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Freedom to live, freedom to die: Health disparities in El Salvador

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Freedom to live, freedom to die: Health disparities in El Salvador

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FREEDOM TO LIVE, FREEDOM TO DIE
HEALTH DISPARITIES IN EL SALVADOR

by
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[In El Salvador] the rich have freedom to live and the poor have freedom to die.

Dr. Virginia Funes

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Background and Methods

For the first time in the summer of 2008 Eastern Michigan University offered a study abroad course to El Salvador. The two-part course called “Poverty, Human Rights and Health” was co-listed as a political science and health administration course.¹ HLAD/PLSC 390 was a didactic experience open to any interested student, but served as a pre-requisite for anyone taking part in HLAD/PLSC 391, a ten-day academic study abroad field study to the post-civil war nation of El Salvador. This narrative is about my experiences in both of these courses.

While in El Salvador we toured a private hospital, two public hospitals, and spoke with a physician in a rural healthcare clinic. This paper focuses on the health disparities in El Salvador comparing those who can afford private medical care and those who must use the government funded public health care system. Beyond these comparisons there will be an in depth discussion about additional challenges and disparities that are faced by people living in the rural regions of El Salvador as compared to urban dwellers.

My data are based on field notes and personal observations recorded while on the ten-day EMU academic study abroad trip to El Salvador. The notes that I took during tours of several health facilities and during group meetings with physicians became powerful first hand accounts of the health situation in El Salvador. Library research was used to write the background sections about the underlying causes, historical processes, the health problems of rural populations, and to validate my personal observations.

Introduction

¹ HLAD 390-391; PLSC 390-391 “Poverty Human Rights and Health was approved by the General Education Course Vetting Committee during the winter semester, 2007 and approved for academic study abroad in 2008.

Smaller geographically than the state of Massachusetts, the Central American country of El Salvador has a population of over seven million people, and has the highest population density in Latin America (Montgomery, 1995). Nineteen percent of Salvadorans live on less than \$1 a day and 30% of Salvadorans live below the poverty line (Central Intelligence Agency [CIA], 2009, para. 71). The United Nations Development Programme (UNDP)(2005) ranks El Salvador 104 out of 177 countries based on indicators of life expectancy at birth, adult literacy rate, school enrollment, and GDP per capita. This gives El Salvador a medium human development ranking. Of the 177 countries ranked on the United Nations Development Report, only 57 countries are considered to have high human development (United Nations Development Programme [UNDP], 2005, p. 220).

Health conditions are poor in El Salvador because of poor infrastructure, natural disasters, poverty, and a lack of health care resources. Poor health conditions are present throughout the country but there are added challenges, limitations and health risks in the rural parts of the country. As this paper presents the realities of health care and rural life in El Salvador, consider not only the implications for Salvadorans, but also for all the people living in countries where the situation is worse.

Historical Background

From 1980 to 1992 the Salvadoran government and leftist rebels fought a civil war that cost about 75,000 lives (CIA, 2009, para. 1). In her book, *Revolution in El Salvador*, Tommie Sue Montgomery described two historical trends that began in El Salvador during the days of Spanish Colonial rule, and continued after gaining independence. From the beginning there was an unequal distribution of resources, which

was made worse by the size of the Salvadoran population. Second, in El Salvador there has always been conflict between communal lands and private property, and the elite minority of landowners have regularly gained at the expense of those on communal lands (Montgomery, 1995, p. 25). The civil war was “the culmination of decades of militarisation, intense political violence, and repression which produced thousands of victims” (Ugalde, Selva-Sutter, Castillo, Pas, Canas, 2000, p. 169). Much of the militarization of the Salvadoran government was a direct result of anti-communist political interventions of the U.S.A. and part of the final phase of the Cold War.

Post-War Health/Effect of the War

During the war era the health system went neglected. Reports of the effect that the war had on health in El Salvador are mixed. The study by Ugalde et al. suggested that the need for reconstruction of health infrastructure was limited to one hospital and twenty-two health centers in combat zones. The same study showed that some health indicators, such as life expectancy at birth, maternal mortality and mortality from infectious diseases, actually improved during the course of the war (Ugalde et al., 2000).

James Roush (1997), a retired member of the U.S. Agency for International Development, participated in the evaluation of two USAID/El Salvador projects. In 1997 he wrote an essay that cited El Salvador’s post-war special health needs as being the need to expand or establish health care facilities in former conflict zones, providing care for the war-wounded, and addressing post-traumatic stress disorder afflicting close to one-fifth of all Salvadorans (Roush, 1997).

The Role of the Church

“El Salvador” translates to “the savior,” and with 52% of Salvadorans identifying as Roman Catholics, it is not surprising that the Catholic Church has long had close ties to politics in El Salvador (CIA, 2009, para. 39). During the 1970s the Catholic Church began to stray away from its “centuries old alliance of Church, military, and the rich elites,” and began to “defend the rights of the oppressed” (Montgomery, 1995, p. 83). Through Liberation Theology and grassroots ministry efforts, the church began furthering its reach beyond urban areas into the rural areas.² Considered “The Voice of Those Who Have No Voice,” Archbishop Oscar Arnulfo Romero was assassinated during a mass in 1980, but the people of El Salvador have never forgotten the sacrifice that he and other members of the church made for them.

² Liberation Theology refers to a “theology of liberation that has interpreted the gospel as demanding that Christians be a force actively working to liberate the great majority of the people from poverty and oppression” (Montgomery, 1995, p. 84).

The Salvadoran Health Care System

The health care system in El Salvador today consists of two distinct sectors; public and private. A third unofficial sector is comprised of non-governmental organizations (NGOs) and Church sponsored services. The public sector is financed by the Ministry of Health (MOH), and provides care for about eighty percent of Salvadorans (Pan American Health Organization/World Health Organization [PAHO/WHO], 2007, p. 29). There are five entities that make up the public sector: The Ministry of Health and Social Welfare, Salvadoran Social Security Institute, Higher Council for Public Health, Military Health, and Teachers' Welfare. The private sector consists of privately funded clinics and hospitals.

The Ministry of Health and Social Welfare (MSPAS)

MSPAS is “the agency in charge of determining, planning, and implementing national health policy; promulgating the applicable standards; and organizing, coordinating, and evaluating the implementation of health-related activities.” The MSPAS is supposed to cover 80% of Salvadorans, but actual coverage is much lower because of lack of resources. There are 427 total health facilities run by the Ministry including 16 hospitals. There are 2,964 hospital beds total under the MSPAS (PAHO/WHO, 1998, p. 265).

Salvadoran Social Security Institute (ISSS)

The ISSS is run through the Ministry of Labor and Social Security. The social security offered by the ISSS covers 17% of Salvadorans. The ISSS “provides coverage to workers in private enterprises and government employees, along with their respective beneficiaries.” There are 69 health facilities run by the ISSS including 10 hospitals. There

are 1,583 beds total under the ISSS (PAHO/WHO, 1998, p. 265). Most treatments offered the ISSS are curative in nature.

Other Public Sector Entities

The Higher Council for Public Health (CSSP) functions to “safeguard the health of the people” (PAHO/WHO, 2007, p. 29). This function is accomplished through the oversight of the health professions that require licensure. Other health coverage providers in El Salvador include the National Telecommunications Association (ANTEL), the Electric Lighting Company (CEL), Teachers’ Welfare, and the Military Health Service, which provide health care for their respective workers and families. Together, these public entities provide care for 2.3% of the population (PAHO/WHO, 2007, p. 29).

Problems in the Public Sector

A 2005 MSPAS publication entitled “Quality Assurance of Services of Health in El Salvador” identifies five problem areas in the public health care system. These problems are: preparation and resource adequacy, shortcomings in the management of healthcare supplies, gaps in monitoring and oversight, lack of standardization in service delivery, and the absence of a system of categorization (Ministry of Health and Welfare, 2005).

There are problems in the public sector that I was able to observe in the public facilities and that our guides shared with us. For instance, there is no specialized medical training in El Salvador. Any physician who wishes to receive training in radiology must travel to another country. There is currently a low demand for radiologists in El Salvador though, as the only MRI machine in the public health care system is at the children’s hospital. There is no MRI machine available for the majority of adults in El Salvador.

Private Sector

About twenty percent of Salvadorans receive care from the private sector. The private sector is financed through social security, private insurance, and private pay (Coello, 2008). Concentrated in the country's three most populated departments, the private sector health facilities offer second and third level care.^{3,4}

NGOs and Church Sponsored Care

NGOs, which for the sake of this discussion include organizations funded by the church, are far ranging in structure and mission. Often NGOs are internationally funded organizations serving to provide services for the poor and promote social justice and community organizing. In El Salvador and other developing nations, NGOs often provide health care for free or at low costs. In El Salvador there are many health clinics sponsored by Catholic organizations. NGOs services often develop to response to a void in services available in poor and isolated communities (Cardelle, 2003).

³ El Salvador is divided into 14 departments that are further divided into 262 municipalities.

⁴ Primary or first level care includes health promotion, education, protection and screening. Secondary care includes emergency, acute, and critical care, as well as elaborate diagnosis and treatment. Tertiary, or third level care, includes rehabilitation, long-term care, and end of life care (Craven & Hirnle, 2006).

Common Illnesses and Diseases in El Salvador

The most common health problems afflicting the people of El Salvador take rise from a life of poverty. There are environmental and demographic factors that also affect the health of Salvadorans. For example, El Salvador has a tropical climate, which influences the rates of vector borne diseases. In 2001 El Salvador experienced two serious earthquakes. An earthquake with a magnitude of 7.6 struck on January 13, and a second with a magnitude of 6.6 struck on February 13 (Woersching & Snyder, 2003, p. 105).⁵ Many earthquakes have struck El Salvador in the last 100 years, but the two that struck in early 2001 were so far the most damaging. Some of the health problems facing Salvadorans that increased in incidence following the earthquakes included a dengue epidemic, diarrhea caused by rotavirus, *Vibrio cholera*, leptospirosis, and malaria infection (Woersching & Snyder, 2004).

In terms of rates of disease, the age distribution of Salvadorans is incredibly important. The International Programs Center of the United States Census Bureau estimated that in the year 2000, 58% of the Salvadoran population was under the age of 24. Forty-two percent of Salvadoran women age 20-24 have given birth before the age of 20. These statistics suggest the population growth rate, infant and child mortality and illness, and strain on the health system will continue to rise with population growth (United States Agency for International Development [USAID], 2008, p. 8).

Table 1 presents morbidity trends in El Salvador from 1990-2005. Following the table is a brief discussion of five of the most common health problems in El Salvador.

⁵ Earthquake magnitude reported using the Richter scale.

Table 1. Ten leading causes of illness seen in outpatient health clinics, by five-year periods: 1990-2005, El Salvador

Rank	Periods		
	1990-1994	1995-1999	2000-2005
1	Acute respiratory infections	Acute respiratory infections	Acute respiratory infections
2	Acute rhinopharyngitis	Intestinal parasites	Intestinal parasites
3	Influenza	Other disorders of the urethra and the urinary tract- urinary tract infections, site not specified	Other disorders of the urethra and the urinary tract- urinary tract infections
4	Intestinal parasites	Ill-defined intestinal infections or diarrheal disease	Ill-defined intestinal infections or diarrheal disease, or presumably infectious gastroenteritis
5	Ill-defined intestinal infections or diarrheal disease	Bronchitis not specified as acute or chronic, acute lower respiratory infections	Bronchitis not specified as acute or chronic, or bronchiolitis
6	Other disorders of the urethra and the urinary tract	Essential hypertension	Acute and chronic gastritis and duodenitis (diseases of the stomach and duodenum)
7	Acute pharyngitis or acute pharyngotonsillitis	Infection of the skin and subcutaneous cellular tissue, or skin infections	Mycosis
8	Bronchitis not specified as acute or chronic	Acute rhinopharyngitis	Non-inflammatory disorders (diseases) of the female genitalia
9	Colitis, enteritis, gastroenteritis	Asthma and unspecified bronchial spasm	Migraine – tension headache
10	Bronchopneumonia	Vaginitis	Trauma to different parts of the body

(PAHO/WHO, 2007, p. 12)

Respiratory Problems

In rural areas, meals are cooked over open wood burning fires. This cooking method leads to respiratory problems for those who do the cooking, mainly women and children (Renner, 2008). Respiratory problems account for more than half of the illness episodes reported in El Salvador (Lewis, Eskeland, & Traa-Valerezo, 1999, p. 19).

Nationally, pneumonia is one of the most common causes of morbidity and mortality (PAHO/WHO, 1998).

Malnutrition

The national chronic malnutrition rate in El Salvador is 11.2%, with rural areas facing rates twice as high (14%) as urban areas (7.2%) (PAHO/WHO, 1998, p. 263).

Malnutrition in childhood can cause stunting, impaired cerebral development, underdeveloped motor skills and decreased resistance to infection. The children most affected are those in poor, indigenous, and rural communities.

There are several factors that contribute to malnutrition in El Salvador and other Central American countries, but lack of food is not one of them. Contributing factors include: poor maternal health, inappropriate infant care and feeding, and lack of access to clean water and sanitation. Supply side factors include exhausted land, lack of crop diversity, and limited staple foods. There is also an abundance of corporate agriculture that ships food outside of the country, rather than supplying food for Salvadorans. This agricultural structure raises the cost of food in El Salvador. For someone living on less than a dollar a day, even the most basic food items are often out of reach financially.

Mental Health Problems

According to the Pan American Health Organization, the most common mental health problems in El Salvador are depression, anxiety disorder, and alcoholism (PAHO/WHO, 1998). As was mentioned early, it is estimated that close to one fifth of Salvadorans suffered symptoms of post-traumatic stress disorder (PTSD) following the war. Other factors affecting the mental health of Salvadorans are natural disasters and a general feeling of lack of control. The two large earthquakes that struck El Salvador in 2001 caused a great deal of damage in El Salvador , and the Pan American Health Organization estimates that over 20% of the population affected by the earthquakes

required mental health assistance (PAHO/WHO, 1998, 264; Woerschling & Snyder, 2004).

For people living in poverty there are few choices in life. Lack of education, lack of economic opportunities, poor access to food and insufficient availability of health care are all factors that contribute to stress and anxiety. Another less obvious factor is the loss of native culture. In the PBS documentary, *Unnatural Causes*, Dr. Donald Warne discusses how loss of language, livelihood, land and traditions has led to identity and self-esteem issues and depression in Native American populations (Fortier, 2007). It is clear upon arrival in El Salvador there is a strong U.S. influence. This is evidenced by the fast food chains, American pop-culture references, and even the use of the U.S dollar as the national currency.

Stress contributes not only to the development of mental health issues, but also plays a significant role in the deterioration of physical health. Dr. Jack Schonkoff, Director of the Center on the Developing Child at Harvard University, uses the term ‘toxic stress’ to describe the effect of stress on a developing child. Toxic stress is negative stress that lasts for days, weeks or longer while the child has no coping mechanism available. This triggers the flight or fight response, which chemically affects development of brain circuitry (California Newsreel, 2008). Chronic stress also negatively affects birth outcomes and increases risk of heart disease and alcoholism.

Violence and Injuries

In 1994 external causes of death were the second leading cause of mortality in El Salvador accounting for 19% of deaths. Eighty-three percent of these deaths occurred in males with accidents and homicide as the leading causes. Based on 1994 data, external

causes accounted for 41% of deaths in children, 46% of deaths in adolescents, and 35% of deaths in adults (PAHO/WHO, 1998, p. 264).

Communicable Diseases

In 1995 dengue fever reached an epidemic level in El Salvador. There were 9,529 cases of dengue fever, and 129 cases of dengue hemorrhagic fever identified. While malaria is present throughout Central America, the reported cases in El Salvador remain low. In 2003 the malaria rate was 1 case per 100,000 people. In 2006 there were 3,385 reported cases of tuberculosis (USAID, 2008, p. 7). The first reported case of Cholera in El Salvador was in 1991, and over the next four years there were a total of 35,358 reported cases. Parasitic intestinal diseases and diarrheal diseases are consistently among the leading causes of morbidity in El Salvador (PAHO/WHO, 1998, p. 264).

Rural Life

As is the case in the United States, the difference between life in urban rural areas of El Salvador is drastic. Rutherford and Roux (2002) described rural El Salvador as “[having] a lifestyle that dates to the pre-industrial, pre-technological era” (Rutherford and Roux, 2002, p. 6). Most families are supported by subsistence farming, which is primarily a man’s role. Women are mostly stay at home mothers and sometimes sell produce or crafts. Home ownership by families is high but the features in homes vary greatly from family to family. The study by Lewis et al. found that many homes had dirt floors, 19% of homes had piped water, 50% had electricity, and less than 5% had pick-up trucks (Lewis et al., 1999).

It is worth noting that during the civil war that lasted from 1980-1992, approximately one-third of the population of El Salvador, or 1,700,000 people were internally displaced or sought refuge in other countries (USAID, 2008, p. 8; Meyers et al., 1989).⁶ Residents living in and around conflict zones were seen by the Armed Forces of El Salvador as support for the rebel opposition forces, the FMLN, regardless of age and gender of residents. Many rural villages in El Salvador today are considered “repopulated,” in that displaced persons returned after the peace accords were signed in 1992.

Rural Healthcare

According to the United Nations Development Project, physician to population ratio is a key indicator of the state of health care. In the United States, a Health

⁶ The United Nations defines internally displaces persons as individuals or groups who have been forced to flee their homes to escape armed conflict, generalized violence and human rights abuses. Civilians are considered refugees when the cross an international frontier to seek sanctuary in another country (United Nations High Commissioner for Refugees, 2007).

Professional Shortage Area is a geographic area that has a ratio of more than 3,500 persons per one primary care physician (Zimmerman, McAdams, Halpert, 2004, p. 220).

In rural El Salvador, there are only four doctors for every 100,000 residents, or one doctor for every 25,000 people (Coello, 2008). On the national level, there are 124 physicians per 100,000 Salvadorans (UNDP, 2005, p. 237). At one private hospital in San Salvador, Hospital de Diagnostico, there are at least two doctors on each floor at all times – in a hospital only capable of treating thirty-two patients at a time, or a 1 to 4 physician to patient ratio (M. Lopez, 2008).

Challenges for Rural Health Care

Many of the factors that limit access and quality of care in rural areas are also present in urban areas. For instance, poverty, unemployment, underemployment, under resourced clinics, and overcrowded facilities are issues in both urban and rural settings. There are additional factors unique to rural areas that complicate health care delivery. Some of the biggest challenges to the U.S. rural health system are physician shortages, transportation issues, and special health threats based on occupation. These are all problems that are very relevant to the health of people in rural El Salvador, and elevated due to the extreme poverty faced by the Salvadoran people.

Health Promoters

Health promoters serve to provide basic care to rural communities, with a focus on women and children. Health promoters are trained and coordinated either through NGOs or the MSPAS. During the war health promotion efforts were primarily the responsibility of NGOs. The 1999 study of rural health care strategies in El Salvador by

Lewis et al. found that NGO health promoters are generally better equipped than their MSPAS counterparts.

In order to become a health promoter, one completes four years of primary education and twelve weeks of health training. Following the twelve week health training there is no requirement that health promoters complete continuing education. The most common tasks completed by health promoters are vaccinations for children, treatment of diarrhea and dehydration, and providing peri-natal education (Lewis et al., 1999).

Lewis et al. reported many concerns that rural villagers expressed about health promoters. Health promoters often travel from village to village, and do not form bonds with the people in the villages that they provide care for. The relationship is strained because of villagers' hesitation to trust promoters because they are not physicians. Another common complaint from villagers is that promoters "preach" about making changes that are out of their control (Lewis et al., 1999).

Private vs. Public Health Care

This section will provide an observational comparative analysis of three health care settings in El Salvador; urban/public, urban/private, and rural. The data were collected on tours of two hospitals in the capital city of San Salvador and a visit to a rural health care clinic. The variables I will be comparing are: waiting rooms, patient rooms, family relations, mode of payment, physical appearance, patient transportation and additional observations.⁷

Facility Information

Built in 2001, the Hospital de Diagnostico (Diagnostico) is a private hospital in El Salvador. Diagnostico operates several clinics so that the hospital can treat only emergencies and has four treatment areas within the hospital. Total there are thirty-two patient rooms in Diagnostico, fifteen are reserved for stable care patients. Owned by the hospital's physician group, the physicians at Diagnostico are the best paid in their area of San Salvador (M. Lopez, 2008).

Hospital Rosales (Rosales), a public hospital funded by the MOH, was constructed in 1897. Rosales is the oldest and largest public hospital in El Salvador. As a third level reference and teaching hospital, Rosales does not treat minor conditions, but operates a walk-in clinic for treatment of minor ailments. There are 525 patient beds at Rosales. Several parts of Rosales were damaged in the 2001 earthquakes. In order to rebuild the damaged facilities, the MOH applied for grants from various countries. After five years of searching, Japan offered a grant to build one area under the terms that the Ministry would build two areas themselves (Funes, 2008).

⁷ Our visit to the rural health care clinic followed a different format than our visits to the urban hospitals. I was not able to obtain comparable information about the rural clinic for some variables.

To discuss the rural healthcare situation in El Salvador I will draw on examples from the small, repopulated community of Ita Maura (formed in 1991) and the nearby town of San Pablo Tacachico. In Ita Maura there is a small building used as the community health clinic. Inside there is very little to see; a stack of building supplies, an exam table, an empty cabinet, and two toilets that are partially installed. Once a month a health promoter comes to the community to do immunizations and provide basic care. For the people of Ita Maura, the next closest health clinic is in the town of San Pablo Tacachico (T.R. Lopez, 2008).

In San Pablo Tacachico there is a health clinic funded by the Ministry of Health, so patients are not required to pay for care. The Tacachico clinic serves 32,000 people has three doctors, three nurses, and one clinical lab worker (T.R. Lopez, 2008).

Waiting Rooms

At the private hospital, we entered the air-conditioned waiting room to find flower arrangements on side tables, clean upholstered chairs, and paintings on the walls. Both sets of doors, those leading outside as well as those leading into the emergency department, were sliding automatic glass doors. There were less than ten people in the waiting room, and there were enough chairs for 20-30 people total.

The waiting area at the public hospital served as our introduction to the drastic differences between these two hospitals. At the public hospital the waiting area is outdoors. There are no walls but an awning covers the area. Every day 800 people pass through this waiting area (Funes, 2008). They sit for hours on plastic chairs, lined up in rows all facing in one direction. Food vendors have carts set up along the walkway.

Patient Rooms

Patient rooms in the private hospital are designed to accommodate the patient's family. Like most hospital rooms in the United States, the room is equipped with the basic needs of the patient; a bed, monitoring equipment, and a restroom. Other features include two chairs, a couch, a TV, a switch for air conditioning, and a mini-refrigerator. A door opens to a small balcony with a bistro set and a decorative tree. Every patient room in Diagnostico is a single room.

There are no patient rooms at the public hospital. Instead there are patient wards or corridors. All the patients being treated under a service area are lined up in one large corridor, there are no partitions separating one patient from another. Some beds have curtains that can be pulled around them. In the room we entered there was a small station at the front where nurses were preparing food and drinks for the patients; flies were swarming around the stand.

Patient and Family Relations

As the previous section explained, the private hospital's patient rooms were designed to accommodate the family. In the public hospital where there are no individual rooms, there are strict guidelines regarding visiting hours. Each patient can have visitors between the hours of one to three in the afternoon. There are two visitor passes for each patient, so only two visitors can be in the hospital at a time. If there are more family members that would like to visit the pass must be passed from person to person. This means that no family members can stay at the hospital overnight (Funes, 2008).

Due to budget restraints the clinic in San Pablo Tacachico is only open during the day. Because the clinic closes at night, patients can only be treated for eight hours. If

more treatment is needed at closing time, a patient must be transported to a hospital (Physician, 2008).

Mode of Payment

At the private hospital, eighty to ninety percent of costs are covered by social security or private insurance. When patients enter the hospital they are asked to give their insurance card. If they do not have their insurance card on them, they can give a down payment to ensure care until insurance is proved (M. Lopez, 2008). Visa cards are accepted as a method of payment.

The Ministry of Health pays for the public hospital and the clinic in San Pablo Tacachico. There is no requirement that patients pay to receive treatment in facilities funded by the Ministry. The hospital does ask that patients make a donation if they are financially able, but few patients are able to make any donation.

Physical Appearance

The private hospital's walls were covered in clean crisp wallpaper. The floors were covered with white tile that shined. There were paintings on the walls; showcases for pottery. A hallway waiting area had marble benches; another had plush couches around wooden tables with dark finish. The entire facility was impeccably clean. We passed very few people as we walked through the hospital. Most of the people that we saw were staff sitting behind desks.

At the public hospital the walls were covered in neutral colors of paint, and covered with scuffmarks. There was garbage on the floor, and rags in many doorways. There were patients, doctors, nurses, medical students, and visitors everywhere. Most of the walkways are outdoors. There are wards on either side of a center garden courtyard.

Patient Transportation

The private hospital has its own ambulance for internal use; it does not go out on general emergency calls. The ambulance can be used to transfer a current patient to another facility, or to pick up a former patient from their home. When a returning patient calls for pick-up, the ambulance leaves the hospital with a nurse and a physician on board who are prepared to meet the needs of the patient (M. Lopez, 2008).

Patients traveling to Hospital Rosales have transportation options based on their financial abilities. Many families in San Salvador own cars or bicycles. There are also buses and taxicabs in the city that individuals could use to travel to the hospital.

Transportation is much more of an issue in the rural areas. Most people in rural El Salvador don't have automobiles, and if someone in their community does have one, the price of gasoline is likely to prevent an individual from seeking care.⁸ Rural roads are rarely paved and become difficult to travel when damaged by weather. This is a common problem for rural health care everywhere. Even when there is an option for care available, the opportunity cost of traveling to receive care must be considered.

Other Observations

One of the biggest problems facing Rosales is a shortage of medicines. On August 15, Rosales was already out of its monthly supply of medicine. Dr. Virginia Funes, our guide, explained to us that Rosales does not receive donated medicines, except when occasionally a donor will try to give expired medicine (Funes, 2008). Without medications to give its patients, a hospital is extremely limited in treatment options.

⁸ About \$.60/gallon higher than U.S. gas prices when I was in El Salvador in August 2008.

When a patient cannot receive the medicine that they need from the hospital, the patient can be referred to the pharmacy where the price of medicine is very expensive.

A detail that really illustrates the disparities in this health care system is the sheer number of people in Rosales; the hospital has 525 beds and is always at 100% capacity (Funes, 2008). While I was on a tour of Diagnostico, there were no patients in the intensive care unit. The hospital with beautiful decorations, top of the line equipment, and only thirty-two beds, wasn't even at full capacity. It's hard not to wonder how useful could the financial resources that developed this facility have been if used in a different way; if a more modest facility had been built, that would be less costly, and more accessible to more people. With financial assistance Hospital Rosales could have more quickly repaired some of the earthquake damage done to their facilities, or bought an MRI machine so that there would be one available for adults in the public sector of the health system.

Discussion

There are two factors that have an effect on all aspects of health delivery in El Salvador; preventative care and the cost of medicine. Part of the reason that the health care system is flooded in El Salvador is the absence of preventative care. The government of El Salvador invests less than \$200 per year per person into public health spending (Coello, 2008).

The clinic in San Pablo Tacachico can offer no preventative medicine because it is too expensive. All conditions are treated once they develop, including diarrhea and dengue fever. Because El Salvador lacks the financial resources to properly educate and prepare communities about health, the country is by default using a curative model of medicine (Physician, 2008). For a routine, preventative trip to a doctor, sometimes the wait can be three to six months (Oti, 2008). As care is delayed medical conditions become harder to treat, and as is sometimes the case, the patient could die before receiving any care.

It is not surprising that the Ministry of Health and individuals in El Salvador have a difficult time paying for medicine. According to one doctor that we spoke with, the price of medicine in El Salvador is far higher than the price of medicine in other Central American countries. Even medicines produced in El Salvador sell for lower prices in other countries. Drug prices are high because there is no law regulating the price of drugs or the profit margins that pharmaceutical companies can make (Coello, 2008).

Comparisons and Parallels to the United States

El Salvador represents a more drastic example, but there are many similarities that can be drawn between the challenges to the Salvadoran health care system and the U.S. health care system. Close to twenty percent of Americans don't have health insurance (National Coalition on Health Care, 2009). For these individuals the cost of health insurance and the cost of private pay for health care is too expensive. Many families are forced to make decisions between paying for care, paying for prescription drugs, or paying for food and rent.

The U.S. also lacks a focus on preventative medicine and public health measures. A report released by the Trust for America's Health projected the return on investment of increased spending on community-based programs to increase physical activity, improve nutrition, and prevent tobacco use. The study projected that an investment of \$10 per year per person could save the country \$16 billion annually within five years; or a return of \$5.60 for every \$1 invested (Levi, Segal, & Juliano, 2008). It would be interesting to see the figures in a similar report about El Salvador, using programs to increase access to potable water, complete nutrition, and improved patient education.

A parallel can also be drawn between the hopes for health care reform as a result of the recent national elections in each country. Since taking office President Obama has expressed that providing access to affordable healthcare for all Americans is a top priority for his administration. In El Salvador there has been debate about whether or not to privatize health care. The left-wing party, the FMLN, developed a health care platform that included increasing investment in health care, creating universal health

coverage and taking away the MOH clinical function, increasing the quality of health services, and ensuring that all resource needs are met (Coello, 2008). In March 2009 the FMLN presidential candidate, Mauricio Funes, won the election in El Salvador (BBC News, 2009).

Conclusion

Our guide at Hospital Rosales said, “[In El Salvador] the rich have freedom to live, and the poor have freedom to die” (Funes, 2008). The new political leadership in El Salvador has a choice to make, should they continue to support a health care system that leaves 80% of Salvadorans unable to access adequate medical care and prescription drugs? If a government sponsored hospital in the center of a capital city like San Salvador cannot offer prescription drugs to patients that pass through their doors, what kind of message does that send to the average Salvadoran?

Despite the problems with the health care system in El Salvador, something I read during my research struck me as symbolic and powerful. In 1985, in the midst of civil war, then Salvadoran president Duarte brokered a deal with the FMLN to orchestrate a series of cease-fires to allow children to receive immunizations. Periodic cease-fires continued until the signing of the peace treaties in 1992. Today El Salvador has a strong national program for immunizing children. Immunizations are free for everyone, and close to 100% of Salvadoran children are immunized (World Health Organization, 2001). If two sides in the middle of a brutal civil war can agree to set aside their differences briefly to allow for the accomplishment of a common goal, then why can't a similar process be used during a time without war?

With an FMLN president in power, it could be time to work toward accomplishing another common goal as a country such as improving access to potable water in rural areas or requiring continuing education for health promoters. Perhaps the new leadership should consider systemic changes. Dr. Benjamin Coello, who spoke with us in El Salvador, explained that the FMLN would like to take away the clinical function

of the Ministry of Health. Should this happen, NGO and church sponsored alternatives could expand with the MOH acting as an oversight board. Another option the leadership could consider would be to introduce more academic medicine to El Salvador. A clinician who is trained in the area they are from is more likely to stay in that area to practice medicine after completing their education than one that had to move to another area. Creating more programs to train physicians, nurses, and health promoters in El Salvador could increase the number of qualified health care workers in the country (Tesson, Curran, Pong, & Strasser, 2005).

For me this field study served as a powerful introduction into the realities of global health. As a student I am accustomed to reading about local, national, and global health problems, but until I saw the facilities and people with my own eyes there was a disconnect. Studying statistics and theories is informative, but looking into the eyes of people who are suffering and speaking to individuals who work every day to try to improve their lives is a learning experience that has left its mark on me. My thanks goes out to all of the people we met in El Salvador that opened their doors and their hearts to us; they made this trip the amazing learning experience that it was.

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