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LACRSS

THE LAW FOR THE PROVISION OF FREE MATERNITY AND CHILD CARE IN ECUADOR

JORGE HERMIDA, M.D.
PATRICIO ROMERO, M.SC.
XIMENA ABARCA, M.D., M.P.H.
LUIS VACA, M.D.
MARÍA ELENA ROBALINO, M.H.S.
LUIS VIEIRA, M.D., M.P.H.
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CONTENTS

LIST OF TABLES AND FIGURES

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This paper was prepared by the Quality Assurance and Workforce Development Project (QAP) as part of an operations research study supported by the U.S. Agency for International Development's Latin America and Caribbean Regional Health Sector Reform Initiative (LACHSR). The report describes the development, implementation, and early results of the Law for the Provision of Free Maternity and Child Care, a major recent health sector reform initiative in Ecuador designed to extend coverage and improve the quality of priority health services. A subsequent report, *Scaling Up and Institutionalizing Continuous Quality Improvement in the Free Maternity and Child Care Program in Ecuador*, documents the institutionalization of a quality assurance mechanism in public sector healthcare facilities participating in the Free Maternity Program.

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EXECUTIVE SUMMARY

This report describes the design process, main features and early implementation experiences of Ecuador's Law for the Provision of Free Maternity and Child Care (LFMC), from 1997 to 2002.

Between 1995 and 1999, the Ecuadorian population became dramatically impoverished: the number of poor inhabitants escalated from 3,900,000 in 1995 to 8,600,000 in 1999. Women and children were the most affected. This reality stimulated the creation and subsequent modifications of the Law for the Provision of Free Maternity and Child Care (LFMC), whose initial version was approved by the National Congress in 1994. From its original 1994 text, the LFMC has been changed several times, the most important and extensive one being approved in 1998. It is the main characteristics of the 1998 version of the LFMC that are described in this report.

The Free Maternity Law is an attempt to modify maternal and child health care delivered to Ecuador's poorer population. It aims to contribute to the reduction of maternal and infant mortality, the improvement of women and children's access to quality health care, and the reinforcement of society's participation in decision-making processes and control over the quality of services. By guaranteeing access to free prenatal care, labor and delivery, and basic child health services, the LFMC made a significant advance toward fulfilling the State's role in the provision of healthcare to the country's most vulnerable groups: women and children. By reducing the economic barrier that prevents access to healthcare, the LFMC stimulated expansion of coverage. The Law also contributed to the incorporation of the concepts of health as a civil right and the importance of quality of care in the delivery of public health services.

The LFMC incorporated a number of innovative reforms to the health system in its design and implementation, including: separating the functions of financing/paying for health services and healthcare delivery; transferring funds for healthcare to municipalities, with oversight by local management committees as opposed to solely by the Ministry of Public Health; creation of citizens/users' committees to monitor the Law's implementation; the creation of a built-in mechanism for continuous improvement of quality of care; and payments to health facilities based on the volume and quality of services produced. These reforms were designed based on international and Ecuadorian experiences with health sector reform, as well as on discussions led by Ecuadorian women's organizations, including the National Council for Women (CONAMU), the Women's Political Coordinating Committee, the Women's Forum, and Women for Autonomy. Another innovative feature of the Free Maternity Law was to engage municipal governments as co-managers of health services.

The Law created a LFMC Executive Unit in charge of receiving the resources from the Solidarity Fund and channeling them to Local Health Management Committees in different counties (*cantones*). The Local Health Management Committee not only received the funds transferred by the central Executive Unit, but also receives additional resources from municipal governments and any other local financing source. The role of the Management Committees is significant because they integrate local governments and representatives from civil society into the management process, conferring them the ability to administer funds, a prerogative of the MOH in the past. Management Committees and Users' Committees are two important mechanisms that promote the participation of social actors, such as women's organizations, indigenous groups, and local governments, in the management of healthcare delivery. The LFMC has also led to greater diversification of healthcare providers, including non-profit organizations and traditional health practitioners, such as traditional birth attendants, by allowing local Management Committees to contract with these entities to provide covered services.

An important step in the design of the LFMC was the identification of the health services that should be covered through the Law's financing mechanisms. The following criteria were used to determine health services covered by the Law: a) The country's epidemiological profile for women and children, emphasizing most frequent diseases and main causes of death; b) the service delivery capacity of healthcare facilities of the Ministry of Public Health; c) demands from women's movements; d) international agreements signed by the Government of Ecuador; e) the cost of each service to be covered; and f) the expected annual amount of funds available through the Law to finance services. Based on these criteria, consultants and technical experts from participating institutions defined a set of basic health services.

Financing of the LFMC was made available through the Solidarity Fund for Human Development. The Fund is a financial and development-oriented institution created in 1996 by the Government of Ecuador based on profits from its electric and telephone companies, and from future sales of other State companies. Other sources for financing the Law were: a) resources from the National Fund for Infant Nutrition (FONNIN) created in 1988 and operating in three Ministries: Health, Social Welfare, and Education; b) resources from the National Institute for Women and Children (INNFA); and c) local municipal governments who would pay for the cost of transportation of obstetric and pediatric emergencies, as well as local activities to promote reproductive health.

The budget assigned to the implementation of the Law for Free Maternity and Child Care has increased with time, gradually rising from USD$ 8,000,000 in 1999, to USD$ 12,000,000 in 2002. By the end of 2003, approximately USD$ 23,000,000 was assigned to the implementation of the Free Maternity Program.

The number of individuals who received health services covered by the LFMC has also steadily increased: in 1999, the number of individuals covered was 1,600,000, while in 2002 it reached 2,248,000 women and children. Women are the main beneficiaries of the LFMC, accounting for 70% of the population served by the program.

The Ministry of Public Health has applied the LFMC throughout its facilities since 2000. The mechanisms employed by this Law have become increasingly important tools for the improvement of healthcare coverage and quality of services in Ecuador. Among such mechanisms are the publication of clinical guidelines, calculation of costs for reimbursement of services, reimbursement to facilities based on production, implementation of a continuous quality improvement system with practical tools to measure and improve quality and attainment of goals, management agreements for co-management with municipalities, and the organization of users' committees to ensure the quality of services.

The Law for the Provision of Free Maternity and Child Care has had a major impact on maternal and child health services in Ecuador. A main contribution of the LFMC has been to ensure the continuity of essential health services for women and children, regardless of changes in political administration and ministers. Moreover, the LFMC has contributed to the creation of effective mechanisms that guarantee the right of Ecuadorian women to reproductive health.

ACRONYMS

AME	Association of Municipalities of Ecuador
CONAMU	National Women's Council
CONASA	National Health Council
CQI	Continuous Quality Improvement
DPAIS	National Directorate for Integral Healthcare and Promotion
EUFMC	Executive Unit for the Provision of Free Maternity and Child Care Program
FONNIN	National Fund for Infant Nutrition
ICE	Tax on Special Consumption
IESS	Ecuadorian Social Insurance Institute
IMCI	Integrated Management of Childhood Illness
INNFA	National Institute for Women and Children
LFMC	Law for the Provision of Free Maternity and Child Care
LACHSR	Latin America and Caribbean Regional Health Sector Reform Initiative
MCH	Maternal and Child Health
MODERSA	Healthcare Modernization Project
MOH	Ministry of Public Health
NGO	Non-governmental Organization
OR	Operations Research
PAHO	Pan American Health Organization
QA	Quality Assurance
QAP	Quality Assurance Project
SOLCA	Ecuadorian Society Against Cancer
TBA	Traditional Birth Attendants
UNFPA	United Nations Fund for Population Activities
UNICEF	United Nations Children's Fund
URC	University Research Co., LLC
USAID	United States Agency for International Development

I. INTRODUCTION

The Law for the Provision of Free Maternity and Child Care (LFMC) was originally passed by the Ecuadorian Congress in 1994 but did not begin to have an important impact on the healthcare system in the country until 2000, after several amendments to the law were introduced that strengthened its financing and implementation mechanisms. The package of services guaranteed by the LFMC that are delivered to Ecuadorian mothers and children by Ministry of Public Health facilities have served as a major initiative to increase coverage of critical health services. Moreover, because of the reforms the LFMC has introduced to the health system for the management and oversight of the covered services, the Law has been a driving force for reform in Ecuador's health system.

Because the LFMC included an explicit emphasis on assuring the quality of the services guaranteed to the population under the Law, the Quality Assurance Project (QAP) saw the opportunity to study the introduction of a systematic approach to quality improvement on a national scale, as part of the natural evolution of the Free Maternity Program.

In 2003, QAP initiated the operations research study, "Scaling Up and Institutionalizing Quality Assurance in Ecuador's Public Health System." The study had the following objectives: a) describe and document the process, methods and results of scaling-up and institutionalizing quality assurance within the Free Maternity Program of the Ministry of Public Health of Ecuador; b) explore associations between results of institutionalization and the presence of reforms to the health system introduced by the Law, believed to be favorable to the quality assurance institutionalization process; and c) synthesize lessons learned that can be adapted and applied to other Latin American countries that seek to institutionalize quality assurance mechanisms.

This report is the first product of that study. The report documents the historical development and implementation of the Law for the Provision of Free Maternity Services and Child Care. It briefly describes the institutional circumstances and actors that played a part in the creation, discussion and approval of the Law, its main components and mechanisms, and the experiences gathered after two years of implementation of the Free Maternity and Child Care Program it created. A subsequent report[1] describes the three-staged approach and methods used for scaling up and institutionalizing a continuous quality improvement program in the hospitals and health centers of the MOH that provide services under the Free Maternity Program.

This report was written based on a review of documents (i.e., policies, plans, agreements, conventions, regulations) produced by different institutions involved with the LFMC, including the Ministry of Public Health, the Women's National Council, the National Institute for Family and Children, the Association of Municipalities of Ecuador, and the National Health Council. Extensive use was made of data collected by the Executive Unit for the LFMC. In addition, focus groups and interviews to key informants were conducted in order to determine lessons learned.

[1] Scaling Up and Institutionalizing Continuous Quality Improvement in the Free Maternity and Child Care Program in Ecuador. LACHSR Report Number 65. Available at http://lachsr.org.

II. THE HEALTH SITUATION OF ECUADOR AT THE TIME OF APPROVAL OF THE FREE MATERNITY AND CHILD CARE LAW

Between 1995 and 1999, the Ecuadorian population became dramatically impoverished, with the number of poor inhabitants escalating from 3,900,000 in 1995 to 8,600,000 in 1999. Women and children were the most affected.[2] Maternal and infant mortality rates were high at the beginning of the 1990s. The maternal mortality rate in 1990 was 117 deaths per 100,000 live births, while the infant mortality rate for the same year was 30 deaths per 1000 live births. Rates decreased slowly throughout the decade until they reached their lowest point in 1998, with 53 maternal deaths per 100,000 live births and 19 infant deaths per 1000 live births.[3] The maternal mortality rate has increased during subsequent years. The latest official data available report 81 maternal deaths per 100,000 live births.[3] However, this figure should be treated with caution since information systems are deficient and do not register vital events adequately, resulting in under-registration of maternal deaths.[4]

The main causes of maternal mortality remain unchanged in the past decade: pregnancy-induced hypertensive disorders (40%), hemorrhage (22%), and complications of abortion (5%). The main causes of child mortality are acute diarrhea, respiratory infections, congenital anomalies, and malnutrition.[3]

Fertility rates for 1994-1999 registered an average of 3.3 children per woman of childbearing age, a decline from prior years. Rural areas had a higher fertility rate than urban areas (4.3 children vs. 2.8 children).[5] Likewise, the overall fertility rate was higher among women without any formal education (5.6 children) than among women with some high school education (2.9 children). The percentage of pregnancies among teenagers (15 to 19 years of age) has risen in Ecuador in recent years. In 1994, 7.9% of adolescents became pregnant; in 1998, this percentage increased to 9.8%[6].

The use of birth control methods in 1994 was 51.1% among women of childbearing age who were either married or with a stable partner. With respect to place of residence, 66% of women living in urban zones used some method of birth control in comparison to 44.4% of women living in rural areas.[5]

Coverage of antenatal care provided by facilities of the Ministry of Public Health between 1994 and 1999 reached 47.0% and 55.5%, respectively, with an average of 5.5 antenatal visits per pregnancy.[5] During 1999, the rate of institutional delivery was 34.4%.[5] In rural areas, 49.3% of deliveries were not attended by skilled birth attendants.[5] In the case of indigenous women, 73% did not access institutional care during delivery.[7] In 1994, coverage of postpartum care reached 43.2% in urban areas and 23.2% in rural zones.[5]

Although neonatal mortality decreased from 22 per 1000 live births in 1994 to 19 per 1000 live births in 1999, comparison of the mother's place of residence showed 19 neonatal deaths per 1000 live births in urban areas and 24 in rural zones. Low birth weight is an indirect indicator

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[2] Report presented by UNICEF to the Honorable National Congress of Ecuador. 2000.

[3] INEC Vital Statistics Yearbooks. UEPMGAI - MSP ECUADOR 2003.

[4] Ecuador's Integrated System of Social Indicators. 2003 Version 3.5.

[5] CEPAR. ENDEMAIN General Report 1999.

[6] INEC. Survey of Living Conditions. 1994-1998

[7] SIISE. Women's Portrayal. 1998.

of the mother's condition during pregnancy and is the cause of 80% of deaths among newborns in Latin America[8]. In Ecuador, low-weight births amounted to 18.8% during the year 1994; in 1999 the situation did not change, registering 18%[9]. Children who survive suffer more diseases, experience delays in the development of learning abilities, and have greater possibilities of suffering malnutrition.

In Ecuador, public and private healthcare providers offer basic health services only to 75% of the population. The Ministry of Public Health provides coverage to 30% of the population; the Social Insurance Institute (IESS) covers 20%; the Armed Forces cover 3%; the Beneficence Board, the Ecuadorian Society against Cancer (SOLCA), and other non-governmental organizations (NGOs) cover 7%, while private providers cover 15%, leaving 25% of the population without any coverage.[10]

The institutional fragmentation of Ecuador's health sector is one of the structural problems that hampers its performance. Each institution has its own politics, programs, services, and financing sources, which in addition to creating a lack of coordination and misuse of resources, leads to the frequent duplication of activities that constrain the impact of healthcare investment on the population.[11]

Some of the main problems identified with respect to health services delivery in Ecuador are: inadequate access to health services, inequitable distribution of resources, and poor quality of healthcare services. An additional problem lies in the fact that 9 out of 10 physicians work in urban areas.[11]

III. Background and Actors of the Law's Design and Approval

The national and international context in which the LFMC was created and approved can be characterized by two important elements: the first one involved the upsurge of social movements working for the improvement of women's living conditions, while the second one related to initiatives linked to the reform of the health sector.

Achievements of the international women's movement during the 1990s, particularly the International Meetings in Cairo and Beijing, had important effects on the advancement of women's movements in Ecuador and their claim for reassertion of women's rights. This became evident, for example, through the approval of the Law against Intra-family Violence in 1994, the National Plan for Equal Opportunities in 1997, the creation of the National Women's Council in 1997, the Constitutional Reforms dating from 1998, the Law for the Provision of Free Maternity Services and Child Care (LFMC) in 1998, and the Law of Quotas for Women's Political Participation in 1999.

With respect to the reform of the health sector, a 1994 proposal by the National Modernization Council (CONAM) incorporated a strong participation of private insurance companies. This proposal was rejected by the population in the Popular Referendum exploring the privatization of the Social Insurance. In 1996, the National Health Council presented a new proposal wherein the Ministry of Health would assume the leading role of a multi-institutional

[8] UNICEF. Childhood World Situation 1998.

[9] CEPAR. ENDEMAIN General Report 1999

[10] MOH, Health Services Modernization. 1998

[11] MOH. National Health Plan 2000-2005

National Health System. This idea was also abandoned, despite the fact that the National Congress approved a new National Healthcare Law. The country's extreme political instability, manifested in the succession of Governments and Ministers of Health lasting only short intervals of time in power likely contributed to the lack of progress of health reform. In view of these difficulties, several institutions at the national level realized that the LFMC had the greatest potential for approval and application. Indeed, the implementation of the LFMC has effectively managed to introduce important reforms in Ecuador's health sector.

The National Women's Council (CONAMU) was the leading actor in the Law's design and approval, supported by the Health and Environmental Commission of the National Congress and the Pan American Health Organization (PAHO). They were joined by the Ministry of Public Health and the National Health Council (CONASA). Technical assistance was provided by the Healthcare Modernization Project (MODERSA) financed by the World Bank and by the NGO CEPAR.

The participating institutions worked on two levels. At the political level, focus was on developing necessary alliances to legitimatize and facilitate the Law's approval. At a technical level, they were in charge of formulating and proposing specific elements related to the Law such as its financing mechanisms, management model, healthcare delivery model, coverage of health services, the role of local governments, and the role of users' organizations, among other aspects. The group working on the political arena consisted of CONAMU's Director, the President of the National Congress' Health Commission, the PAHO Country Representative, the Minister of Health, and the Executive Director of the MODERSA Project. The technical group was formed by representatives from the above-mentioned institutions, including CEPAR, which had technical expertise in health sector reform. The technical committee guided the proposal's development, negotiating with authorities from each institution, and led the team of consultants who conducted the necessary studies.

Advice provided by PAHO was key to the process. PAHO recommended seeking advice from Xavier Torres Goitia, former Minister of Health of Bolivia, where a recent process of government reform resulted in the creation of a Basic Health Insurance, as well as the Law of Decentralization and Participation. CONAMU's main contribution was to assert women's and children's rights to health as the State's responsibility. CONAMU affirmed that healthcare financing should be a permanent State policy in order to change the unstable and arbitrary distribution of public funds to address maternal and infant mortality. CONAMU also considered women's reproductive health to be of central importance, stating that issues such as the body's autonomy, and women's resultant empowerment, should be reflected in lower maternal mortality rates and higher family planning coverage. Using these guidelines, consultants from the National Congress' Health Commission identified health services to be covered by the Law. Consultants from CONAMU and CEPAR carried out studies on healthcare costs, while a consultant from MODERSA identified possible financing sources.

IV. Definition of Health Services Covered by the Law

The definition of the health services to be covered by the LFMC was necessitated by the Law's financing mechanisms. The challenge was to find an adequate balance between the population's healthcare needs and the amount of funds assigned to the Law. This helped to establish priorities and limits to what could be financed.

The following criteria were used to determine health services to be covered by the Law:

- The country's epidemiological profile of women and children, emphasizing most frequent diseases and main causes of death.
- The service delivery capacity of health facilities of the Ministry of Public Health
- Demands from women's movements
- International agreements signed by the Government of Ecuador
- The cost of each health service to be covered
- The expected annual amount of funds available through the Law

Based on these criteria, a group of consultants and technical experts from the institutions that participated in the development of the Law defined a set of basic health services. Two years later, the number of health services was expanded in view of the needs of the beneficiary population.

Table 1 shows the list of health services covered by the LFMC, classified by recipient group and type of service. The health services highlighted in gray were added to the program's coverage in 2002.

An issue subject to debate was whether the Law should cover treatment of obstetric complications or obstetric emergencies. Technical experts from the Ministry of Health argued that the Law should finance treatment of all obstetric complications, not only emergencies. Nevertheless, financial data indicated that if all complications were to be financed, then the majority of the Law's funds would be used by hospitals (second and third level of care) and cover only 3% of problems related to maternal health. This is due to the relatively high cost of treatment for obstetric complications in comparison to other types of maternal care.

After much discussion, it was agreed that the Law should prioritize primary healthcare and interventions of higher cost-effectiveness as part of a public health strategy. Accordingly, it was decided that the Law would primarily finance obstetric and pediatric emergencies. With respect to obstetric complications not considered emergencies, financing would only be provided for complications that were among the ten most important causes of maternal deaths.

Another issue subject to debate was whether the diagnosis and treatment of HIV-AIDS should be covered by the Law. Ultimately, it was determined that the Law would finance the diagnosis and treatment of sexually transmitted diseases, but not HIV-AIDS. This was attributable to the fact that the high cost of diagnosis and treatment of HIV-AIDS would use up a high proportion of available funds, leaving few resources to finance the remaining health services.

With respect to health services provided to children, immunization was excluded from coverage by the Law given that a different Law explicitly created for this purpose was approved and granted an exclusive budget months before the approval of the LFMC. Based on the epidemiological profile, it was determined that health services provided to children under five should focus on the treatment of childhood's most common illnesses included in the Integrated Management of Childhood Illness (IMCI) strategy.

In 2002, the National Congress finally approved the Guidelines and Regulations for the implementation of the LFMC, after three years of dialogue among experts from different technical areas and participating institutions, including CONAMU, the MOH, the National Institute for Family and Children, and the Association of Municipalities of Ecuador (AME). The Guidelines and Regulations of the LFMC provide a detailed description of health services financed by the Law and establish the role of each participating institution, along with the mechanisms to assign funds to Management Committees working with municipalities.

TABLE 1: HEALTH SERVICES COVERED BY THE LAW FOR THE PROVISION OF FREE MATERNITY SERVICES AND CHILD CARE[12]

HEALTH SERVICES PROVIDED TO WOMEN	HEALTH SERVICES PROVIDED TO CHILDREN UNDER 5
Antenatal Control	Immediate care of newborns
First control	Treatment of healthy newborns
Subsequent controls	Diagnosis and treatment of congenital hyperthyroidism
Dental care	Diagnosis and treatment of illnesses in newborns
HIV/AIDS diagnosis	Intensive care
Diagnosis of congenital anomalies	Intermediate care
Identification and referral of pregnant women by a community agent	**Treatment of children under 5 using the strategy Integrated Management of Childhood Illness (IMCI)**
Early referral of high-risk pregnancies	Treatment of children under 1
Delivery	Treatment of children under 5
Normal Delivery	Dental care
Cesarean section	Diagnosis and treatment of child abuse
Early referral resulting in normal delivery or cesarean section, by a community agent	In-hospital complications
Obstetric Emergencies	Early identification and referral of children under 5 by a community agent using IMCI
Pregnancy-induced hypertension	Supply of blood and blood-related products
Hemorrhage during the first half of pregnancy	
Hemorrhage during the second half of pregnancy	
Hemorrhage during delivery and puerperium	
Sepsis	
Immediate postpartum care	
Postpartum control	
Postpartum referral and referral of newborns under 7 days	
Recruitment and referral of women with hemorrhage and postpartum complications	
Family Planning and Reproductive Health	
Counseling and prevention	
Diagnosis and treatment of women affected by intra-family violence, including expert legal appraisal	
Bilateral surgical sterilization	
Vasectomy	
Early detection of breast cancer in women between 34 and 64	
Sexually Transmitted Diseases	
Syphilis	
Gonorrhea	
Vaginal Herpes	
Papilloma Virus (HPV)	
Leucorrhoea	
Supply of blood and blood-related products	

[12] Executive Unit of the Free Maternity Program.

V. FINANCING OF THE LAW FOR THE PROVISION OF FREE MATERNITY SERVICES

During the 1990s, investment in public health by the Ministry of Public Health amounted to USD$ 16.00 - 39.00 per capita or 1.5 – 2.6% of the country's Gross National Product.[13] From another viewpoint, in 1996, Ecuador's health sector received 2.8% of the government's General Budget, 85% of which was used to pay salaries.[14]

In addition to the government's resources, important investments were made by bilateral or multilateral international cooperation agencies in order to reduce infant and maternal mortality, including USAID, the United Nations Fund for Population Activities (UNFPA), the United Nations Children's Fund (UNICEF), and PAHO. Public health projects financed by the World Bank that included the reduction of maternal and infant mortality as one of their main objectives received approximately two hundred million US dollars. Nevertheless, the majority of these funds were not specifically employed toward the reduction of maternal and infant mortality, but used by hospitals and ambulatory health facilities either to increase their size or for general improvement.

When the National Congress approved the first version of the LFMC in 1994, it also established the 3% Tax on Special Consumptions (ICE) as its source of revenues. During the 1990s the tax generated approximately USD$ 2,000,000 per year.

The need to expand this source of financing was identified in 1998, when the most important reform to the Law was introduced. Technical advisors recommended that the Government of Ecuador maintain the ICE as the primary source of financing for the LFMC but to expand it sources of funding with the following resources:

1. Solidarity Fund for Human Development: Approximately USD$ 15,000,000 available each year. The Fund is a financial and development-oriented institution created in 1996 by the Ecuadorian State based on profits from its electric and phone companies, and on future sales of other State companies. One of the Fund's objectives is to finance programs related to healthcare, prevention and rehabilitation, as well as programs specifically related to the provision of Free Maternity Services and Infant Nutrition.[15]
2. National Fund for Infant Nutrition (FONNIN): This Fund was created in 1988 and serves three Ministries: Health, Social Welfare, and Education. The amount assigned to Health is approximately USD$ 3,000,000. Analysis of the use of these non-budgeted funds during 1988-1998 showed they had not been subject to the rigorous management of regular funds from the national budget. Before these funds became a financing source for the LFMC, they were being used by authorities from the above-mentioned Ministries to help solve budget deficiencies and hiring of technical and administrative personnel.
3. Other possible financing sources: Other resources, such as from the National Institute for Women and Children (INNFA), were left to be identified as the Law's implementation evolved. Additionally, it was determined that resources from international cooperation agencies would preferably be used to support the Law's implementation.

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[13] Ecuador's Integrated System of Social Indicators -SIISE, 1999-2003.

[14] Ecuador's Health, Equity and Development Virtual Library. www. opsecu.org/bevestre/legisla.htm

[15] Solidarity Fund. Ecuador. www.fondodesolidaridad.gov.ec

4. Financing by local municipal government: In addition to paying the cost of transportation of obstetric and pediatric emergencies, local municipal governments would also finance activities to promote the reproductive health of the population.

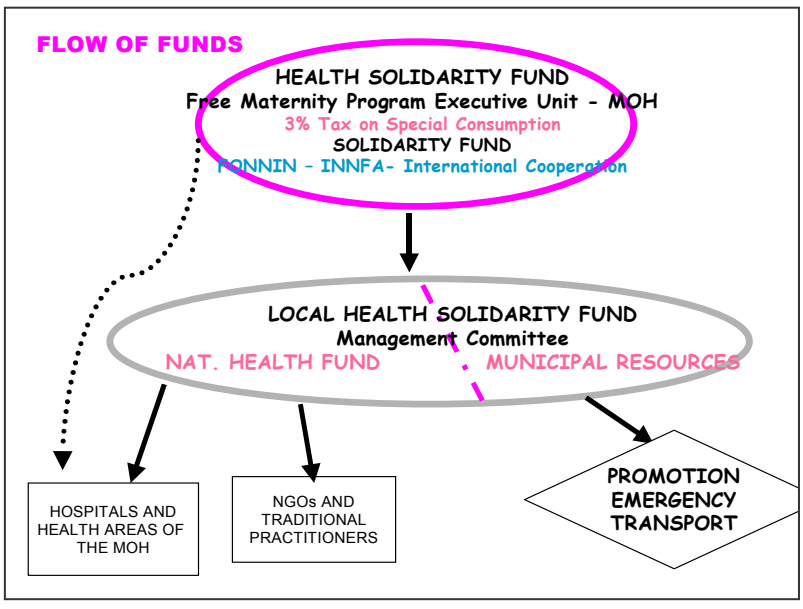
All the financing sources combined would make approximately 20 to 25 million dollars available every year to support the Law's implementation. The group who designed the LFMC suggested that these funds should be exclusively used by health facilities to finance the acquisition of medicines, supplies, lab exams, micronutrients, blood and blood-derived products required to provide the health services covered by the Law. Meanwhile, the general budget assigned each year to the Ministry of Health would continue to finance wages, general equipment for health facilities, meals for patients and personnel, medical equipment, facilities maintenance, etc.

VI. Co-management Model for Oversight of the Free Maternity and Child Care Program

Role of Municipalities

An important innovation to the LFMC consisted of a new model for the co-management of funds assigned by the central government (Solidarity Fund) and funds from local municipal governments. The traditional way of financing salaries and other expenses not covered by the LFMC requires the annual approval of the State's general budget by the National Congress. The Ministry of Finance then transfers resources to the Ministry of Health, which distributes them among Provincial Health Directorates and Health Districts. The entire procedure is carried out within the institutional levels of the Ministry of Public Health. The co-management model introduced by the LFMC creates an Executive Unit in charge of obtaining the resources and channeling them toward Local Health Management Committees, as depicted in Figure 1.

Figure 1: Flow of Funds Assigned to the LFMC



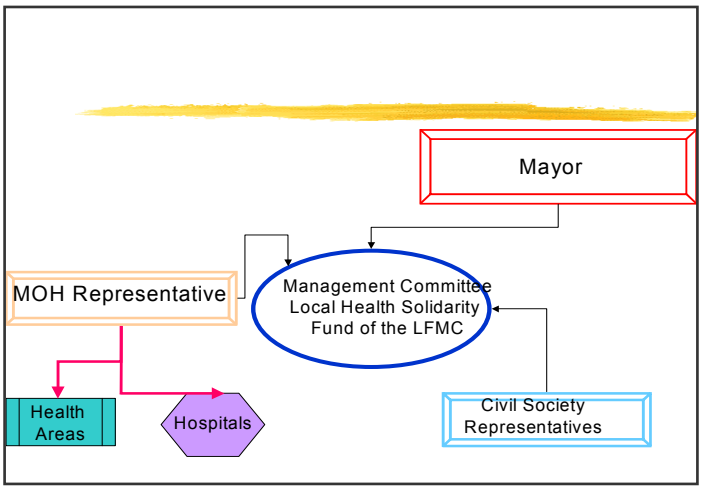
Source: Law for the Provision of Free Maternity and Child Care.

Note: the dotted arrow represents the provisional flow awaiting the complete implementation of Management Committees.

The Local Health Solidarity Fund not only received funds from the central level, but also receives resources from municipal governments and any other local financing source.

The role of Management Committees is significant because they integrate local governments and representatives from the civil society into the management process, conferring them the ability to administer healthcare funds, formerly the sole prerogative of the MOH in the past. Figure 2 shows the composition of a local LFMC Management Committee.

FIGURE 2: RELATIONSHIPS BETWEEN MUNICIPALITIES AND LFMC MANAGEMENT COMMITTEES



Source: Law for the Provision of Free Maternity Services and Child Care

Local LFMC Management Committees assign funds to hospitals and health districts of the Ministry of Health system. These funds are in the form of reimbursements made monthly according to the number and type of health services delivered by the local health facilities. The Management Committee and the Mayor in particular, employ the Operations, Technical and Financial Manual for the application of the LFMC, which establishes costs for each health service as well as procedures to evaluate coverage and quality standards. This mechanism separates financing and reimbursement functions from the actual provision of health services. A monitoring and accountability mechanism is thus created with the participation of the Mayor and representatives from civil society.

SOCIAL PARTICIPATION IN THE CO-MANAGEMENT MODEL

The LFMC created two important mechanisms to promote the participation of social actors, such as women's organizations, indigenous groups, and local governments. Although traditionally excluded from healthcare decision-making, their participation in the management of maternal and child health services delivered under the Free Maternity Program is critical to the Law's success. These two mechanisms are:

Local Management Committees, which administer the Law's funds (Local Health Solidarity Fund). Committees are formed by the Mayor, the Health District Director, a representative from community organizations, a representative from women's organizations and, in municipalities where the indigenous population is greater than 50%, a representative from indigenous organizations. In addition to administrating the Local Solidarity Fund, the Management Committee's work is to strengthen the role of the municipal government in local

healthcare management through the identification of public health priorities, the incorporation of citizens' perspective into health management, the identification of potential resources, and the assessment of the local health situation, among others.

Users Committees, defined as organizations of healthcare service clients whose functions include the production of reports regarding the quality of services delivered, the promotion of citizen and family participation in healthcare, and the coordination of activities with health facilities to improve the quality of health services. The concept of Users Committees stemmed from the work developed in Ecuador during approximately 8 years by the Ministry of Public Health, USAID's Quality Assurance Project (QAP) and PAHO. Prior work in Ecuador in continuous quality improvement of health services featured client satisfaction as one of its central concerns, including the creation of mechanisms allowing health facilities to measure and improve clients' satisfaction. In the case of the LFMC, the creation of Users Committees strengthens the work of health facilities and articulates a perspective based on citizen participation independent from the provision of services.

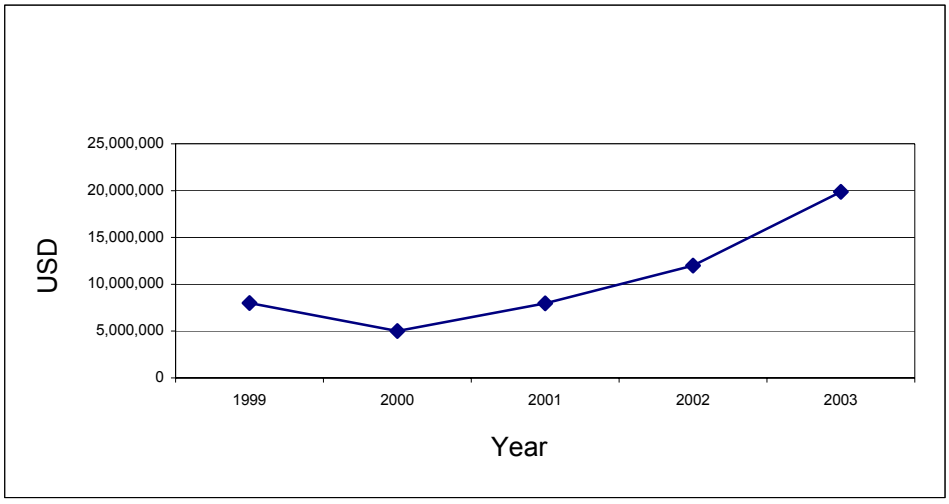
VII. ACCOMPLISHMENTS OF THE LFMC 2001-2004

FINANCING

The budget assigned to the Free Maternity and Child Care Program has increased with time. It has gradually gone from USD $8 million in 1999 to USD $12 million in 2002. This amount rose to USD$ 20 million in 2003.

The budget increase is a function of the results achieved by the Free Maternity Program and of the pressure from civil society, which demanded government compliance with the Law. Ecuador's First Lady, female members of Congress and its Women's Commission, CONAMU, and other Ecuadorian women's organizations, have become involved with the Law's implementation and have closely monitored the financing mechanisms to make sure they have conformed to agreements. Figure 3 shows the increases in the financial resources of the LFMC since 1999.

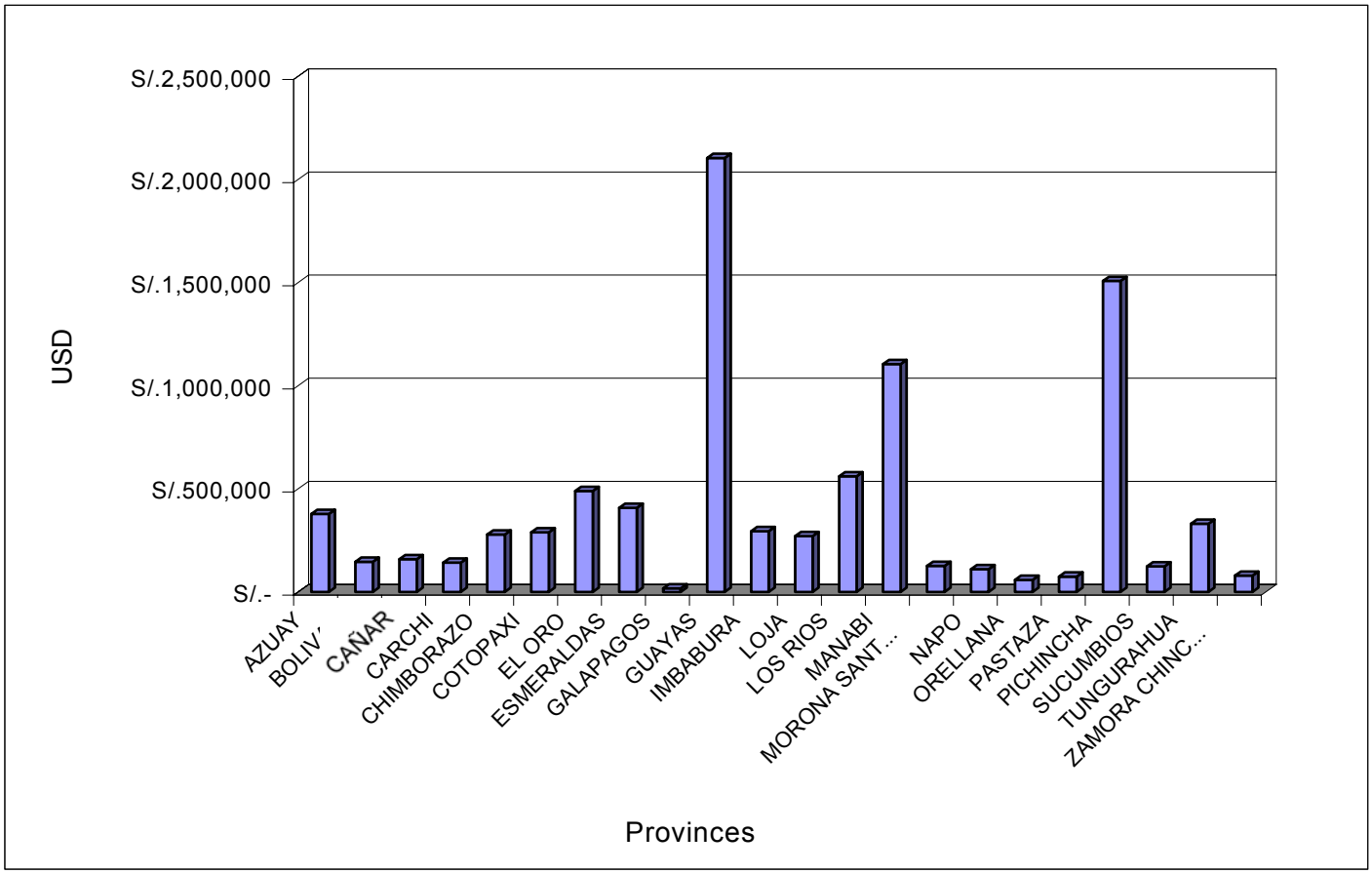
FIGURE 3: FINANCIAL RESOURCES OF THE LFMC, 1999-2003



Source: Executive Unit of the LFMC

Figure 4 shows the annual distribution of LFMC resources to each of Ecuador's provinces in 2002. As shown, more financial resources were assigned to provinces with higher numbers of inhabitants: Guayas, Pichincha, and Manabí.

FIGURE 4: LFMC FINANCIAL TRANSFERS TO PROVINCES, 2002

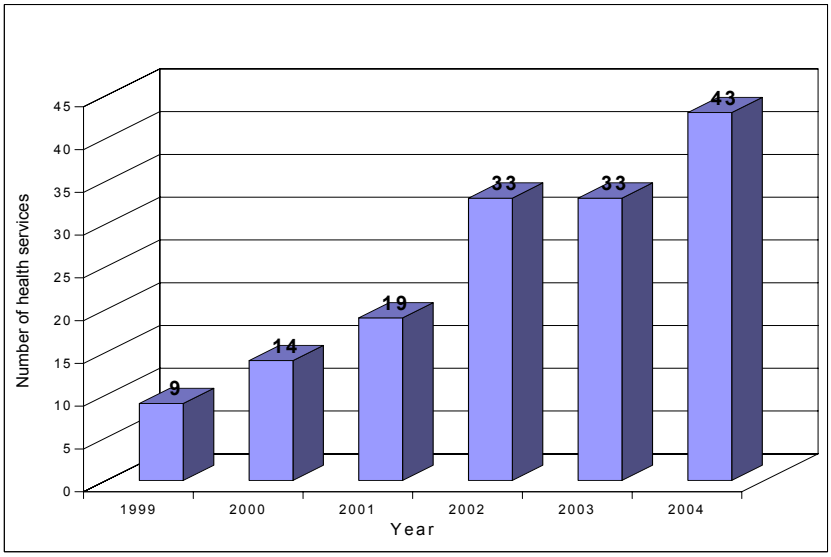


Source: Executive Unit of the LFMC

HEALTH SERVICES COVERAGE

Originally, only nine health services were covered by the LFMC. As shown in Figure 5, by 2003, the number of services to be covered would rise to 42. (See Table 1 on page 6 for a complete list of services covered by the LFMC.) The increase in the number of health services covered was based on the dispositions featured in the Law's Rules and Regulations, the population's needs, and the consensus among institutions that form the Committee to Support and Monitor the Law's implementation.

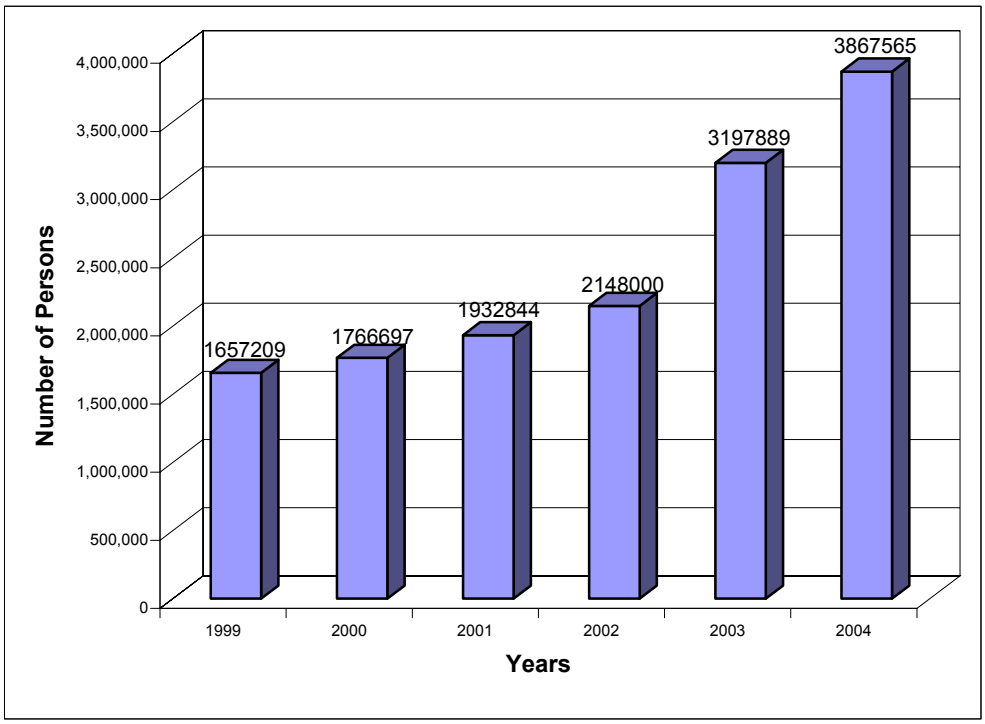
FIGURE 5: NUMBER OF HEALTH SERVICES COVERED BY THE LFMC



Source: Executive Unit of the LFMC

The number of individuals who received health services covered by the LFMC has also steadily increased, as seen in Figure 6. In 1999, the number of individuals covered was over 1,600,000, while in 2004 the Free Maternity and Child Care Program reached 3,867,000 women and children.

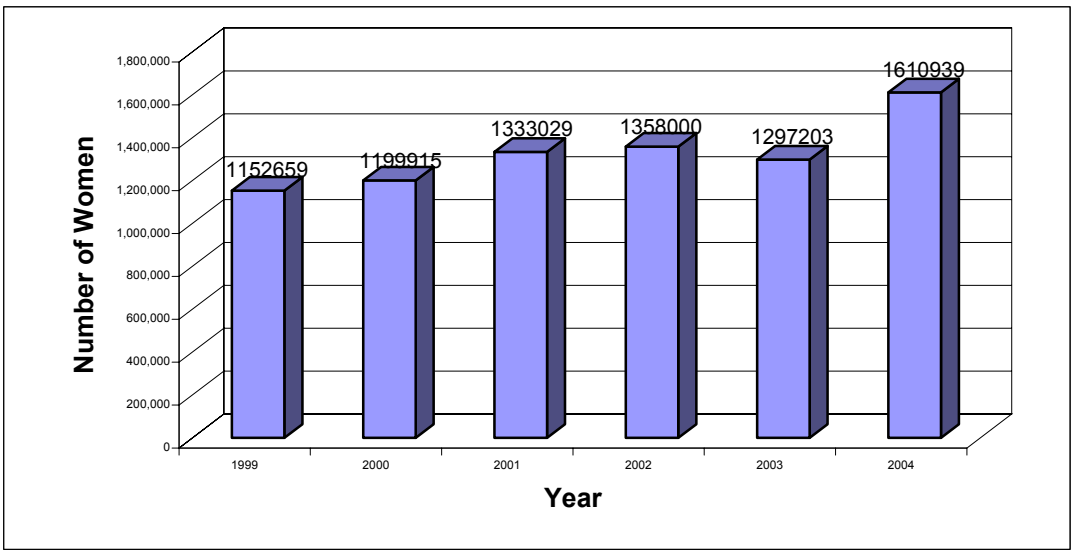
FIGURE 6: NUMBER OF INDIVIDUALS RECEIVING SERVICES UNDER THE LFMC, 1999-2004



Source: Executive Unit of the LFMC

Women are the main beneficiaries of the LFMC. Figure 7 shows the number of women served by the Free Maternity Program from 1999 through 2004.

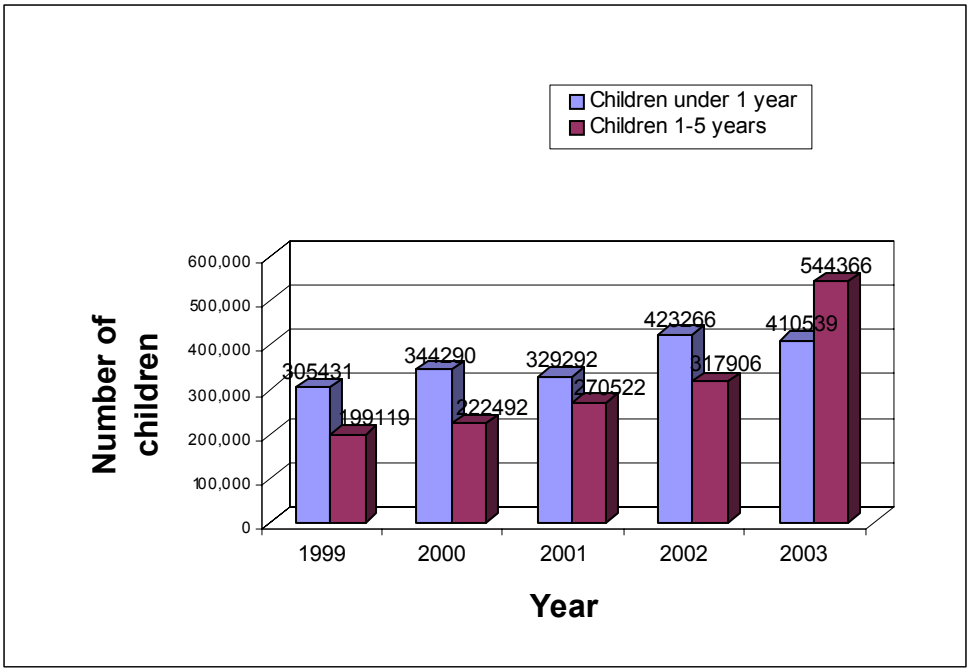
FIGURE 7: NUMBER OF WOMEN RECEIVING SERVICES UNDER THE LFMC, 1999-2004



Source: Executive Unit of the LFMC

The number of children who received services under the LFMC has also increased during these years, reaching 954,000 children in 2003, as shown in Figure 8. Most of the services provided to children were consultations using the Integrated Management of Child Illness (IMCI) protocol.

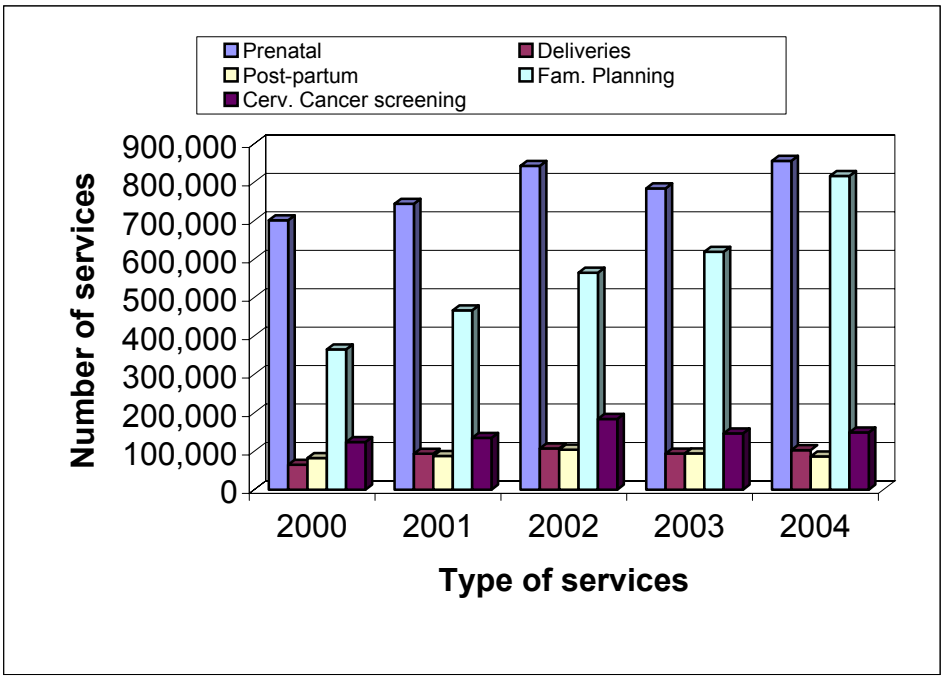
FIGURE 8: NUMBER OF CHILDREN RECEIVING SERVICES UNDER THE LFMC, 1999-2003



Source: Executive Unit of the LFMC

As to be expected from the increase in the number of beneficiaries of the Free Maternity Program, the number of health services provided has also risen, particularly with respect to antenatal controls, postpartum care, family planning, timely diagnosis of cervical-uterine cancer, and care delivered to children under five. Figure 9 compares the evolution of selected health services from 1999 through 2004. New health services, such as HIV-AIDS diagnosis, are not included because the information system does not record this service.

FIGURE 9: VOLUME OF SERVICES PROVIDED BY TYPE, 2000-2004



Source: Executive Unit of the LFMC

VIII. SIGNIFICANCE AND CONTRIBUTIONS OF THE LFMC TO HEALTH SECTOR REFORM

Ecuador's Law for the Provision of Free Maternity and Child Care represents a large-scale attempt to modify the delivery of maternal and child healthcare to the poorest population groups. It aims to contribute to the reduction of maternal and infant mortality and the improvement of women and children's access to quality healthcare, as well as to enable social participation in decision-making processes and control over the quality of services. To achieve these goals, the LFMC introduced specific reforms to the healthcare management model, in order to increase the effectiveness, coverage, efficiency, and quality of maternal and child health services. The reforms included: a) assuring stable financing for a set of basic health services, free from the influence of political comings and goings involved in the approval of public sector budgets; b) payment based on reimbursements for services delivered by health facilities; c) the creation of an Executive Unit and Local Health Management Committees that manage the reimbursement process and that are independent from the facilities that provide these services; d) the diversification of healthcare providers, including non-profit organizations and traditional health

practitioners, such as traditional birth attendants (TBA); e) the incorporation of local municipal governments and community organizations into local health management; f) the creation of Users Committees with an active oversight role for healthcare quality; and g) the introduction of continuous quality improvement as an integral part of health service delivery.

A main contribution of the LFMC has been to ensure the continuity of public health services for women and children. Due to its status in Law, the Free Maternity Program has become a State policy that is not affected by changes in administration and ministers. Moreover, the LFMC has contributed to the creation of effective mechanisms that guarantee the exercise of rights to reproductive health. A brief discussion of each of these reforms follows.

STABLE FINANCING OF A BASIC HEALTHCARE PACKAGE

Traditionally, approximately 85% of the regular budget of the Ministry of Health assigned to facilities is spent on salaries, effectively limiting the capacity of health facilities to purchase supplies and drugs. As a result, patients or their relatives frequently had to purchase the necessary supplies to receive care at MOH facilities. Such expenditures, added to the cost of medical appointments, transportation, food for accompanying persons, among others, made the total cost of healthcare a severe barrier for poor individuals.

Thirty percent of Ecuador's population lives on less than one dollar per day. Prior to the introduction of the Free Maternity Program, 25% of the country's population did not have access to healthcare, while 73% of indigenous women did not receive skilled care during childbirth. Since the introduction of LFMC, approximately USD$20 million outside the Ministry of Health's budget are now assigned annually to the Free Maternity Program and used by health facilities to purchase medicines and supplies required to deliver maternal and child healthcare.

Although in the initial years of the Law's implementation, a large number of health facilities continued to charge patients and to demand that relatives purchase medicines and supplies, these practices have been reduced through monitoring by the Executive Unit. As a result of the LFMC, economic barriers preventing access to healthcare for Ecuador's poor have been substantially lowered, and health facilities are progressively ensured the necessary supplies and equipment to provide quality care.

REIMBURSEMENT FOR SERVICES DELIVERED BY HEALTH FACILITIES

In general, MOH health facilities are assigned funds by means of annual global budgets calculated based on each facility's historical expenditures. This practice constitutes a **negative** incentive to quality improvement and efforts to increase the demand and generation of services.

The LFMC introduced a reform never implemented before in Ecuador to reimburse health facilities for their expenditures for medicines, supplies, lab exams, blood products, and micronutrients. Reimbursements are based on production reports from each facility, including both hospitals and ambulatory care units. In view of the possibility that this new reimbursement system might lead to a decline in production costs and compromise the quality of services, technical staff from the MOH, with support from QAP/USAID, created quality standards and patient care protocols for each service covered by the Law. Costs and reimbursement rates were estimated for each health service.[16]

[16] Technical details are available in the Operations, Technical, and Financial Manual for the Application of the LFMC, available at http://www.mortalidadmaterna.org/ in the section, "*Biblioteca*".

Thus, for instance, if a county hospital (serving a municipality) assisted 20 normal deliveries on a given month, the Management Committee of the Local Health Solidarity Fund would reimburse the hospital USD$ 500 for expenses authorized by the LFMC, such as medicines, supplies, lab exams, and blood. The hospital costs for salaries, equipment, utilities, and physical plant continue to be financed by the MOH with funds from its regular budget.

Informal interviews with several directors of MOH facilities have revealed delays in payments on the part of Management Committees to be a central problem related to reimbursements based on service volume. This situation is attributable to the fact that the Executive Unit does not receive funds on time from the Solidarity Fund, while the latter experiences the same delay in the transfer of funds from the central level. This was a particularly frequent problem in 2002; the regularity of the flow of funds improved in 2003.

Another problem involves service production reports submitted by some hospitals which include an abnormally large proportion of the most expensive services, such as intensive care provided to newborns. To address this problem, the Executive Unit reviews the monthly reports submitted by each hospital for appropriateness and makes supervision visits to individual facilities.

NEW MECHANISMS TO FUND SERVICES, INDEPENDENT FROM HEALTHCARE FACILITIES

The separation of financing and reimbursement functions from the provision of health services was achieved through the creation of an Executive Unit for the LFMC, operating on a national level, and of the Local Health Management Committees, in which municipal authorities play a lead role. Resources assigned to the LFMC are handed over to the Local Solidarity Fund, thereby fully achieving the separation between financing functions and the provision of health services. It is important to emphasize that this reform did not result in large additional costs for the administration of local funds because it employs the municipality's existing institutional and administrative capacity (administrative and accounting personnel, offices, equipment).

The transfer of funds from the National Solidarity Health Fund to municipal accounts required the development of new regulations and the signing of management agreements between the MOH, the Executive Unit of the LFMC, and Local Management Committees. The agreements signed are legal tools to enforce the achievement of goals and quality improvement, including indicators to evaluate compliance with these requirements. The goals and indicators for coverage and service quality that appear in the management agreements were developed by the Executive Unit of the LFMC and the Association of Municipalities of Ecuador (AME), with support from the Quality Assurance Project, QAP/USAID.

As was envisioned in the LFMC, local municipal governments have become involved in the transportation of obstetric emergencies and health promotion activities, a significant change from the past.

DIVERSIFICATION OF HEALTHCARE PROVIDERS

Funds from the MOH only finance services offered by its own facilities. The LFMC authorizes the use of its funds to reimburse services provided by other healthcare providers such as NGOs, the Ecuadorian Social Insurance Institute (IESS), and even traditional health practitioners. This reform is quite important since it opens up real possibilities to expand coverage.

A critical management decision determined the manner in which participating institutions would interact so that their actions could complement each other's, instead of duplicating or

replacing them. NGOs who wanted to benefit from the Law's resources could only provide healthcare to segments of the population not covered already by other public sector institutions. To provide such services, the NGO must sign a management agreement whereby it consents to provide services free of charge, coordinate activities with the MOH, observe protocols and quality standards, and use referral and counter-referral procedures to access the system. A further achievement was the incorporation of facilities from the Rural Social Insurance, a branch of IESS, into the Free Maternity Program.

With respect to traditional health practitioners and TBAs, one of their most important roles is to counsel patients and refer them to health facilities. For each pregnant woman or child under five years of age referred by a community agent or TBA to a health facility, the LFMC allows Local Management Committees to reimburse them USD$ 2-4. At the time this report was written, this mechanism was not yet implemented.

INCORPORATING LOCAL GOVERNMENTS, CIVIL SOCIETY REPRESENTATIVES, AND WOMEN'S ORGANIZATIONS INTO LOCAL HEALTHCARE MANAGEMENT

The local management of health services in Ecuador traditionally has been fragmented and devoid of any coordination between local institutions. Provincial Health Directorates of the MOH and their facilities have provided healthcare to the poor; IESS facilities provide services to their affiliates; Municipal Departments of Sanitation have dealt with public health issues such as garbage management, water supply, and environmental sanitation; and the Red Cross was responsible for the supply of blood and assistance in case of accidents. Coordination among them has been scarce or non-existent. One reason for this is that prior to the LFMC, there was no mechanism to allow civil society organizations to play an effective role in local healthcare management. Users of public services have also been traditionally absent from local management and deprived of mechanisms of representation and advocacy to advance their interests.

Reforms introduced by the LFMC have helped to solve these problems. Local Health Management Committees constitute an operational mechanism to bring local governments into health management, in coordination with local representatives from the MOH and other institutions. The Local Health Committee has the potential to become a forum to establish health priorities and strategies and to coordinate efforts between numerous institutions and civil society organizations.

By incorporating civil society groups (community organizations, women's organizations, and peasant and indigenous groups) into Local Management Committees, the LFMC assigns them a fundamental role they did not have before, giving them not only access to deliberations, but also authority to make decisions as part of the local entity in charge of the administration of the Law's funds.

In addition to participation in Management Committees, the LFMC establishes the creation of Users Committees whose active role is to oversee and support the quality of healthcare. Users Committees are organizations representing civil society, independent from health facilities, State institutions, or political parties. Accordingly, Users Committees are expected to examine on a quarterly basis the quality of services financed by the Law and make a report to the Local Management Committee, who will use the quality information to evaluate compliance with Management Agreements and to establish payments to healthcare providers. Users Committees are also expected to work with health facilities in undertaking activities to improve the quality of health services. This aspect of the LFMC has been slower to develop, and only now are specific procedures for working with Users Committees being tested in some provinces.

INTRODUCTION OF QUALITY IMPROVEMENT AS A KEY OBJECTIVE

In Ecuador, neither the public nor the private health systems have typically relied on permanent, legally established, operational mechanisms to assure the quality of healthcare. The result has been poor technical quality of healthcare and users' dissatisfaction. A key reform introduced by the LFMC assigns a prominent role to the quality of services financed by the Law, creating the operational mechanisms needed to effectively monitor and continuously improve healthcare quality. The Law was designed so that its Executive Unit, Local Management Committees, and Users Committees, all have important roles in guaranteeing the quality of healthcare. Management agreements that establish explicit goals concerning quality must be fulfilled by health facilities. These mechanisms define quality healthcare in operational terms and link quality to reimbursements for services delivered.

The MOH and the Executive Unit of the LFMC, with support from the Quality Assurance Project, has created patient care protocols and quality standards for basic services provided by the Law, based on technical norms of the MOH. These tools enable health facilities to measure and continuously improve the quality of the services they provide. Other tools created included a monitoring system and a monthly report of quality indicators to be sent by facilities to the MOH Provincial Health Directorates, and then to the central level of the MOH. The MOH and QAP created a Technical Advisory Group for the Continuous Quality Improvement Program, working alongside PAHO, UNFPA, and Family Care International to support the expansion of the continuous quality improvement model. As of March 2005, the expansion had covered 70 hospitals and health centers in 11 Ecuadorian provinces.[17]

Training was provided to staff from each Provincial Health Directorate in charge of running the continuous quality improvement (CQI) team at every hospital and health center in the province. The CQI teams are comprised of physicians, nurses, midwives, and statistics personnel from each facility and monitor and report quality indicators and users' satisfaction on a monthly basis, in addition to implementing rapid improvement activities.

[17] The introduction and expansion of the continuous quality improvement mechanism within the Free Maternity Program is discussed in depth in LACHSR Report Number 65, *Scaling Up and Institutionalizing Continuous Quality Improvement in the Free Maternity and Child Care Program in Ecuador,* available at www.lachsr.org.

QUALITY ASSURANCE PROJECT
University Research Co., LLC
7200 Wisconsin Avenue, Suite 600
Bethesda, MD 20814 USA
Tel: (301) 654-8338
Fax: (301) 941-8427
www.qaproject.org