HEALTH FINANCING PROFILE - GUATEMALA

Guatemala is an upper-middle income country in Central America. The Guatemalan Peace Accords ("Accord for a Firm and Lasting Peace") were signed on December 29, 1996 bringing to an end over three decades of civil war marked by high casualties, emigration and internal displacement. The Peace Accords contained articles dealing with social justice issues, including codification of the right to health services for all.

Life expectancy at birth has risen from 62.3 in 1990 to 70.6 in 2012. Though Guatemala has made progress towards the Millennium Development Goals, it continues to lag behind other upper middle income countries in many areas such as infant and maternal mortality, contraceptive coverage and skilled birth delivery coverage (Table 2).[1]

Both access to healthcare and health outcomes vary widely between the urban population and the rural, often indigenous, populations. For example, close to 77% of women have skilled birth assistance in urban areas compared to 36% of women in rural areas.[2]

The Guatemalan government continues to address these inequities mainly through the Expansion of Coverage Program (PEC) which explicitly targets health and nutrition service coverage to rural, indigent and mostly indigenous populations, largely through contract agreements with non-governmental organizations (NGOs).

Health Finance Snapshot

Total Health Expenditure (THE) as a share of gross domestic product (**GDP**) has risen from 4% to 7% from 1995 to 2012.

General Government Expenditure on Health (GGHE) as a percentage of THE, however, continues to hover around 35% while out of pocket expenditures remain high.

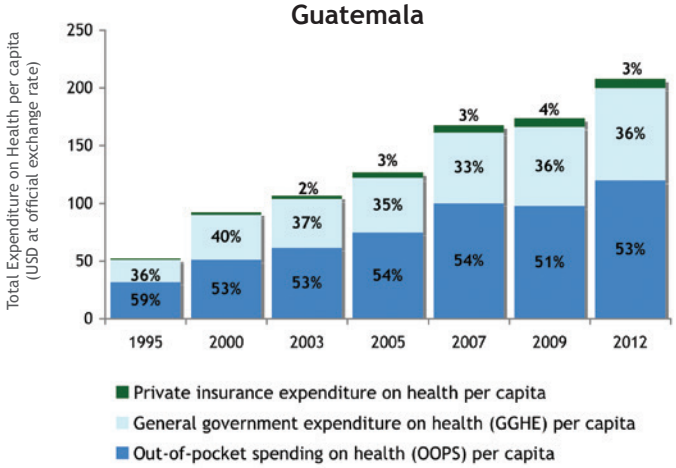
Table 1. Health Finance Indicators: Guatemala

	1995	2000	2003	2005	2007	2009	2012
Population (thousands)	10,016	11,237	12,099	12,717	13,359	14,034	15,083
Total health expenditure (THE, in million current US$)	**538**	**1,079**	**1,397**	**1,755**	**2,456**	**2,663**	**3,405**
THE as % of GDP	4	6	6	6	7	7	7
THE per capita at exchange rate	54	96	115	138	184	190	226
General government expenditure on health (GGHE) as % of THE	36	40	37	35	33	36	36
Out of pocket spending as % of THE	59	53	53	54	54	51	53
Private insurance as % of THE	2	2	2	3	3	4	3

Source: WHO, Global Health Expenditure Database; National Health Accounts, Guatemala

- **Out of pocket spending (OOPS) makes up a considerable portion of health spending** (Table 1, Figure 1), consistently representing over 50% of THE.
  - OOP costs are point-of-service fees (i.e.: for consultations, medications, etc.) and do not include private insurance premiums.
  - Those in the highest income percentiles pay relatively high shares of their income for consultations, while lower income earners pay high shares of their income for medications that are not available in public facilities.[3]
  - Private insurance expenditures as a percentage of THE remain low at just 3% of THE and have only increased by 1 percentage point since 1995.

Figure 1. Total Expenditure on Health per capita, Guatemala



Source: WHO, Global Health Expenditure Database; National Health Accounts, Guatemala

Health Status and the Demographic Transition

Non-communicable diseases are on the rise in Guatemala with obesity rates, diabetes and cardiovascular conditions gaining in importance. High mortality from violence continues. Guatemala has a gradually aging population with the dependency ratio expected to increase considerably after 2025.[3] This is concerning as only 18% of Guatemalans are enrolled in the nation's social security scheme and are eligible to receive retirement or disability benefits.

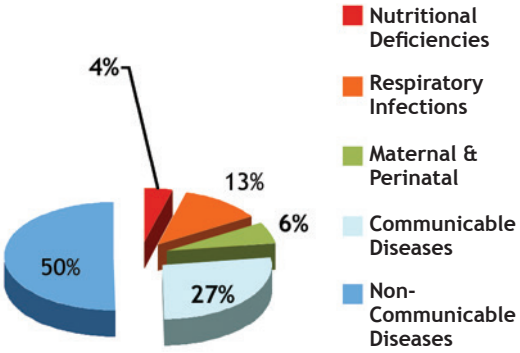
Demographic Transition

- Birth rates are declining (Figure 2).
- Life expectancy is increasing.
- The 'bulge' in the population pyramid is slowly moving upward (Figure 3).
- The total fertility rate (TFR) has fallen from 5.6 in 1990 to 3.9 in 2011.

Epidemiological transition

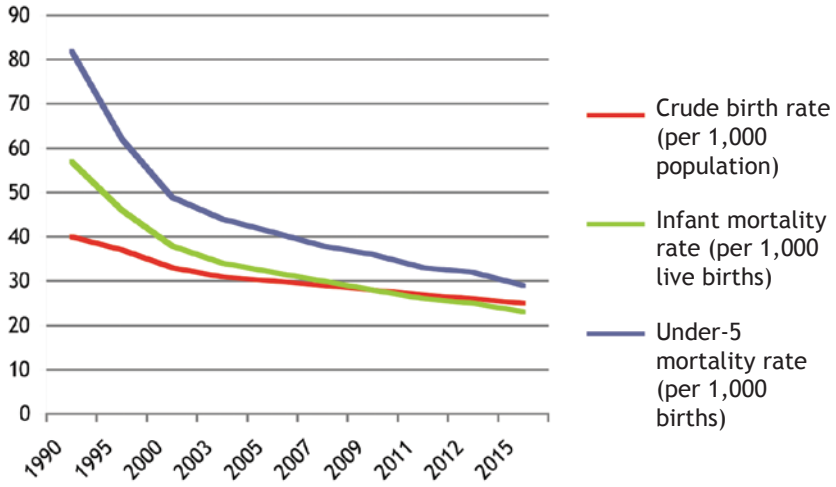
- Mortality from infectious disease and nutritional deficiencies remains high while non-communicable disease mortality is creeping up (Figures 4 and 5).

Figure 4. Mortality by Cause, 2008, Guatemala



Source: WHO, Global Burden of Disease Death Estimates (2011)

Figure 2. Demographic Indicators, Guatemala



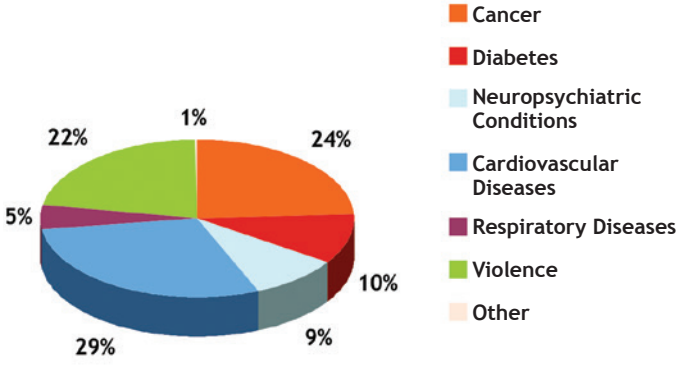
Source: United Nations Statistics Division and the Instituto Nacional de Estadística, Guatemala.

Table 2. International Comparisons: Health Indicators

	Guatemala	Upper Middle Income Country Average	% Difference
GNI per capita (year 2000 US$)	2,195.3	1,899.0	-13.5
Prenatal service coverage	93.2	93.8	-0.6
Contraceptive coverage	54.1	80.5	-26.4
Skilled birth coverage	51.5	98.0	-46.5
Sanitation	78.6	73	5.6
TB Success	83	86	-3
Infant Mortality Rate	29.1	16.5	12.6
<5 Mortality Rate	34.3	19.6	14.7
Maternal Mortality Rate	120	53.2	66.8
Life expectancy	70.6	72.8	-2.2
THE % of GDP	7	6.1	0.9
GGHE as % of THE	36.3	54.3	-18
Physician Density	0.9	1.7	-0.8%
Hospital Bed Density	0.6	3.7	-2.9%

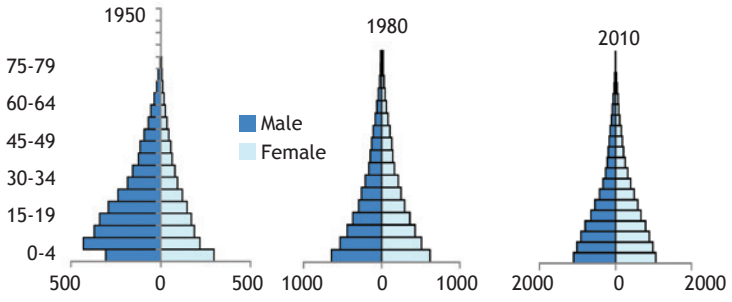
Source: The World Bank, World Development Indicators database

Figure 5. Non-Communicable Disease Mortality, 2008, Guatemala



Source: WHO, Global Burden of Disease Death Estimates (2011)

Figure 3. Population Pyramids of Guatemala



Source: Population Division of the Department of Economic and Social Affairs of the United Nations Secretariat, World Population Prospects: The 2010 Revision.

Health System Financing and Coverage

Guatemala's health system is fairly unique in its formal reliance upon contract agreements with NGOs both for health service delivery as well as administrative duties (although the latter has mostly been phased out as of 2011). Following the Peace Accords in 1996, healthcare services were guaranteed to all citizens. Since that time, Guatemala has introduced and continues to modify programs (such as the Expansion of Coverage Program, PEC) meant to expand the reach of public health services, particularly into poor rural areas with large indigenous populations. Financing for these expansion programs, however, has fluctuated greatly and has been characterized as being overly vulnerable to the changing priorities of consecutive political administrations.[2]

Figure 6. Timeline of Guatemala's Public Health System[2,3]

1996

Guatemala's civil war ends with the Peace Accords and explicit rights to health are codified and guaranteed.

Health Services Improvement Program (HSIP) initiated to expand coverage and improve efficiency and equity.

1997

Integrated Health Care System (SIAS) containing the **Expansion of Coverage Program (PEC)** implemented to contract with NGOs to provide health services in mainly rural areas in the poorest Departments.

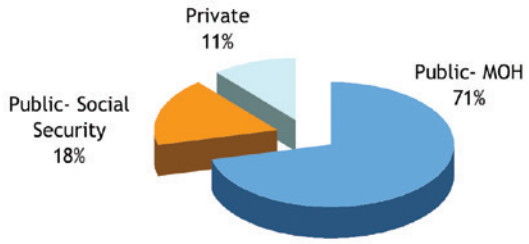
Public sector:

- **Ministry of Public Health and Social Welfare (MOH)**
  - Funded through general taxation (non-contributory).
  - Provides free or low-cost primary, secondary and tertiary care to all who receive services at public facilities.
  - Provides universal coverage with access to and availability of MOH facilities being the limiting factors.
- **Guatemalan Social Security Institute (IGSS)**
  - Funded through worker and employer contributions for those in the formal sector.
  - IGSS runs its own facilities with a strong curative focus and also provides coverage for specialized services from private providers (i.e.: ophthalmology, oncology, cardiology, hemodialysis, etc.).
  - IGSS facilities are concentrated in urban areas.

Private sector:

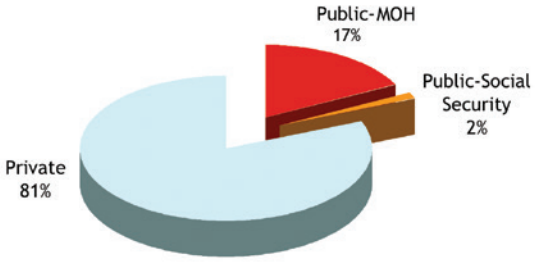
- **Non-profit** providers (faith-based organizations, civil society, foundations, etc.).
- **For-profit** providers (medical facilities, pharmacies, traditional Mayan providers, etc.).

Figure 7. Population Health Coverage by Sector



Source: Lao Pena, Christine. "Improving Access to Health Care Services through the Expansion of Coverage Program (PEC): The Case of Guatemala", World Bank UNICO Series, No. 19, 2013

Figure 8. Health Facilities by Type



Source: Lao Pena, Christine. "Improving Access to Health Care Services through the Expansion of Coverage Program (PEC): The Case of Guatemala", World Bank UNICO Series, No. 19, 2013

Table 3. Contributions and Coverage in Guatemala's Health System.

	Beneficiary Contribution	Employer Contribution	Health Services covered	Type of facilities used
Public: Ministry of Health	None, no enrollment required (Some point-of-service, out-of-pocket fees apply).	N/A	Primary, secondary and tertiary; prescription medications when available at the public facility.	Public.
Public: Guatemalan Social Security Institute (IGSS)	Payroll contributions: Obligatory 3% of salary for accident, disability, retirement and survivorship insurance. Additional 0.85% of salary to add on optional maternity & common diseases coverage.	7% of worker's salary.	Primary, secondary and tertiary; prescription medications.	IGSS facilities and private facilities.
Private	Insurance premiums vary with for-profit insurers. Co-payments of varying amounts must be paid to private providers.	N/A	Private insurers offer varying coverage options.	Private (for-profit, non-profit and traditional Mayan care).

Source: Bowser, Diana, Mahal, A. "Health Financing in Guatemala: A Situation Analysis and Lessons from Four Developing Countries", Harvard School of Public Health. 2009.

The Expansion of Coverage Program (PEC)[2]

- Mainly targets women and children for primary-level health and nutrition services in rural, largely indigenous areas.
- Has expanded from 3 to 20 of Guatemala's 22 Departments since inception in 1997.
- Population coverage has increased from 0.46 million in 1997 to 4.3 million in 2012 (Figure 10). PEC is estimated to provide health and nutrition services to 54% of the country's rural population.
- PEC services are based upon a model of mobile health care where local contracted NGOs staff a health team that travels through the jurisdiction.

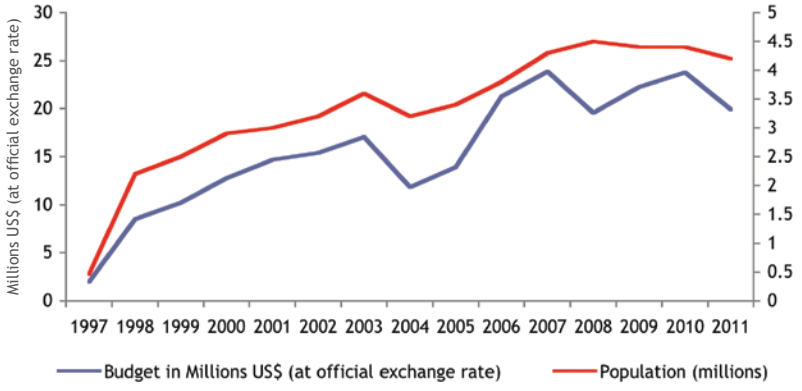
PEC Financing[2]

- Capitation payments of US$6 – 9 are made to non-profit NGOs who are responsible for mobile service provision in jurisdictions of approximately 10,000 individuals each.
- PEC 2012 and 2013 budgets were significantly increased in order to help achieve primary care targets that are included in the new results-based agreement between the Ministry of Finance and the MOH.
- Recurrent delays in payments (up to 6 to 12 months) to NGOs have been anecdotally reported to have led to cutting back of services.
- Around 15% of PEC's funding comes from external sources; the bulk comes from government revenues, enhancing the influence of changing political priorities.

PEC: Basic Health Package[2]

- Care for women: during pregnancy, birth, and postpartum; nutritional supplements; family planning; and cervical and breast cancer detection.
- Infant and toddler care: immunizations; control of common illnesses and nutritional deficiencies; and growth monitoring for children up to two years of age.
- Illnesses and emergency care: endemic and infectious diseases; accidents and injury.
- Environmental health: vector control, proper waste disposal, water quality, and food and home hygiene.

Figure 9. PEC's Budget and Population Covered, 1997-2011



Source: Lao Pena, Christine. "Improving Access to Health Care Services through the Expansion of Coverage Program (PEC): The Case of Guatemala", World Bank UNICO Series, No. 19, 2013

Challenges and Future Agenda[2]

- Up until 2008, the Guatemalan government had two mechanisms to audit the work of NGOs contracted through the PEC: the social audit system and technical teams based in regional offices. These were eliminated due to lack of funding and have yet to be replaced by any systematic and institutionalized form of monitoring and evaluation.
- At present, the significant increases in the PEC's annual budget apply only to operating costs, excluding funding that would be needed to construct, equip and staff health centers to provide regular services to rural populations.
- Most existing feedback mechanisms between the government and NGOs are punitive. Performance may be enhanced through the use of results-based systems with positive incentive mechanisms.
- PEC has increased vaccination rates and prenatal services coverage in rural areas, reaching populations that typically do not have access to MOH-run facilities. User satisfaction with these NGO-provided and administered services is high. It will be important for the government to carry out systematic reviews to understand these successes in relation to the challenges inherent in providing health services to remote and highly dispersed populations.

References

1 World Bank. World Development Indicators database.
2 Lao Pena, Christine. "Improving Access to Health Care Services through the Expansion of Coverage Program (PEC): The Case of Guatemala", World Bank UNICO Series, No. 19, 2013
3 Bowser, Diana, Mahal, A. "Health Financing in Guatemala: A Situation Analysis and Lessons from Four Developing Countries", Harvard School of Public Health. 2009.

This profile was prepared by Dr. Deena Class, A. Sunil Rajkumar and Eleonora Cavagnero with inputs from Michele Gragnolati.