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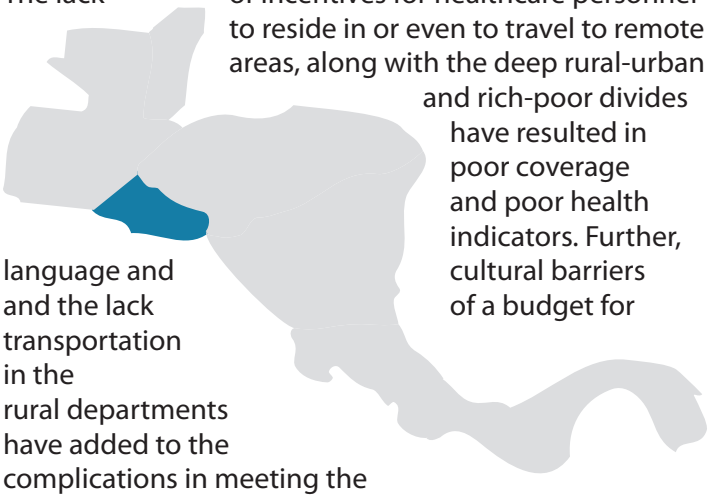
Extension of Health Services Coverage in El Salvador: The RHESSA Project Experience[1]

Introduction

For a variety of reasons, the governments of Central America have struggled to provide basic healthcare services to their rural and impoverished populations. The lack of incentives for healthcare personnel to reside in or even to travel to remote areas, along with the deep rural-urban and rich-poor divides have resulted in poor coverage and poor health indicators. Further, cultural barriers language and and the lack of a budget for transportation in the rural departments have added to the complications in meeting the needs of the poor.



In El Salvador, these failures were found primarily in the Northern rural regions; however, after the earthquakes of 2001 damaged healthcare facilities, destroyed roads, and added to the general poverty, these failures extended to the Central and near-Central regions. At that time, nearly 2 million people—one third of the population of 6.4 million—lacked basic access to healthcare. Preventable communicable and infectious diseases, malnutrition, diarrhea, and respiratory infections were common and disproportionately affected the vulnerable populations. Life expectancy stabilized at a low of 69.4 years, maternal mortality was 120 per 100,000 live births, and infant mortality was 35 per 1,000 live births, while the number of hospital beds barely reached 1.2 per 1,000 and only 11.7 doctors and 4.4 nurses served every 10,000 inhabitants. The rural areas presented an even bleaker picture: a 1998 study revealed that children in the poorest quintile were three times more likely to be ill and had a 60 percent higher rate of infant mortality than children in the highest quintile.

In addition, clients of the healthcare system expressed deep dissatisfaction. For example, they pointed out: "Healthcare facilities operate only twice a week. Consultation is only until noon. The doctor is not always there. Waiting time is three hours on average. Only those that arrive by 8:00 get a consultation." Or they complained: "The facility here is useless because there is no doctor or nurse, and it is only open two days a week until noon. Waiting time is 3.5 hours average and there is a lack of medication."

In an effort to address the poor health indicators and the clients' complaints, to achieve equitable access to healthcare, and to reach the goals established by the Millennium Development Goals, the Salvadoran Government sought to extend essential healthcare services to disadvantaged populations, especially mothers and children, the poor, and rural and indigenous populations. To do so, the Ministry of Health embarked on an innovative approach to delivering services by pursuing two modalities of extension of coverage:

1. **NGOs:** Contracting out the provision of basic healthcare services to private non-governmental organizations (NGOs); and
2. **Institutional Units:** Creating internal contracting models, known as Institutional Units, within the Ministry of Health with their own local public mobile providers.

With the help of a World Bank loan, the Ministry focused

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on: (1) solidifying the provision of health services to remote and poor areas; (2) expanding coverage; and (3) institutionalizing the program to assure its sustainability and governance for improved health results. Given the emerging financial crisis, which could affect the size and effectiveness of social budgets, the challenge is to maintain this program and consolidate the improvements of the health indicators.

Although the goal of extending coverage in the North had been articulated before 2001, the Ministry's administration was fragile and did not have a unified strategy to supervise and monitor the provision of services. The Ministry lacked the ability to contract, monitor and evaluate the work of the contractors, and to lead the sector with a national priority-based health strategy. Previous programs, such as SALSA and "Promotores," were helpful in extending coverage to poor people, but varied greatly in the quality of services they provided–and they failed to provide widespread coverage. In addition, there was no strong evidence that these programs represented a sustainable solution to the health disparities.

How the Program Works

The Program included various mechanisms to improve performance standards and to ensure that program goals were met. However, each of the two modalities needed different incentives and tools to achieve a similar set of goals. For the NGOs, legally-binding contracts between the Ministry and each mobile unit specified the minimum requirements to be fulfilled by each unit—such as services to be provided, geographic areas to be served, and general guidelines for the health professional team. Indicators served as monitoring tools to gauge whether the goals met and the project objectives were achieved. These included most critical health interventions and non-health performance measurements that could be quantified to provide a simple and easily implemented tool for monitoring and evaluation. To assess progress, the Ministry of Health and independent auditors audited monthly reports from the NGOs.

Financing was also structured to reinforce compliance and enhance performance. First, providers billed the Ministry for services rendered plus or minus bonuses or withholdings. The bonuses and withholdings depended on whether and to what extent the goals were met. Second, fixed fee-for-service type payments shifted partial risk from the contractor onto the providers. Discretion regarding the use of funds created incentives to achieve higher performance standards and to provide more innovative and cost-effective services. At the same time, accountability for fulfilling minimum requirements assured that the quality of services and the responsiveness to beneficiaries were not compromised.

For units within the Ministry of Health, the performance contracts did not carry the same kind of legal responsibility. However, they included the same indicators and performance guidelines as the NGO contracts and underwent monthly monitoring to assure compliance. The performance indicators evaluated monthly were also measured in the same way; the Ministry, however, could not reinforce the indicators due to a lack of financing as a tool for performance enhancement. The performance in this modality was more dependent on the Ministry's ability to enhance its internal institutional capacity to deliver services effectively.

Results

As a result of these advances in extension of coverage, the Ministry has succeed in increasing access to healthcare, and the beneficiary populations have experienced important improvements in health. Overall, over 635,805 inhabitants, 75 percent of whom were living in extreme poverty, gained access to most basic essential healthcare services in 104 municipalities and 591 cantons. Contracts for extension of coverage (private sector and within the Ministry) were signed with 77 mobile teams; over US$ 8.4 million were invested into healthcare supplies, medications, equipment, and staff training seminars, among others. Each NGO team carried out an average of seven visits per month. The Ministry's mobile teams averaged over two visits per canton.

As a result of these gains in coverage, 95.3 percent of children are now immunized with the six most essential vaccines, and 95.5 percent receive a critical check-up before turning 28 days old. Most pregnant women (76.6 percent) now receive at least five pre-natal checkups to ensure better health for themselves and their future children. Most intermediate and health objectives were not only fulfilled but surpassed their planned goals.

Health

The advances in coverage lead to many important improvements in the health of the beneficiary population. However, many of the improvements in health status are not observable in the short-term—and past failures will continue to be reflected in the present. As coverage expands, the positive incremental advances will also accumulate.

Children's Health: There were considerable improvements in coverage for newborns and children under one year of age.

- 100 percent of children under one year are enrolled in the program;
- over 70 percent enrolled before turning 28 days;
- 99.2 percent received complete vaccination coverage; and

THE TWO MODALITIES		
	NGO Mobile Teams	**Institutional Mobile Teams**
Coverage Area	Northern Region	Central and near-Central Regions
Conditions	Remote and poor areas lacking healthcare facilities.	Earthquake-affected poor areas with damaged healthcare infrastructure.
Contracting Method	Contract out services to NGO providers.	Contracting in of services to health units and signing performance agreements with SIBASI-run mobile teams.
Roles and Responsibilities	Provide services to each community at least once a month. Health promoter resides in each canton.	Provides services within the plan; visit once per month. Health promoter resides in each canton.
Basic Package of Services	Basic health and nutrition services for children, mothers, and other at risk groups.	
Financing	Fixed fee for medical coverage, equipment, and human resource costs.	Purchase of medical supplies and medications, transport, and direct hiring and supervision of the medical team.
Risk	Decision-making by the team. Risk of overspending by NGO.	Ministry of Health responsible for services.
Monitoring and Evaluation	Monthly verification of indicators for the most critical services.	Performance agreements supervised through monitoring and evaluation reports.
Advantage for Ministry of Health	Transfers risk to the mobile team providers and assures remote access for vulnerable populations.	Infrastructure in place; direct control of activities.
Strength	1. Private sector cost-effective approach. 2. Strong human resource motivation	1. Less Costly. 2. Direct control of the outcome.
Weakness	More expensive	
Combination	1. Comparative tool for monitoring the differences. 2. Best allocation of resources possible at the time. 3. Enhanced competition due to the insertion of public-private partnership. 4. Incentives for the Ministry of Health to develop both strong purchasing capacity and supervision capacity.	

- 97.8 percent received at least one form of medical attention.

Some improvements were also made in child nutrition and weight control: 99.5 percent of children were evaluated for those indicators. Malnutrition (moderate or severe) has diminished to 15.2 percent of the children's population. The infant mortality rate also improved: for areas attended by NGOs there were 16.1 deaths reported per 1,000, and 13.3 deaths 1,000 in the areas attended by the Institutional Units. These data represent a significant improvement from the 22 per 1,000 reported by UNICEF in 2006 and are lower than the 17 per 1,000 Millennium Development Goal for 2015. Mortality from diarrhea and respiratory infections fell to zero (in the NGO areas) and 2.02 per 1,000 persons (in the Institutional areas).

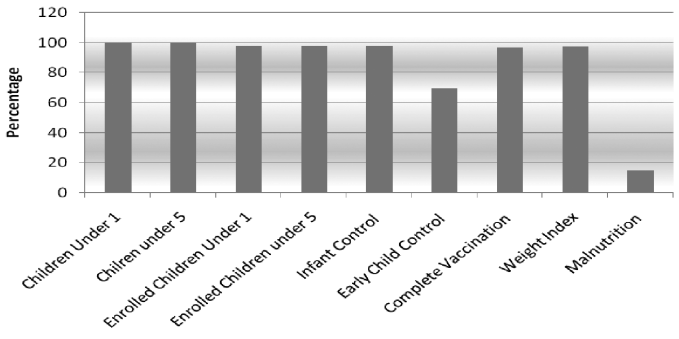
Women's Health: Increased coverage reduced the proportion of unattended births by 25 percentage points. At the end of 2008, 86.3 percent of pregnancies were attended by qualified professionals. There were also some increases in the percentage of women who underwent an adequate number of prenatal visits; 52 percent of those who subscribed early in their pregnancies complied with the five and up requirement.

Postnatal visits increased considerably to 89 percent of women registered. Additionally, there were no recorded cases of mortality during birth. The percentage of women who received regular Pap smear tests for early detection of cervical cancer also increased to 79 percent in the NGO modality and over 90 percent in the Institutional modality.

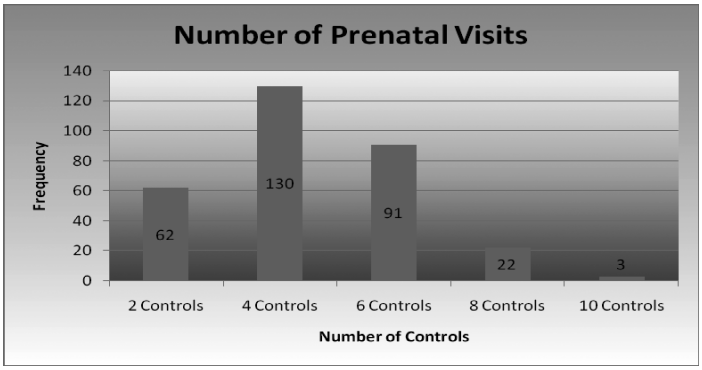
Assuring Sustainability: Institutional Strengthening and Financial Support

One of the most challenging components of externally financed social projects is the difficulty in sustaining the project activities once the outside support ends. The institutionalization of the project is a critical component to assure that the program becomes entrenched in the country's health system and continues despite political and administration changes. In El Salvador, the Ministerial Accord No. 1000 made official the process of institutionalization of the extension of coverage, while the

Basic Healthcare Coverage in Children and Infants



OBJECTIVES AND RESULTS			
Objective	**Program Goals**	**Baseline Indicators**	**Results (as of 2009)**
Intermediate Goals	Extend coverage	0 beneficiaries	77 mobile teams, 635,805 persons covered in 104 municipalities and 591 cantons.
	Extend coverage in the Northern region.	0 beneficiaries	NGO teams extended services to 282,353 inhabitants in the 61 municipalities in Northern region.
	Extend coverage in the Central, near-Central, and Eastern regions	0 beneficiaries	Coverage extended to 316,821 inhabitants.
Final Objectives	Increase vaccination of children under 2 years of age by 20%	76.6 % vaccinations	95.35 % vaccinations
	Increase coverage of pre-natal visits by 20%	76.6 % received at least 5	78.1% receive at least 5.
	Increase number of per capita contracts in communities by 50%	0 contracts	Seven contracts per NGO and 1.57 contracts per mobile team.
	Promote child growth sessions: by 90%	74.6% of children under 5 enrolled	97.4% of children under 5 in cantons enrolled.



creation of the unit within the structure of the Ministry of Health made it operational.

The Ministry of Health was eager to secure financial sustainability in the early stages of the project. The Salvadoran Government and international donors were impressed with the Program's success and impressive achievements and supported its continuance. To that end, the Government budgeted US$4.3 million to continue the services through 2009. The Ministry also obtained another US$2.9 million to continue with the process of institutionalization. This support is critical in ensuring that the program continues and that recent gains are not lost.

Beneficiary Satisfaction and Comments

In addition to meeting the objective goals, the Project boasts a high level of beneficiary satisfaction. Between 98.4 percent and 100 percent of beneficiaries considered the services as valuable for improving their communities' health; close to 98 percent also indicated an adequate supply of medicines available; and between 95.5 percent and 97.6 percent of beneficiaries indicated that their health needs were met by the extension coverage teams. Additionally, respondents mentioned substantial drops in out-of-pocket spending on healthcare and reduced average time of travel to the health units by about 15 minutes.

Conclusion

The successful extension of coverage through the two modalities and institutional strengthening is encouraging for progress in overcoming one of Central America's most severe challenges in healthcare provision. The strategy of public-private partnerships and institutional enhancements provides an equitable and cost-effective use of limited-resources to meet the basic healthcare needs of the most vulnerable. In the future, the Salvadoran Government will face the challenge of internalizing the provision of services to remote groups into the current public health system. The Government will also require creating an effective surveillance and information system to strengthen its management of decentralized health units. Finally, it will need to maintain and enhance the mobile health units' strategy, which has proven to be an effective instrument and a sustainable solution in the context of economic crisis and increasing health needs.

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