AID VIA ACTION GLOBAL HEALTH JOURNAL

Manuscript

Aid Via Action Global Health Journal 1(1); 2023:6-13 [www.aidviaaction.org]

Current challenges to health care access in Guatemala

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Abstract

Guatemala is an upper-middle-income country in Central America, with a high poverty rate and significant inequality. The health care system is divided into three large sectors: the private sector, the Guatemalan Social Security Institute, and the public sector. However, the government's health care expenditure is low, which has resulted in inadequate access to medical services for many citizens, especially for the indigenous population, who face disproportionately high poverty levels and limited health care services compared to non-indigenous individuals. Over the past 63 years, various international efforts have tried to address the inequity in health care access, with one example being the Behrhorst program. This program aimed to offer basic medical care to impoverished rural communities in the late 20th century and was a success but faced significant challenges due to the widespread violence and oppression that took place in the late 1970s and the early 1980s. Despite many efforts, significant challenges remain, particularly in addressing the health disparities between urban and rural areas.

AvaGHJ 1(1): 6-13 https://doi.org/10.59016/avaghj.78634

Keywords:
Low- to middle- income countries,
Global health,
Health care access,
Health care insurance,
Central America,
Poverty,
Inequality,
Aid Via Action

About this article:
Received Feb 20, 2023
Accepted Mar 8, 2023
Published Mar 8, 2023

Reviewers:
M. Argo
J. Favela

Introduction

Guatemala is the most populous country in Central America, with more than 17 million people as of 2022. According to the World Bank, it is classified as an upper-middle-income country and had the largest economy in the region as of 2018. In terms of macroeconomic rankings, its gross domestic product (GDP) was $9,931 in purchasing power parity by 2022, placing it within the upper-middle income category. Of the 192 countries listed, Guatemala´s GDP ranked 121st. [1-3]

Despite its classification as an upper-middle-income country, it faces significant challenges of poverty and inequality. This is illustrated by the fact that nearly half of the nation's population in 2014, lived below the poverty line, which means 7.8 million people. Of this number, 9% lived below the international poverty line, earning less than $1.90 per day in the same year. [4,5]

Moreover, the government's limited funding towards the health care sector has resulted in a deficient health care infrastructure, which has led to limited access to medical services for a considerable segment of the population. In addition, only a small fraction of citizens holds health insurance, which worsens the problem of unequal health services access.[6]

The country's high poverty rate of 59% and extreme poverty rate of 23% are evident in considerable economic disparities, such as the Gini coefficient for income distribution of 0.59.[7]

Government expenditure on health care remains low, with only 17.8% allocated to the sector in 2014, and the total per capita expenditure on health is correspondingly low at $476 in the same year.[7] Indigenous Guatemalans face disproportionately high levels of poverty and limited access to

medical services compared with non-indigenous individuals. Recent data shows that 79.2% of those living in poverty in Guatemala are indigenous [Figure 1]. Unfortunately, access to health care for this population remains limited. [8,9]

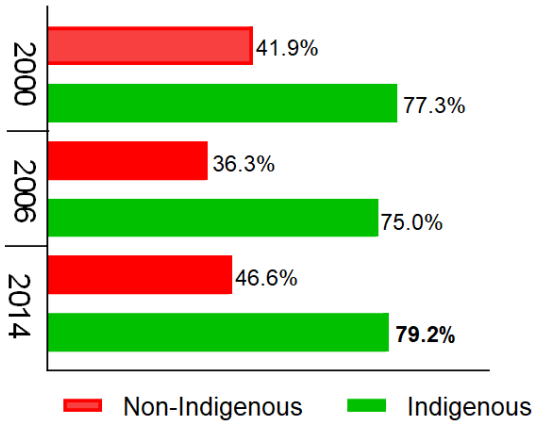

Figure 1. Incidence of poverty by ethnicity in Guatemala. Adapted from Instituto Nacional de Estadistica.[9]

Health Care System Sectors of Guatemala

Currently, three large sectors provide medical care to the people of Guatemala[10,11]:

1. The private sector
    a. For-profit
    b. Non-profit
2. The Guatemalan Social Security Institute (IGSS)
3. The public sector

1. The Private Sector

The private health care sector in Guatemala is divided into for-profit and non-profit organizations.

1a. For-profit facilities, which consist of private hospitals, clinics, pharmacies, and laboratories, provide a wide range of services that are comparable to those available in most industrialized nations. This sector has experienced significant growth over the last two decades, resulting in the establishment of approximately 400 private hospitals and 4,000 private clinics, with the majority founded after 1996 and the implementation of neoliberal health reforms. The healthcare infrastructure provided by the public sector consisted of 44 hospitals and 333 health centers that had a relatively equitable geographic distribution, however, most of these facilities were situated in urban regions. Conversely, private health care services were highly concentrated in metropolitan areas, resulting in a significant disparity in coverage between rural and urban areas.[7]

During the period from 1995 to 2006, the private sector expanded considerably with the establishment of 292 new hospitals and 2614 clinics, which provided health care services under both for-profit and non-profit models. Despite the requirement for out-of-pocket payments to access private health services, a significant proportion of households relied on it. Results from 2000 and 2006 indicated that most Guatemalans, irrespective of their income level, preferred to seek medical treatment at private clinics or pharmacies, with 37% and 41% of outpatient care recipients in 2000 and 2006, respectively, opted for private clinics. In addition, as per data from 2001, less than 5% of the population had access to private insurance coverage. [10,12]

In 2014, approximately 11% of Guatemala's population had access to private health care services. Despite the high cost of private health services, 26% of the individuals using private clinics were still considered poor. From 2000 to 2014, there was a decline in the percentage of the Guatemalan population who sought private health care services, dropping from 36.2% to 29.2%. Meanwhile, the usage of public health care

centers and hospitals increased. By 2014, this had decreased significantly, with only 1.4% of the population having access to private insurance [Figure 2].[9]

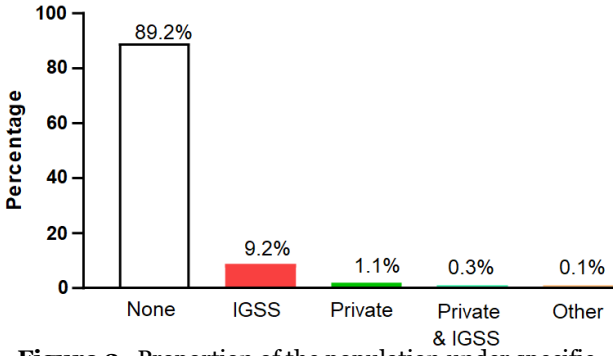

Figure 2. Proportion of the population under specific health care coverage in Guatemala in 2014, expressed as percentage. Adapted from Instituto Nacional de Estadistica.[9]

This change in medical care-seeking behavior is thought to be attributed to two main reasons: people perceiving their illness as non-severe (44%) and financial constraints (37%). Specifically, the percentage of citizens who described financial hardship as the reason for not seeking medical attention increased from 29% to 36% from 2000 to 2014. These data were taken from the Living Standard Measurement Survey distributed to Guatemalan citizens in the year 2014. [5,9]

1b. Non-profit: As of January 2020, the Public Information Office of the Ministry of Governance in Guatemala reported 1,394 registered non-governmental organizations (NGOs), 12,601 civil associations, and 796 foundations operating in the country. Most of the funding for the nonprofit sector comes from donations originating in the United States, and many organizations rely heavily on U.S. fiscal sponsors and philanthropic consulting services to tap into the philanthropic culture of the United States.[13-15]

2. The Guatemalan Social Security Institute (IGSS)

The Guatemalan Social Security Institute is a self-governing entity funded by mandatory contributions from workers and employers based on wages. It operates its own medical care network to provide a limited range of services to formally employed workers, who are primarily urban wage earners. In 2000, 8.2% of the population with health insurance was covered by IGSS, but by 2014, this coverage increased to 9.2% [Figure 3].[9,10]

Figure 3. Proportion of the population under Instituto Guatemalteco de Seguridad Social (IGSS) access in 2014 in Guatemala, expressed as percentage. Adapted from Instituto Nacional de Estadistica.[9]

3.The Public Sector

The Ministry of Public Health and Social Assistance (MSPAS) operates the public health care sector, which comprises government hospitals, health centers, and health posts. Although health care is a universal right for all citizens in Guatemala according to its constitution, limited resources make it challenging to implement this right effectively. Because of the increasing costs associated with private medical care, most of the people depend on public services. Between 2000 and 2014, there was an increase in the percentage of the population utilizing public health care centers (from 15% to 19%) and public hospitals (from 9% to 18%).

According to the 2014 Living Standard Measurement Survey, health posts (27%) were the most frequent locations for seeking medical care, followed by private clinics (22%), and public hospitals (18%). This distribution contrasts the patterns observed in 2000 and 2006. Also, 43% of the population had insurance under the public sector. [8-10,13]

One analysis of the Guatemalan Health Care System by the Pan American Health Organization indicates that the MSPAS is ineffective in ensuring the provision of medical care services, to the point that the population does not advocate for this right.

As an example, in 2001, approximately 18.8% of Guatemalans had no access to health care services.[10] On the other hand, in 2014, 89.2% of the population did not have any form of insurance [Figure 4].[9]

As of March 2020, the MSPAS managed 46 hospitals, roughly 1,200 health care posts and centers, and 232 clinics and care centers located throughout Guatemala, providing services to 75% of the population. According to a World Bank report in 2020, the number of hospital beds per 1,000 inhabitants in the country was less than one, ranking it as one of the lowest in the region. This highlights the insufficiency of the government's investment in hospital and medical care infrastructure.[16]

Closing the Health Care Gap in Guatemala in the 20th century: The Implementation of the Behrhorst and the Basic Services Coverage Extension Programs

International initiatives have attempted to address challenges of accessing quality health care for Guatemalans over the last six decades, with various development

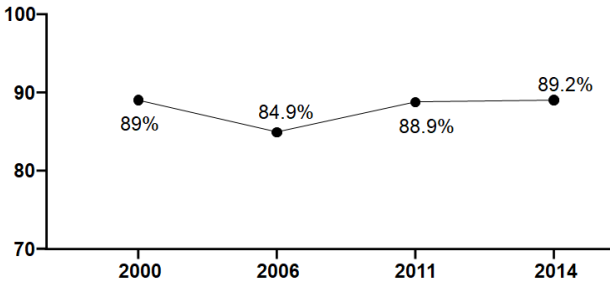

Figure 4. Proportion of the population without any form of insurance in Guatemala in 2014, historic series from Living Standard Measurement Survey, expressed as percentage. Adapted from Instituto Nacional de Estadistica.[9]

strategies implemented.[10] Among them is The Behrhorst program in the department of Chimaltenango, a primary health care program (PHC) founded in 1962 by Dr. Carroll Behrhorst, who recognized the social causes contributing to the ill health of rural populations and aimed to provide basic medical services for impoverished rural communities.[17-19]

The program aimed to provide inexpensive training by implementing health promoters, such as training the Kaqchikel Mayan population to serve as “mini doctors” who could treat the most common diseases. Dr. Behrhorst believed that agricultural extension work was an important part of health promotion and established a land loan program (ULEU) in 1970 to provide loans to communities of Mayan farmers who wished to buy their own land.[18]

The program additionally featured specialized training for experienced Kaqchikel women, encompassing a diverse range of topics such as household health, nutrition, hygiene, sewing, cultivation of home gardens, raising of chickens, and family planning sessions. [18]

Another persistent health hazard was the lack of potable water, so the program

implemented water programs such as Program for Rural Sanitation in Chimaltenango (SARUCH), in conjunction with the Guatemalan Ministry of Health and Agua del Pueblo, to obtain supplies of purified water. [17]

Dr. Behrhorst reinforced legal and organizational issues to ensure that the program was governed by a local board and administered by local staff on their own. Subsequently, it was catalogued as a private agency under Guatemalan law, with all policy matters on the land of local directors. [17]

In 1976, an earthquake hit the nation, and the Dr. Behrhorst clinic, known as "Hospitalito del Gringo," which was built in 1962, collapsed. However, the clinic was rebuilt because of the overwhelming response of the donors.[18]

He believed in new strategies such as dependence on local resources, both human and material, to achieve health services outside the concept of pills and injections. Community workers would create awareness among people of their situation and understanding of how to solve problems themselves. According to Heggenhougen, this change resulted in PHC workers becoming a creative force for radical structural changes that threatened the status quo. Development agencies used community participation as an organizing tool to further their reformist objectives, which included training community leaders to play an active role in demanding state social services. However, as popular participation in such efforts grew, organizing for any reason was defined as a threat to state rule.[17-18]

The violence and oppression that occurred in Guatemala during the late 1970s and the early 1980s severely impacted the Behrhorst program. Many of its collaborators were killed or disappeared by gunmen, and the program was left in the shambles. The killing of PHC workers by the Guatemalan military demonstrated the risks posed by PHC to the government. The Behrhorst village-based health work continued to provide services to the community despite the volatile climate of violence.[19]

The program was successful in improving health outcomes for rural communities, and it continues to operate today under the name of "Fundación Carroll Behrhorst" and "Advance Local Development through Empowerment and Action (ALDEA)."[19]

The Basic Services Coverage Extension Program

The Basic Services Coverage Extension Program (PEC) was introduced in Guatemala in 1997 as part of the government's public policies to rebuild the nation following the civil war. The program prioritized health care as a fundamental need and aimed to improve access to these services in underserved areas, particularly in rural regions where indigenous populations had limited access to MSPAS facilities. To address this, the Comprehensive Health Care System was established through partnerships with NGOs. [11,20]

The PEC program's expansion was made possible through contractual agreements between MSPAS and NGOs, which stipulated a standardized payment rate for every jurisdiction with a population of 10,000 inhabitants, in exchange for

delivering a basic package of preventive services. The services were mainly preventive in nature, with ambulatory physicians or nurses making monthly visits to communities supplemented by local community volunteers. The care team comprised one paid worker for every nine volunteers and was responsible for disease monitoring and ensuring compliance with specific interventions.[20]

Between 1999 and 2010, the PEC program's coverage expanded from 2.9 million people to 4.5 million people in remote rural areas through the signing of 144 agreements with approximately 90 NGOs. However, due to insufficient funding, NGOs contracted to provide medical care services often found themselves unable to cover their costs. Reports indicate that NGOs repeatedly failed to achieve their targets, with only 39% or 11 out of 28 indicator targets being met for the entire program in 2011. Delayed payments from the government to NGOs, with delays lasting up to 12 months in some cases, were cited as one of the reasons for this shortfall. Furthermore, the targets were not coordinated with the NGOs and did not reflect the context of each jurisdiction, further contributing to the inability to meet targets.[11,21-22]

One line of criticism of development programs, such as the Berhorst program, is their potential failure to address the fundamental origins of poverty, which is strongly correlated with poor health outcomes. Another critique is that these programs may inadvertently perpetuate corrupt practices within governmental structures and intensify the marginalization of economically disadvantaged communities that they aim to benefit.[10]

Conclusion

It is apparent from the data that a uniform epidemiological profile cannot be found for Guatemala, and instead, there exists a complex profile. Although the health care system of the country encounters numerous difficulties, there are chances for improvement by enhancing investment and cooperation.

Initiatives such as The Behrhorst program and the Basic Services Coverage Extension Program have demonstrated the potential for success, and similar approaches could be scaled up to address other health care challenges.

One possible proposal to improve equitable access to high-quality medical care for all citizens is to reinforce and coordinate the three primary health system sectors, with a particular emphasis on remote and rural regions. This approach could enhance health care delivery, which would provide better access to health services for all Guatemalans.

References:

1. Instituto Nacional de Estadística de Guatemala. Proyecciones Nacionales Estimaciones y proyecciones de población 1950-2022 [Internet]. Guatemala City, Guatemala: Instituto Nacional de Estadística de Guatemala; 2019 [Accessed Feb 11, 2023]. Available from: https://www.ine.gob.gt/proyecciones/.
2. The World Bank. New Country Classifications by Income Level: 2018-2019 [Internet]. World Bank Blogs; 2018 [Accessed Feb 12, 2023]. Available from: https://blogs.worldbank.org/opendata/new-country-classifications-income-level-2018-2019.

3. International Monetary Fund. World Economic Outlook Database [Internet]. World Economic and Financial Surveys; 2022 [Accessed Feb 17, 2023]. Available from: https://www.imf.org/en/Publications/WEO.
4. The World Bank. Total population in Guatemala [Internet]. The World Bank Group; 2023 [Accessed Feb 13, 2023]. Available from: https://data.worldbank.org/indicator/SP.POP.TOTL?locations=GT.
5. Parra-Osorio J. Poverty & Equity Brief in Latin America & the Caribbean: Guatemala [Internet]. The World Bank; 2020. [Accessed February 14, 2023]. Available from: https://databankfiles.worldbank.org/public/ddpext_download/poverty/33EF03BB-9722-4AE2-ABC7-AA2972D68AFE/Global_POVEQ_GTM.pdf.
6. Cabrera M, Lustig N, Morá H. Fiscal Policy, Inequality, and the Ethnic Divide in Guatemala [Internet]. Washington DC: Center for Global Development; 2015 Mar. Report No.: 397. [Accessed February 15, 2023]. Available from: https://www.cgdev.org/publication/fiscalpolicy-inequality-and-ethnic-divide-guatemala-working-paper-397.
7. Labonté R, Crooks VA, Valdés AC, et al. Government roles in regulating medical tourism: evidence from Guatemala. *Int J Equity Health*. 2018;17(150):2-3. Available from: https://doi.org/10.1186/s12939-018-0866-1.
8. Cerón A, Crooks VA, Labonté R, Snyder J, Flores W. Medical Tourism in Guatemala: Qualitatively Exploring How Existing Health System Inequities Facilitate Sector Development. *Int J Health Serv*. 2019;49(4):754-772. Available from: doi:10.1177/0020731419866085.
9. Instituto Nacional de Estadística de Guatemala. Encuesta Nacional de Condiciones de Vida 2014 Tomo 1 [Internet]. Guatemala City, Guatemala: Instituto Nacional de Estadística; 2016 [Accessed Feb 16, 2023]. Available from: https://www.ine.gob.gt/sistema/uploads/2016/02/03/bwc7f6t7asbei4wmuexonr0oscpshkyb.pdf.
10. Green T, Green H, Scandlyn J, et al. Perceptions of short-term medical volunteer work: a qualitative study in Guatemala. *Global Health*. 2009;5(4):1-13. Available from: https://doi.org/10.1186/1744-8603-5-4.
11. Becerril-Montekio V, López-Dávila L. Sistema de salud de Guatemala. *Salud Publica Mex*. 2011;53 supl 2: S197-S208.
12. Bowser D, Mahal A. Guatemala: The economic burden of illness and health system implications. *Health Policy*. 2011;100(2-3):159-166. Available from: https://doi.org/10.1016/j.healthpol.2010.11.011
13. Roche S, Brockington M, Fathima S, Nandi M, Silverberg B, Rice H, et al. Freedom of choice, expressions of gratitude: Patient experiences of short-term surgical missions in Guatemala. *Social Science & Medicine*. 2018;208:18-25. Available from: doi: 10.1016/j.socscimed.2018.05.021.
14. Ministerio de Salud Pública y Asistencia Social de la República de Guatemala. Cuentas nacionales en salud: financiamiento de la salud en Guatemala, período 1995-2014 [Internet]. Guatemala City, Guatemala: Ministerio de Salud Pública y Asistencia Social; 2015 [Accessed Feb 18, 2023]. 14 p. Available from: https://transparenciapresupuestaria.minfin.gob.gt/wp-content/uploads/2021/06/MSPAS2015FinanciamientodelaSaludenGuatemalaal952014.pdf
15. Rolland A. History and current context of philanthropy in Guatemala [Internet]. Indianapolis, IN: Indiana University, Lilly Family School of Philanthropy; 2020 [Accessed Feb 19, 2023]. Available from: https://blog.philanthropy.iupui.edu/2020/06/10/history-and-current-context-of-philanthropy-in-guatemala/.
16. Mota L. Guatemala Health Care Infrastructure [Internet]. United States: International Trade Administration, Market Intelligence; 2020 [Accessed Feb 20, 2023]. Available from: https://www.trade.gov/market-intelligence/guatemala-healthcare-infrastructure
17. Behrhorst C. A New Dawn in Guatemala: Toward a Worldwide Health Vision. 1st ed. Prospect Heights, IL: Waveland Press, Inc; 1993.
18. Green LB. Consensus and Coercion: Primary Health Care and the Guatemalan State. *Med Anthropol Q*. 1989;3(3):246-257.
19. Advance Local Development through Empowerment and Action (ALDEA). A timeline of impact [Internet]. New York, United States of America: ALDEA; 2023. [Accessed Febraury 19,

2023]. Available from: https://aldeaguatemala.org/our-history/.
20. "El remedio de nuestros males: Un análisis sobre los mecanismos, costos y formas de financiamiento para mejorar el sistema de salud pública en Guatemala, 2012-2021." Serie de documentos de análisis, Boletín ¡Contamos! N° 6. Ciudad de Guatemala: Instituto Centroamericano de Estudios Fiscales y Fondo de las Naciones Unidas para la Infancia; 2011.
21. Lawton A. The Right to Health in Indigenous Guatemala: Prevailing Historical Structures in the Context of Health Care. *Health and Human Rights Journal*. 2015. Available from: https://www.hhrjournal.org/2015/08/the-right-to-health-in-indigenous-guatemala-prevailing-historical-structures-in-the-context-of-health-care/
22. Lao Pena C. Improving access to health services through the Extension Coverage Program. UNICO Studies Series; No. 19. Washington, DC: World Bank; 2013. Available from: https://openknowledge.worldbank.org/handle/10986/13283.