funds; and
- create an organized health system and increase its efficiency and effectiveness.

The term *Primary Health Care* (PHC) can be taken two ways: first, as a process of decentralization and community participation in health services with a corresponding strategy for the provision of services (WHO/PAHO); and second, as a synonym for the first level health services including health promotion, preventive health care, education, and basic curative services for the most common health problems. For the duration of this sectoral study, the ANSAL team and Salvadoran institutions agreed to use the second meaning of PHC, that is, referring to first level basic health services.

Insufficient coverage, inequities, and the lack of financial sustainability of the current health system demand greater contributions by the users of the system and by the GOES. The government should concentrate its resources on subsidizing care for low-income groups and focus on delivery of PHC services, while the users who can afford it should pay higher fees for their health care. The system's inefficiency can be reduced by transferring the responsibility for the provision of health services to the local level and to the private sector; at the same time, changes should be made in administrative practices, particularly in the system of personnel incentives.

The health reform, developed with the cooperation and support of local institutions and proposed by ANSAL, has four components:

1. Institutional Reorganization
2. Reorganization of Primary Health Care
3. Reorganization of Specialized and Hospital Care
4. Support for Environmental Health Activities

ANSAL recommends that the reform activities be integrated so that the health system is modified as a whole; that all of the components of the reform be carried out; that the changes be gradual; that the reform activities

have strong support from political leaders as well as from the general public; and that the activities be executed through a strategy based on participation and flexibility.

Institutional reorganization consists of redefining the role of the state in health care; creating a unified health system; decentralizing PHC services; transferring management of hospitals to the private sector; institution strengthening; developing human resources; and emphasizing health promotion and preventive care. Through the Ministry of Health (MOH), the state will strengthen its role of manager, regulator, supervisor, and financier by restructuring its organization and strengthening its technical capacity.

Delivery of PHC services will be transferred to municipal governments, which will either provide the services directly or contract with a variety of private organizations, depending on the preference of each community. The MOH will pay for all of the services provided to persons below the poverty level through a transfer of funds to each municipality. Calculation of this subsidy will be derived from a standard cost per person for a package of services to be provided by local organizations. In order to guarantee access to the basic services for the poor, the GOES will have to increase the level of funds for this purpose from approximately 230 to 565 million colones.

Reorganization of specialized and hospital care (SHC) consists of transferring management (though not necessarily the property) of public sector hospitals and institutions providing specialized care to private organizations. This transfer will be accompanied by a complete overhaul of the equipment and buildings, a substantial increase in financing, and a change in the way budgets are calculated, from the use of historical budgets to the calculation of an overall cost per person for coverage.

Private organizations will have great autonomy in their management; they will compete for the hospital services to be provided in the expanded health package of services. The expanded package will consist of a mix of more complex services than those included in the basic package, excluding highly specialized or very expensive treatment. Between the services covered in the basic health package and those in the expanded health package, approximately 90 percent of the health problems in the country will be covered.

The expanded package of health services will be financed by the users, who will be able to choose the hospital in which they want to be treated. A universal and compulsory health insurance is proposed to cover the payment of the expanded health services. The premiums of the poor will be subsidized by the state according to the beneficiaries' ability to pay. Both the government and the individual users will make their contributions to a new National Health Fund (FONASA) which will emerge from a transformed Salvadoran Social Security Institute (ISSS).

Finally, to improve Salvadorans' health, activities related to the environment should be strengthened. Providing potable water, sewage treatment, and garbage collection and disposal should become a high priority. This implies an increase in financing for this purpose as well as cost recovery programs based on user fees.

Reform of the health sector will substantially improve the health of the Salvadoran people, especially the poor population, at a reasonable cost. It will allow children to have the good health necessary for their development and for the society to continue to consolidate peace and to foster economic growth.

II. GENERAL BACKGROUND

1. Political, Economic, and Social Environment

The factors that could affect health care in the political, economic, and social environment inherited by the newly-elected government include:

- politically: a desire to strengthen the democracy after achieving peace
- economically: a period of economic growth, marked by the modernization of the state, emphasis on fiscal discipline, liberalization of the economy, and the need to prepare for the drastic reduction of foreign aid
- socially: after a period of neglect by the state, high expectations by the poor for a substantial increase in social services

Together these factors have created a climate that is receptive to the changes needed in the social sectors, particularly health and education.

The signing of the peace agreement in January 1992 in Mexico initiated an intense process of national reconciliation in El Salvador, encouraging a stable climate necessary for economic growth and peace, the reduction of foreign aid, the institutionalization of democracy, and an increase in all forms of citizen participation. The past administration (replaced in May 1994) began the process of structural adjustment and economic change that included the opening of the economy, fiscal reforms, and modernization of the state. The international organizations working with El Salvador support a development process based on a balance between economic and social progress; existing factors allow for and encourage reorganization of the state and at the same time increase the expectations that social change will occur.

Modernization of the state involves a significant change in government functions. The state will move from serving as a direct provider of services to being less interventionist; it will concentrate on managing, facilitating, and supervising development. In the social sectors, this means strengthening the capacity of the central government to manage, regulate, supervise, fund, and distribute, while reducing its role as a service provider.

Fiscal reform emphasizes the reduction of inefficiency, improved cost effectiveness, the reduction in the budget deficit, and the lessening of inequities through redistribution. Finally, foreign aid donors have already announced a marked cutback in the level of bilateral aid, particularly grant funding.

These three factors—modernization of the state, fiscal reform, and a reduction in foreign aid—demand a new approach to financing the health sector to achieve the objectives of reducing financial inefficiency and inequity, reinforcing and diversifying national funding sources, and reducing the dependence on foreign aid.

The general support for democracy, the elections, and the climate of peace have created conditions in which greater social benefits are demanded, above all for the poor. It is also recognized that adjustments, at times difficult, are necessary to improve equity and efficiency. The March 1994 elections demonstrated that there exists a national consensus on a development model that supports civilian leaders, encourages economic growth, and strengthens social investment. There is widespread opinion that the state is generally inefficient in the delivery of services and that all citizens should contribute to the country's social welfare. The emphasis on democratic processes and the end of the civil war encourage the contribution from groups from all sectors (NGOs, municipalities, and private enterprise), at the same time as there is a great need to develop effective channels for citizen participation.

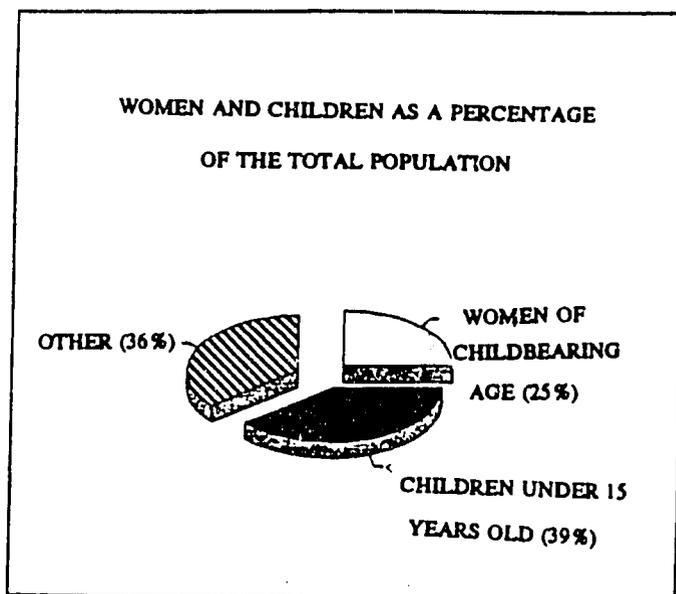
Economic development demands a competitive labor force, which can only exist when the population is healthy and educated. It also calls for social and labor stability, which is why the private sector and the labor sector concur in the need to make efficiency and equity a priority for both health and education.

The last, but perhaps the most important structural factor affecting health sector reform, is the historical neglect of large sections of the population. The historical distribution of wealth, income, and opportunities has been very unequal in El Salvador, with particular negative impact on the rural and marginal urban poor. The poverty rate is very high, particularly in rural areas, and it is a moral imperative for the country to reduce the overall level of poverty. The World Bank estimates that approximately 50 percent of the population should be classified as poor, with 12 percent falling into the classification of absolute poverty. The figures of the Ministry of Planning show an even larger proportion of the population in poverty.

Within this context, health reform is an important part of the effort to reduce the level of poverty and will complement the government reforms already undertaken.

2. Demographic and Health Situation

The data from the 1992 population census show that the population pyramid has a wide base. In 1992, 39 percent of the population was less than 15 years old, and almost 25 percent (approximately 1.2 million people) consisted of women of childbearing age, together totalling close to 65 percent of the entire population. For the period 1990-95, the annual population growth rate is estimated at 2.2 percent, with an average fertility rate of 3.5 children per woman of childbearing age.



As the poor population is the target of social programs, it is important to note some of its principal characteristics. The rural poor are spread out geographically, while the marginal urban poor are more concentrated. Educational levels are low; the 1992 data show that 29 percent of adults were illiterate, with higher rates among women and in the rural areas; 24 percent of children aged 7 to 12 years were not enrolled in grades one through six.

Data on population distribution by age group, global fertility (especially high in rural areas), early childbearing, and mortality underscore the importance of emphasizing maternal and child health care services.

Conditions which have improved:

- the infant mortality rate has been reduced from 118/1,000 in 1970 to 57/1,000 in the period 1985-90
- immuno-preventable diseases have been reduced by increasing the vaccination rate
- the incidence of whooping cough, measles, and neonatal tetanus has decreased
- malnutrition in children under the age of five has diminished
- the rates of iodine deficiency and goiter have decreased by more than one half
- the number of malaria cases was reduced from almost 100,000 in 1980 to 4,000 in 1993

The overall health condition of the population has improved in recent years, as shown above. The maternal mortality rate dropped from 4.6 in 1987 to 3.7 in 1990 (per 10,000 live births) and the malnutrition rate has decreased, especially in children under five. During the period 1950-1993, El Salvador reduced its infant mortality rate by two thirds, while other countries in the region only lowered it by one half.

Increased immunization coverage has resulted in a significant reduction in the incidence of immuno-preventable diseases. According to the WHO, El Salvador is now free of polio and diphtheria, and the rates of whooping cough, measles, and neonatal tetanus have decreased. The rates of iodine deficiency and goiter have decreased by more than 50 percent during the period 1965-90, while the number of malaria cases dropped from almost 100,000 in 1980 to less than 4,000 in 1993.

Despite the achievements mentioned above, infectious diseases and other health problems caused by poor nutrition and environmental pollution still present a major challenge to the health system.

The five main causes of child mortality are diarrhea, acute respiratory infections (ARIs), low birth weight, congenital abnormalities, and birth trauma. In 1990, more than 80 percent of the outpatient consultations and hospital visits for children under five years old were due to ARIs, intestinal infections, and intestinal parasites. A high percentage of children's deaths are avoidable, particularly those caused by acute diarrheal disease (ADD), ARIs, and low birth weight.

Health services for children less than one year old should emphasize preventive, educational, participatory, and basic health care. The major components of any effective strategy to reduce infant mortality should include a reduction in environmental pollution, improved nutrition for pregnant women and children, and closer monitoring of pregnancy, birth, and child growth. Pregnant women should have timely access to health services and should be educated on the importance of breast-feeding and the need for prompt referral of high risk cases.

Among children aged one to four, ARIs are the principle cause of death, with serious cases frequently evolving from relatively mild infections. In many developing countries, child mortality from ARIs has been reduced partly through training health promoters in the timely detection and treatment of these infections. The MOH health promoters can treat mild cases, though they cannot prescribe antibiotics. Serious cases are referred to health establishments. Only 60 percent of the referred cases complete the referral process, however, and medicine is frequently taken without any prescription or supervision, especially in rural areas.

Poor nutrition constitutes one of the most important health problems of pregnant women, newborns, and children under five years old. Chronic malnutrition continues to affect more than 20 percent of Salvadoran children, with the rate rising to 28 percent in rural areas.

The level of malnutrition varies from one area to the next and so health programs should concentrate their efforts in the municipalities with the highest malnutrition levels. The most pronounced micronutrient deficiencies are iodine and vitamin A. Though improvements have been made, the rate of iodine deficiency (which affects mental capacity, motor coordination, and neuromuscular development) is still very high. This problem could be eliminated by easily implemented and inexpensive programs, such as the iodization of salt. A similar problem exists with vitamin A deficiency, which has been shown to have a strong correlation with deaths from diarrheal disease and measles. In 1988 the rate of vitamin A deficiency was 36 percent; fortifying sugar with vitamin A would be a simple method to solve this problem. The MOH and the Ministry of Education have implemented several effective food programs, but they have had limited coverage.

The health problems of women of childbearing age are important due to their number relative to the general population and to the intensity of reproductive activity. The main problems are the high fertility rate, short intervals between pregnancies, sexually-transmitted diseases (STDs), and cervical-uterine cancer. Many women begin their sexual activities at an early age and do not use any method of contraception to prevent or adequately space their pregnancies, resulting in high fertility rates. By age 18, 50 percent of women have had their first sexual encounter, and by 20 years old the same proportion of women have had at least one child.

Family planning in El Salvador has increased, with the percentage of childbearing-age women using some form of birth control rising from 22 percent in 1975 to 53 percent in 1993. The use of contraceptive methods in rural areas is less than in urban areas. Only 15 percent of women are using effective temporary methods, however, reflecting the high number of sterilizations and the low acceptance rate of effective temporary family planning methods. Health promoters and midwives are ideal resources for increasing the coverage of sex education and reproductive health programs for high risk groups. Involvement of MOH health promoters in family planning programs varies according to the level of coordination that the promoters have established with doctors from the health facilities to which the patients are referred. This highlights the importance of an integrated approach to the reorganization of the health system.

The incidence of cervical-uterine cancer in El Salvador is one of the highest in Latin America. The number of people with STDs and AIDS has been increasing steadily. The primary reasons are: social and sexual customs; the early age at which sexual relations are initiated; the number of sexual partners; and most importantly, the lack of effective prevention, sex education, and reproductive health programs.

The identification and treatment of the carriers of sexually-transmitted diseases is very important. For many women prenatal monitoring is the only opportunity to carry out this screening. The incidence of HIV/AIDS infection has risen, and the current estimate is that 30,000 people in El Salvador are infected with the HIV virus. It is during the early stages of the spread of this disease, before it reaches epidemic proportions, when prevention is needed most and when it is more efficient, less costly, and has the greatest impact.

Another major cause of mortality in the country is violence, particularly homicides and accidents (traffic as well as other kinds of accidents). Contributing factors include: alcohol and drug use, poverty, the lack of education and job opportunities, personal and family problems caused by the civil war, and economic recession. These last two factors are also related to less obvious forms of violence. Many of these causes can be alleviated by increased education, recreational activities, work opportunities, and alcohol and drug abuse programs.

Environmental problems

- 45 percent of water sources are polluted
- 67 percent of the population is not connected to any sewage system
- 48 percent of the rural population has no garbage disposal system
- 50 percent of the solid wastes generated in urban areas are not collected
- 69 percent of the departmental capitals (in El Salvador there are fourteen departments which are equivalent to provinces) have no garbage removal system

The environment in El Salvador is in very poor condition and disproportionately affects low-income households. Only 55 percent of the population has access to public water, while in rural areas this figure is reduced to 16 percent. A recent study indicated that 45 percent of the public water was contaminated, and only one third of the population is connected to a sewage system. Almost half of the rural population lacks a solid waste disposal system, while more than half of the solid wastes generated in the cities is never collected; in hospitals, biological and potentially toxic wastes are not properly separated.

The recent demographic and health assessment highlighted some of the most important factors affecting health policies. First, highest priority should be given to women of childbearing age and children. Second, the principle health problems are not complicated, but they can become serious if not treated promptly. Finally, timely treatment requires: 1) a focus on preventive, educational, and basic curative services; 2) easy access to health services, particularly in rural and marginal urban areas; 3) an integrated health system which provides for efficient referral of high risk cases; and 4) an increase in the availability of potable water and better environmental protection.

Based on the analysis carried out, ANSAL selected ten areas that should be targeted by the health sector, ranging from specific health problems to groups of health activities. The recommendation is to focus available resources on these areas:

- integrated prenatal, childbirth, and postpartum care
- family planning to reduce multi-parity and insufficient birth spacing, especially for younger women
- infant and child survival, with emphasis on the control of diarrheal diseases, ARIs, and immuno-preventable diseases
- maternal and child nutrition; breast-feeding
- sexually-transmitted diseases, AIDS, and cervical-uterine cancer
- access to potable water in rural and marginal urban areas as well as treatment of liquid wastes
- insufficient capacity for the collection and disposal of solid wastes
- prevention and control of major endemic diseases (malaria, tuberculosis, etc.)
- physically and mentally handicapped war victims
- accidents and violence

3. Health System

Over the past five years, important efforts made by the GOES have resulted in an improvement in the overall health situation. In spite of this, however, the health system currently faces major difficulties: limited access to health services for the rural poor; basic inefficiencies in the system; concentration of health services in the metropolitan area of San Salvador; and a focus on curative care that is inappropriate for the epidemiological profile of the population. The development and implementation of health sector policies and fulfillment of the MOH's supervisory role suffered during the civil war as the state focussed its limited resources on the direct delivery of services. Delivery of public health care became centralized, inefficient, and scattered in terms of the services provided and the population covered.

In spite of an increase in government spending over the past four years, health sector financing remains inadequate and partially dependent on foreign sources, while significant budgetary inequities exist within the system. In addition, the GOES lacks effective human resource policies and there has been minimal coordination with the institutions responsible for training health personnel. The centralized management of personnel and the inadequate incentive and remuneration system have also contributed to inefficiencies. All of this has brought about an imbalance between the supply and demand of health personnel.

Role of the Government

The state is more deeply involved in the health sector than in other sectors. The MOH has focussed its own limited resources on the delivery of health services, while limiting its participation in the implementation of general health policies. A National Health Plan is in effect, but it has not been implemented by all of the health sector institutions because many of them do not recognize or follow the leadership of the MOH.

According to the Constitution, the Public Health Council (CSSP) and the boards of the health professionals are responsible for overseeing the health sector, yet legally the MOH also has the same responsibility. Furthermore, the autonomy of the Council and the professional boards is somewhat limited by the fact that their funding comes from the MOH budget.

This situation has created a shared responsibility for monitoring and controlling the health sector with clear institutional boundaries, thereby dissipating each institution's commitment and leading to only partial fulfillment of the government's mandate as established in the Constitution. The major constraints to fulfillment of the state's obligation, however, come from the lack of technical capability and insufficient political will.

Health services

Health services are supplied by a wide variety of organizations and individuals. Within the public sector the main institutions are the MOH and the ISSS; in the private sector the main providers are the pharmacies, NGOs, and physicians. It is estimated that the MOH covers 50 percent of the population in terms of basic health services and 75 percent in terms of hospital services, while the ISSS, through its coverage of the individuals enrolled in its programs and their dependents, covers 12 percent of the population.

Some health coverage is also provided by the Bienestar Magisterial (teachers' organization), the National Administration of Telecommunications (ANTEL), the Lempa River Hydroelectric Commission (CEL), the National Administration of Aqueducts and Sewerage (ANDA), and the Department of Defense.

Approximately one hundred NGOs carry out health-related activities. Most of their programs focus on preventive and basic curative services. The NGOs serve the important function of providing basic health services to low-income residents in rural areas.

Of the 3,000 doctors in El Salvador, 66 percent practice in the department of San Salvador and 10 percent in the department of Santa Ana. These figures make it apparent that a very small number of physicians service other cities and the rural areas.

Given the high degree of self-medication in the country, pharmacies are an important part of the health system. There are 1,044 pharmacies in all of El Salvador.

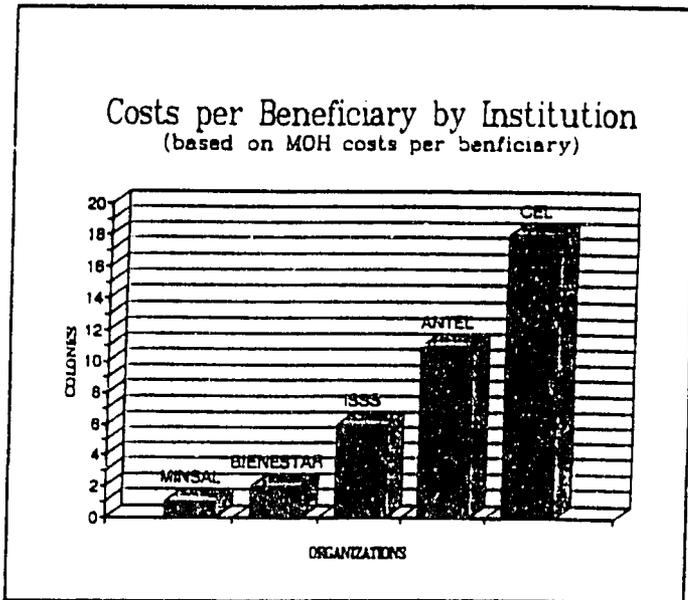
Hospital births accounted for 51 percent of all deliveries in 1992; 37 percent of the deliveries were assisted by midwives and generally took place in the home, primarily among women with minimal educational and socio-economic levels living in the rural areas.

Most maternal and child health services are provided by the MOH, with some supporting services for rural and low-income populations provided by NGOs. The private sector, the ISSS, and other health programs together cover approximately 20 percent of the population, mainly educated individuals in upper socio-economic levels who live in Metropolitan San Salvador.

Financing. The financial resources for the health sector are insufficient and are inequitably distributed among institutions and geographical areas. In 1992, health care expenditures (total resources spent by the state, the

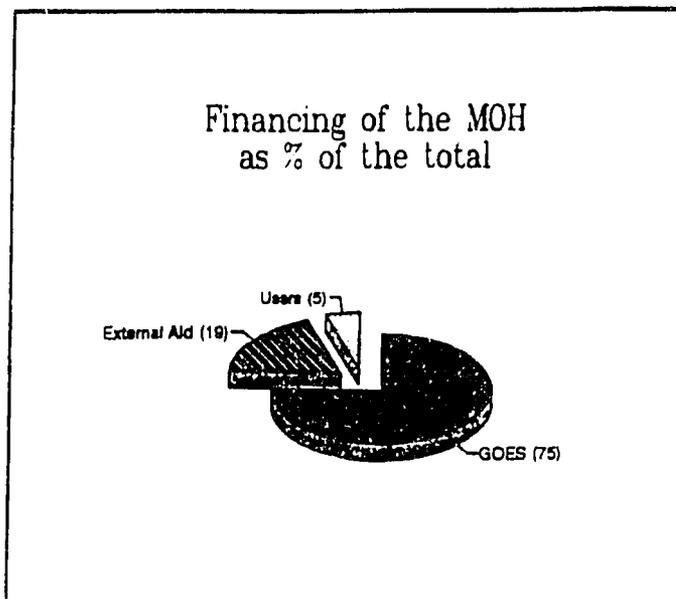
private sector, individuals, etc.) amounted to only 3.7 percent of GNP, which is low relative to that of other intermediate developing countries (as El Salvador is currently classified) which spend between 4 and 8 percent of GNP.

The MOH receives less than 22 percent of the health sector's financial resources, yet covers 50 to 75 percent of Salvadoran residents, many of whom have the worst health conditions and are most likely to become ill. Furthermore, some services are provided by the MOH free-of-cost to people with sufficient income to pay for the services themselves, thus stretching the already limited resources even further.



An analysis of the expenditure per individual for each institution demonstrates the inequity of the system. For every colón spent on an individual by the MOH, Bienestar Magisterial spends 2, the ISSS 6, ANTEL 11, and CEL 18 colones, resulting in a wide disparity in the quality of services provided. In 1992, the ISSS provided an average of 4.9 medical consultations per beneficiary, while the MOH provided only 1.5 consultations. In addition, ISSS has almost three times more physicians per beneficiary than the MOH.

The imbalance of resources becomes even more important in view of the evolution of MOH financing over the past twenty years. During this period real spending per beneficiary decreased. In spite of substantial budget increases over the past three years, in 1993 MOH spending (in constant colones) was still below the 1976 level.

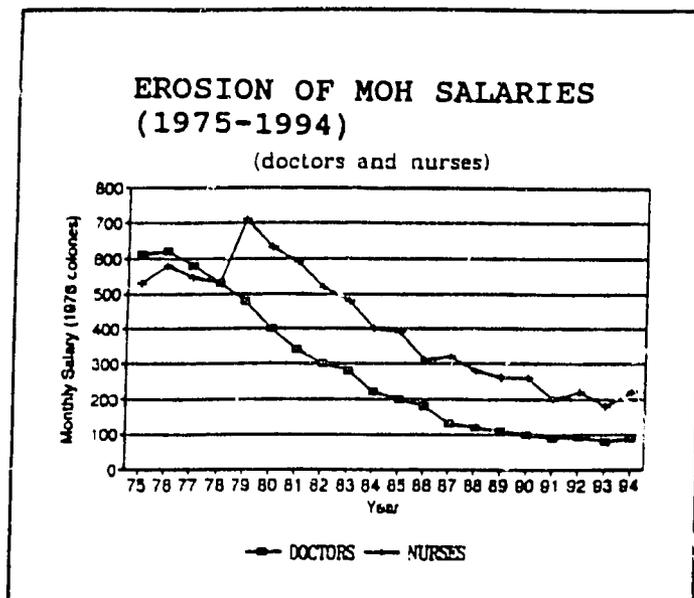


Approximately 75 percent of MOH funding comes from the GOES, 19 percent from international assistance, and 5 percent from user fees. This dependence on foreign assistance is unhealthy; USAID financed close to 50 percent of the cost of medicines and supplies and almost 11 percent of the operation costs of the MOH during the past decade.

Geographic imbalances are also evident in that almost two thirds of total health expenditures take place in Metropolitan San Salvador (MASS). Both public and private sector institutions are concentrated in metropolitan areas, with the exception of the MOH and NGOs which are active providers of care in the rural areas. This spending pattern results in a serious lack of services for the rural residents who comprise 50 percent of the total population. San Salvador has 8.6 doctors per 10,000 habitants and San Miguel has 5.2. The other regions have on average only one third of the recommended number of doctors per inhabitant of 8 per 10,000 (PAHO).

Technical and Administrative Inefficiencies. The salaries of MOH personnel have been affected negatively by two factors; first, by the leveling of the salary scales, and second, by the erosion in purchasing power. The current salaries of doctors and nurses have decreased in real terms to one sixth and one third of their respective 1978 values.

The erosion of salaries has contributed to the following problems: a decrease in the number of full-time personnel (most doctors are currently contracted for only two hours per day); an increase in the number of employees with more than one job; decreased productivity; increased labor conflicts; loss of well-trained personnel; and low job appeal for qualified replacements. The increased number of part-time personnel is due to both the organization of health services and the lobbying of health professionals regarding inadequate compensation.



The above problems are aggravated by inefficient human resource management, including: a tendency to hire specialists instead of general doctors; centralized personnel management; little decision-making authority at the technical levels; restricted hours for outpatient care (resulting in the use of higher cost emergency services); a health care model that relies too heavily on physicians; ineffective incentive systems; the lack of workplace guidelines; and insufficient training in health services management.

There are other inefficient administrative practices as well: the unregulated and excessively open health care models; the allocation of resources based on past budgets; the lack of a unified budget; the lack of an integrated financial system; and the lack of efficient long-term financial planning.

A further source of inefficiency derives from the excessive proportion of total health sector spending on curative services, primarily by the private sector and health insurers. Although the MOH and the NGOs spend significant portions of their budgets on preventive health services, the bulk of their spending is also concentrated on curative services.

To summarize, the health sector has four main problems:

- * Low coverage and limited access to preventive and basic curative services, especially for the high risk population (rural and low-income population).
- * Inequities resulting from the inverse relationship between the need for services and the availability of the resources to provide such services.
- * Inefficiency due to poor administration, resulting in low productivity and a health care model inappropriate for the epidemiological profile of the population.
- * Lack of sustainability linked to underfunding of the sector which has created a dependence on foreign resources.

III. NEED FOR MAJOR CHANGES IN THE HEALTH SECTOR

1. Maintenance of the Status Quo

The previous chapter describes the poor health status of the majority of Salvadorans and a health care system that is struggling to make improvements. If the necessary reforms are not made in the health sector, the following will result:

- Deterioration of the overall health situation
- Maintenance of the inequities in health care services
- Financial collapse of the health care system
- Deterioration in the quality of services provided
- Increased costs of sectoral reform in the future

Good health is a necessary condition for learning and working. According to the Constitution of El Salvador, good health is a right of all citizens. While the rural and urban poor have the worst health indicators and need the most services to restore and maintain their health, they receive the fewest benefits. Therefore, if changes are not made, inequalities in the system will remain and perhaps become even greater. There are other factors which, in the absence of change, could exacerbate the situation, namely, increasing pollution and the spread of infectious diseases. These problems demand social discipline and a fully functioning health system to avoid epidemics of diseases such as AIDS and cholera.

If the method for financing the health sector is not modified, then the whole health system will collapse. The MOH and the NGOs depend heavily on foreign donors that have already announced drastic cutbacks in the levels of assistance over the next few years. In addition, ISSS expenses are increasing at a rate greater than the capacity of the employers and workers to pay into the system. This is due to the general inefficiency of ISSS service delivery and the lack of regulations which limit the number and complexity of the services provided.

Maintenance of the status quo will also lead to a progressive deterioration in the quality of health care, as the population continues to grow, the infrastructure continues to deteriorate, and productivity declines. The country's population is increasing at an annual rate of 2.2 percent, with the greatest growth occurring among the poor. If there is increased spending for primary level health care, the poor will stand to benefit most. If there is no expansion of primary level care, it is these people whose health status will deteriorate, leading to a greater demand for more expensive health services.

The lack of preventive maintenance shortens the life of the equipment and the physical infrastructure. The cost of replacement is several times higher than the cost of maintenance. Preventive maintenance is hard to achieve, however, when there is centralized management and a lack of incentives for maintenance, especially when the management of the services is not linked to the user community.

The inequities and inefficiencies of the health sector make reform a necessity. The longer such a reform is delayed, the higher its political, economic, and social costs will be. If primary level health care is not improved, the costs of curative medicine will increase and vested interests will be strengthened.

2. Approach to the Reform

The review of the health system performance led ANSAL to develop specific recommendations for the problems identified, including nutrition and food programs, breastfeeding, family planning, health sector financing, and human resources. The extent of the problems and the corresponding recommendations led ANSAL to develop a more global proposal: the Health Sector Reform that is the main topic of this and the following chapter. A list of the specific recommendations in abbreviated form is presented in Appendix 1.

The negative consequences of maintaining the current situation moved the ANSAL team to look for alternative models for the health sector in El Salvador. The study was complemented by an extensive discussions with representatives of public and private sector health organizations, users of the health system, politicians from a variety of political parties, and representatives of international organizations. The process led to a consensus between Salvadorans and the ANSAL team on both the importance of reforming the health sector and the basic approach for the proposed reform.

Objectives of the Reform

- Redefine the role of the government
- Focus the government's attention on primary care and on the poor
- Strengthen the ten priority health programs
- Make health promotion and prevention high priorities
- Increase financing and restructure financial sources
- Create an organized system of health care service delivery
- Decentralize and increase the efficiency of the health system

Redefine the role of the government

In its redefined role the state would emphasize its function as manager, coordinator, regulator, supervisor, and financier of the system, while progressively diminishing its role as a service provider. The MOH would be the manager of the system and would be responsible for: development of the National Health Plan; inter-institutional and intra-sectoral coordination; promotion of individual and collective responsibility for health care and the environment; monitoring of general health conditions; and the oversight of health posts and centers, health services and medicine. The MOH would also establish policies and programs, develop human resource policies, and ensure basic health care for the poor. Though the MOH would have final authority and responsibility, a participatory decision-making process, involving the NGOs, commercial private sector, and other health sub-sectors, would ensure the smooth functioning of the sector.

ANSAL highly recommends establishing a Health Advisory Board (Consejo Consultivo de Salud/CCS) to facilitate sector coordination among private and public entities and to promote, consult, and seek consensus on health programs and plans. Meanwhile, the Public Health Council (Consejo Superior de Salud Pública/CSSP) would continue to oversee the practice of health professionals, and the ISSS would operate the National Health Fund, through which specialized and hospital services would be financed. The MOH and the ISSS would reduce their participation in the direct delivery of services.

Focus on primary health care and the poor

Government resources would focus on the delivery of health services to the population at the highest risk. The state would fully subsidize primary health care for all persons below the poverty level, as well as health education and epidemic control programs. State financing of higher level health care would be limited to a restricted group of services (expanded package of health services) and the subsidy would vary according to the user's ability to pay.

Strengthen the ten priority health programs

The MOH would focus on the programs that address the ten major health problems. The programs would emphasize preventive and basic curative health care. A basic package of services would be developed and delivered to the population through a community health unit or the Community Health System (SALUCO). These would be composed of a variety of local providers, including health posts near a health unit.

Emphasize health promotion and prevention

The MOH would strengthen the preventive and educational focus of its programs. Coverage in the rural and marginal urban areas would be increased by the MOH and the NGOs by providing additional promoters, trained

midwives, and other personnel. Educational campaigns directed towards the ten target areas would receive a significant increase in funding and attention.

Increase financing and diversify sources of funds

The GOES would gradually increase the level of resources dedicated to the health sector in order to fully fund the basic package and to partially fund the expanded package of health services for the poor. Users with incomes above the poverty level would be required to pay higher fees for the services they receive. Dependence on foreign assistance would decrease and a universal and compulsory health insurance program would be created. Foreign aid would cover the costs of the system's reform (estimated at \$200 million). By the fifth year of the reform, the government's expenditures would have been increased by 63 percent. (See Appendix 2 for a preliminary estimate of the costs of the reform).

Create an organized system of health care

The present health system would be totally reorganized into a network of institutions. The Health Advisory Board would be the inter-institutional coordinator. More decision-making authority would be delegated to local technical personnel (midwives, promoters, and nurses) to detect and refer complicated cases to the health unit, which in turn would refer cases requiring specialized care to the hospital network.

Decentralize and increase efficiency

PHC services would be transferred to the municipalities which would manage their own budgets and contract other institutions (NGOs, private organizations, etc.) to provide services. Hospital administration and even hospital property would be transferred to private institutions. Criteria to measure the efficiency and productivity of services would be established, technical assistance would be organized according to MOH priorities, local decision-making authority would be increased, local organizations would be given autonomy in the management of resources including savings, hospitals would compete among each other for users and would be paid by person (not by service), managed care systems would be introduced, a single information system would be developed, and responsibility for training of health personnel would be transferred to institutions outside of the MOH.

3. Factors Affecting the Proposed Reform

Reform of the health sector is a complex task; some factors will facilitate the desired changes and others will make the reform more difficult to achieve.

In general, the current circumstances in El Salvador favor reform. The pervading national optimism has created an atmosphere of confidence in which people believe that major challenges such as a restructuring of the health system can be achieved. Reforms by the previous administration are consistent with the main features of the proposed reform. Democratic processes are creating expectations of greater social services and citizen participation. The reduction in foreign aid is forcing the government to modify the financial structure of the health sector and to improve its financial accountability. There is consensus that changes such as those proposed by ANSAL are desirable and possible; the health and nutrition component of the Ministry of Planning's 1994-99 National Development Plan coincides with ANSAL's proposal. Finally, international organizations have already expressed their support for the proposed restructuring of El Salvador's health sector.

In summary, the factors which could facilitate the reform are:

- a national climate of optimism
- the compatibility between the reforms of the previous administration and the proposed reform
- the modernization of the government
- higher social expectations
- the trend towards increased financial accountability and the reduction in foreign assistance resulting from the restructuring of the sector's financial base

Other factors impede change. Institutional reorganization involves changes in the relationship of power between the principal actors; this would be especially true for the delegation of responsibility for the delivery of primary care services to the municipalities and for hospital care to the private sector. The proposed decentralization involves the transfer of authority from the regional and central levels to the municipalities, which would be resisted by those who are used to exercising their authority.

The health benefits of some groups would change under the reform; the ISSS beneficiaries would probably believe, incorrectly so, that their benefits would be reduced. The compulsory health insurance could involve the introduction of co-payments, limits to the type of treatment covered, the exclusion of certain rare medical conditions, and limits on specialized care.

Medical personnel would have to deal with two major changes that could be hard for them to accept. First, they would have to ration health care (through the new universal insurance), and second, their labor relations would change. Employees of the MOH and the ISSS who are currently providing services that would be transferred to community organizations or private enterprise would experience significant change in their working relationships.

In general, inefficient management allows some individuals and organizations to derive benefits otherwise not possible; reforms that eliminate these benefits would generate resistance. Decentralization of management would require strengthening of the management capacity both at the local level and in the public sector.

In summary, the factors which could impede the reform are:

- requisite changes in the power structure between the principal actors
- transfer of authority from the central and regional levels to local levels
- resistance by groups fearing a reduction in benefits
- limited management capacity of local organizations and public institutions
- the need for the reform to be integrated in order to achieve maximum impact rather than create greater problems

IV. PROPOSED HEALTH SECTOR REFORM

The four main components of the reform are:

- Institutional reform
- Primary health care reform
- Specialized and hospital services reform
- Strengthening of environmental protection activities

The last component is important to improve the health status of the population, and thus it cannot be ignored in the reform. Nevertheless, it is not closely linked to the other components and ANSAL has not focussed on environmental issues. Recommendations related to the environment, therefore, have been kept at a general level.

The reform should be characterized by the following: an integrated approach; gradual implementation; strong political support and leadership; citizen participation; and flexibility.

Integrated approach: The entire health system should be changed and all four components of the strategy implemented. Partial changes will be ineffective. One example of this concerns primary and hospital care. On one hand, if only primary care services are modified, then the care of patients referred to hospitals may not be assured. On the other hand, if only hospital care is improved, then the demand for hospital services could become excessive and unnecessarily costly.

Gradual implementation: The magnitude and innovative character of the changes make gradual implementation necessary.

Political support and leadership: Because of its importance and scope, the reform needs high level political support and leadership as well as agreement among diverse social and political sectors.

Citizen participation: Wide citizen participation is needed to ensure success of the preventive approach of the reform, to generate strong political support, to increase the efficiency of the administration of some programs, and to foster changes in the attitudes of users of the system and health care workers.

Flexibility: The proposed reform should be perceived as an ongoing process in which lessons learned from initial experiences are incorporated into the reform, mistakes are corrected, and suggestions from users, workers, and institutions are welcomed.

1. Institutional Reorganization

The institutional reorganization consists of:

- redefinition of the function of the government
- creation of an organized health system
- clear definition of institutional boundaries
- institution strengthening
- human resource development
- health promotion and preventive care

Redefinition of the function of the state: Through the MOH, the state would become the leader of the health sector for development of policies, approval and implementation of plans and sectoral standards, monitoring the general health of the population, and managing the budget. The MOH would gradually transfer responsibility for the management and delivery of health services to municipal governments and private organizations. At the same time it would maintain and strengthen its vertical preventive care and health education programs which it would manage directly.

In order to facilitate coordination of policies, plans, and programs, the Health Advisory Board (Consejo Consultivo de Salud) would be created; it would serve only in an advisory capacity, and would include public and private sector organizations involved in the health sector, particularly those that deliver health services and pharmaceutical products. The Board could be organized in committees covering topics such as: human resources, finance, the environment, worker health care, and health system performance. The Board and its committees could obtain technical support from the MOH.

With the redefinition of its own functions, the MOH would need to transfer the administration of the nursing school and health training schools to autonomous entities.

Creation of an organized health system: The reformed system would be composed of the MOH, FONASA, and the municipalities from the public sector, and the SALUCOs, NGOs, and local private organizations providing PHC and specialized and hospital care (SHC) from the private sector. These institutions would form a network under the technical and political management of the MOH. The system would be designed to deliver PHC and SHC efficiently and effectively and to provide the basic and the expanded packages to the entire population in an equitable manner.

Institutional jurisdictions: The government has the ultimate responsibility for ensuring the quality of the health services and goods provided in the country. The institutions involved in this quality control would be the MOH, the Public Health Council (CSSP), and the professional health boards, but the reform proposal has not delineated the role and responsibility of each institution, such as who will be responsible for providing medical supplies, equipment, and medicine to health facilities. Additional research is needed to establish the appropriate roles and responsibilities for the various groups.

The creation of the Secretariat for the Environment (SEMA) and its taking the lead on addressing environmental health issues should relieve the MOH of the responsibility for issuing policies and implementing programs in this area. The MOH should improve its monitoring and inspection capabilities in the following areas: water, sanitation, garbage disposal, air pollution, the sale and use of pesticides, and the distribution and handling of food.

Institution strengthening: For the MOH to become an effective leader of the health sector, it must strengthen its technical capacity to conduct research and to formulate policies. A multidisciplinary team should be established (with economists, demographers, epidemiologists, and health administrators) to provide high quality technical input into the decision-making process. The unit would function as a technical support unit to the Health Advisory Board (CCS), in a manner similar to that of the Economic and Social Advisory Group (GAES) in the Ministry of Planning; it would also support the implementation unit for the health reform.

At the same time, other technical teams within the MOH should receive support for their work supervising compliance with MOH norms and standards. The MOH should also develop information systems and analytical tools to guide the formulation of health policies, to guide budget planning and implementation, to assist in the collection of vital statistics, and to facilitate disease surveillance.

Development of human resources: The formulation of clear national policies for human resource development in the health sector is of prime importance. The policies should cover: planners, economists, health service

administrators, community health doctors, public health nurses, midwives, promoters, educators, and social workers. It is critical to establish a method to coordinate the coordination between the training institutions and the health providers.

Health promotion and preventive care: The MOH should allocate adequate resources for health promotion and prevention activities, particularly related to the ten target programs. Legislation should be enacted to support the broadcasting of messages to promote good health and preventive care and to prohibit those which have a negative health impact (i.e., violence, cigarettes, and alcohol). Finally, there needs to be coordination with the Ministry of Education to introduce health education curricula into the schools.

2. Reorganization of Primary Health Care

The reorganization of PHC would be implemented gradually and would begin with pilot programs in various municipalities. If the pilot programs were successful, they would be implemented throughout the country over a period of ten years.

The reorganization of PHC consists of:

- decentralization of services
- community health system (SALUCO)
- basic package of health services
- health care for the poor financed by the MOH
- reorganization of the MOH
- incorporation of an incentive system for PHC workers
- training of key health care workers
- delegation of authority to community level personnel

Decentralization of services: The health services included in the basic package would be administered by the municipalities. They would contract local organizations for the delivery of services. The choice of organization would be made by the local authorities based on the community's preference. Such organizations could be NGOs, foundations, private for-profit enterprises, health worker cooperatives, etc. In very small municipalities the programs could be jointly run with other municipalities or the responsibility for the delivery of services could be delegated to the departmental development councils. The decentralization process would require a concurrent process of strengthening local administrative capacity; the development and implementation of these programs could be coordinated with COMURES and ISDEM.

Community health system (SALUCO): The basic unit of PHC services would be defined by the size of the population to be served and the geographic area covered. The relationship between SALUCOs and municipalities would vary; a SALUCO could depend directly on a municipality, serve various municipalities, or serve only one part of a municipality. Each SALUCO would consist of a referral center and community health workers for the area covered. The referral center would have at least one doctor and a team of technicians and assistants; it would receive referrals and would supervise the personnel of the community to which it is providing services. Each SALUCO would be responsible for managing its own budget, contracting, making salary payments, controlling inventory and ordering supplies, etc. The SALUCO would work with the community so that it could participate at an institutional level in the planning and supervision of health services.

Basic package: This group of services would consist of primary care interventions that could be provided in the community by community health care personnel and by the referral center. It would include:

- Immunizations
- Prevention and treatment of diarrheal diseases and respiratory infections
- Nutrition programs
- Health education
- Prevention, detection, and treatment of parasitic infections
- Prevention and control of STDs
- Family planning
- Pap smears and breast exams
- Prenatal care and normal deliveries
- Well-child care

In coordination with the SALUCOs, the MOH would design, implement, and evaluate technical modules for the delivery of basic health care in the rural and marginal urban areas. These modules would include: specific services to be provided; definition of the kind of personnel who would provide the care; technical and administrative procedures to be used; and a managerial system for the SALUCOs. Technical-educational modules for health promotion and prevention would also be developed.

Financing: The delivery of the basic package of services would be fully financed by the MOH for those below the poverty level. The guarantee of these services for the poor would require an increase in government funding for PHC. The payment for PHC services to the municipalities, which in turn would have to pay the local institutions, would be carried out through contracts which would include: a per capita cost adjusted to local levels; community health education programs; availability of supplies; the basic package of health services; and mechanisms for community participation.

Reorganization of the MOH: The MOH would still be responsible for establishing programs, policies, and regulations related to PHC, to the basic health services package, and to the SALUCOs. The MOH would have oversight responsibilities in these areas. It is recommended that support and supervisory units reporting to the MOH be created at the department level. Personnel for these units could be drawn from the existing regional offices.

Autonomous agencies would take over the MOH purchasing responsibilities and would provide procurement services to the SALUCOs. While the agencies would make their services available to the SALUCOs, the SALUCOs would be free to decide if they would use that or any other mechanism. A system of accreditation of municipalities and SALUCOs would be developed.

Incentive system: Appropriate incentives would be established to make the positions in remote communities more attractive. Some of these could include: flexible management; emphasis on community control; payment on a per capita basis; and opportunities for continuing education.

Training of key health care workers: Personnel to be trained include general practice doctors, medical technicians, nurses, health promoters, midwives, and SALUCO administrators.

Delegation of authority to community level personnel: The health promoters and midwives would be given greater authority to prescribe antibiotics and contraceptives under well-defined circumstances and with appropriate technical supervision.

3. Reorganization of Specialized and Hospital Care

Expanded package: The health care services in the expanded package complement the primary care services provided in the basic package. Highly complex or expensive care is not covered under either package. Between the two packages, approximately 90 percent of the medical problems in the country would be covered. The patient referral system would have to be improved. The expanded package includes standard secondary level care such as: abdominal surgery; treatment of malaria, tuberculosis, and other infectious diseases; high-risk deliveries; emergency care; outpatient and inpatient care in the four basic medical areas; and the use of certain medicines. There is no coverage for treatments such as computerized tomography, neurosurgery, cardiovascular surgery, intensive care, etc. It is expected that public hospitals and health centers would have the human and technical resources to provide all of the services in the expanded package.

Transfer of the management of public hospitals to the private sector: The SHC system would be run by the private sector. The MOH and the ISSS would transfer the management of their hospitals, laboratories, and clinics to private organizations (foundations, NGOs, medical cooperatives, for-profit companies, etc.). This transfer of responsibilities to the private sector could take place with or without the transfer of property ownership. Due to potential complications related to the sale of government property, however, ANSAL recommends that the property not be passed to the private sector, at least during the initial stages of the reform. Possible problems could arise from the creation of monopolistic situations or from the difficulty in establishing the real value of the property.

Reform of specialized health care services:

- Expanded package of services
- Transfer of hospital management from the public to the private sector
- Development of the means to finance the expanded package
- Transformation of the ISSS and the creation of FONASA
- Increased technical and administrative efficiency
- Strengthening of the institutions involved in the SHC system
- Training of qualified human resources

Development of the means to finance the expanded package: Delivery of the health care services in the expanded package to the whole population would entail substantially increased costs. User fees would increase gradually in order to cover these costs. The increased financing would allow the expanded package to cover additional kinds of care and to improve the quality of the services already provided. Users would have the freedom to choose the hospital in which they want to be treated.

In order for the expanded package to be accessible to the entire population, low-income groups should receive either full or partial subsidies from the state depending on their financial circumstances. Access to the services for those who do not receive any subsidy would be through a compulsory health insurance program. Both low risk and high risk individuals would participate, and there would be incentives for the user to prevent illnesses (through savings in insurance premiums). The universal character of the services guarantees that everyone would have access to health services when needed, thus eliminating situations in which individuals need health care but cannot afford to pay the fees.

With the exception of low-income residents whose payments would be covered by the state, all residents of El Salvador would make health insurance payments. The government would subsidize 100 percent of the cost for the very poor (12 percent of the total population), 85 percent of the cost for the 2nd and 3rd income deciles (18 percent of the total), and 50 percent of the cost for the next two population deciles (20 percent).

Transformation of the ISSS and creation of FONASA: The National Health Fund (FONASA) would be created by transforming the ISSS health program into an autonomous institution with a board of directors headed by the Minister of Health. The state and users with incomes above the poverty line would pay premiums directly to FONASA, which would administer the funds and pay health care providers.

A plan for reform of the ISSS was being developed parallel to the ANSAL study. If the reform is carried out, the ISSS would be left with only its health program, and thus it is likely that it would pass from the Ministry of Labor to the MOH.

The basis of the insurance would be voluntary contracts between FONASA and the entities providing health services. Providers and insurers would be free to contract with each other or not, depending on costs, type of care provided, type of client served, etc. The insured individual would be able to choose the institution providing the services and would have to stay with that institution for a minimum time period. FONASA's payments to the service providers would be based on the number of people covered (a fee per person per year), not by the number of services provided.

The agreement between FONASA and the service providers would cover the following: the services to be provided; implementation costs of providing such services; a clear delineation of the state subsidies; classification of users by income level; and the formula for FONASA payments. Guidelines would be established for the regulation of surpluses and the circumstances under which additional charges could be made to the user for services that are not part of the expanded package.

Increase in administrative and technical efficiency: The reform proposes to introduce a managed health care system to increase efficiency and equity. Managed health care entails a set of guidelines that limits referrals and services and attempts to provide appropriate services at the lowest cost. This would be achieved through management techniques such as usage control, the use of qualified personnel, generic medicines, clinical standards, and critical paths for patients.

Institution strengthening plan: The MOH would develop an accreditation system for private organizations that provide hospital care and a standardized information system to be used by institutions providing hospital health care.

Health worker training: Trained personnel are vital to the success of the sectoral reform. There needs to be a critical mass of hospital administrators and directors. Also needed is in-service training of clinical personnel in the application of MHC instruments, as well as incentives for increasing efficiency.

4. Strengthening of Environmental Health Activities

According to the program to modernize the government, ANDA would no longer be a direct provider of services; it would remain as the manager, regulator, technical advisor, and supervisor of potable water and sewage programs. Delivery of services would be decentralized and transferred to other public and private sector institutions. High priority areas would be improvement in the provision of potable water, sewage treatment, and garbage collection and disposal. A recent study done by USAID, National Strategy for Sectoral Organization: Structural Options and Policies for the Water and Sanitation Sector, could serve as a valuable resource.

Institutions which could provide technical assistance on the construction and maintenance of public services, such as FIS, ANDA, COMURES and ISDEM, should be given support. Finally, increased financing for the environmental sector would be necessary and cost recovery through users' fees would be improved.

APPENDIX 1. RECOMMENDATIONS

This appendix summarizes the major recommendations made by ANSAL consultants. The recommendations were made prior to the design of the health reform proposal, and therefore some of them do not concur with certain aspects of the health reform (i.e. the increase in the number of MOH promoters).

RECOMMENDATIONS CONCERNING HEALTH ISSUES

Maternal child health

- * Concentrate resources on high risk groups (rural homes in which the mother has a limited education and low socio-economic level).
- * Strengthen maternal child (MI) health care programs through a committee of the Health Advisory Board (CCS).
- * Offer the basic package of MI services in rural areas where these services are currently not provided.
- * Design educational programs which emphasize priority areas and health risks.
- * Integrate the different programs and departments of the MOH that work in MI into one unit.
- * Strengthen supervisory capacity and focus on the resolution of problems identified through the supervision of MI activities.
- * Integrate coordination at the local level, using the local health system (SILOS) concept.
- * Increase the number of MOH and NGO promoters and midwives.
- * Increase the decision-making authority of promoters and midwives.
- * Integrate the various MOH information systems or at least make them compatible.
- * Improve the detection and reporting of infectious diseases, especially of HIV/AIDS.
- * Improve the collection of vital statistics at the municipal level.

Breastfeeding

- * Promote the approval of the breastfeeding law.
- * Include in the Labor Code regulations which allow breastfeeding mothers time to nurse their children.
- * Publicize norms and standardized procedures which foster/promote successful breastfeeding.
- * Implement policies to encourage immediate contact between the mother and her newborn, reduce the use of general anaesthesia, and reduce the time between delivery and sterilization.
- * Include information about infant feeding in the training of health professionals.
- * Educate the public on the benefits of breastfeeding during the first six months of life (it provides all of the necessary nutrients and promotes the development of the infant during this period).

Nutrition programs

- * Create a special committee of the Health Advisory Board for feeding and nutrition programs.
- * Improve the logistical arrangements for food delivery (at the local level there should be family packages) to ensure the continuity of food delivery.
- * Make nutritional programs regular programs of the MOH and the Ministry of Education.
- * Make sure that nutritional education programs are coordinated with food delivery and promote family and community responsibilities.
- * Develop information systems for the evaluation of nutrition projects.
- * Carry out quality control of the food being delivered.
- * Ensure financial sustainability of nutrition programs.

Family planning

- * Integrate family planning into reproductive health programs.
- * Increase the authority of the National Population Council and make it a committee of the Health Advisory Board so it can serve as a coordinator.
- * Evaluate the program to redirect assistance to the highest priority areas and to redesign the information system.
- * Increase the contraceptive options available.
- * Train health staff in the use of the IUD, the use of oral and injectable contraceptives, and the application of new technologies (i.e., Norplant), including training in possible side effects and risk factors.

STD/HIV/AIDS

- * Concentrate program activities in high risk geographic areas and population groups.
- * Combine intervention strategies to encourage a synergistic effect.
- * Train program staff in the use and interpretation of KAP (Knowledge, Attitude, and Practice) surveys.
- * Coordinate diagnosis and treatment of STDs, AIDS and cervical-uterine cancer.
- * Promote behavior change through communication strategies.
- * Organize and broaden the condom distribution network and condom quality control; distribute instructions on their appropriate use.
- * Ensure careful observation of high risk groups, such as commercial sex workers, and identify other high risk population groups, such as long-distance truck drivers, through on-site studies.
- * Provide equipment and supplies to the blood banks to accurately screen blood and to observe proper procedures for the handling blood.
- * Evaluate the social marketing of condoms program in light of a possible expansion of the program.
- * Promote the active participation of NGOs and other private organizations in MSC activities.

Physical environment

- * Reorganize the institutional guidelines for the management of river basins and for the administration of urban and rural water and drainage systems; consider the participation of other more efficient public and private organizations.
- * Promote the participation of NGOs, municipalities, and community organizations in water and drainage programs.
- * Approve the water law; the law should establish the standards for water quality and for dumps.
- * Increase cost recovery through rationalization of water use and expanded coverage.
- * Protect water resources through sanctions, fines for polluters, and educational programs.
- * Improve water supply of the rural population with the support of the FIS and MEA.
- * Design and implement a hospital waste disposal plan.
- * Design and implement a toxic and dangerous waste disposal plan.
- * Strengthen the capacity of COMURES, ISDEM and other entities to support the municipalities.
- * Design and build sanitary landfills in areas where there is no danger of contamination of river basins.
- * Obtain financing for garbage collection and disposal systems.
- * Draft (MOH and SEMA) regulations for garbage disposal.
- * Support the adoption of a national environmental strategy prepared by SEMA and other entities.
- * Support PAHO's "Plan Regional de Inversiones en Ambiente y Salud" (Regional Investment Plan for Health and the Environment).
- * Support health and environmental programs, such as MASICA (MOH/ANDA/SEMA).

Social sector

- * Support an inter-sectoral approach (MOH and MINED) to health education.
- * Promote literacy campaigns with the participation of the public and private sectors and volunteers.
- * Strengthen mental health programs, incorporating them into PHC.
- * Support community-based rehabilitation programs and self-help groups.
- * Promote multi-sectoral efforts to reduce poverty.
- * Focus health care on the poorest groups.
- * Support the health components of programs to reincorporate war victims into the society.
- * Make services for abused women and children a priority.
- * Strengthen family health programs and programs directed towards street children.
- * Support voluntary, private sector, and public sector programs for drug abuse prevention.

Death from external causes (homicides, violence, accidents)

- * Identify the contributing factors for deaths from external causes.
- * Identify the age groups most affected by specific causes of death.
- * Increase educational opportunities, alcohol prevention and treatment programs, recreational activities, and work opportunities.
- * Identify the importance of other categories of accidents such as drowning, fire, falls, poisoning, food poisoning, and asphyxia.
- * Identify the importance of accidents of young children (under five) in the home and propose corrective measures.
- * Design multi-sectoral programs to prevent or treat the problems mentioned above.
- * Encourage public and private sector institutions to participate in the launching of broad prevention, control, and rehabilitation programs.

RECOMMENDATIONS CONCERNING THE HEALTH SYSTEM

Health service system

- * The top priorities of the MOH should be: define and implement a sanitation policy and the National Health Plan; establish regulations for adequate health care for the population; monitor overall health status of the population; ensure basic and intermediate health care for the poor; and promote individual and collective responsibility for the maintenance of good health.
- * Implement a unified health system to be coordinated by the Health Advisory Board.
- * Focus government resources on PHC and determine a basic package of health activities.
- * Decentralize MOH decision-making power and administration and transfer to the municipal level.
- * Coordinate foreign assistance.
- * Separate the administration of the contributions of the riesgos diferidos of the ISSS from the health contributions of different institutions.

Financing

- * Develop a unique, universal, and compulsory health fund financed by contributions from all employers and employees.

MOH

- * Double PHC financing and focus services on low-income groups.
- * Increase user fees for specialized care and hospital care and develop other sources of funding.

- * Lower costs and improve efficiency.

MOH budget during implementation of the reform

- * Plan the budget on the basis of the needs of each service.
- * Develop a new formula for hospital budgets which is not based on historical data, but rather on actual costs and projected revenues.
- * Implement the decentralization of the services including training and control systems.
- * Break the budget down by municipality or department.

Human resources

- * Establish the MOH as responsible for defining policies for human resource development.
- * Coordinate MOH and educational institutions to ensure that the health needs of the population are considered in the training of health professionals.
- * Transfer the national nursing schools and the Health Training School (and its resources) to the education sector.
- * Emphasize training in deliveries for health personnel at the technician and assistant level.
- * Review the profile of MOH promoters and expand their decision-making authority.
- * Encourage the training of community health doctors.
- * Promote the training of nurses.
- * Review the technical careers in health so that there is a match between the careers offered and the country's needs.
- * Establish a rural residency program (three years) for doctors.
- * Strengthen the affiliation of nurses and technicians to the health services.
- * Promote six to eight-hour/day schedules for doctors, with a minimum of four hours.
- * Expand the schedule for health consultations to include the afternoon and early evening hours.
- * Standardize the assignment of personnel according to the model of care.
- * Increase the salaries of MOH professional and technical staff.
- * Provide positive incentives for MOH service providers.
- * Improve the supervision, continuing education, and follow-up for employees.
- * Ensure that the institution in charge of the licensing and control of health professionals is autonomous, with an independent budget and financial independence.
- * Require licensing of health professionals and update the list continuously.

Demand for health services and community perception

- * Strengthen the supervision and training of promoters and midwives; provide them with equipment and medicine to treat common health problems such as ARI.
- * Emphasize maternal and child health services in promoter activities.
- * Train a larger number of midwives to improve coverage in marginal urban and rural areas.
- * Establish an efficient patient referral system.
- * Hire local institutions for the delivery of PHC services.
- * Develop and implement marketing programs for PHC services.
- * Include pharmacists in the PHC system.
- * Provide basic community health services to marginal urban communities.

Administration of pharmaceutical products

- * Implement a national pharmaceutical policy based on essential drugs.
- * Strengthen the Public Health Council so that it can regulate and control drugs as established by law.

- * Implement the Central American free trade treaties for pharmaceutical products.
- * Verify the observance of the Buenas Practicas de Fabricacion (standards for the production of pharmaceutical products) of the WHO.
- * Request entry into the Esquema de Certification de Calidad de Productos Farmaceuticos (quality control system for pharmaceutical products) of the WHO.
- * Implement a computerized information system for drug registration.
- * Standardize the forms used for medication by public sector institutions, beginning with PHC medications.
- * Conduct an ABC analysis for the procurement of drugs by the public sector; analyze the feasibility of joint MOH and ISSS purchases for PHC pharmaceutical products.
- * Assess the feasibility of cost recovery for pharmaceutical products.
- * Share MOH and ISSS resources in the area of quality control to guarantee adequate quality control.

Infrastructure

- * Focus on maintenance of all existing infrastructure and equipment.
- * Avoid the construction of new hospitals in the next five years.
- * Limit the expansion of MOH infrastructure to primary health care.
- * Emphasize preventive maintenance programs.
- * Continue to support physical microplanning in the health sector.

APPENDIX 2. HEALTH REFORM COSTS

HEALTH REFORM: COSTS IN PHC AND SHC, 1994-2000***
(in 1993 colones)

Year	Year 0 1994	Year 1 1995	Year 3 1997	Year 6 2000
COST OF REFORM IMPLEMENTATION (foreign assistance)	0	361	661*	0
COSTS OF PHC:				
- Total:	230	300	565	565
- Government:	130	220	525	565
- Foreign assistance:	100	80	40	0
COSTS OF SPEC. & HOSP. CARE				
- Total:	690	690	1,380	2,070
- Government:	605	605	660	990
- Users:	45	45	720	1,080
- Foreign assistance:	40	40	0	0
COSTS OF SPEC. & HOSP. CARE (POPULATION STATUS):				
- Indigent pop. (12% pop.):				
- Government (100% subs.):	103	103	206	309
- Poor level 1 (18% pop.):				
- Government (95% subs.):	155	155	275	413
- Users:	7	7	49	73
- Poor level 2 (20% pop.):				
- Government (50% subs.):	171	171	179	269
- Users:	8	8	179	269
- Non-poor (25% pop.):				
- Government (no subs.):	216	216	0	0
- User:	30	30	492	738
TOTAL COSTS (PHC/SHC):				
- Government:	735	825	1,185	1,555
- Users:	45	45	720	1,080
- Foreign assistance:	140	481	701	0
TOTAL GENERAL COST:	920	1,351	2,606	2,635
% OF COST INCREASE IN RELATION TO YEAR 0:				
- Government:	0	90	450	820
- Users:	0	0	675	1035
COST PER CAPITA (SHC) **	185	185	370	555

* In year 2 there will be a similar cost; ** in 1993 colones; *** For 75 percent of the population presently covered by the MOH.
Note: The figures in each column correspond to costs for that year.