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Costa Rica and El Salvador: Finding the Appropriate Role for the Public and Private Sectors in Poverty Reduction

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Executive Summary

The health-sector reform in Costa Rica and the education reform in El Salvador both succeeded by decentralizing responsibility and accountability for service delivery to local and private actors while strengthening the policy and regulatory responsibilities of the public sector. Both countries introduced systems with greater built-in incentives and accountability mechanisms, a more balanced mix of public and private social intervention, and more cost-effective services. These reforms have improved the targeting of services to the poor and have greatly improved the poverty impact and sustainability of public spending in their respective sectors.

The context for reforms: economic performance, social public spending, and poverty

Most of the five countries of Central America have widespread poverty and a highly concentrated distribution of income. Nevertheless, there are marked differences among them. Costa Rica, with a per capita income of nearly \$4,000, ranks higher on the UNDP's Human Development Index (HDI) than the other countries; El Salvador, with a per capita income of \$1,752, is in an intermediate position.

Conflict engulfed the region during the 1980s. In El Salvador, the civil war cost more than 70,000 lives, drove tens of thousands of people from the country, and severely affected the economy. By 1989, GDP was 32 percent below its 1978 level. Costa Rica, with a long-standing commitment to democratic values and the only country in the hemisphere without a standing army, avoided internal conflict, but it was still affected by the surrounding conflict and, like many other Latin American and Caribbean countries, experienced a debt crisis during the 1980s. But economic growth improved dramatically in the 1990s, and by 2000 Costa Rica's real per capita income was 25 percent higher than in 1978. El Salvador's was still 10 percent below its preconflict peak.

Historically, Costa Rica and El Salvador have pursued different policy approaches to improving social indicators and reducing poverty. While both have relied on growth as a driver of poverty reduction, Costa Rica has accorded the state a central role in financing and delivering social services, while El Salvador has relied on a mix of the public and the private sectors. Reflecting these differences in approach, Costa Rica's social public spending was 16 percent of GDP in 2000, one of the highest levels in Latin America. El Salvador's was about 11 percent of GDP, or one-third below Costa Rica's. In Costa Rica, with its long tradition of higher social public spending, the poverty rate has been only half that of neighboring El Salvador. But during the 1990s, both countries succeeded in reducing poverty significantly: El Salvador down to 40 percent of its population, and Costa Rica down to 20 percent

Costa Rica's health sector reform

Costa Rica's health sector has long been dominated by the public sector, and while public interventions in health in Latin America have often had poor outcomes, Costa Rica's have

achieved impressive results. The country's 1949 constitution required the state to finance and ensure the provision of far-reaching social services to the people. A result of this mandate was the establishment of a universal health system, which gave the state an overwhelming presence in the health sector. Starting in the 1960s, efforts to strengthen the health system focused on public sector financing and delivery. A single public institution—the Caja Costaricense de Seguridada Social (CCSS)—was the sole provider of health insurance, and the Ministry of Health and CCSS provided most of the curative and preventive services.

By the early 1990s, the health system was under serious financial strain and not fully responsive to evolving needs. But the successful reforms implemented during the 1990s ensured that the achievements realized in the previous decades were not only sustained but also improved upon—and with less public spending

Costa Rica has transformed its health system from a supply-based to a population-based model. It has introduced performance contracts for health providers and a clearer division of responsibilities among institutions, thereby increasing accountability. The coverage of primary healthcare has been expanded. At the same time, public health spending has been reduced from 6.7 percent of GDP in 1990 to a more affordable 5.3 percent. The reform has increased the share of health spending allocated to poor neighborhoods and to primary healthcare. In real terms, between 1997 and 2000 spending for primary healthcare rose by 82 percent, while spending for specialist and hospital services rose by only 20 percent; meanwhile, hospital productivity improved. The overall efficiency of public spending has risen, and health outcomes have improved. Over the 1990s, Costa Rica raised life expectancy by two years, to 77.5 years, and reduced infant mortality rates from 15 to 10 per thousand—one third of the average rate in Latin America and the Caribbean.

El Salvador's education reform

El Salvador's education system, weak at the start of the 1980s, was further severely debilitated by the country's 12 years of conflict. By the end of the 1980s, more than one-fourth of the population was illiterate; 20 percent of the primary-school-age children were not reached by the system, especially in the rural areas most affected by the war; and school dropout and repetition rates were high. Since the early 1990s, El Salvador has implemented a successful reform program that has significantly improved educational outcomes. The reform was supported by a series of sector loans from the World Bank.

El Salvador's education reform has transferred resources and decision-making capacity to schools and empowered communities and parents. Schools receive support for teacher training and administration, as well as for purchase of inputs to improve educational quality. Teachers' job security and pay depend on their performance. Public spending on education has risen significantly, from 1.9 percent of GDP in 1992 to 3.3 percent in 2002, reaching the average for Latin America and the Caribbean. The share of basic education has increased—from 71 percent of the government's education budget in 1996 to 75 percent in 2001—while the share of higher education has been reduced. The geographic distribution of basic education resources favors low-income, and especially rural, areas. Over the 1990s, the reform has permitted El Salvador to

significantly increase the primary enrollment rate (from 81 to 111 percent), to double the secondary enrollment rate (to 50 percent in 2000), and to greatly reduce repetition and dropout rates.

Key factors of success

Both the reforms reviewed here have helped to improve social indicators and reduce poverty. In keeping with Costa Rica's tradition, that country's approach to health reform has focused more on public sector financing and delivery of services; El Salvador in its education reform has relied more on stakeholder involvement under strong public sector leadership. Some of the general lessons from both experiences are:

- *Both the public and the private sector have critical roles to play in improving social indicators and reducing poverty—neither can do it alone effectively.* The government of Costa Rica succeeded in making public spending more efficient in the health sector by redefining the responsibilities of the main public sector actors, expanding private sector provision, and by improving the incentive and accountability mechanisms. El Salvador's successful education reform was made possible by effective government leadership, strong stakeholder participation in service delivery, and strong private support to the reform process, together with increased public financing to the sector.
- *A strong national commitment to the reforms is needed.* The governments of both countries spent considerable time and effort to build broad national support for reform. Without such government leadership and effort to promote dialogue and consensus building for change, the sustainability of a reform effort is compromised.
- *Efforts to ensure efficient and effective resource use are critical.* Given that most countries face severe fiscal constraints, social programs must be cost-effective and targeted to the poor. The public sector must ensure that social services are adequately financed and that they draw on the private sector and local actors to help deliver social services in a competitive, efficient, and accountable way, while promoting stakeholders' social auditing of resource use.

Key factors in the success of these reforms are based on balancing public and private participation in providing social services. Social development policies emerge from a country's historical conditions, the state's social contract with its citizens, and the relative strength of community organizations, the private sector, and other actors. But there appears to be a consensus that governments should have the responsibility for financing basic social services and for ensuring that poor have access to these services, even if the services are provided by the private sector, NGOs, or other groups that give guarantees that the services are delivered in an efficient and accountable way. El Salvador and Costa Rica have done this in their own ways by:

- *Developing a clear vision of social sector strategies.* This is fundamental to forge a strong political commitment to see the strategies implemented and, to the extent possible, ensure their continuity as governments and public officials change.

CASE STUDIES IN SCALING UP POVERTY REDUCTION

- *Ensuring that social policies and programs are technically sound.* The design of strategies, policies, and programs is a complex technical undertaking that should be based on a thorough diagnosis of the state of the sector—and of alternative options and their costs.
- *Engaging in dialogue and consensus building.* Consultation and discussions need to ensure that participants have influence in the definition of the proposed strategies, policies, and programs. Too many consultation and consensus-building processes fail because they are conducted as mere public relations exercises.
- *Securing the support of critical stakeholders.* This is particularly important when sectors are highly politicized or controlled by workers or interest groups opposed to changes that they perceive to threaten their privileges.
- *Decentralizing delivery systems and empowering beneficiaries.* To make empowerment meaningful, local actors and stakeholders must have control over resources and decision-making.
- *Modernizing and decentralizing the ministries or other public institutions.* Institutional reform and decentralization are essential complements to the transfer of resources and responsibilities to other layers of the system. This ingredient of the reform process is often delayed because it requires complex changes in large institutions and strong political commitment.
- *Establishing incentive and accountability mechanisms.* A clear set of incentives for institutions and staff to perform efficiently and effectively must be put in place and perverse incentives eliminated. The private sector will be reluctant to participate in social sector development if the “business plan”—including how resources will be used and accounted for—is not clear. Social auditing by key stakeholders has proven to be an effective instrument to improve control over resource use.

Introduction

This case study explores the experiences of Costa Rica and El Salvador with social sector reform and success in improving social indicators and reducing poverty, within an environment of regional post-conflict reconstruction. Historically, the two Central American countries have pursued different policy approaches to improve social indicators and reduce poverty. While both have relied on growth as a driver of poverty reduction, Costa Rica's has given the state a central role in the financing and delivery of social services, while El Salvador has relied on a mix of the public and the private sector. This study discusses Costa Rica's and El Salvador's recent efforts to reform the health and education sectors, respectively. It shows that both countries have improved outcomes by: (a) developing a clear vision for the sector and enjoying support from key stakeholders and civil society and (b) pursuing a sector reform that gave more responsibility and accountability for service delivery to local and private actors while strengthening the public sector's policy and regulatory responsibilities. Both countries have achieved systems with greater built-in incentives and accountability mechanisms, a more balanced public/private social intervention mix, and more sustainable outcomes. After this brief introduction, the discussion is organized in four sections. Section II reviews the recent growth, public social spending and poverty record; Section III discusses the health reform in Costa Rica; Section IV discusses the education reform in El Salvador; and Section V summarizes the lessons learned.

Table 1. Population and Key Development Indicators, 2000 a/

	Total Population (Millions)	Population 0-14 years old (percent of total)	Per capita income (Constant 1995 US\$)	Human Development Index b/	Human Poverty Ranking c/	Income share held by lowest 20 percent	Income share held by highest 10 percent
Costa Rica	3.8	32.4	3912	0.820	2	4.5	34.6
El Salvador	6.3	35.6	1752	0.706	32	3.3	39.5
Guatemala	11.4	43.6	1558	0.631	40	3.8	46.0
Honduras	6.4	41.8	711	0.638	36	2.2	42.7
Nicaragua	5.1	42.6	466	0.635	41	2.3	48.8
CA	33	39.2	1680	N/a		3.2	42.3
LAC	515.7	31.5	3856	N/a		N/a	N/a

a/ Estimates of income shares are for 1998

b/ Human Development Index (HDI) is a summary measure of human development that takes into account three dimensions of development: a long and healthy life measured by life expectancy at birth; knowledge measured by education enrolments and literacy; and decent standard of living measured by per capita income.

c/ Ranking from a sample of 88 developing countries

Source: World Bank's World Development Indicator (WDI) and UNDP's web page for the Human Development Index (HDI)

Costa Rica and El Salvador together with Guatemala, Honduras, and Nicaragua comprise Central America (CA). The five countries have a total population of 33 million. Their per capita income averaged US\$ 1,680 in 2000 (in constant 1995 US\$), less than one-half of the average for Latin America and Caribbean (LAC). In most countries, poverty is widespread and the distribution of income is highly concentrated (**Table 1**). Nevertheless, there are marked differences between the countries. According to the UNDP's Human Development Index (HDI), Costa Rica has achieved a much higher development than the other countries; El Salvador is in an intermediate position; and Honduras, Nicaragua, and Guatemala are at the bottom.

Conflict engulfed the region during the 1980s. Internal dissension that had simmered in Central America for decades worsened in the 1970s and erupted into open confrontation in the 1980s in El Salvador, Nicaragua and Guatemala. In **El Salvador**, the conflict would cost over 70,000 lives and drive tens of thousands of Salvadorans out of the country. **Costa Rica** with a long-standing commitment to democratic values, no standing army, and far-reaching *Social Guarantees* for the people given by the 1949 Constitution, avoided internal conflict though it was adversely affected by the regional turmoil.

A regional peace plan unveiled in 1987 by President Arias of **Costa Rica** was adopted by the Central American Presidents. This watershed agreement that earned President Arias that year's Nobel Peace Prize, charted a course for national reconciliation in the post-conflict phase. In February 1990, Violeta de Chamorro was elected president of Nicaragua, marking the end of the confrontation between the Sandinista regime and the opposition known as *Contras*. In **El Salvador** the government and the guerrilla movement (FMLN) reached a peace agreement on January 16, 1992 and the FMLN became a political party. In Guatemala a peace accord was signed in late 1996. All three countries immediately launched reconstruction programs to help rebuild their shattered social and economic fabric. El Salvador began building its democratic institutions and free elections have been held since then.

Economic Performance, Social Public Spending and Poverty

While economic growth is an important determinant of poverty, investment in human capital, particularly in the education and health of the poor, is the key determinant of sustained poverty reduction. While growth has been a driver of poverty reduction in both countries, this section shows that Costa Rica has achieved better poverty results as it maintained higher levels of social public spending, though its fiscal situation has been strained. On the other hand, El Salvador spends less on the social sectors and has higher poverty, but in recent years it has increased social public spending with improved poverty outcomes, while maintaining a stronger macroeconomic framework.

Growth and Public Spending

The internal strife had a severe impact on **El Salvador**'s economy. During the first half of the 1980s, GDP per capita dropped sharply and by 1989 it was 32 percent below its 1978 level (**Table 2**). **Costa Rica** faced the impact of the regional conflict and experienced a debt crisis as many other Latin American and Caribbean (LAC) countries during the 1980s. By 1989, Costa Rica's real per capita income was 6 percent below its level in 1989, evidence of the "lost decade", as the 1980s are known in LAC. In the 90s, the situation has changed dramatically, for the better. In **El Salvador**, growth accelerated rapidly particularly after the 1992 Peace Accord, though it has since 1995 slowed down; in **Costa Rica**, GDP growth has remained strong during the whole period in part owing to significant foreign direct investment in mid-90s, though it has also slowed down in the last three years. Nonetheless, the impact of internal conflicts are lasting; by 2000, El Salvador's real per capita income was still 10 percent below its 1978 pre-conflict peak, while in Costa Rica it was 25 percent higher than in 1978.

Table 2. GDP Growth, 1980-2000 (Annual simple average, percent)

	1980-84	1985-89	1990-94	1995-00
Costa Rica	0.4	4.0	5.4	4.8
El Salvador	-5.2	1.2	5.9	3.5
LAC	1.2	2.6	3.3	2.7

Source: World Bank's World Development Indicators (WDI).

Costa Rica total public spending reached 23 percent of GDP in 2000 (Table 3). Social public spending (social sector plus social protection) equivalent to 16 percent of GDP and to over two-thirds of total public spending in 2000, was among the highest in LAC. In El Salvador total public spending at 16 percent of GDP in 2000, was one-third lower than Costa Rica. Public social spending has increased in recent years and reached about 11 percent of GDP, or two-thirds the level of Costa Rica. This marked difference in public spending in the two countries reflects the different roles of the State. While in Costa Rica the State has had a strong presence in the economy and in the social sectors, in El Salvador the private sector has had a more important role in these areas. Another illustration of these different approaches is that Costa Rica still has a strong public presence in banking, insurance and utilities, while in El Salvador these sectors have been privatized.

Costa Rica fiscal situation has been strained for many years and public debt continues to pose major challenges to the authorities. After declining to 2 percent of GDP in 1998, the fiscal deficit has increased to 5.4 percent of GDP in 2002. Total public debt has remained close to 60 percent of GDP, with the reduction in external debt being compensated by an increase in domestic debt. In **El Salvador**, the fiscal situation has been stronger for most of the 90s but deteriorated in 2001 owing to the large reconstruction expenditures associated with two major earthquakes. The Central Government deficit increased to 3.3 percent of GDP in 2001 but it is expected to decline below 2 percent of GDP in 2004.

Table 3. Social Public Spending, 1996-2000 (percent)

	1996	1997	1998	1999	2000
Costa Rica					
Total Public Expenditures/GDP	24.9	23.3	22.7	22.2	23.3
Social Sector Expenditures/GDP a/	10.9	10.7	10.6	10.5	N/a
Social Protection/GDP b/	4.3	5.0	4.9	5.4 c/	N/a
Social Sector Expenditures/Total Public Expend.	43.8	45.9	46.7	47.3	N/a
El Salvador					
Total Public Expenditures/GDP	15.3	14.8	16.0	15.1	15.7
Social Sector Expenditures/GDP a/	4.8	4.8	5.4	5.5	5.7
Social Protection/GDP b/	N/a	N/a	N/a	5.2 /	N/a
Social Sector Expenditures/Total Public Expend.	31.4	32.4	33.8	36.4	36.3

Note: Costa Rica public expenditures refer to General Government; El Salvador refers to Central Government.

a/ Social sector expenditures include education, health, housing and other social expenditures but exclude social protection.

b/ Includes pensions and social assistance programs

Source: “Costa Rica: El Gasto Social y la Pobreza”, World Bank, 2003, Table 36; Marques, José Silvério, “El Salvador: Evaluación de la Red de Protección Social”, processed, World Bank, April 2002, Table 5.2; Marques, José Silvério, “Central America: Social Safety Net Assessments- Cross Country Review of Principal Finding”, processed, World Bank, August, 2003, Table 9.

Poverty Trends

Poverty in El Salvador at the beginning of the 90s affected 60 percent of the households, twice Costa Rica’s poverty rate (Figure 1). Since 1992, Costa Rica has been able, from an already low base, to reduce its poverty rate by an additional 10 percentage points to 20 percent, while El Salvador’s poverty was reduced by 20 percentage points to 40 percent. What accounts for these poverty trends? Economic growth is an important determinant of poverty, but by not means the only determinant; social policies matter. Indeed, growth has decelerated in both countries in recent years and poverty reduction particularly in El Salvador continued at a fast pace. Therefore the social policies pursued by these countries may also help explain the poverty outcomes.

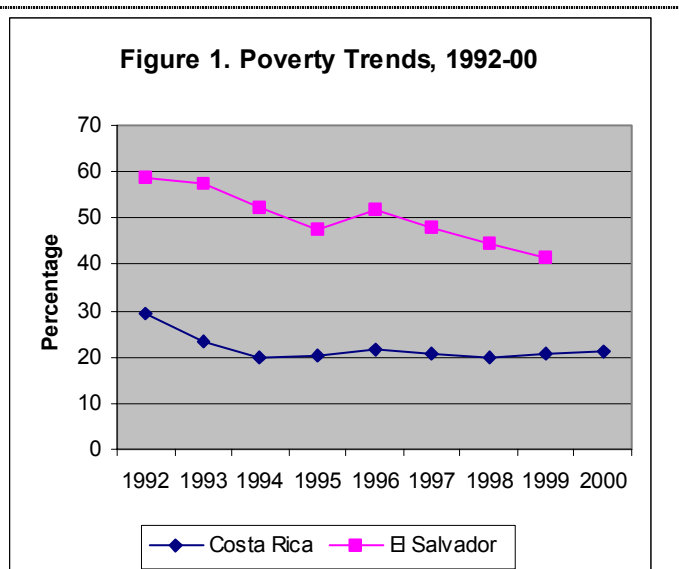
In sum, Costa Rica social public spending is much higher than El Salvador and its poverty rate one-half of its neighbor. This marked difference in public spending in the two countries reflects the different roles of the State. Since 1992, Costa Rica has been able to reduce its poverty rate by an additional 10 percentage points; El Salvador by 20 percentage points. While economic growth was an important determinant of these results, the successful social sector reforms implemented by these two countries also help explain the poverty outcomes.

Costa Rica's Health Reform

The Costa Rica health sector has been dominated by the public sector. While public interventions in Latin America have often been associated with poor outcomes, the health sector in Costa Rica has achieved impressive results. However, by the early 90s, the public health system was under serious financial strain. The successful reforms implemented since then, ensured that the achievements realized in the previous decades were not only sustained but also improved upon, and this with relatively less public resources. This section shows that the success of the health reform hinged on the strong government leadership in forging a national consensus that helped change the underlying accountability and incentive mechanisms of the public health system.

Sector Situation in 1990

An outgrowth of Costa Rica's constitutionally mandated *Social Guarantees* was a universal health system.¹ This gave the State an overwhelming presence in the sector. A single public institution—the *Caja Costaricense the Seguridad Social* (CCSS) was the sole provider of health insurance and the Minister of Health and CCSS provided most of the curative and preventive services. The private sector had a minor presence in the sector. In 1990, public health expenditures equivalent to 6.7 percent of GDP in 1990 were among the highest in Latin America and Caribbean (LAC). The public sector was responsible for 80 percent of total health expenditures and the private

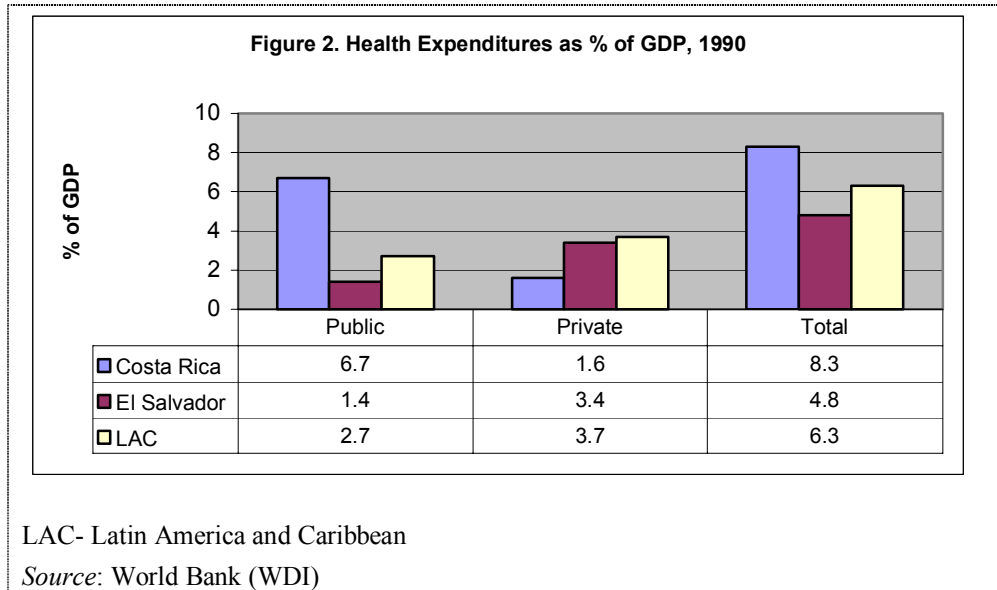


Note: For Costa Rica the poverty estimates are based on headcount; for El Salvador is based on households. To the extent that poor families are larger, household poverty estimates for Costa Rica would be slightly lower.

Source: “Costa Rica-El Gasto Social y la Pobreza” World Bank, 2003; “El Salvador: Poverty Diagnostic”, draft report, World Bank, April 2002.

¹ The public health insurance was established in the early 40s and a 1961 Constitutional amendment made it universal.

sector for the remaining 20 percent. This contrasted with the 43 percent public share of total health spending in LAC and with the 29 percent share in El Salvador (**Figure 2**).



The public health system had succeeded in improving substantially the health conditions in the country. Indeed, by 1990, health conditions in Costa Rica were among the best in LAC: life expectancy at birth was 8 years higher than LAC; mortality rates in infants and children under five, were about 4 times lower; severe malnutrition was minimal (0.6 percent of children under six years old); and health coverage reached 65 percent of the labor force.

However, by then, the demands on the system were becoming more complex as epidemiological and demographic profiles changed. These factors and the effects of the debt crisis of the 1980s exposed the health system to significant risks that threatened to reverse the gains made. Some of the underlying problems of the health system were its poor organization that undermined accountability and the lack of incentives to use resources efficiently and effectively. There were duplication and overlapping of services between the Ministries of Health and the *Caja Costaricense de Seguridad Social* (CCSS). The Ministry of Health had a strong presence in the delivery of primary health care through its health posts and mobile teams; CCSS had the public hospitals and clinics that operated in many of the same areas as the Ministry of Health posts. In clinics and hospitals productivity had declined, as medical staff had no rewards for performing better; indeed, since poor performance was not penalized, doctors sought to dedicate less time to their jobs and more to their private practices. Health costs had risen rapidly, ahead of funding; long waiting lists for diagnostic tests, surgeries and specialist care began to emerge, hospitals and medical equipment were deteriorated, and the staff was demoralized.

Sector Reform

To correct these problems, the Government of Costa Rica outlined a general reform of the health sector at the beginning of the 90s. The reform was intensively debated in the country and received the support from key stakeholders and from the broader medical community as well as from

Costa Rica's political parties. The World Bank loan that supported the implementation of the reform received a unanimous vote of approval from the legislature.

The reform focused on four priority areas: i) institutional reorganization; ii) management modernization; iii) a new healthcare model; and iv) reform of the financing model.² The institutional modernization sought to improve accountability by delimitating the areas of responsibility of major sector actors. The Ministry of Health shifted from a regulatory, financier and provider of services to become a regulatory and policy formulating agency. All remaining health care provision and financing became the sole responsibility of the CCSS. Within the CCSS, the reform involved separating financing and service provision functions. Hospitals, health posts and staff were transferred from the Ministry to the CCSS. In addition, the CCSS's financing, purchaser and providers functions were clearly separated and a new organizational structure was created for managing health services at regional and local levels. Inside the CCSS, the reorganization also aimed to encourage an administrative and functional separation of the health and pensions branches.

A new resource allocation mechanism was introduced with explicit incentives for performance. The primary healthcare system was reorganized into more than 90 Health Areas, each one with responsibility for the health of a population averaging 45,000 people. This change allowed increasing coverage in rural areas while improving efficiency. Private health cooperatives with the responsibility to provide integrated services in specific metropolitan areas were established. Performance contracts were introduced. For Health Areas, the contracts set payments based on historic per capita expenditures for primary care, while the performance contracts for hospitals established payments per activity based on the Hospital Production Unit (UPH). The budget assigned to each hospital is subject to their delivering agreed levels of activity, reflected in the UPH annual volumes. Under the scheme, 10 percent of the value of each UPH is retained in as incentive or compensation fund, whose payment is subject to fulfillment of quality and organizational goals established in the contract. By 1999, 21 hospitals, 34 Health Areas and 6 cooperatives had signed management contracts and for the year 2001 all health providers (29 hospitals, 92 Health Areas and 6 cooperatives) had management contracts with the CCSS.

The new health care model implemented as part of the reforms is characterized by an integrated and continuous approach to care to promote the health of people and the environment, with an emphasis on promotional and preventive actions executed by primary care providers. The population was divided into 92 Health Areas, with each geographic area averaging 40,000 to 50,000 people. Each Health Area provides support services of key specialists (in pediatrics, obstetrics, mental health and dermatology) as well as diagnostic services (lab and x-ray, predominantly). These Health Areas were in turn subdivided among basic health teams, *Equipos Basicos de Atencion Integral de la Salud (EBAIS)* consisting of 1 physician, 1 nurse and 1 primary care technician. The EBAIS provide coverage to between 1,500 and 4,000 people depending on the geographic conditions. Social participation is widely promoted in three areas:

² *Costa Rica- Gasto Social y Pobreza*, World Bank, 2003, page 99

self-care, implementing community activities for health promotion and prevention, and planning and management evaluation of health services.

A national health plan was developed based on an analysis of the health priorities at national level. The analysis established twelve priority programs including: acute respiratory infections, intestinal infections, arterial hypertension and cerebral-vascular disease, uterus and breast cancer, diseases that can be prevented by vaccination and pre-natal care. These priorities are integrated into five programs: Integrated Care for children, and Care Programs for Adolescents, Women, Adults, and the Elderly, developed by the three levels of care. The management contracts then incorporated specific targets for each program.

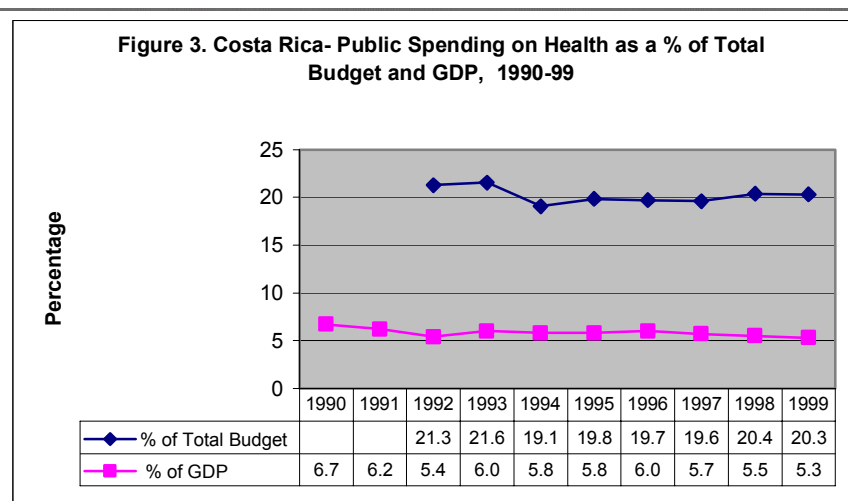
Finally, the financing component of the reform concentrated on two areas: i) increasing the coverage of contributions by applying stricter obligations on wage earners to contribute to the CCSS, more effective evasion control and extending contributory coverage to independent workers; and ii) redesigning the financing model, in order to attain greater contribution transparency and harmonization, including redefining contribution rates for independent workers and retired persons, and modifying the government's CCSS contribution for the poor and uninsured.

What did the reforms achieve? The Ministry of Health and the CCSS have made significant progress in implementing institutional restructuring and in establishing a clearer division of responsibilities, increasing accountability. A new set of incentives was put in place with the introduction of performance contracts in primary healthcare and hospitals. A new health care model was progressively applied and the health system has been gradually transformed from a supply-based model to a population-based model. Overall public spending was contained while health outcomes improved further, as discussed in the following paragraphs.

Public Spending and Outcomes

In Costa Rica public health sector spending reached about 6.7 percent of GDP in 1990 but has since declined to about 5.3 percent (**Figure 3**). In 2000, primary healthcare absorbed 26 percent of the CCSS ordinary budget; general hospitals (secondary level), 27 percent; and specialized hospitals (third level), 47 percent. Between 1997 and 2000 the share of total CCSS spending allocated to primary healthcare increased from 19 percent to over 26 percent. This increase reflects a substitution from specialist and hospital services to primary healthcare. The transition was made by increasing annual expenditures for specialist services at a slightly slower rate than the increases in primary healthcare allocations. The shift is confirmed by the fact that real expenditures on primary healthcare have increased much more than hospital care. In real terms, between 1997 and 2000 PHC expenditure increased 82 percent, while hospital care increased 20 percent. On the other hand, this shift was achieved with an increase in hospital productivity.

Has the cut in relative spending affected outcomes? Or the system's equity? During the 1990s Costa Rica further increased life expectancy to 77.5 years and reduced infant mortality rates in infants to 10 percent (three times lower than LAC), while expanding the health insurance



Source: World Bank (WDI) and “Costa Rica- Gasto Social y Pobreza”, World Bank, 2003, Table 35, page 65

system to 67 percent of the labor force (or 85 percent of the population) (Table 4). On equity, a recent analysis of the CCSS' redistributive impact shows that the utilization of health services is quite uniform by level of income.³ The lowest income quintile uses 22 percent of the health resources, and the bottom 50 percent of the population income distribution uses 56 percent of health resources. On the other hand, estimated contributions to the CCSS are highly progressive, with the bottom 20 percent of the population contributing only 2.9 percent of the total and people in the bottom 50 percent of the income distribution contributing only 17.5 percent. As a result, the study estimates that the lowest income decile receives 19.7 times more in health services than their contributions by quotas, while the top decile uses one fifth of its contributions in public health services.

Table 4. Costa Rica Health Indicators, 1988–90 and 1999–2000

	Life expectancy at birth, total (years)	Mortality rate, infant (Per 1,000 live births)	Mortality rate, under-5 (Per 1,000 live births)	Severe Malnutrition (percent of children under 6 years)	Health Insurance Coverage (percent of Labor Force)
1989/1990					
Costa Rica	75.4	14.8	16	0.5	64.8
LAC	67.9	41.3	49.4	N/a	N/a
1999/2000					
Costa Rica	77.5	10.2	13.4	0.4	67.3 a/
LAC	70.4	29.0	36.7	N/a	N/a

a/ 1996

Source: World Bank (WDI) and Costa Rica “El Gasto Social y la Pobreza”, World Bank, 2003.

³ “Costa Rica- Gasto Social y Pobreza”, World Bank, 2003,

Cost Effectiveness and Sustainability

The determination of the cost effectiveness of specific health policies is a complex task given that health outcomes depend on many factors some of which are beyond the control of the sector. For example, the status of basic infrastructure such as water and sanitation influences health outcomes; education also influences the health status of the household. Nevertheless, there are strong indications that resources are now used more effectively in the health sector. As mentioned above, health outcomes further improved while public spending declined (as percent of GDP). Also, while there was a reallocation of resources from curative care to primary healthcare, hospital productivity increased. In fact, a recent study indicates that since the beginning of the reform, the number of ambulatory visits increased from 2.6 to 3.5 visits per person; and the share of first visits to total visits from 38 percent to 44 percent; while hospitalization with prolonged stay have declined from 8 to six days. At the same time, CCSS has improved revenue collection and cost controls, enhancing the sustainability of the health programs.⁴

In sum, the reform initiated in early 90s, have introduced incentives for improved performance of health providers, both in preventive and curative care, and more clear division of responsibilities between institutions, increasing accountability. The Ministry of Health and the CCSS have made significant progress in implementing institutional restructuring, hospital productivity has increased, health outcomes further improved, while public health spending as percentage of GDP was reduced. This demonstrates the Government capacity to identify structural problems, forge a consensus among stakeholders, political parties, and civil society to accept changes, and introduce the incentive and accountability mechanisms for improved efficiency within the public structure. The successful health reforms in Costa Rica, which have been supported from their inception by the World Bank, have contributed to further reduce poverty in the country, from its already low levels by Latin American standards. As a result of the advances made, the challenges facing Costa Rica's health sector are now similar to those facing much more advanced countries, as its epidemiological and demographic profile changes. Increases in chronic diseases such as cancer, hypertension and diabetes signal the need to increase investment in prevention and promotion, and also invest in technology and diagnostic techniques that will improve health status.

El Salvador's Education Reform

Since the early 90s, El Salvador has implemented very successful education reforms and improved significantly education outcomes. These reforms were made possible by effective public sector leadership of the process and a close partnership with stakeholders, NGO and private sector in support of the reforms. The strong local ownership to the process elicit timely and substantive support from the international community, particularly the World Bank, making it

⁴“*El Proyecto de Fortalecimiento y Modernización del Sector Salud en Costa Rica: Un Proceso en Marcha*”, Presentation prepared by SANIGEST Health Solutions

possible to advance rapidly with the reforms and reap earlier results than otherwise would have been likely, further strengthening the local support to the reform process.

Sector Situation in 1990

The education system, which had been weak to begin with at the start of the 1980s, was severely debilitated following 12 years of conflict. At the end of the 1980s, more than one-fourth of the population remained illiterate; 20 percent of the primary school age children were still not reached by the system, particularly those in the rural areas most affected by the war; and the dropout and repetition rates were high.

At the beginning of the 90s, the public education system in El Salvador was generally characterized by being highly centralized, bureaucratic and with a strong urban bias. Urban areas—particularly capital cities—received a disproportionate share of education funding. Teachers and parents had little involvement in the administration of education systems. Personnel administration was inefficient. Duplication of efforts, neglect or vague understanding of responsibilities, and a slow bureaucracy were just some of the symptoms. A large number of public school teachers switched schools every month, particularly in the countryside, causing students to lose class days and producing high repetition rates. While payroll costs ate up most of the education budgets, a large share (a full one-quarter) of employees in the Ministry of Education was non-teaching staff. Teacher assignments and labor issues were resolved in the capital, and every personnel action required reams of paperwork. Teacher unions were politicized and teacher strikes were frequent.

The presence of the private sector in the education sector has been important. In terms of enrollment, the public sector has covered in recent years 79 percent of preprimary education, 88 percent of basic education (nine grades), and 66 percent of secondary education. The National University of El Salvador, UES, enrolls 30 percent of a total university population of 100,000. In contrast, in Costa Rica, the public sector has had traditionally a more important role in the sector at all levels of education: 92 percent of total enrollment at the preprimary level, 93 percent at primary level, and 87 percent at secondary level were in public schools. If subsidized private schools are included, these shares increase to 94 percent, 94 percent and 91 percent, respectively. Nearly all special education and higher education students in Costa Rica attend public institutions or private subsidized ones.

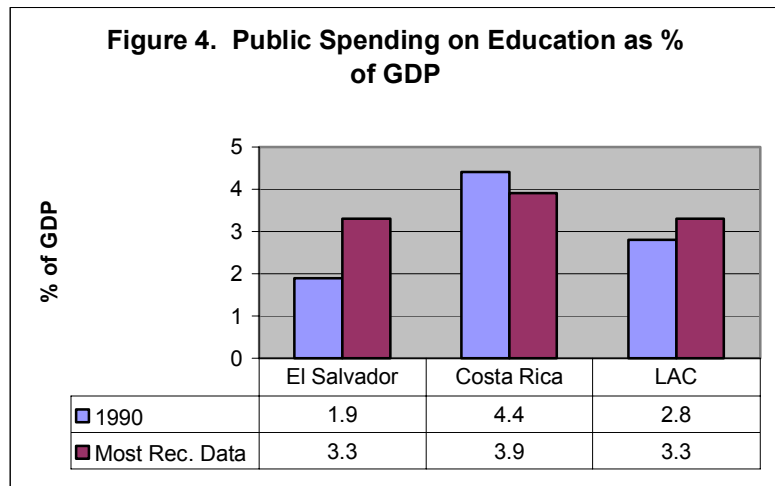
In contrast to the health sector, there is no information on the distribution of education spending between the public and private sectors. Nonetheless, **Figure 4** shows that the public sector in El Salvador in 1990 spent much less than Costa Rica on education (1.9 percent of GDP versus 4.4 percent of GDP) and below the LAC average of 2.8 percent of GDP. This situation has however changed during the 90s as result of the education reform.

Sector Reform

There were no specific education goals or targets in **El Salvador's** 1992 peace accords.⁵ The underpinning of the social strategies implemented in the last decade were laid out by the *Fundación Salvadoreña para el Desarrollo Económico y Social* (Salvadoran Foundation for Economic and Social Development—FUSADES). FUSADES, a foundation supported by the private sector, issued a set of proposals towards

the end of the 1980s to tackle the country's severe economic and social problems. After extensive public discussions these proposals became a plank in the electoral platform of presidential candidate Alfredo Cristiani. Following his 1989 election, Cristiani invited the FUSADES team to join his administration and implement the program they had developed.⁶

With strong leadership from the Government team in general and of the education authorities in particular, a strategy to begin correcting the sector's key weaknesses was devised. The initial efforts were to be concentrated in increasing enrollment in rural areas, because it was here where the majority of the poor lived and many of these areas had been left unattended by the official system during the conflict. Indeed, in the most strife-torn rural areas, some local and spontaneous alternative education structures emerged. El Salvador's *Escuelas Populares* set up in regions where the fighting was fiercest were run largely by communities and local educators, many of whom had completed only two grades of basic education themselves. The main mission of these schools, most of them supported by foreign NGOs and church groups, was to teach local children to read and write.



Note: MRD-most recent data: El Salvador (2002); Costa Rica (1999); and LAC (1996).

Source: World Bank's World Development Indicators database; "Costa Rica: El Gasto Social y la Pobreza" World Bank, 2003; and Marques, José Silvério "El Salvador: Evaluation of Public Expenditures on Education and Health", processed, World Bank, June 2003.

⁵ For a detailed review of the post-conflict education reforms in Central America see Marques, José Silvério and Ian Bannon, "Central America: Education Reform in a Post-Conflict Setting, Opportunities and Challenges", Conflict Prevention and Reconstruction Unit, Working Paper No. 4, World Bank, April 2003

⁶ Marques, Mirna Liévano de "El Salvador: Un País en Transición", 1996. Mrs. Mirna Liévano de Marques was Director of Economic and Social Studies in FUSADES during the late 1980s. She was appointed Minister of Planning of President Cristiani and chaired on behalf of the President the Economic and Social Cabinets during the 1989-94 period. The Minister of Education during this period was Mrs. Cecilia Gallardo de Caño who was succeeded in mid-90s by Mrs. Abigail Castro de Perez.

Two months after the peace accords were signed, for the first time in twelve years officials of the Ministry of Education visited the zones that had remained under guerrilla control, in the Department of Chalatenango. The country had already begun to overhaul its education system but a field assessment was needed of the education system, especially in the conflict zones. After observing first-hand the operation of the *Escuelas Populares* they put together a plan to support this initiative. It was decided that a portion of the assistance from the United States Agency for International Development (USAID) would be used to set up an accelerated program to train "community educators" and purchase educational material for these schools. The community teachers were enrolled in EDUCO teacher training programs (see below), which were already in operation. An open national dialogue was launched on community-based education approaches in El Salvador and strategies were mapped out to mesh these with the formal education system.

Around this time, the authorities of the Ministry of Education created the National Commission for Coordination of Education Reform and launched a campaign "Education Matters" to encourage schools to seek and welcome support from the community, the private sector, NGOs, and private agencies or foundations. Equally important, the campaign aimed, above all, to instill a sense of ownership of the reform in the Ministry of Education's own staff.

As the first strategic prong of the reform, the Ministry of Education drew up in 1991 a roadmap for boosting rural enrollment rates through the Community-Managed Schools Program, better known by its Spanish acronym EDUCO, which latter capitalize on the experience of the *Escuelas Populares*. These efforts were supported by a series of World Bank sector loans, which received the unanimous approval from the National Assembly, including, after 1992, from the recently incorporated FMLN. Two prominent features of EDUCO initiative are strong community participation and decentralization of Ministry of Education structures, especially financial administration. Newly empowered communities now appoint and hire teachers and arrange their benefits.⁷ The Ministry quickly reaped the benefits of this far-reaching decentralization. It now had a filter—the local community—through which to deal with issues that had created such an onerous workload in the past: permanent teacher appointments, transfer approvals for teachers wanting to switch schools, processing of sick-leave requests and dealing with teachers' personal problems and working conditions in individual schools. Since communities were in day-to-day contact with their children's teachers they were in the best position to supervise local school matters.

It was no easy task to bring the EDUCO program on stream. The Ministry of Education had been one of the main, if not the main, focus of political cronyism through teacher appointments, whereas EDUCO put parents in charge of teacher selection. The largest teachers' union, *ANDES 12 de Junio*, initially interpreted the program as a move to privatize education. For the union, EDUCO represented a loss of power and a step backward in what the union termed its "teacher gains", since the performance of EDUCO teachers, hired on annual contracts, was to be assessed every year by parents and provide the basis on which to decide whether or not their contracts would be renewed. Incompetent teachers would be dismissed. It was the end of an era of

⁷ A separate paper on the EDUCO experience is being presented to this Conference.

job security and tenure that teachers entering the system had come to expect. After teacher strikes and work stoppages, and following a process of dialogue, the EDUCO program ultimately found acceptance along with a host of other education reforms.

At the same time, the Ministry of Education was undergoing a reorganization to decentralize operations to the country's 14 Departments. Once the Ministry reorganization was firmly on track and area directors and supervisors had been trained, attention turned to the schools' own internal organization, which was to be modeled on the EDUCO program's organization and *modus operandi*. This was the genesis of the School Steering Boards (CDEs) created in every school in the country, made up of the principal, a representative of the teaching staff, a student representative and a parent representative. This structure was gradually put in place in public schools across El Salvador.

As the new structure took hold by mid-90s, the Ministry of Education began focusing on the quality of education. Several instruments were deployed. First, planning instruments were developed at school level: the Institutional Education Project (PEI), which sets forth the school medium term objectives and the associated Annual School Plan (PAE). Second, the Ministry established a teacher training/development program that is administered in a decentralized manner with strong school participation and the support of the Pedagogic Advisors, who replaced the previous school supervisors. Third, the Ministry created a decentralized system of administrative support to the schools and strengthened its Departmental Offices. Fourth, the Ministry established incentives for teachers in rural areas and a performance-based incentive system for all teachers. Finally, the Ministry of Education established a system of resource transfers to the schools (vouchers) for several purposes, but with the main objective of putting resources and decision-making directly in the schools and promoting the quality of the education system.⁸

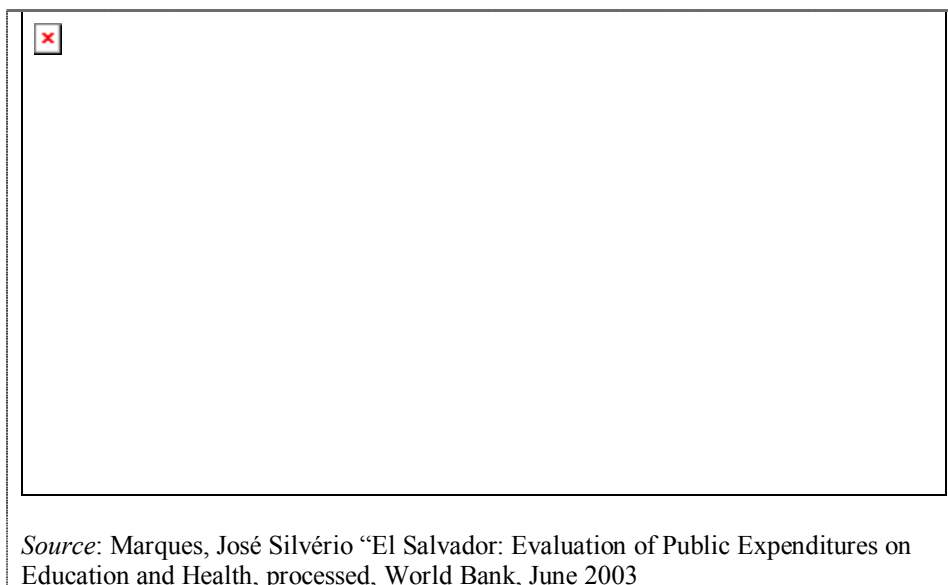
At the same time the Ministry of Education introduced a series of special programs to keep more children in school, raise promotion rates and deliver better-quality education. For example, the *Alternative Classrooms* program is designed to offer greater flexibility in rural education through a multigrade, participatory methodology. The *Accelerated Education* program aims to address the problem of children over-age for grade by providing special assistance to children who fall behind. The *Healthy School* program provides school lunches and medical attention to all basic education students in rural areas (over 700,000 children) as well as school basic infrastructure improvements. And, the recently initiated “*Escuela 10*” program gives incentives to schools to achieve high quality standards.

Public Spending and Outcomes

As the reforms were being implemented, public education spending increased substantially, from 1.9 percent of GDP in 1992 to 3.3 percent in 2002, reaching the average for LAC (**Figure 5**). The share of education on the overall Central Government budget has increased by 6 percentage

⁸ Marques, José Silvério “*El Salvador: Costo-Eficiencia de los Bonos Educativos*”, processed, World Bank, December 2002.

points, from 12 percent in 1996 to 18 percent in 2002. Basic education (nine grades of obligatory education) absorbs the greatest share of the education budget (73 percent of the overall budget during 1996-01). Preprimary, secondary and higher education absorbed on average 9 percent, 10 percent, and 8 percent, of the total budget, respectively. Allocations for basic education have increase from 71 percent of total education budget in 1996 to 75 percent in 2001. In contrast, allocations for higher education, which are mostly to the University of El Salvador (UES), declined as a share of total Ministry of Education’s budget from 10 percent in 1996 to 7 percent in 2001.



Is the spending on education commensurable to the outcomes? Is it equitable? El Salvador has increased significantly primary and secondary education enrollments, managing in addition to reduce repetition rates (Table 5). The rapid increase in primary education enrollments particularly in rural areas has meant that the actual coverage gap for poor children is now greater in urban areas. This resulted from EDUCO, which focused on the most isolated, rural communities as well as from other public programs that gave priority to the rural areas where poverty is more pervasive and education enrollments were lower. For instance, the school lunch program focuses exclusively on rural areas.

As for the equity of the education system, a recent study finds that education spending in the country has been pro-poor. In addition to the above coverage trends, the gender gap appears to be closing in El Salvador: the 2001 household survey indicates that though 22 percent of women have no schooling compared to 20 percent of men, for girls aged 6-14, 31 percent have no schooling compared to 32 percent of boys of the same age. Also, the same proportion of man and women, 21 percent, had completed the first 6 grades of schooling. Finally, the study concludes

that the geographic distribution of education resources appears to favor the Departments with lower per capita income.⁹

Table 5: El Salvador: Education Indicators, 1990/91, 1999/2000 (percentages)

	Adult Illiteracy Rate	Gross Primary Enrollment	Gross Secondary Enrollment	Gross Post-Secondary Enrollment	Repetition Rate Primary Male	Repetition Rate Primary Female	Persistence to Grade 5
1990/1991							
El Salvador	27.5	81	26	16	7.5	8.6	58
LAC	15.2	106	49	17	N/a	N/a	75
1999/2000							
El Salvador	21.3	111	50	18	6.8	8.3	71
LAC	11.6	129	65	19	N/a	N/a	N/a

Source: World Bank (WDI)

Cost Effectiveness and Sustainability

As in health, the determination of the cost effectiveness of specific education policies is a complex task given that education outcomes depend on many factors. For example, the state of health of the students influences their learning capabilities. Nevertheless, two recent studies seem to indicate that in general resources are used effectively in the education sector. For example, the transfer of resources to the schools through vouchers has empowered them; school authorities and parents now can allocate resources to their priorities needs.¹⁰ Teacher training is a case in point. Until recently it was centralized in the Ministry; it decided which were the training needs of the teachers and it required teachers to attend training often in the capital city with loss of teaching time. Now, with the support of the Pedagogic Advisor, schools decide which training their teachers need and finance it from the teacher development voucher. Schools are lumping together resources to procure jointly the training, which frequently is scheduled in-house and during off-class periods.

As for the sustainability of the reforms, additional resources are needed in the sector. Despite the significant increase in public education resources in the last 12 years, El Salvador still spends too little on education compared for example to Costa Rica. In order to ensure that additional resources are forthcoming without jeopardizing the fiscal situation, El Salvador needs

⁹ Marques, José Silvério, “*El Salvador: Evaluation of Public Expenditures on Education and Health*, processed”, World Bank, June 2003.

¹⁰ Marques, José Silvério “*El Salvador: Costo-Eficiencia de los Bonos Educativos*”, processed, World Bank, December 2002 and Marques, José Silvério, *El Salvador- Evaluación de la Red de Protección Social*, processed, World Bank, 2002.

to renew its commitment to deepen the education reforms for which continued government leadership is necessary.

In sum, El Salvador has implemented a very successful education reform during the 90s. The reforms implemented transferred to schools resources and decision-making capacity; it empowered communities and parents. The schools received support for teacher training and administration, as well as for purchase of education quality enhancing inputs. Teacher received performance related incentives. Public education spending increased significantly. As a result, sector outcomes have improved substantially. These achievements were made possible by effective public sector leadership and a strong national commitment to education improvement, together with timely and substantive support from the international community, particularly the World Bank. Given the success with the reform, the challenges facing the education system now are to increase secondary education enrollments and further improve the quality of the overall system.

Lessons Learned

The previous sections discussed the experiences of Costa Rica and El Salvador with health and education reforms, which contributed to improving social indicators and reduce poverty. The two Central American countries have pursued different policy approaches to improve social indicators and reduce poverty. While both have relied on growth as a driver of poverty reduction, Costa Rica's approach has focused more on public sector financing and delivery of services, while El Salvador has relied more on stakeholder involvement under strong public sector leadership. What lessons can be derived from these experiences? Some of the general lessons are:

- **A strong national commitment to the reforms is required.** The Governments of Costa Rica and El Salvador spent a considerable amount of time and effort to ensure broad national support for the reform process. Without such government leadership and effort to promote dialogue and consensus-building for change, the sustainability of the reform effort is compromised.
- Both the public and the private sector have critical roles to improve social indicators and reduce poverty—neither can do it alone effectively. In the case of Costa Rica, the Government had assumed full responsibility for financing and delivery of social services, but the approach was not fully responding to the health demands of a more mature system and was becoming fiscally unsustainable. The Government of Costa Rica succeeded in making public spending more efficient in the health sector by redefining responsibilities of the main public sector actors, expanding private sector provision and by improving the incentive and accountability mechanisms. In the case of El Salvador, the successful education reform was made possible by effective government leadership, strong stakeholder participation in service delivery, and strong private support to the reform process, together with increased public financing to the sector.

- **Effort to ensure efficient and effective resource use is critical.** Given that most countries face severe fiscal constraints, social programs must be cost-effective and targeted to the poor. The public sector must ensure that social services are adequately financed and draw on the private sector and local actors to help delivery of social services in a competitive, efficient and accountable way, while promoting stakeholder social auditing over resource use.

What specifically can be done to achieve an appropriate balance between public and private sector participation in the social sector reform? Although there are no prescriptions, because social developed policies outgrow from the country's historical conditions, the State's social contract with its citizens, and the relative strength of community organizations, private sector and other actors, there appears to be a consensus that governments should have the responsibility for financing basic social services and for ensuring that poor have access to these services, while the provision of the services may be realized by the private sector, NGOS, or other groups that give guarantees that the services are delivered in an efficient and accountable way. To arrive at an appropriate balance, consideration may be given to the approaches followed by the Governments in the experiences reviewed.

- **Develop a clear vision of social sector strategies.** This is fundamental to forge a strong political commitment to see the strategies implemented and, to the extent possible, ensure their continuity as governments and public officials change.
- **Ensure that social policies and programs are technically sound.** The design of strategies, policies and programs is a complex technical undertaking that should be based on a thorough diagnosis of the state of the sector, and of alternative options and their cost.
- **Engage in dialogue and consensus building.** Consultation and discussions need to ensure that participants have influence in the definition of the proposed strategies, policies and programs. Too many consultation and consensus-building processes fail because they are seen as mere public relations exercises.
- **Secure the support of critical stakeholders.** This is particularly important when sectors are highly politicized or controlled by workers or interest groups opposed to changes that threaten, or are perceived to threaten, their privileges.
- **Decentralize delivery systems and empower beneficiaries.** To make empowerment meaningful, ensure that local actors and stakeholders have control over resources and decisions making.
- **Modernize and effectively decentralize the Ministries or other public institutions.** This is essential to complement the transfer of resources and responsibilities to other layers of the system. This ingredient of the reform programs is often delayed because it requires complex changes in large institutions and strong political commitment, but if not effectively addressed, it risks derailing or delaying the reform process.
- **Establish incentive and accountability mechanisms.** A clear set of incentives for institutions and staff to perform efficiently and effectively must be put in place and perverse incentives eliminated. Also, the private sector will be reluctant to participate in the social

sector development if the “business plan”, including how resources will be used and accounted for, is not clear. Social auditing by key stakeholders has proven to be an effective instrument to improve the control over resource-use.

Following such approach and keeping in mind that macroeconomic stability is fundamental for growth, which in turn is a driver of poverty reduction, countries may forge a productive public/private sector partnership for social development and poverty reduction.

References

- Marques, José Silvério, *El Salvador- Evaluación de la Red de Protección Social*, processed, World Bank, 2002.
- Marques, José Silvério, *El Salvador: Costo-Eficiencia de los Bonos Educativos*, processed, World Bank, 2002.
- Marques, José Silvério, *Central America- Social Safety Net Assessments- Cross Country Review of Principal Finding*, processed, World Bank, 2003
- Marques, José Silvério and Ian Bannon, *Central America- Education Reform in a Post-Conflict Setting, Opportunities and Challenges*, Conflict Prevention and Reconstruction Unit, Working Paper No. 4, World Bank, 2003.
- Marques, José Silvério, *El Salvador- Evaluation of Public Expenditures on Education and Health*, processed, World Bank, 2003.
- Marques, José Silvério, *El Salvador- Policy Options to Increase Coverage in Upper Basic (3th Cycle) and Secondary Education*, processed, World Bank, 2003
- Marques, Mirna Liévano de, *El Salvador: Un País en Transición*, ESEN, 1996.
- UNDP web page: World Development Index
- SANIGEST, Health Solutions, “*El Proyecto de Fortalecimiento y Modernización del Sector Salud en Costa Rica: Un Proceso en Marcha*”, Presentation
- World Bank, *El Salvador: Poverty Diagnostic*, draft report, 2002
- World Bank, *World Development Indicators*, 2002.
- World Bank, *Costa Rica- El Gasto Social y la Pobreza*, 2003
- World Health Organization, *World Health Report*, 2002