# Improving Access to Quality Healthcare:

## A Political Economy Analysis of the Prospects for Municipal Health Insurance Schemes in Guatemala

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## Introduction

In Guatemala, one-third of the population lacks access to health services, a level that is much higher in rural, indigenous areas where quality is mostly poor (Pena, 2013). The health system's structural problems cause it to fall into recurrent crisis, as can be seen today, and existing insurance coverage is so limited and fragmented that out-of-pocket costs now constitute more than half of total health financing (MSPAS, 2015). Health infrastructure is generally poor and has been for decades (Abt Associates, 2015).

Financial protection is critical to preventing loss of access to healthcare, especially given that Guatemalans' ability to pay for care shrinks as the cost of living grows faster than household income. An essential function of insurance generally is the provision of *en bloc* negotiation of prices and quality, which helps provide that basic protection. Municipal insurance schemes are best described as a collective compact in which the municipal government is a lead (if not the only) actor involved in designing, risk pooling, allocating, purchasing, and supervising a healthcare financing arrangement—an insurance policy—for the provision of health services to residents of the municipality. Participation is defined by geographic location—residency in the municipality—and is usually treated as voluntary. Like

## Key Findings and Recommendations

A study on the opportunities and obstacles for municipal health insurance schemes in Guatemala revealed the following:

- Guatemala's legal and regulatory framework makes it feasible to develop health insurance schemes at the municipal level.
- Given the complexity of a municipal insurance scheme, collaboration with the governing national agencies is strongly recommended in the critical design phase.
- Municipal capacity and financial constraints, and the potential deepening of inequities that can occur, must be given serious consideration in any scheme.
- Municipal insurance is an idea worth exploring in full recognition of the challenges involved. A pilot approach is warranted.
- Leadership at the highest level is required for the success of decentralization, which would probably improve the prospects for municipal insurance schemes. A presidentially mandated agenda for decentralization is currently being developed.

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health financing arrangements, municipal health insurance promises to help provide financial protection against the impoverishing effects of illness, support sustainable access to healthcare, and reduce social exclusion (Preker et al., 2013). Given the severity of the health crisis in Guatemala, the benefits of municipal insurance should merit serious consideration.

Municipalities in Guatemala are formally accorded autonomy and a broad mandate under the country's constitution and laws, and can provide services that "improve the quality of life of the inhabitants," including "preventive health."[2] Several municipalities currently provide health services to varying degrees, and there are current examples of insurance providers designing innovative insurance packages for targeted groups of beneficiaries. Legally, municipal insurance is a feasible proposition. There seems to be little doubt that at least some municipalities or a grouping of them—whether the wealthiest, most progressive, or better managed—could collaborate with the relevant national agencies to devise and institute a workable municipal insurance scheme. As an examination of relevant political factors should demonstrate, however, this does not necessarily mean that municipal insurance can, should, or will happen.

## One Example of Guatemalan Municipal Health Insurance

A little more than two years ago, the Guatemalan municipality of Villa Nueva—a large (population of 710,218), suburban, and relatively wealthy municipality located south of Guatemala City—designed a model for establishing municipal health insurance. The goal was to create a sustainable cost recovery mechanism for health services provided by the municipality. Existing and upgraded infrastructure and services would be used to create a primary healthcare package for municipal residents, who would access services through a collective health insurance policy. Community leaders hired by the municipality would offer the non-obligatory, low-cost policy to Villa Nueva residents, ideally generating a large enough pool of beneficiaries, and a contracted insurance provider would reimburse the municipality at pre-established rates. Services would include ambulances, a medical emergency center, X-rays, general medicine, gynecology, ophthalmology, laboratories, mammography, and a call center.

The Villa Nueva public health company (Empresa Municipal de Salud, or EMUS), which was to be established to operate the system, planned to generate additional revenue by keeping service costs low. EMUS was also seen as an opportunity to generate income for the municipality by offering services for insurance reimbursement under the systems operated by the Ministry of Public Health and Social Assistance (MSPAS) and the Guatemalan Social Security Institute (IGSS). Ultimately, Villa Nueva was unable to secure the necessary authorization from the Ministry of Finance and the national Comptroller General (Contraloría General) to proceed. Though seen as technically and budgetarily feasible, the scheme was considered a profit-making endeavor that violated Guatemala's legal prohibition on charging fees to users of public healthcare services. It was also criticized for being pursued without collaboration with MSPAS.

The case of Villa Nueva did succeed in generating a policy debate about the viability of municipal insurance in Guatemala, which had not been tried previously, especially in view of the emergence of subnational

[2] Translated from the Guatemala Constitution, article 257; Health Code Decree No. 90-97; General Decentralization Law No. 14-2002; and Municipal Code Decree No. 12-2002.

and community-based health coverage in countries across Latin America. What is municipal insurance and how would it work in Guatemala? Is it permissible under the applicable laws? Is it a means of helping to resolve the Guatemalan health crisis or will it simply exacerbate existing challenges? This policy brief examines municipal insurance through a political lens and addresses these questions in turn. By better understanding the political economy surrounding municipal insurance, policymakers and practitioners will be better able to determine if, when, and how the pursuit of such schemes—and perhaps related reforms, such as health decentralization—can be successful.

Examination of an ideal model of municipal insurance requires considerable technical analysis of financing alternatives and its potential effects, and is beyond the scope of this brief. Deciding on one or more models—likely to be highly political given the issues and range of stakeholders involved—must be informed by appropriate evidence and is left for future discussion.

## Methodology

This policy brief presents findings from a study conducted by the Health & Education Policy Plus (HEP+) project, funded by the U.S. Agency for International Development (USAID). The study began with a desk review that examined peer-reviewed and grey literature covering topics such as health insurance laws and policies, the challenges of universal health coverage in the developing world, and international examples of related health insurance schemes. The desk review also informed the study design and field research questions. Core research questions included:

- What relevant institutions—laws, regulations, and policies—have an impact on the prospects for municipal health insurance reform?
- Who are the important stakeholders and influential political actors with respect to municipal health insurance? What are their respective interests or perspectives?
- What are the potential opportunities for, and constraints on, such reform?
- What are the major considerations for implementing health insurance at the municipal level?

The next step was data collection, primarily key informant interviews.[3] The authors identified stakeholders and, in February 2017, conducted 26 semi-structured interviews representing 23 institutions.[4] Respondents included representatives from national and municipal government, nongovernmental organizations, insurance companies, international aid agencies, professional associations, and civil society organizations.

## Potential Obstacles to Municipal Insurance Reform

1. Municipal insurance as yet **lacks a large constituency** of support. It is a new and apparently not well-known reform idea. Municipal insurance can be designed in various ways, each with its own advantages and disadvantages. The Villa Nueva case is just one example in which insurance per se was not the objective. There is currently no single proposal to scrutinize or debate. Decentralization of healthcare is a large, complex, and politically fraught topic within which municipal insurance could be included. It remains to be seen whether the Villa Nueva model, which has received some

[3] All interview participants were accorded anonymity.

[4] In three institutions, the authors conducted separate interviews with two people.

criticism, or some other approach will be more widely accepted.

2. **MSPAS is not currently supportive** of the decentralization of health services or municipal insurance schemes. MSPAS would presumably refuse to support any initiative or formal agreement (known as a *convenio*) viewed as advocating an approach, such as privatization, of which it did not approve. MSPAS is reportedly committed to limiting any attempt to privatize health services. Rather, it is committed to treating all health issues "from the perspective of public service and not from a market logic" (translated from Hernández, 2016). From MSPAS' point of view, a market-driven approach does not guarantee Guatemalans their right to healthcare; rather, access to a package of services is limited by their ability to pay. Health insurance schemes are viewed as a means of bringing private, profit-making insurance providers into the realm of public healthcare, not as an opportunity to increase access to care.

3. Well-known **concerns about the effects of decentralization** will surely be cited in opposition to such schemes. The capacity of most municipalities is weak, authorities are often seen as corrupt, and heavy clientelism leads to wasteful, misdirected investment not in the public interest. Municipal insurance could exacerbate these problems, especially as it may involve the management of large insurance monies.[5]

4. Concerns about **equity** can be a powerful political argument. In rural areas where services are poor, residents do not have access to care. With the possible exceptions of coverage for catastrophic healthcare and publicly financed primary healthcare at the community level, it is not clear that municipal insurance can help.

Municipal insurance is viewed as feasible for urban municipalities with heavy formal employment, where large risk pools can be generated to ensure financial sustainability or profitability. Municipal insurance may therefore mostly benefit heavily urban populations that already have huge advantages (although cities do have higher incidences of traffic accidents, violence-related injuries, obesity, and chronic disease). For example, there is a significant gap in the density of health workers (doctors, nurses, and midwives) between urban and rural areas (25.7 per 10,000 inhabitants versus 3.0 per 10,000 inhabitants); there is a scarcity of bilingual workers in rural areas (Abt Associates, 2015); and existing private facilities are concentrated in large urban areas while, generally, the poor state of public health infrastructure has not changed substantially in decades. In addition, limited-coverage packages leave the insured without critical services, and deep poverty in rural areas severely limits residents' ability to pay insurance premiums.

Enforcement of a regulatory framework for healthcare, notably the standardization of care and the monitoring of its quality, is poor in Guatemala. According to some respondents, it may be impossible to ensure the provision of quality services for the insured. Even assuming that a relatively small, rural municipality is somehow able to find the means to deliver healthcare, its residents may prove unwilling to pay the premium because they lack confidence that quality care will be available when they later become ill.

5. Municipal governments' **ability to finance** municipal insurance is limited. Depending on the model, administrative costs, potential subsidies, and any provision of new services will need to be covered. Several respondents brought up the source of financing, municipal capacity to pay, and appropriate use of the

[5] Note that Guatemalan law does require municipalities seeking delegation of a new responsibility to demonstrate solvency, sustainability, and transparency and prove that the central government does not already provide the service.

budget for insurance or policies. Moreover, most municipalities are highly dependent on mandated transfers from the national government and thus have little financial space within which to maneuver.

6. To the extent that municipal insurance schemes are perceived to contravene deep-seated values like **gratuity** for public sector healthcare or the use of **private sector outsourcing**, support for municipal insurance is likely to suffer.[6] Key respondents faulted the municipality of Villa Nueva's attempt to utilize insurance to help recover costs and garner revenue to sustain EMUS. The use of municipal insurance in a way that suggests the commercialization of public healthcare provision was widely considered politically untenable. The notion that public healthcare is a right and therefore should be free is drawn from Guatemala's constitution and is explicitly stated in the health code.[7] It is embedded in Guatemalan political culture. Likewise, there are also strong objections to the outsourcing of public healthcare that turns a profit.

7. Municipal insurance may be viewed as contributing to the further **fragmentation** of the healthcare system. One of the major obstacles to health financing reform is "the coexistence of different health subsystems with different financing modalities addressed to different population strata. These services differentiate by payment capacity, economic position, social class, and labor market insertion" (translated from MSPAS, 2015, pg. 16). Some interview respondents argued that municipal insurance schemes would add to fragmentation and that it would be better for municipal efforts to focus on local health improvements in water and sanitation, the environment, and similar areas.

8. Laws and regulations related to **auditing municipal finances** are subject to interpretation and strictly enforced, often leaving municipalities worried or fearful of being cited for violations. Inconsistent interpretation can paralyze municipal activity. Interviewees confirmed that interpretations can differ among institutions and within a single institution (e.g., the Comptroller General) around the role of municipalities in an activity like health insurance. Inter-institutional collaboration is a means to address this issue.

## Factors Favoring Municipal Insurance Reform

1. After a 15-year hiatus, **decentralization** has returned to the policy reform agenda in Guatemala under the leadership of President Jimmy Morales (2016–2019). Although the reform agenda has yet to take shape, interview respondents pointed out that a presidential directive, if provided, would quickly lead to movement in health or any other sector deemed a priority. This is good news for anyone interested in having municipalities take on new healthcare responsibilities.

In early February 2017, the Secretariat for Executive Coordination of the Presidency (SCEP)—in collaboration with the Ministry of Finance, Presidential Dialogue Commission, and Secretariat for Planning and Programming of the Presidency (SEGEPLAN), and with support from USAID—announced a 2017–2020 plan of action for decentralization. The seven-point plan is considered integral to

[6] Apparently, these principles do not apply to IGSS, which provides pre-paid insurance and outsources for services. However, contributions to IGSS insurance are obligatory and are considered tax income (payroll tax), not payment for services. Both IGSS and MSPAS have within their respective regulations the authority to contract for services as needs require.

[7] The national health code was reformed in 2003 to state that MSPAS and all other public institutions must ensure that health services are provided free of charge. This article limits the ability of the public sector to generate revenue from people's contributions for health services. Most respondents interpreted this provision as restricting the costs of premiums for health insurance, especially if the insurance is mandatory.

the accomplishment of the country's national and urban-rural development plans. Following the announcement of the plan, President Morales called for the development of a decentralization agenda, expected in mid-2017.

2. Despite longstanding obstacles to decentralization, most respondents felt that municipalities have **sufficient authority** to institute municipal insurance. As explained in the following point, key respondents reported that the process through which an insurance scheme is designed and implemented matters most.

Municipalities' constitutionally protected autonomy and legally delineated role in public service provision is central to the notion of municipal insurance. However, most municipalities do not have the institutional and financial capacity to develop and sustain a municipal insurance program. Urban, high-income governments with a large base of formal employment are considered the best candidates. The idea of all municipalities participating to create a large risk pool—perhaps under the auspices of the National Association of Municipalities (ANAM), the current president of which is the mayor of Villa Nueva—has also been advanced.

3. Several key actors indicated that **municipal insurance is feasible** if done in a collaborative and transparent fashion, respectful of planning, budgetary, and other regulatory requirements. They often mentioned use of a convenio with the *ente rector*, or governing authority (usually meaning MSPAS or IGSS), for the coordinated development of municipal provision of a new service.

Municipalities are independently involved in health infrastructure and the provision of primary healthcare services although none has ever been involved in providing health insurance. However, most respondents considered healthcare—insurance in particular—a delegated or shared function. In the absence of a national directive, individual municipalities must develop a convenio to take on the new responsibility. Such agreements are not always easily reached. Strategic cooperation with IGSS, which is presently under pressure to expand coverage to ensure its operation, is also a potential entry point for municipal health insurance schemes.[8]

In addition, municipal insurance is highly technical and involves a variety of stakeholders ranging from civil society to multiple agencies of the central government. In practical terms, it is unlikely to be done successfully in the absence of buy-in generated through collaboration. Guatemalans cite the transfer of the property tax to municipalities, done with technical assistance from the Ministry of Finance in the mid-2000s, as a successful nationwide decentralization initiative. One can also find various examples of existing convenios for the coordinated delivery of public services in which the municipality contributes land and infrastructure (such as for building a hospital) while the ministry provides the required personnel (hospital staff).

4. **Advocates for municipal autonomy** promote decentralization and naturally appear more likely to support the idea of municipal insurance. The failures of the health system are seen in part as a failure to implement decentralization to strengthen democratic accountability for the provision of critical social services at the municipal level. Indeed, the state has fallen far short of its constitutionally mandated obligation to ensure the health and social welfare of all Guatemalans. This is, in part, the rationale for decentralization, which has yet to occur in the

[8] Implementation of any new social security scheme cannot duplicate IGSS services and must be authorized by IGSS.

health sector, currently being supported by the Morales government.

When viewed as part of a broader initiative for decentralization of healthcare services, the argument for municipal insurance becomes stronger. Decentralization can be highly controversial, however, and its proponents—municipalities, community empowerment organizations, state reformers, among others—are typically arrayed against an equally powerful group of opponents, notably the line ministries who fear a loss of power and labor unions concerned about job security. According to interview respondents, much of the same can be expected of any debate over municipal insurance.

5. An increase in **municipalities' own-source revenue** of non-tax origin could be used to invest in health insurance premiums for those who cannot afford them and to support the administrative costs of an insurance scheme. Unlike taxes, which must be defined by the national congress, municipal fees and charges can be legally established by the municipal council (Bonet and Rueda, 2013). Fee revenue must be used exclusively to cover the expenses of the municipal public service for which it is collected. Municipalities often fail to take advantage of their broad authority to establish fees, and the fees they do have are not effectively collected.

6. Municipal **financial information systems and support** are available, if not required, to assist in financial reporting, fiscal oversight, and transparency in the design and implementation of municipal insurance schemes. For example, the online Integrated Accounting System for Municipal Governments (SICOIN-GL) is reportedly prepared to provide financial systems support for municipal insurance implementation. In addition, the national Comptroller General is prepared to monitor the preparation of any insurance scheme and accompany its implementation through concurrent audits.

7. In Guatemala, it is entirely feasible to develop **insurance products** tailored to a population and provide specific coverage. Any new insurance product must be developed by an authorized insurance company and then approved by the Superintendent of Banks. Innovative insurance products can be developed. For example, Banrural (Guatemala's rural bank) provides low-cost, collective insurance for women ages 18–84 that offers preventive consultations and screenings, and limited treatment of common cancers. The monthly premium for this insurance is US$4. If cancer is diagnosed, the policy provides about US$4,000 in compensation. Banrural also has healthcare plans for workers and their families and mixed products for students. College students can obtain coverage against personal accidents for US$1.50 per month. Cooperatives also offer a wide array of healthcare plans for children, families, and elderly people.

## Policy Implications

- Advocates of municipal insurance should focus on how to design a consensus-based system to address the healthcare crisis in an equitable—or inequity-reducing—fashion. The objectives and potential negative effects of any scheme should be made as clear as possible.
- The institution of municipal insurance requires a comprehensive, collaborative approach and must consider designs that can improve health financing, healthcare coverage, and financial protection, while carefully considering the country's developmental challenges.
- Given the complexities, a pilot approach should be considered before moving to scale. All options should be considered, including schemes for a single municipality, designs involving groups of municipalities (such as *mancomunidades*), a nationwide

plan through an institution such as ANAM, and the possibility of cooperating with the IGSS, which is the lead authority with respect to health insurance. For its part, MSPAS does not appear inclined to become involved at present. Collaboration around a convenio could become more of a possibility as the national government moves forward with its decentralization agenda.

- Public perceptions about gratuity, outsourcing, and commercialized healthcare must be carefully managed to develop a solid political consensus around any municipal insurance scheme.
- Advocates should attempt to identify how the pursuit of an effective municipal insurance program can support or be part of a larger program for achieving health decentralization.
- The design of such a program should avoid adding to the existing fragmentation of the health system, including the social security system under IGSS. Any plan will need to coexist with MSPAS, IGSS, and private insurance operations, ideally in a fully complementary fashion.
- Health insurance products (and other insurance-related operations) will need to be developed with one of Guatemala's authorized insurance companies. Another, more ambitious option is the constitution of a new insurance company for this purpose, fully authorized and supervised by the Superintendent of Banks and in full recognition of the pitfalls associated with the expectation that public healthcare should be free of charge and not a profit-making enterprise.

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