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Financing Primary Health Care Services for the Urban Poor in Choluteca, Honduras: A Case Study (Dialog #8)

Charles Frankenhoff

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Dialogue #8

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By: Charles Frankenhoff
Associate Professor
Health Services

PREFACE

Charles Frankenhoff received his Ph.D. in Economics from Georgetown University in 1963 and his M.P.H. in Hygiene and Public Health in 1976 from Johns Hopkins University. Since 1980 he has been an associate Professor of Health Economics in the Department of Health Services Administration at Florida International University.

Dr. Frankenhoff has wide experience throughout Latin America in the area of urban development and environmental planning. His research in Honduras follows other similar research in Chile, Brazil and Puerto Rico.

Mark B. Rosenberg
Director

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> El divorcio entre el tipo de atencion de salud que se brinda y la situacion socioeconomica de la poblacion, da como consecuencia el alejamiento o la perdida de las posibilidades de producir un impacto en la salud y el aumento de la brecha entre los que tienen acceso real a la salud y aquellos que no la poseen,..."[1]

Charles A. Frankenhoff, Ph.D.
Florida International University
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One risk in presenting a case study of health services in a developing country is ignoring the health and development environment which affects the particular enterprise and its clients. Honduras is a Central American country at the stage of development take-off. Choluteca is a Department in southern Honduras which lies on the Bay of Fonseca between Nicaragua and El Salvador. The clinic which is the focus of the case study in Choluteca, the capital city, is a private, nonprofit institution which receives no recognition in the National Health Plan. A number of health care clinics serve the health care needs of middle-income and wealthy families. The subject of this case study, Clinica San Jose Obrero, serves the urban and urban-rural poor.

The case study is only one component in a more general ongoing analysis of primary health care services for the urban poor in Honduras. A significant dimension of Honduran development, beginning in the early Seventies, has been the displacement of thousands of rural families and individuals into the major urban centers.[2] In 1981 in Tegucigalpa, 35 new communities ("barrios") were formed by in-migrants. To what extent are the health care needs of these populations being met? Can the network of health services available in rural areas be transplanted into an urban environment? The experience of Choluteca can provide us with one set of insights to respond to these questions.

The concept of financing primary health care services for the urban poor is only superficially clear. Financing health care services in the United States is a familiar experience. Services are reimbursed in a monetary system. However, for the rural and urban poor in a developing country like Honduras, many services, e.g. residential, recycling clothing, sanitation, haircuts, and health, are on the periphery of the monetary economy. Indeed, one important function of an urban marginal or slum community is to help its members make the transition from the non-monetized economy of the rural poor to the monetary economy of the major city.[3]

Changing Demographic Composition.

The population of Honduras is among the poorest (per capita income less than $500) and most illiterate (14 of the 18 Departments have over 50% illiteracy) in Latin America. The population in 1980 was 3.6 millions, increasing at an annual rate of 3.5%. Two-thirds of the population is rural; one third urban. The major population corridor in this sparsely populated country of 112,000 square kilometers lies on a north south axis between the capital city of Tegucigalpa in the mountains and San Pedro Sula lying near the Caribbean coast.[4]

Any static view of the demographic composition of Honduras must yield to the dynamics of urbanization taking place through internal immigration. The capital city of Tegucigalpa is increasing annually at 6%; and San Pedro Sula, the "Chicago" of the country at 9.4%.[5] These estimatesmade almost ten years ago, have almost certainly increased with popular awareness of urban-rural wage differences, improved highways, continuing rural poverty combined with price inflation, and developing democratic processes culminating in recent elections in November, 1981. In 1976, the Latin American Demographic Center (CELADE) predicted that rates of urban population increase would surpass by threefold the rural population increase before the year 2,000.[6]

Rural torural migration has also taken place as the National Agrarian Institute resettled thousands of landless, agricultural workers from the south, Choluteca, to the northeast, Aguan Valley. Many of these families, however, remigrated into urban areas.

The National Health Plan, 1979-1983, identifies two major population segments at risk for health: the rural poor and the urban poor.[7] No census data enumerates these populations. Neither are per capita income estimates useful for those living in the periphery of the monetary economy. One dependable indicator of poverty is lack of access to services, particularly to potable water services.

Data available in the National Health Plan indicate that in 1977, 573,000 (26%) of rural inhabitants had ready access to water and 1,628,000 (74%) had poor access to potable water.[8] The conclusion that 74% of the rural population suffers from some degree of poverty is supported by data on land ownership. 44% of the rural population in 1974 owned no land; 35% of the rural population owned small plots sufficient for subsistence farming.[9]

The urban population in 1977 enjoyed superior access to potable water services, although only 53% (592,000) had water services in the house. 47% of the urban population or 525,000 people can be placed in the poverty category on this basis.

Health Status.

The National Health Plan identifies water-related disease as causing 12.2% of the deaths in Honduras in 1976.[10] The five leading causes of hospitalization in 1978 were: complications of pregnancy, infectious diseases and parasites, accidents and violence, respiratory disease and digestive disease.[11] 40% of all deaths occured among children below five years of age.

In Honduras regional differences in health status are striking. In the urban centers (1974) life expectancy was 61 years, the fertility rate was 4.7, and infant mortality rates were 85 per 1,000 live births. By comparison, rural inhabitants in the south had a life expectancy of 57 years, a fertility rate of 8.2 and infant mortality of 131 per 1,000 live births.[12] Specific data are lacking to compare the health status of rural with urban poor, but with the prevalence of malaria and polluted water, the odds appear to favor the latter.

Together with diarrheal disease malnutrition contributes significantly to morbidity and mortality rates.[13] 67% of the population has a diet deficient in calories; 43% a diet deficient in proteins. The National Nutrition Plan also estimated that over 50% of pregnant women suffered from inadequate nutrition.

Health Service Pyramid Levels.

Public health care services in Honduras, inpatient and outpatient, constitute a pyramid of six levels.[14] Level 6 consists of five national hospitals with a total of 1,866 beds (1977) located in Tegucigalpa. Level 5 consists of 6 regional hospitals with a total of 884 beds. Level 4, again in 1977, had seven area hospitals with a total of 385 beds. Level 3 is the CESAMO, a primary health care center under the direction of a physician and located for the most part in rural areas. There were 72 such centers in 1977. Level 2 consists of 284 rural health centers (CESARs) directed by a nurse auxiliary. Level 1 consists of a significant group of rural village workers, the first-aid worker ("guardian"), the sanitation worker ("promotor", and the midwife ("partera empirica").

The Honduran health system, administered by physicians, is heavily hospital-oriented. In 1978, 74% of the total health program budget was spent on hospital construction and operation.[15] Traditionally in developing countries the lion's share of the health budget is claimed by the capital city. Tegucigalpa was projected to receive almost 65% of the total 1979 hospital service budget of US$16.8 millions. The capital already had a bed ratio of 4.8/1,000 compared to 0.1/1,000 for the rest of the country.

Clinica San Jose Obrero.[16]

The Clinica San Jose Obrero is a private, nonprofit organization which serves urban marginal populations and rural village populations in the Department of Choluteca. This Department lies in the south of Honduras on the Gulf of Fonseca between El Salvador and Nicaragua. The Department had 264,589 inhabitants in 1979. The capital city of Choluteca, which is the immediate service area of the Clinica, has less than 25% of this population.[17]

The Clinica is an autonomous part of a private, nonprofit association formed by Alejandro Lopez Tuero in 1972. The mission of San Jose Obrero Association is to train unskilled workers and to provide them with employment. The Association consists of a leather glove factory which exports to Panama and Costa Rica; a wooden furniture factory which exports to Miami; and a small artisan factory. The Association runs a training school and is also constructing some 180 low cost homes of concrete blocks made by the Association. Managers are selected from among the workers.

The Clinica SJO was formed in 1974 and now serves 1200 clients monthly. In addition to the Clinica, there is a Well Child Clinic which serves 1,000 children each quarter. This latter clinic is directed by a Peace Corps R. N. and charges no fees.

While the Clinica SJO does not form a part of the public health system, it is a primary health care service operating at Level 3. The City of Choluteca is also served by a small regional hospital, whose physicians and residents were recently on strike to protest lack of supplies, and several private clinics and laboratories. The Clinica is self-supporting through patient fees.

A brief description and evaluation of the Clinica follows:

1. Service Population
2. Health Services
3. Health Manpower
4. Project Facilities
5. Linkages with other Organizations
6. Project Management

1. Service Population: The Clinica SJO serves the workers of the Association and their families, some 2,000 people, and urban and urban-rural low income families. The Clinica itself is located in Barrio La Libertad in the City of Choluteca on a dusty road several blocks from the center of the city. In 1978 1198 patients were served by the Clinica. 55% of the patients came from the city. 8% came from small villages nearby, and 35% from more distant rural villages.[18] Breakdown of data by sex and age was not available, but observation indicated that the great majority were women and children with some elderly.

Major barriers to use of health services by urban poor include:

- -The tradition of caring for own sick, especially the male adult.
- -Low level of literacy and lack of awareness of available health services.
- -Poor habits of personal hygiene.
- -Poor roads and high cost of bus transportation.
- -Crowded outpatient facilities of regional hospital. Tickets for outpatient visits limited to 200 daily.
- -Lack of funds to pay for visit, laboratories and medicines.
- -Lack of medical supplies within the public hospital system.
- -Poor maintenance of existing public hospital equipment.

2. Health Services: The Clinica serves an average of 45 patients daily, with numbers varying greatly according to day of week and season of the year. The normal charge per visit to the physician is US$1.25 with additional charges for laboratory, injections and medicines. The charges are higher than those at the Regional Hospital, US$.50 per visit, but far lower than other private clinics which charge US$5. While no patient is refused for lack of money, most do pay.

Services include work-up by experienced practical nurse, who also gives injections; diagnosis and treatment by physician; laboratory services when needed, e.g. blood and urine tests; dental care in the form of tooth extraction and filling; and availability of medicines at low price at the pharmacy.

Services are most crowded in the weekday mornings, 8-12, although there are hours in the afternoon from 1-3PM. Laboratory services are limited to 8-10AM due to parttime technicians.

3. Health Manpower: Presently the Clinica is served by a physician who is serving his year of "servicio social" following graduation; a practical nurse with 20 years experience; two dentists, one parttime and one serving her year of "servicio social"; two parttime laboratory technicians; one pharmacist; and one receptionist who also registers patients and maintains simple books.

In addition to this immediate staff, there is a network of volunteer village health workers called "promotores", but who are not to be confused with the sanitation "promotores" of the public health system. The village health workers are volunteers selected by their village parishes who received an intensive 8-week course in the Casa Guadelupe in Choluteca. The course is given twice yearly to groups of 20-25, many of whom are married women. The "promotores" dispense some medicines and refer patients to the Clinica.

4. Project Facilities: Clinica SJO is an outpatient clinic without beds. It is presently located in a rented corner home perhaps one-half mile from the bus depot. The Clinica staff works in separate rooms with adequate waiting room space. There is storage space for pharmaceutical supplies.

Present plans are to build a new Clinica some 300 square meters at an estimated cost of US$115 per square meter. The building of a satellite clinic in one of the outlaying villages is also under serious consideration.

5. Linkages with other Organizations: In spite of lack of inclusion in the National Health Plan, the Clinica belongs to a network of health care systems, formal and volunteer, which includes the poor in Choluteca and the rural poor from outlying villages who choose to travel to it. Linkages with the villages

are through the "promotores". Referrals are made to the inpatient section of the regional hospital. Often patients who cannot receive outpatient care at the regional hospital will come to the Clinica. There are very few referrals from the CESARs and none from private clinics.

6. Project Management: The Clinica SJO is directly under the supervision of the General Director of the Association and the Director of Operations. The latter receives the funds and accounts on a daily basis. The physician is in nominal charge of the Clinica, but he does not perform management functions on a regular basis. Personnel decisions are made by the General Director on an ad hoc basis. A brief assessment of the management function of the Clinica follows:

- Planning: Apart from facility planning for the new Clinica there has been no needs assessment nor strategic plan development.

- Statistics: Some patient data and finance data has been collected though not analyzed for planning purposes.

- Decisionmaking: Lack of "hands on" management.

- Personnel: Recruitment, supervision, training and development of personnel does not take place as it does with other components in the Association San Jose Obrero.

- Budget: No budget exists. The Association management believes the project to be self-financing.

- Cost Accounting: No establishment of unit costs. Simple accounts of patient fees scrupulously kept on daily basis.

To sum up, the kind of management control enjoyed by the factory component of the Association and by the low cost housing project is not yet available to the Clinica.

Some Lessons from the Clinica Case Study Analysis.

Some lessons from the analysis of the Clinica SJO experience can indicate areas for improvement within the organization. Other lessons suggest the need for further study of supply and demand forces affecting primary health care services, including health promotion, for the urban poor.

1) The poor are willing and, in many cases, able to pay small sums for health services.

2) The Ministry of Health and Social Assistance has neither the resources nor the administrative capacity to provide adequately for the health needs of the urban and rural poor.

3) The provision of health services to the poor by private, nonprofit enterprise, often under religious auspices, is an essential complement to the public health service system.

4) The poor themselves, both in rural and urban areas, can be capacitated to serve legitimate health care needs.

5) Health education as an instrument to form people to take better care of their own and their community health remains largely undeveloped. The medical cure mode tends to dominate.

6) Effective management of scarce health care resources, including the maintenance of existing equipment, is a priority need at all levels of the health service pyramid.

7) The dynamics of continuing urban immigration suggest that greater attention should be given to helping the urban poor provide for their own health care needs at the primary level.

Footnotes

1. Ministerio de Salud Publica y Asistencia Social, Plan Nacional de Desarrollo:Plan Nacional de Salud, 1979-1983.

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3. Charles Frankenhoff, "The Economic Potential of a Slum Community in a Developing Country, United Nations Department of Economic and Social Affairs, Improvement of Slums and Controlled Settlements, New York, 1971. See also S.V. Sethuraman, The Urban Informal Sector in Developing Countries, Geneva, 1981. ILO Publication

4. Consejo Superior de Planificacion Economica, Planificacion Para el Desarrollo Regional y Local, Tegucigalpa, Nov., 1978. Ch. 1.

5. Robert Fox, Jerrold Huguet, Demographic Trends and Urbanization in Honduras, Interamerican Development Bank, Washington,DC,1974

6. Latin American Demographic Center (CELADE), Boletin Demografico, Santiago de Chile, 1976. No. 18.

7. Ministerio de Salud Publica, Plan Nacional de Salud, 1979-1983. Introduction.

8. Ibid., Annex 7. Table 13.

9. CONSUPLANE, Plan Nacional de Desarrollo, 1979-1983: El Plan de Alimentacion y Nutricion, Table 17.

10. Ministerio de Salud Publica, Plan Nacional de Salud: Plan Operativo Anual, 1979, Tegucigalpa, 1978. p2.

11. Frederick Hartman, A Strategy for Strengthening Basic Health Services in Honduras, USAID, 1980.

12. CELADE, Boletin Demografico, 7:13, 1974.

13. CONSUPLANE, Plan de Nutricion, 1979. For a brief analysis of the nutrition problem in Honduras see Jose De Codes, Charles Frankenhoff, Observaciones Sobre el Sistema de Salud Hondurena Con Posibles Areas de Intervencion, USAID Document, March 23, 1979.

14. Ministerio de Salud Publica, Plan Nacional de Salud, 1979.Table38

15. Ibid., Presupuesto.

16. This Study is based upon my visit to Clinica San Jose Obrero in December, 1981 invited by the Director General of the Association, Alejandro Lopez Tuero.

17. Dr. Bernardo Cruz Guevara, Analisis de las Actividades de Salud Bucal en la Clinica San Jose Obrero, Universidad Nacional, 1980.

18. Ibid.