HEATH SERVICES – PHASE II

(GU-0125)

EXECUTIVE SUMMARY

Borrower and guarantor:	Republic of Guatemala	
Executing agency:	Ministry of Health and Social Assistance (MSPAS)	
Amount and source:	IDB (OC):	US$55.44 million
	Local:	US$10.68 million
	Total:	US$66.12 million
Financial terms and conditions:	Amortization period:	30 years
	Execution period:	4 years
	Disbursement period:	4.5 years
	Grace period:	4.5 years
	Interest rate:	variable
	Inspection and supervision:	1% of total loan amount
	Credit fee:	0.75% per annum on undisbursed balance
	Currency:	U.S. dollar from the Single Currency Facility

Objectives: The objective of the program is to improve the health status of people in Guatemala through expanded coverage in basic health services, institutional modernization, and investment in maternal-child services. The specific objectives are: (i) to improve the MSPAS's institutional capacity to perform the functions of regulation and supervision; (ii) to expand the coverage and quality of basic health services for rural communities living in poverty; (iii) to strengthen the process of competitive procurement for health services; (iv) to modernize health risks financial administration in the Guatemalan Social Security Institute (IGSS); and (v) to raise productivity and the quality of health services in at least seven MSPAS pilot hospitals.

Description: Most (51%) of the financing for the program will be used to broaden coverage of basic health services for rural communities living in extreme poverty. The technical assistance funding will help with the institutional strengthening of the main actors in the health sector, particularly the Ministry of Health at the central and decentralized

level, the Guatemalan Social Security Institute, public hospitals, and nongovernmental providers of basic health services.

The strategy of the program is based on a dual approach of using procurement for basic services as an element for spurring modernization of the sector while strengthening the institutional capacity of institutions in the sector to consolidate the advances made during phase one of the health sector reform.

The program is divided into four components: (i) **Institutional strengthening of the MSPAS** through the development and consolidation of a new organizational structure at the central and regional level and boosting its capacity to perform the functions of regulation and supervision that come within its purview; (ii) **support for expanded coverage** to supplement the Guatemalan government's efforts to expand basic health services for poor rural communities, modernize the procedures for basic health services procurement and replace the current procedures with unrestricted competitive mechanisms, and to promote the development of technical and administrative innovation by public and private providers of basic health services, (iii) **strengthening of the health insurance function of the Guatemalan Social Security Institute** by means of a technical assistance program that introduces improvements in financial management and the hiring of consultants to modernize its function as a health risks insurer. Given the close relationship between the pension and health systems studies will be commissioned to propose actions that ensure the future sustainability of the reforms in the health service and pension areas; and (iv) **hospital management improvement program** (PROHOSPITAL) to raise productivity and the quality of service in at least seven MSPAS hospitals through improvements in their administrative, management, and financial structures.

Relationship of project in Bank's country and sector strategy:

The PMSS-II as proposed is consistent with the Bank's strategy in Guatemala which seeks to bring about within 10 to 12 years substantial improvements in order: (i) to achieve in specialization by the MSPAS in supervision and regulation functions and by the IGSS in insurance functions; (ii) to decentralize the operations of the MSPAS and the IGSS to their regional and/or local offices; (iii) to separate the health service provider and financing functions; (iv) to convert hospitals into deconcentrated bodies; and (v) to introduce innovative financing mechanisms for the health sector, mainly through the establishment of new public and private insurance plans.

Environmental and social review:

The project is not expected to have any direct impact on the environment. On the recommendations of CESI, standards of biosecurity and hospital waste management will be applied in

component 4 and effective practices of traditional medicine will be incorporated into basic health services (CSBS) in component 2. Strengthening of capacity to coordinate and exchange information and data between the MSPAS and Guatemalan environmental authorities has been incorporated into component 1.

Benefits: The program will contribute to efforts to achieve health-services integration and modernization of the sector and broaden coverage of health services to include groups in poverty in rural areas. The initiatives proposed under the program will result, within five years, in the country having a measurable improvement in the health status of poor rural communities; a Ministry with bolstered regulatory, supervisory, and technical capacity and with the institutional credibility to protect the public from major risk factors; a health services procurement capability developed in the MSPAS and the IGSS; public and private providers better positioned to supply basic health services; and hospitals converted into independent public institutions with management, administrative, and financial structures of their own.

Risks: The main risks associated with the program have to do with ensuring financial sustainability and attaining expanded coverage targets. To alleviate these risks, the program has been so designed to ensure that: (i) it does not replace public spending on health services; (ii) it succeeds in raising government spending gradually over time; and (iii) it guarantees the availability of resources in the future for the spending needed to maintain the expanded coverage being financed under the program. To accomplish this aim, the scale of the Bank's financing in terms of beneficiaries and resources is declining. An accounting and technical audit is inducted as part of the program to verify the spending targets and to make sure that IDB funding is not being used to replace local financing. Also, the program provides for the design and early implementation of an information system to facilitate monitoring of costs and productivity of public and private basic health service providers with which the government will have planning mechanisms that are more effective for bringing new beneficiaries into the plan and the fiscal resources needed for the expanded coverage program.

Special contractual clauses: As a condition precedent to the first disbursement, the Bank must approve the program Operating Manual, which is to contain the model agreements that will be used during execution of program components. The conditions precedent to the first disbursement for specific components are as follows: for component 2, signature of a contract, upon declaration of eligibility for disbursement under this component, with the firm that will be in charge of the concurrent audit; and for component 4: (i) approval by the Bank of the Operating

Regulations for PROSHOSPITAL, and (ii) signature of a contract, upon declaration of eligibility for disbursement under this component, with an outside firm to administer it.

The Bank will disburse up to US$100,000 from the loan for start up of program activities prior to fulfillment of the aforesaid conditions precedent provided that the borrower has satisfied the basic conditions precedent set out in the loan contract.

For expenses incurred prior to approval of the operation, the Bank will recognize up to US$800,000 as chargeable to the loan and US$1 million as chargeable to the local counterpart funding.

Poverty-targeting and social sector classification:

This operation qualifies as a social equity enhancing project, as described in the indicative targets mandated by the Bank's Eighth Replenishment (document AB-1704). It also qualifies as a proverty-targeted investment insofar as its focus is poverty reduction in rural areas (paragraphs 2.28 and 2.29) and given the nature of the beneficiary population (paragraphs 4.21 and 4.22). The borrower will be using 4% in additional financing (paragraph 2.33).

Exceptions to Bank policy:

None.

Procurement:

International competitive bidding will be mandatory for contracts valued at more than US$1.5 million in the case of construction works, more than US$250,000 in the case of goods, and more than US$200,000 in the case of consulting services. A threshold of US$300,000 is recommended only in the case of basic health service provider contracts for component 2.

Contracts in amounts below these thresholds will be awarded as follows: local competitive bidding will be used for construction works valued from US$100,000 to US$1,499,999, for goods valued from US$50,000 to US$249,999, for consulting services valued from US$50,000 to US$199,999, and for basic health service provider contracts for component 2 valued from US$50,000 to US$299,999. For contracts below these thresholds, a system of price shopping based on 3 quotations will be employed, and terms of reference will be included for consulting services.

During year one of the program, the Bank will conduct an ex post review of goods and services procurement chargeable to the local counterpart funding and for amounts below the equivalent of US$100,000.

Commencing in year two, depending on the results of the first annual technical review, the Bank may increase this amount and perform ex post reviews of all procurement and contracts below the thresholds

established for international competitive bidding. The procurement schedule is presented in Annex II.

I. BACKGROUND

A. Introduction

1.1 **Guatemalan society.** Guatemala has a population of nearly 12 million inhabitants, the largest in Central America, and the strongest economy in the region. The peace agreements signed in late 1996 set the stage for economic and social reform. The population growth rate is 2.9%, the highest in Central America, and the country has the greatest inequality in income distribution in the region. In the period 1989-1991, the highest quintile earned 63% of income whereas the lowest accounted for only 2%. In Guatemala, 80% of the population lives in poverty, and 60% in extreme poverty. Poverty is concentrated mainly in rural areas (86%), particularly in indigenous communities (93%), which make up 42% of the country's population.[1]

1.2 **Health conditions.** The health status of the Guatemalan population continues to be below the level of other Latin America, with a similar level of development. A recent maternal/child survey (1998-1999) found that the global fertility rate (GFR) was 5.0 per woman of child-bearing age, making it the highest in Latin America.[2] More recent data show that maternal mortality for the 1990-1995 period was 190 per 100,000 births, one of the highest in the Hemisphere.

1.3 Guatemala finds itself in the early stages of an epidemiological transition. Maternal and child health conditions have steadily improved over the last 10 years although most disease is still attributable mainly to infection and malnutrition. Infant mortality declined to 45 per mil live births in the 1998-1999 period from 57 in 1995. These successes are due largely to increased immunization of children under 1, where coverage now exceeds 80%. A similar improvement has not been achieved, however, with chronic malnutrition. Low height was found among 46% of children under 5 in 1998, compared with 50% in 1995.[3]

1.4 National health rates conceal the significant differences that exist between regions and between ethnic groups, as shown in table I-1. Indigenous, extremely poor, rural populations account for most of the premature and preventable mortality. For instance, although child mortality rates are similar in urban and rural areas, they are

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[1] IDB. Guatemala country paper, October 18, 1996; IDB. The Economies of the Central American countries: common challenges on the eve of the 21st. Edition V, July 1998.

[2] In 1995, the average for Latin America was 3.1 for GFR and 45 mil live births for infant mortality.

[3] 1995 National Survey of Maternal Child Health. 1998-1999 National Survey of Maternal Child Health, Preliminary Report. Guatemala: INE, MPSAS, USAID, UNICEF, FNUAP, Macro International, World Health Organization, and UNICEF, 1996. Estimated maternal mortality, 1990. In the sources consulted, the rates vary considerably.

twice as high among indigenous groups as among nonindigenous (ladino) groups. Differences in delivery care, which is critical for reducing maternal and neonatal mortality, is more dramatic still. One half of ladino women who give birth are attended by a doctor, whereas the ratio is only 14.5% for indigenous women. For every baby delivered by a doctor in the western altiplano region, seven are delivered by doctors in the Metropolitan Guatemala City area.

Table I-1
Mortality rates by area of residence and ethnic affiliation (1998/1999)
(per mil live births)

Mortality rate	Urban	Rural	Nonindigenous	Indigenous	Total
Neonatal	31	22	44	56	26
Infant	49	49	12	24	49
Child	58	69	56	79	65

Source: Guatemala: Mother-Child Health Survey, 1998-1999. Preliminary report

1.5 **Problems in the sector before the reform.** In the mid-1990s, the Government of Guatemala (GoG) faced four types of interrelated problems which contributed and to some extent still contribute to the present health situation: (i) low and unequal level of health services delivery; (ii) insufficient and declining financing for the sector; (iii) inefficient allocation of public resources; and (iv) inefficient use of resources in public agencies.

1.6 To address this situation, the Ministry of Public Health and Social Assistance (MSPAS) has been carrying through a health services enhancement program (PMSS-I 890/891 OC-GU), that is being financed by means of a sector credit of US$25 million and reimbursable technical-cooperation funding of US$13.5 million. The program was approved in late 1995, and two disbursements have been made - an initial one of US$10 million in October 1996 and a second one of US$5 million in December 1998. The third disbursement for US$10 million is expected to be approved in October 1999. The accomplishments of this program are described in the following section.

B. Accomplishments of PMSS-I

1.7 Over the last four years, Guatemala has made significant headway to improve public health services. By reversing the trend towards prioritizing the allocation of resources, the MSPAS succeeded in broadening the coverage of basic health services to nearly 3 million people living in poverty (60% of whom are indigenous). This dramatic achievement was brought about by a government strategy that combined: (i) identifying and according priority to financing highly cost-effective solutions (comprehensive basic health services or CSBS); (ii) focusing the supply of such services on population groups in extreme poverty; and (iii) supplying such services under agreements with nongovernmental organizations.

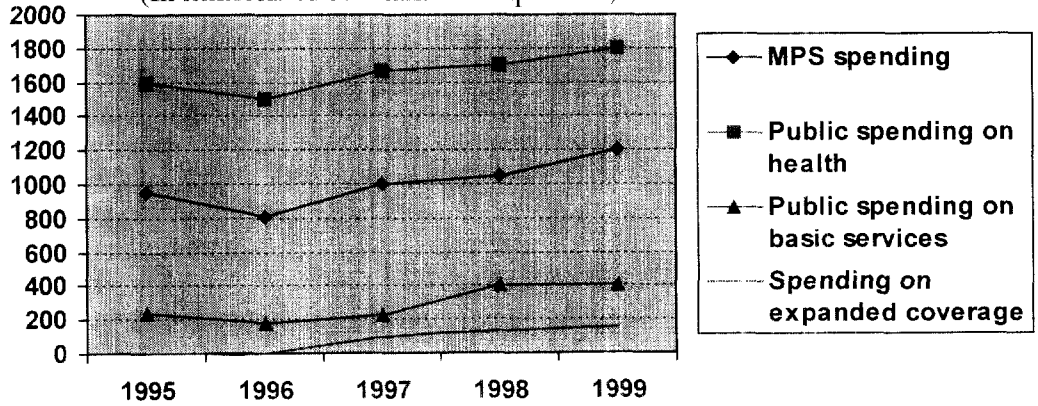
1.8 Previously, between 1995 and 1997, the government increased the Health Ministry's budget for recurring expenses, excluding payroll, by 32% in real terms. Spending was kept at this level in 1998. Also, spending was oriented towards basic health services in order to bring it more into line with the country's epidemiological profile and give preference to preventive care. The budgetary structure now reflects percentage increases in basic services and a proportionate reduction in hospital expenses. In 1998, 46% of the MSPAS's budget went on basic health services, a record level for the country.

1.9 In addition to the changes in the care and public spending allocation model, the program made it possible to lay the foundations for institutional modernization of the Ministry. Not only was public resources redirected to priority investments, the efficiency with which resources were allocated improved significantly as well. In terms of its overall budget performance, the MSPAS's was successful in carrying out 96% of planned spending in 1998, thanks in part to the decentralization of spending from the Ministry of Finance to the MSPAS and the introduction of expeditious administrative procedures and a financial information system.

1.10 Moreover, in a move to delegate more responsibility to the MSPAS for the health sector reform, a new code of health went into effect in February 1998. Under the code, the MSPAS is authorized to take on a key regulatory and supervisory role, enabling it to hire private entities as service providers, to sell its services, to establish new coordinating mechanisms, and to facilitate administrative decentralization of the Ministry and the development of organizational structures more attuned to the reform strategy.

Spending on health

(In millions of constant 1999 quetzals)



Source: CIEN. Macroeconomic indicators, 1995-1997. MPSAS, National Health Accounts, 1995-1997; MSPAS/Financial Subdepartment, Budget performance report, 1999; MSPAS/SIAS. Improvements in coverage, 1999. *US$1 = Q 7.35.

1.11 Under the MSPAS's organizational restructuring, completed earlier this year, operational units have been created to enable the Ministry to perform its new role

and duties. In the new structure, the functions of regulation, epidemiological surveillance, public health protection, financing and procurement of health services and coordination of the public provider network are administered at the central level. A Health Sector Cabinet has been set up as a mechanism to coordinate efforts between the MSPAS, the Guatemalan Social Security Institute, and other actors in the sector. This allows financial and human and physical resources management functions to be left to the health departments and hospitals.

1.12 In a show of its new leadership role, the MSPAS promoted dialogue and later negotiated the admission of the Guatemalan Social Security Institute to the Program. Under a landmark inter-agency agreement, there arouse a comprehensive view of reform and common policy tools such as the coordinated implementation of programs to extend coverage for informal rural and urban population groups, hiring of private sector providers, and hospital modernization.

1.13 Lastly, the Program attempted to reform the public hospital incentive structure through the introduction, as a pilot experiment, of greater autonomy and accountability at five hospitals across the country. Although the progress made in improving hospital management has not been as spectacular as in other areas of health policy, the GoG did succeed in raising the internal efficiency of these organizations through a sustained drive to improve procurement procedures and inventory control.

C. Challenges and problems

1.14 The mid-term evaluation of the Program and the sector program disbursement reports show key points for sustainability of the reform process. The government has pursued sector policy reforms that go beyond the agreements with the Bank and the reform process has been advancing faster than expected. Nevertheless, the processes initiated are still in their early stages and will demand efforts on the political and institutional front in order to become sustainable. Consequently, it is hoped that the next stage of the program will consolidate the main achievements and deepen the sweeping changes underpinning the strategy for sector reform.

1.15 Two interrelated factors are the main challenges facing health policy in Guatemala. The first is the need to press ahead with expanding the coverage of basic health services without reducing existing coverage or the current level of public spending on basic health. The second challenge is the need to pursue this aim through a more institutionalized hiring process that promotes modernization of government responsibilities and provides better quality of service to program beneficiaries.

1.16 **Expansion of coverage of basic health services.** If the MSPAS is to more forward with the process of expanding coverage without reducing existing coverage or the current level of government spending, it must address another more immediate

challenge of strengthening the institutional framework that guarantees the quality of care from public and private services providers.

1.17 If it is to maintain coverage at present levels, the MSPAS will have to consolidate essential activities in order to modernize procurement for basic health services, institutional strengthening of private suppliers, and technical and financial supervision of contractors. It also entails doing a somewhat better job at increasing coverage in areas now covered and gradually increasing the complexity of the interventions included in the basic health package. This could mean concentrating on introducing additional services such as obstetrics and/or information strategies to educate the public about better personal hygiene and health.

1.18 User satisfaction and effective participation by the community in planning, organizing, and supervising the services are further challenges, particularly for indigenous groups with different cultures and very specific health needs.

1.19 For suppliers, the use of institutionalized hiring methods poses an additional challenge since it means acquiring new organizational capabilities, adopting methods that are more responsive to the rules of a regulated market, care for its production and cost structures and a prompt response capability to user needs.

1.20 **Competitve contracts as a mechanism in the new care model.** The expansion of basic health services coverage under agreements with public and private care providers promises to be a policy that promotes efficiency in public spending and strengthens the new care model developed by the MSPAS. The introduction of a competitive process for health services procurement is a strategy that will reinforce the MSPAS as an institution, paving the way for an eventual separation of the health services provider and financing functions, a medium- and long-term goal of the reform.

1.21 Insofar as the delivery of basic health services is open to market-based competition under the supervision of the MSPAS, the agreement will become the main instrument underpinning the relationship between the Ministry and public and private providers. Apart from the institutional strengthening of the Ministry that this process will engender, the beneficiaries from extended coverage will gain in terms of quality and price.

1.22 In addition to the challenges noted, there are areas of concern such as: (i) institutional shortcomings at the Ministry in terms of supervision and regulation; (ii) organizational weaknesses in nongovernmental organizations that provide basic health services under agreement with the MSPAS; (iii) technical shortcomings in the health services provided by the Guatemalan Social Security Institute (IGSS); and (iv) weak hospital management and administration structures with financial resource allocation not based on hospital performance.

1.23 **Institutional shortcomings in the MSPAS.** The MSPAS must develop the human capital and implement the, technology, and information systems that it needs to perform its new functions of supervision and regulation, as it decentralizes and strengthens organizational capacity in the Health and Hospital Departments. Here, the main challenges facing the Ministry are the strengthening of the national epidemiological surveillance system, regulation of public and private service providers, development of highly specialized skills in such internal areas as health services procurement; formulation, monitoring, and evaluation of priority programs; and modernization of its public health response capacity and capacity to cope with consumption, environmental, and natural disaster risk factors.

1.24 One area of development in which the MSPAS has lagged, and which will be particularly important in phase two, is developing skills for reporting, communicating, and generating a consensus on social reforms.

1.25 **Institutional weakness in the IGSS.** The IGSS serves approximately 1.6 million health beneficiaries, or 16% of the population and 30% of the economically active population[4]. The source of IGSS revenues is a 6% payroll deduction imposed in the formal sector for general health coverage. It is shared between employers (4%) and employees (2%).

1.26 The IGSS is an independent entity which, in accordance with the present Health Code, comes under the supervision of the health sector. The Institute performs various functions: (i) insurance for various risks (sickness, maternity, and accidents); (ii) provision of direct health services; and (iii) pensions. The insurance provides comprehensive coverage for government workers, pensioners and much more limited coverage for pregnancy, childbirth, and postpartum care, and for children under 5.

1.27 The IGSS administration structure is deficient and poorly structured, a factor that accounts to some extent for its excessively centralized nature. That the accounting and financial functions of its source and application of funds are not separated hampers management in the different areas of responsibility. The most glaring weaknesses affecting health insurance management are found in such areas as beneficiary affiliation, benefits determination, management of own health services infrastructure, and hiring of, and payment to, private providers.

1.28 Although coverage in the country is now low, it is expected to broaden gradually thanks to: (i) new affiliates in the formal sector joining up in urban areas not now receiving coverage; (ii) affiliates in the urban and rural informal sector; and (iii) family coverage extended benefits. To take up the challenges posed by extended coverage, the IGSS must work out in the short term these weaknesses.

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[4] De la Hoz, J.C., Final consultant's report. Inter-American Development Bank, Washington, July 1999.

1.29 **Public hospitals.** The public health system's worst problems are found in its hospitals. Although they are beginning to account for a smaller share of health spending, and administrative reforms introduced have produced savings over the last 3 years, public hospitals in Guatemala suffer from underutilization, low quality care, and inadequate management performance.

1.30 The incentives in the hospital system are inadequate, encouraging inefficient performance. Also lacking are hospital administrative structures with the capacity for strategic management.

1.31 In addition, the budgeting and payment process is a disincentive to productivity and quality in hospital services. The MSPAS is moving ahead with a reform of the traditional budgetary system in a move to incorporate resource allocation and hospital organizational performance models.

D. The strategy for reform

1.32 The midterm evaluation of the PMSS-I and the reports on sector program disbursements reflect three key aspects of the strategy for reform: (i) the government has moved forward with sector policy reform beyond the agreements with the Bank and the pace of reform has been faster than expected; (ii) as a result, the next stage is expected mainly to consolidate the successes in such areas as institutional development of the MSPAS, extension of coverage and improvements in the quality of basic health services, and modernization of the public hospitals; and (iii) the MSPAS has established a successful policy dialogue with the IGSS, an institution that has gradually embarked on a process of reform thanks to the technical assistance provided under the PMSS-I.

1.33 Over a period of 10 to 12 years, health reform in Guatemala will focus on: (i) specialization of the MSPAS in regulation and the IGSS in insurance; (ii) decentralization of MSPAS and IGSS operational functions to the regional level; (iii) segregation of financial and service provider functions; (iv) conversion of hospitals into public decentralized institutions; and (v) the introduction of innovative financing arrangements for the health sector, mainly in the form of new public and private insurance systems.

1.34 If these changes get off the ground, the country will have within a period of five years: (i) a measurable improvement in the health status of the population in extreme poverty; (ii) a Ministry with bolstered regulatory and technical capacity and with the political credibility to protect the public from major risk factors; (iii) a health services purchasing agency capability developed in the MSPAS and the IGSS; (iv) public and private providers better positioned to deliver basic health services; and (v) hospitals converted into public institutions with modern management, administrative, and financial structures.

1.35 The Bank supports the expansion and improvement of social services and modernization of the State in Guatemala.[5] Importantly, the PMSS-I has managed to develop a fairly reliable census on the direction of sector reform in the years ahead. With PMSS-II, the Bank seeks to encourage the State to continue with its commitment to health sector reform.

E. Coordination with other donors

1.36 In a display of its new leadership role, the Ministry of Health has set an agenda for health, championed and organized financing and technical-cooperation arrangements with international aid agencies, and coordinated flows of resources to programs or regions based on priority. The new basic health care model has become a blueprint for contributing to more effective coordination between the government and international donors.

1.37 The conceptualization of this project has benefited from systematic consultation with the principal international donors and a review of its levels of financing and strategic objectives. The financing proposed here meshes with the priorities outlined by USAID (ensuring quality care, reproductive health, and comprehensive care for childhood diseases), the GTZ (providing essential medicines and inputs), the European Union (human capital formation and improved health infrastructure), and UNICEF (preventive care and health education).

F. Conclusion

1.38 To sum up, Guatemala has successfully embarked on an ambitious plan for health sector reform. With the first phase of political change and pivotal legal reform behind it, the strategy should assist the government in its efforts to consolidate the successes secured and to address the challenges and the problems perceived to have emerged.

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[5] Country paper, October 18, 1996, pp. 21-25.

II. THE PROGRAM, ITS COST AND FINANCING

A. Objectives of the program

2.1 The objective of the program is to improve the health status of people in Guatemala through expanded coverage of basic health services, institutional modernization, and investment in hospital services with a focus on maternal-child care.

2.2 The specific objectives are: (i) to improve the MSPAS's institutional capacity to perform the functions of regulation and supervision; (ii) to increase the coverage and quality of basic health services for rural communities in poverty; (iii) to modernize the health services procurement process; (iv) to modernize health risks financial administration in the IGSS; and (v) to increase productivity and the quality of health services in at least seven MSPAS pilot hospitals.

B. Structure of the program

2.3 The program, which will take four years to implement, will supplement activities urgently needed to increase the coverage of basic health services through medium- and long-term strategies to consolidate health reform in Guatemala. The strategy of the program is based on a dual approach of using competitive bidding for procurement for basic services as an element for spurring modernization of the sector while strengthening the institutional capacity of institutions in the sector to consolidate the advances made during phase one of the health sector reform. To attain this end, most of the program resources are being earmarked for increasing access by low-income rural groups to a basic health services package [conjunto básico de servicios de salud] (CBSS) to be provided by the private sector through a competitive procurement process.

2.4 As part of this strategy, funding will be provided under the program for technical assistance, training, pilot programs, and investment in hospital equipment as well as increased service coverage. The program is divided into four main components. The first one is for the institutional strengthening and organizational development of the MSPAS. The second component is for a program of declining cofinancing of government spending in order to expand basic health services through the use of competitive public and private provider agreements. The third component includes essential institutional strengthening for the development of the IGSS health insurance function. The fourth component deals with raising resources for improving hospital management through a pilot program to promote the reform of its management and administrative structures and to increase the quality of the hospital services provided.

2.5 The relationship between the problems identified in chapter I, the program strategy, and performance indicators is presented in Table II-1. The program logical framework is attached as Annex I.

Table II-1:
Health sector problems, program strategies, and performance indicators

Problem	Strategy	Component	Performance indicators
Expanded coverage of basic health services • Inadequate coverage of the poor in rural areas • Differences in the quality of basic health services • Inefficient public provision • Limited public service supply	• Delivery of basic health services package under contract with the private sector and under management agreements with the public sector	Component 2	• At least 90% of new beneficiaries are covered by basic services package by year 4 • 90% of pregnancies covered under the program received prenatal control in accordance with established protocols by year 4 • Percentage of MSPAS current spending on promotion of health and preventive care increases from 43% in year one to 50% by year 4 of program
Institutional shortcomings • Institutional weaknesses in the MSPAS • Organizational weaknesses in health areas • Organizational shortcomings in private supply of basic services	• Development of activities in support of MSPAS to fulfill functions of supervision and regulation • Strengthening of epidemiological surveillance system and disaster management and prevention system • Strengthening of essential MSPAS organizational capabilities • Decentralization of essential functions to health areas	Component 1 (MSPAS) Component 2 (private sector)	• All departments and hospitals with administrative and financial information systems and structures functioning • All present regulations of the Health Code are being applied • Establishment, implementation, and integration at the central level and in all departments of epidemiological surveillance and disaster prevention and care systems
Weaknesses in IGSS insurance function	• Strengthening of capacity to contract and pay for services, financial management, monitoring, and evaluation	Component 3	• IGSS spending on services under contract for delivery of health services increases from 11% in year one to 35% by year 4 of program

Public hospitals • Poor systems of administration, management, and financing • Low productivity in services • Low quality of services • Organizational weaknesses	• Introduce financial incentives linking payments to hospital performance under management agreements • Implement technical assistance programs to improve hospital management • Modernize performance agreement system between MSPAS and hospitals	Component 4	• All hospitals selected meet targets of productivity, efficiency, quality, and user satisfaction in agreements by end of program

1. Component 1: Institutional strengthening of the MSPAS (US$9.20 million)

2.6 The purpose of this component is to foster the development of essential institutional skills so that the MSPAS can perform the vital functions and duties assigned to it under the Health Code with respect to supervision of the health sector and control of risk factors affecting public health. To achieve this aim, financing will be provided for its activities under two subcomponents.

a. Subcomponent 1a. Organizational development of the MSPAS (US$5.18 million)

2.7 Under this subcomponent, financing will be provided for essential activities that will enable the MSPAS to develop administrative procedures that are crucial for putting in place its new organizational structure and give it the human capital, policy instruments, and technologies that are necessary for it to start up at the central and decentralized level. The following activities will be pursued with the help of technical assistance, training, and investment in equipment:

(i) Organizational development of the MSPAS at the central and decentralized level;

(ii) Development and integration of financing, supply, health statistics, and human resources subsystems in the MSPAS health management information system which was started in phase one of the program;

(iii) Design and installation of an information system to monitor the production, costs, and quality of health services delivered by public and private providers engaged by the MSPAS;

(iv) Organizational development of the Procurement and Maintenance Department, including the development of standards and

procedures for purchasing and procurement and the introduction of innovations to the health service provider payment system;

(v) Strengthening and integration of the epidemiological surveillance and disaster prevention and assistance systems;

(vi) Development of a plan to monitor and evaluate priority health programs; and

(vii) Development, implementation, and evaluation of a communications strategy for promoting consensus and agreements on health reform.

b. Subcomponent 1b: Development of supervisory and regulatory capacity (US$4.02 million)

2.8 Under this subcomponent financing will be provided for financial assistance and training activities: (i) to draft Health Code rules in areas concerned with regulation of medical, pharmaceutical, and food services markets; (ii) develop capacity for formulating, monitoring, and evaluating health policies, plans, and programs as well as the MSPAS strategy planning capacity; and (iii) draft Health Code rules based on consensus with other environmental authorities in areas concerned with protecting the public against environmental risks; and (iv) set the stage for the development of a new system for inspection, surveillance, and control of health risks.

2. Component 2: Support for expanded coverage (US$34.28 million)

2.9 This component has the following objectives: (i) complement the Guatemalan governments' efforts to expand coverage of basic health services for low-income rural communities; (ii) modernize health services procurement by moving gradually to a competitive system; (iii) promote the development of technical and administrative innovation in public and private delivery of basic health services; and (iv) reinforce MSPAS capacity to monitor and assess the expanded coverage program.

a. Subcomponent 2a: Financing for basic health services (US$18.27 million)

2.10 The government's earlier program to extend coverage had a considerable impact. According to the results, the proportion of the population living in extreme poverty that began to have access to basic health services has increased significantly since 1997. Given the social impact of this investment and the peace agreements, the government plans to extend coverage to reach a target population of 4.6 million.

2.11 This subcomponent provides for expanded coverage of the integrated health care system through CSBS financing for up to 500,000 new beneficiaries at an annual

per capita cost of nearly US$12. The annual coverage targets for new beneficiaries and the proposed financing plan appear in table II-2. To ensure that investment in new coverage is sustainable, the IDB financing will decline steadily from 100% for 250,000 beneficiaries in year one to 25% for 500,000 by year four.

Table II-2
Expanded coverage program – plan for financing and expected coverage in thousands of persons

	Year 1	Year 2	Year 3	Year 4	Total
Number of beneficiaries (000s)	250	300	400	500	n/a
IDB financing	100%	75%	50%	25%	n/a
GoG financing	0%	25%	50%	75%	n/a
Program cost (US$000s) (1)	3,000	3,600	4,800	6,000	17,400
IDB financing	3,000	2,700	2,400	1,500	9,600
Local financing	0	900	2,400	4,500	7,800

n/a: not applicable
(1): Does not include monitoring and evaluation costs

2.12 To ensure the success of extending coverage under agreements with private providers, the design is based on the main lessons learned from the mid-term evaluation of the PMSS-I. Regulations will therefore be drafted in agreement with the Bank for the basic services procurement process, including the agreement model to be used by the MSPAS and public and private providers, payment mechanisms, protocols, and clinical standards, as well as performance indicators to gauge contract performance.

2.13 In addition, financing in an amount of US$870,000 will be provided for the design of an information system to monitor public and private provider costs and production and an action plan and terms of reference will be prepared for a concurrent audit program to verify on an ongoing basis the effectiveness of the services provided to beneficiaries and the extent to which coverage and financing targets were met. Financing will be provided for the design and implementation of a system to monitor and evaluate the extended coverage program.

b. Subcomponent 2b: Modernization of basic health services procurement (US$13.10 million)

2.14 The objectives of this subcomponent are: (i) to introduce competitive procedures without restrictions for procurement of basic health services with public and private providers; (ii) to convert at least 70% of existing agreements into competitive agreements upon approval of the present program; and (iii) to evaluate the efficiency gained from the transition. Financing will be provided for up to 30% of the costs of provider agreements for services now being delivered by the MSPAS with NGOs throughout the country. The total funding for this component will not

be more than US$12.1 million by the end of the program. The conversion to competitive agreement targets set for this subcomponent in the three departments are as follows: (i) 10% of agreements in year 1, (ii) 15% in year 2, (iii) 20% in year 3, and (iv) 25% in year 4.

Table II-3
Expanded coverage program. Financing and coverage expected from modernization of basic health service procurement

	Year 1	Year 2	Year 3	Year 4	Total
Number of beneficiaries (000s)	63	162	301	482	n/a
IDB financing	10%	25%	45%	70%	n/a
Cost of program (US$000s)	931	2,163	3,881	6,125	13,100
Modernization of basic health services procurement	756	1,948	3,611	5,785	12,100
Monitoring and evaluation	175	215	270	340	1,000

2.15 An outside evaluation is expected to demonstrate upon completion of the four-year program, the benefits in terms of efficiency that have flowed from the introduction of a competitive contracting process.

c. Subcomponent 2c: Introduction of innovative techniques in providing basic health services (US$2.91 million)

2.16 The purpose of this subcomponent is to implement innovation techniques to increase the efficiency and effectiveness of the basic health services offered by public and private service providers.

2.17 To accomplish this aim, financing will be provided for technical assistance and training for pilot plans and an innovation development program as described below.

(i) Pilot plan for basic health service provider networks

2.18 The objective of the pilot plan is to encourage innovative changes in organization that enhance the efficiency and effectiveness of public and private local health service providers through the integration of administrative functions and inter-organizational coordination of user care.

2.19 The plan will consist of five integrated networks in eligible departments. In these areas, the program will finance studies, seminars, consulting work, and training activities for the purpose of establishing networks through strategic alliances between health service provider organizations (public and private) and a health services administration unit. Under the plan, mechanisms for interorganizational integration will be implemented, support will be provided for the development of

organizational capacity for network members, including mechanisms of communication and coordination and clinical and administrative information systems. Financing will also be provided for an evaluation of the costs and benefits of setting up such networks.

(ii) Health education information program

2.20 As part of this pilot activity, financing will be provided for the design, implementation, and evaluation of a health education information program at a per capita cost of US$2 for nearly 350,000 SIAS beneficiaries in rural areas and indigenous communities. The program will be designed to supplement the delivery of CSBS care, employing the latest advances in health education to develop personal hygiene in the home. It will also make use of the lessons learned from previous technical-cooperation operations funded by other donors in order to devise a communications strategy with a limited number of key messages that have been systematically selected. It will identify primary and secondary target populations and establish a media strategy, including suitable generic printed and audio materials, that may be adapted to different linguistic and cultural milieus. Financing will be provided for adapting and reproducing materials for languages and in volumes sufficient to cover the pilot activity's target population through public and private provider agencies. Financing will also be provided for training MSPAS personnel (at headquarters and in the regions) and the public and private providers basic health teams: doctors, facilitators, promoters, and midwives.

2.21 The pilot program will last 3 years and will be evaluated to determine its impact on the health behavior of beneficiary populations using control groups for purposes of comparison.

(iii) Development of innovative practices for indigenous communities

2.22 As part of this activity, financing will be provided for a program to develop innovations in the delivery of basic health services to indigenous communities. Under the program incentives will be offered, according to the regulations agreed on with the Bank, to those public and private organizations whose contributions to the administration and delivery of basic health services evince practices of excellence and valuable lessons for the delivery of services to indigenous communities:. The program will focus on practices that: (i) increase access to health services by indigenous communities and the quality of such services; (ii) promote the integration of elements of traditional medicine into the CSBS; and (iii) involve indigenous communities in the process of improvement, administration, and social oversight of basic health services.

2.23 The linchpin of this effort will be an annual competition based on merit for public and private service providers that contribute to timing, quality, educational

information, and social oversight and are culturally responsive to the needs of indigenous beneficiaries.

3. Component 3: Strengthening of the IGSS insurance function (US$3.8 million)

2.24 The object of this component is to reinforce the IGSS health risk insurance function. To do so, technical-assistance funding will be provided for: (i) operational, financial, and accounting restructuring of the IGSS, and (ii) the design of financial information systems required for the organizational structure put in place.

2.25 The technical-cooperation funding under this component will permit the IGSS to modernize its health insurance function in terms of institutional capacity, financial management, and health services contracting. In institutional terms; it means: (i) a strategic definition of the basic functions of insurance; (ii) an inventory of human resources; (iii) the design and implementation of a plan for changing the organizational culture; (iv) establishment of supervisory staff for organizational change; and (v) the design and development of management control systems. In terms of financial management, the program will finance: (i) the redesign of the basic processes of revenue collection, membership, and identity card issuance, verification and confirmation of rights; (ii) the design of a financial information system; and (iii) the design of financial management control systems. In terms of contracting health services, technical cooperation funding will be provided for the strengthening of IGSS Services Procurement Department in such areas as contract structure, identification of user needs, benefits packages, innovative payment and negotiation mechanisms and contract monitoring.

2.26 Although the reform of the pension system is not part of the program, given the financial independence between pensions and financial management of health risks, financing will be provided for basic studies to identify the viability of reforms affecting health services delivery and the pension system.

4. Component 4: Hospital management improvement program (US$11.63 million)

2.27 The purpose of this component is to raise productivity and the quality of service in at least seven MSPAS hospitals through improvements in hospital management, administration, and financing. This will be accomplished by means of a technical assistance program to design, carry out, and evaluate: (i) competition between hospitals for investment resources; (ii) development of a decentralized hospital management and administration model; (iii) the deepening of hospital budget systems based on productivity and performance (iv) modernization of the management agreement model in pilot hospitals; and (v) a management

modernization program, including resources for outsourcing of certain hospital services.

2.28 To achieve these objectives, the component will finance the establishment of a hospital management improvement program (PROHOSPITAL), to be carried out in areas with a high concentration of poverty. Under the program, a consulting firm will be hired to coordinate the PROHOSPITAL operation.

2.29 Before PROHOSPITAL becomes operational, hospital financing alternatives will be analyzed on the basis of the results and a set of Operating Regulations will be designed for PROHOSPITAL, describing its operation. PROHOSPITAL will operate as a competitive program, the resources of which will go to improving management. The MSPAS will set program regulated management commitments with beneficiary hospitals.

2.30 The investments in the program will foster improvements in hospital clinics and administration, and accord priority to those areas contributing to better quality obstetric and pediatric services and, as part of these services, to the list of priority equipment outlined in the PROHOSPITAL Operating Regulations.

2.31 The program will promote the introduction of standards on biosecurity, worker safety, and waste disposal as part of the process of modernizing hospital management.

a. Project management (US$4.03 million)

2.32 **Program Coordinating Unit (PCU)**. This involves technical assistance to fund the hiring of short- and long-term consultants for the PCU to help provide support to the MSPAS as executing agency for the program. Financing will also be provided for logistical support to defray the cost of stationery, fuel, furniture, and equipment needed for program execution.

C. Cost and financing of the program

2.33 The total cost of the program has been put at US$66.12 million, according to the breakdown presented in table II-4. These resources will be sourced as follows: (i) US$55.44 million will be contributed by the Bank from the Single Currency Facility of the Ordinary Capital in United States dollars; and (ii) US$10.68 million in counterpart funding from the GoG. Because the program qualifies as a poverty targeted investment (PTI) 4 percentage points will be added to the IDB financing. This includes US$554,000 for inspection and supervision. Also, the GoG will pay the interest on the loan and the credit fee out of current resources, which will be earmarked and disbursed by the Ministry of Finance. The terms and conditions of the loan are given in table II-5.

Table II-4
Total cost
(in US$ millions equivalent)

Expenses	IDB	GoG	Total	%
Component 1				
MSPAS organizational development	4.72	0.46	5.18	
Development of supervisory and regulatory capacity	3.66	0.36	4.02	
Subtotal	**8.38**	**0.82**	**9.20**	**14%**
Component 2				
Financing of basic health services	10.47	7.80	18.27	
Modernization of procurement of basic health services	12.10	-	12.10	
Monitoring and evaluation of the expanded coverage program	1.00	-	1.00	
Innovations in health service delivery	2.91	-	2.91	
Subtotal	**26.48**	**7.80**	**34.28**	**52%**
Component 3: IGSS strengthening	**3.43**	**0.38**	**3.81**	**6%**
Component 4: Modernization of hospital management	**10.47**	**1.16**	**11.63**	**18%**
Administration	**3.83**	**0.20**	**4.03**	**6%**
Financial audit	**0.70**	-	**0.70**	**1%**
Contingencies	**1.60**	**0.31**	**1.91**	**3%**
Financial expenses				
Inspection and supervision	0.55		0.55	
Total financing costs	**0.55**		**0.55**	**1%**
Total cost of project	**55.44**	**10.68**	**66.12**	
% by source	**84%**	**16%**	**100%**	

Table II-5
Terms and conditions of the loan

Source of financing	Ordinary Capital
Currency	Single Currency Facility US$
Amount	US$55.44 million
Terms and conditions	
Disbursement period	4.5 years
Execution period	4 years
Grace period	4.5 years
Amortization period	30 years
Interest rate	Variable
Inspection and supervision	1% of total loan amount
Credit fee	0.75% per annum on undisbursed balance

III. PROGRAM EXECUTION

A. Strategy

3.1 The borrower will be the Republic of Guatemala and the executing agency will be the Ministry of Public Health and Social Assistance (MSPAS) through its line offices based on the model used for PMSS-I. The Ministry will receive support from the Program Coordinating Unit (PCU).

3.2 The proceeds of the financing will be deposited in a bank account with Banco de Guatemala set up for the purposes of this operation. To the extent possible, the proceeds from the account will be used to finance scheduled activities within the Ministry, the IGSS, or hospitals. The Ministry will the sole agent authorized to disburse funds from the account and will be responsible to the Bank for keeping the necessary records for proper financial management of the program.

3.3 The selected design incorporates a flexible operating mechanism consisting of two elements: (i) annual operating plans that will be adjusted by means of technical reviews performed by the project team; and (ii) ongoing follow up on the program targets.

3.4 It is important to recall that the program is a means of effecting the institutional strengthening of the MSPAS. Consequently, during PMSS-II the Ministry will have the technical support of the PCU and consultants hired to ensure the efficient transfer of technology and the institutional sustainability of the program.

B. Operating framework for the program

3.5 Financing will be provided for program activities through funding for health services, technical assistance, and investment. The plan for implementation of the program is as follows:

1. Financing of health services for expanded coverage

3.6 The health services will be delivered through public and private local providers certified by the MSPAS in accordance with program standards.

3.7 Financial and technical monitoring of activities for the basic health services expanded coverage component will be performed by means of a concurrent audit by a specialized firm. **Such a firm must be hired as a condition precedent to the first disbursement of Component 2.**

3.8 The competitive mechanism for procurement of health services will be governed by the Program Operating Manual. The features to be considered must include at least

the payment mechanisms, quality assurance mechanisms, and information requirements. **Approval by the Bank of the Program Operating Manual and the model agreements to be used for program execution shall be a condition precedent to the first disbursement.**

2. Technical assistance funding

3.9 The technical assistance will be used to engage specialized consulting services to help strengthen the MSPAS, the IGSS, hospitals, and public and private basic health service providers.

3.10 **As a condition precedent to the first disbursement of component 4, the Bank must approve the PROHOSPITAL Operating Regulations.**

3.11 The hospital management improvement program will demand two types of technical assistance: (i) administrative support for beneficiary hospitals; and (ii) assistance in coordinating the operation of PROHOSPITAL and follow up on hospital beneficiaries. These activities will be carried out by different consulting firms.

3. Financing of the investment

3.12 The financing for the investment will be used for two purposes: (i) the hospital management improvement program (PROHOSPITAL), and (ii) purchase of computer and radio communications equipment.

3.13 PROHOSPITAL will function as a central and temporary mechanism administered by a specialized firm hired for this purpose. It will have a set of operating regulations establishing the lines of investment, and the evaluation criteria for project selection. In identifying investments priority will be accorded to improving the quality of maternal/child care services.

3.14 The hospitals receiving investments will enter into management agreements with the MSPAS. Fulfillment of the contractual goals will enable the MSPAS to provide incentives for strengthening management and financial capacity with resources from the local counterpart funding.

3.15 **The firm that will coordinate the operations of PROHOSPITAL must be hired as a condition precedent to the first disbursement of component 4.**

C. Administration of the program

3.16 The PMSS-I has a Project Coordinating Unit that is still functioning. This Unit has acquired vast experience carrying out IDB operations, demonstrating skill in executing the budget for phase I. The present structural and operational changes will give the Unit the capacity to coordinate the implementation of PMSS-II. To

this end, two support groups (one technical and the other administrative) will be formed and a specialized consultant will be hired to assist PROHOSPITAL. The structure and functions of the Coordinating Unit are presented in table III-1 and the responsibilities for implementation within MSPAS are shown in table III-2.

Table III-1
Program Coordinating Unit structure and functions

Technical support group	Administrative and financial support group	Prohospital (consulting firm)
• Technical support for MSPAS and IGSS • Technical monitoring of MSPAS hospitals • Preparation of terms of reference for procurement of goods and services • Supervision of program execution • Completion of technical reports	• Financial administration of the program • Drafting of agreements • Support with professional and technical staff for the Procurement and Maintenance Department (PMD)	• Coordination of program activities according to standards established in the Operating Regulations • Evaluation and monitoring of hospital strategic plans • Calls for price quotations held from time to time for investment projects • Evaluation and monitoring of investment projects

3.17 The MSPAS Procurement and Maintenance Department (PMD) will be in charge of procurement for the program. The PCU administrative and financial support group will help the PMD to carry out its functions, through the secondment of three professionals and the necessary support staff for its operation. The financing for the PCU professional staff will charged to the IDB financing on a declining basis, and it is expected that this charge will have been fully transferred to the local counterpart budget by year four of the project. The PMSS-I experience with international procurement agencies in the country has not been favorable. The proposed plan is expected to improve administrative efficiency, reduce the costs of the operation, and strengthen the Ministry's capacity to contract and purchase health services.

3.18 The Coordinator of the PCU will be chosen by the Ministry of Health on the basis of the terms of reference approved by the Bank. The PCU technical, administrative, and financial staff and its permanent support staff will be chosen by the Unit's Coordinator. The terms of reference and the professional profiles will be part of the Program Operating Manual.

Table III-2
Matching of activities and responsibilities

Activities to be carried out	Unit responsible for execution
Institutional strengthening of the MSPAS	
Organizational development	Directorate of Financial Administration
Development of regulatory and supervisory capacity	Directorate of Regulation, Supervision and Control
Support for expanded coverage	
Financing for basic health services	Directorate of Financial Administration - Procurement and Maintenance Department
Support for the transition to a contract system	Directorate of Financial Administration - Procurement and Maintenance Department
Innovations in basic health services	Directorate of Regulation, Supervision and Control
Strengthening of IGSS insurance function	
Institutional and financial strengthening	IGSS Finance Directorate
Strengthening of contracting	IGSS Consulting Services Department
Hospital management improvement program (PROHOSPITAL)	PROHOSPITAL outside coordinating firm Integrated Health Care System Directorate

D. Concurrent audit

3.19 During implementation of the program, the Ministry will have the support of an outside firm which will verify concurrently: (i) compliance with standards and procedures agreed on with the Bank for procurement of basic health services; (ii) the scope of the targets of coverage, quality, and financing planned for in the expanded coverage component; and (iii) effective delivery of services to beneficiaries planned for this same component. This activity will be financed with the proceeds of the Bank financing.

E. Procedures for contracting and procurement of goods, services, and works

3.20 International competitive bidding will be mandatory for contracts valued at more than US$1.5 million in the case of construction works, US$250,000 in the case of goods and US$200,000 in the case of consultants. For providers of basic health services in component 2 only, it is recommended that a contract threshold of US$300,000 be established.

3.21 Contracts below these thresholds shall be awarded as follows: local competitive bidding for works valued at between US$100,000 and US$1,499,999, for goods valued at between US$50,000 and US$249,999, for consulting services valued at between US$50,000 and US$199,999, and for basic health service provider contracts for component 2 valued at between US$50,000 and US$299,999. Price shopping based on 3 quotations will be used for contracts below these thresholds

and terms of reference will be included for consulting services. The procedures to be used for the awarding of contracts and procurement of goods and services are summed up in table III-3.

Table III-3

Procurement and contracting procedures

Works	Goods	Services	Health services
Over US$1.5 million ICB	Over US$250,000 ICB	Over US$200,000 ICB	Over US$300,000 ICB
US$100,000 to US$1,499,999 LCB	US$50,000 to US$250,000 LCB	US$50,000 to US$200,000 LCB	US$50,000 to US$300,000 LCB
Under US$50,000 PS	Under US$50,000 PS	Under US$50,000 PS	Under US$50,000 PS

ICB: International competitive bidding

LCB: Local competitive bidding

PS: Price shopping

3.22 In year one, the Bank will conduct an ex post review of the contracts for construction works and for procurement of goods and consulting services charged to the local counterpart funding in amounts below the equivalent of US$100,000. Commencing in year two, based on the findings of the annual technical review, and after closely monitoring the procurement process being used by the executing agency, the Bank may raise the ceiling and perform ex post reviews of all procurement and contracting in amounts below the thresholds established for international competitive bidding.

3.23 The Program Operating Manual will include procedures and guidelines to be used in the procurement of goods and services and the financing of basic health services. The procurement schedule is given in Annex II.

F. Disbursement schedule

3.24 A tentative disbursement schedule for the program is presented in table III-4.

Table III-4

Disbursements (US$000s)

Source	Year 1	Year 2	Year 3	Year 4	Total
IDB	13.93	15.76	13.22	12.53	55.44
Local counterpart	0.67	1.92	3.06	5.03	10.68
Total	14.59	17.68	16.28	17.56	66.12
%	22%	27%	25%	27%	100%

G. Revolving Fund

3.25 On the basis of the activities to be carried out and the planned rate of advance in year one, it is recommended that a revolving fund be set up for up to the equivalent of 5% of the financing.

H. Monitoring by the Bank during implementation

3.26 The project team (RE2/SO2 and COF/CGU) will provide technical support for project execution in the context of the reform. Among the activities to be carried out in this regard are:

a. Start-up workshop

3.27 Within three months after the operation is declared eligible, the borrower will organize, with the Bank's help, a start-up workshop for the program to be attended by management teams from the MSPAS (headquarters, health departments, and hospitals) and the IGSS (headquarters and hospitals) and the PCU team. The content, duration, and scope of the workshop will be agreed in advance with the Bank. This activity will be financed out of the proceeds of the Bank's financing.

b. Annual technical reviews

3.28 The executing agency will submit to the Bank in February of each year an annual report on program execution describing the extent to which the annual targets have been met. This report and the concurrent audit reports will serve as input for the technical review meeting to be held in the second quarter of each year. The action plan for the following year of the program and the MSPAS draft budget for those actions guaranteeing fulfillment of program targets and the commitment established in the loan contract may be adjusted on the basis of the technical review.

3.29 The activities to be covered in the annual technical reviews tentatively include: (i) review of program execution and achievements for the preceding year; (ii) an evaluation of the mechanisms for program execution and coordination; (iii) a review of the status of the studies and consulting services and what the latter have produced; (iv) consideration of the suggested adjustments to the operating plan proposed by the executing agency for the following year; and (v) adjustments to the targets and indication of corrective steps to be taken for proper program execution and coordination.

c. Mid-term evaluation

3.30 When one half of the proceeds of the loan have been disbursed or two years after the first disbursement has been made, the Bank will conduct a mid-term evaluation to examine the aspects assessed during the annual technical reviews. The terms of reference for this evaluation are in the program files.

d. Technical monitoring of the program

3.31 An integrated system of monitoring and evaluation will be designed under the program. Consulting firms will be hired to provide institutional support for the Ministry, performing on-site monitoring and evaluation and providing technical assistance and training to the MSPAS. The cost of monitoring and evaluating the program, including the concurrent audit of component 2, are part of the costs of each component.

I. External audit

3.32 The executing agency will submit to the Bank during each year of the program the program financial statements audited by a firm of independent auditors acceptable to the Bank and to the Bank's satisfaction. This activity will be financed out of the proceeds of the IDB financing.

IV. BENEFITS AND RISKS

A. Introduction

4.1 Although the proposed program will be implemented in a favorable setting, the sustainability of the health policy in the long run will depend mainly on the reaction of actors in the private sector and the government's capacity to increase fiscal revenues. The government, the MSPAS, and civil society (under the peace agreements) have expressed strong support for expanded coverage of health services for low-income groups, in rural areas.

4.2 The MSPAS has made significant progress in modernizing its management and services, attaining an unprecedented level of coordination with the IGSS. The program investments will benefit the most vulnerable population groups directly through the delivery of a highly cost-effective package of services, increased per capita spending on basic health services, and maternal-child care in particular (thus reducing the financial burden on the families of the poor) and improving the quality of the services provided by public hospitals.

B. Institutional viability

4.3 The MSPAS has been selected to implement the program because of the strengths it displayed during phase one and because the activities of phase two are intended to remove the institutional weaknesses that persist.

4.4 In phase one, the staff of the executing unit was headed by MSPAS line staff, who were directly responsible for functions other than those of the project with the support of consultants. This institutional arrangement produced a high degree of project ownership within the Ministry although in the final analysis it was not enough to ensure that all project objectives were successfully attained.

4.5 In phase two, the PCU will be made up of staff who will be exclusively responsible for coordinating the program whereas its execution will be the exclusive responsibility of the MSPAS. The PCU will coordinate its technical and administrative support functions with the MSPAS personnel in charge of program execution. The formal establishment and expansion of MSPAS executing capacity will be backed by the activities of component 1 and the direct support of the PCU to Ministry's Procurement and Maintenance Department (PMD).

4.6 The introduction of the recently approved Health Code will also contribute to the program's institutional viability since it will streamline and clarify the functions and responsibilities of the different government agencies concerned with health services and health promotion. In particular, the code clearly establishes the role that the MSPAS will play as the principal government agency in regulation and supervision

of the health sector. Component 1 of the program will make it possible to finance the drafting of regulations for the Health Code and will provide technical assistance for strengthening coordination between the Ministry, the IGSS, and private sector health care providers.

4.7 The PMSS-I brought out the MSPAS's weaknesses in administering hospital policy. Based on the present guidelines, phase two of the program will bring continuity and provide technical assistance for enhancing hospital management through the use of specialized firms.

4.8 One of the key areas affecting the success of the program is the response of the public and private sectors to contracting health services. The government's capacity to expand coverage of basic health services under its new care model depends on its own institutional capacity and the speed and quality of the response by the private sector and nongovernmental organizations. The program will improve this response by means of expanded coverage, competitive contracting procedures, and the supply of more and better information on costs and incentives. The program will also provide ongoing technical assistance directly to NGOs and other private organizations through specialized firms.

C. Environmental and social feasibility

4.9 The regulatory framework developed in phase one and the successes secured in hospital waste management will be consolidated during the second phase. The program will concern itself with raising MSPAS capacity to control environmental health risks through enhanced regulatory capacity and coordination with other government agencies. The project technical annexes contain the terms of reference for promoting exchanges of information between environmental and health authorities. Component 4 will consolidate the procedures for hospital waste management as a central element of modernization of PROHOSPITAL beneficiary hospital services.

4.10 The program will contribute to government efforts to alleviate poverty and will serve as an important tool in building up the pool of human capital among the very poor. Because the program includes effective actions to encourage nonrisk maternity and nutrition for mothers, it is expected to have a favorable impact on the health conditions of women.

4.11 The organizational changes to be carried out in phase two are designed to consolidate advances gained in phase one. The program is not expected to result in reductions in force in the public sector.

D. Economic and fiscal analysis

1. Fiscal impact and sustainability

4.12 Although post-2000 budgetary projections by sector are not yet available, the government has managed to funnel the necessary resources into health, education, and other sectors to fulfill nearly all of the targets established in the Peace Agreements. This is significant not only because the targets are ambitious but also because each year the amounts are greater. However, the government has not yet succeeded in increasing the fiscal revenue required to meet this commitment of the peace agreements. To do so, the tax burden would have to increase by 3% of GDP in 2002.

4.13 In Guatemala, health spending, at just 2.3% of GDP, is very low, amounting to approximately US$30 per person. The average for the region is 7% of GDP, or US$240 per person. The public sector defrays 60% of health spending, or US$18 per person, mainly through the IGSS (19%) and the MSPAS (60%). IGSS revenues are assured through an employee payroll tax of 6% for general health insurance. The IGSS serves approximately 1.6 million health beneficiaries, representing 16% of the total population and 30% of the economically active population.[6] MSPAS revenues are derived mainly from the government's general revenue, accounting for approximately 15% of total public spending in 1999.

4.14 Between 1995 and 1997, the government increased the Ministry of Health's budget by 32% in real terms for recurrent expenses excluding payrolls, following at least a decade of declining per capita spending on health. Not only did the Ministry increase spending by 11.5% between 1997 and 1999 (from US$151 million to US$169 million), its priorities shifted to primary care leading to a significant reallocation in resources. Spending on primary care has grown as a proportion of total MSPAS spending from 23% to 34% in the last 3 years.[7] More importantly, however, this reallocation of spending effectively increased coverage of basic health services by providing access to more than 2.5 million poor in the country without previous access to health care.

4.15 The targets set for the health sector in Guatemala are based primarily on expanded basic health services, the chief factor underpinning the growth in projected health spending. The volume of financing that will be required for basic health services and the pace at which it is disbursed depends on two critical factors: (i) the rate of increase in the marginal cost of expanded coverage; and (ii) the pace set by the government (or external constraints) for reaching the target population objective. The total cost of the basic services package will be US$6 million by year four of the

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[6] De la Hoz, J.C., Final consultants' report. Inter-American Development Bank, Washington, July 1999.

[7] Hernandez, N., Final consultants' report. Inter-American Development Bank, Washington, August 1999.

program, of which 25% will be financed by the IDB. This means that to cover 500,000 new beneficiaries, the government will only have to provide an additional US$1.5 million in funding once the IDB financing has been fully disbursed. This net increase in the Ministry's net recurrent expenses a miniscule, representing approximately 3.3% of public spending on health. Given the commitment of achieving even more ambitious targets (2.7 million additional beneficiaries) expressed in the Peace Agreements, the new program will not represent a net increase in spending beyond the government's present commitments. In fact, the IDB financing will speed up the rate at which the country reaches this goal.

4.16 For many countries, a comparable level of health spending is still very low. For Guatemala, however, such a level may be unsustainable if the country is unable to increase tax revenues. On the fiscal front, social spending and investment raised core spending by over 2% to 12.2% of GDP in 1998. At the same time, tax revenues edged up to 9.6% of GDP in 1998 as a result of the tax changes introduced at the beginning of the year. Tax revenue, however, is still below the targets set in the Peace Agreements and the overall fiscal deficit has swelled from 0.5% of GDP in 1997 to 1.5% in 1998.[8]

4.17 Since the fiscal deficit is projected to be around 2.7% of GDP by year-end 1999, the effort now under way to conclude a fiscal pact that would secure a commitment on the part of all the principal actors concerned, including the two political parties augurs well for the sustainability of higher social spending. Such a pact would establish mechanisms for expanding tax revenue thus strengthening the country's financial situation.

4.18 Although such a pact was still lacking when the present proposal was being prepared, the financial sustainability of phase two is ensured not so much by the modest share of GDP that it represents but more from the fact that the program will be strengthening a beneficiary and pressure group community with a social interest in an expanded coverage program. In most Latin American countries that have tried to redirect public spending to more cost-effective primary care, the experience has been that those in charge of secondary and tertiary services resist the reallocation of public funds and may hold up or reverse the process. In the case of Guatemala, however, the direct beneficiaries and the mix of CSBS providers present a formidable counterweight to such pressures and guarantee that the reallocation of resources will be maintained.

2. Cost-effectiveness

4.19 The program is highly cost-effective. The CSBS costs approximately US$12 per beneficiary. According to one technical study, the cost of this package in terms of

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[8] Inter-American Development Bank. Health Services Improvement Program: Third tranche report. August 30, 1999.

its impact on health status is only US$20 per DAYL.[9] [10] This cost compares very favorably with similar programs in other countries. The effectiveness of the package stems largely from the addition of such services as tuberculosis treatment, immunization, prenatal care, and iron supplementation.

4.20 The cost-effectiveness of the program is calculated on the basis of data and projections of the service effectiveness and coverage. To achieve such levels of effectiveness, the management of the program will demand a concurrent audit to ensure that the CSBS services are effectively and fully supplied. It also calls for the collection, monitoring, and evaluation of information on costs to providers in order to ensure that payments are neither too high nor too low. The efficiencies that are expected to flow from the transition to competitive agreement contracts will also increase the cost-effectiveness of the program.

E. Benefits

4.21 The principal beneficiaries of the program are the 500,000 Guatemalans who will have access to the CSBS. These beneficiaries are primarily low-income groups in rural areas. Virtually the entire CSBS is aimed at supplying essential cost-effective maternal-child care.

4.22 Nearly 4.5 million Guatemalans living in poverty, the number of people who are expected to have CSBS coverage by the year 2004, will benefit indirectly from the program through improvements in the quality of services. Most of these people dwell in rural areas. The improvements in quality, which will be made possible thanks to phase two, will enable the Ministry of Health to become a better procurement agent and an effective monitor of services. Those who stand to benefit in terms of quality and timeliness of the expected health services are the 750,000 inhabitants living in areas in which the pilot plans for educational services and communication networks are to be carried out.

4.23 Broadly speaking, the program is expected to have a significant impact on the health status of the population that is poor. Over 1 million DAYL will be "saved" each year. Without the IDB financing, the program would expand far more slowly, leaving 48,000 women without prenatal care and 93,000 children without growth and development programs. The lives of nearly 1,000 new borns will be saved as a result of the 4-year program's prenatal and perinatal activities. In addition, the

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[9] Bitran, Ricardo, et al, Final consultants' report. Inter-American Development Bank. Washington, D.C., August 1999.

[10] Disability-adjusted years of life (DAYL) is a measure of effectiveness that is used more often in studies of cost-effectiveness in the health sector. The concept of DAYL and its methodology is fully explained in the 1993 World Bank Development Report. Other performance measures are not expected to dramatically influence the findings of the CSBS cost-effectiveness ratio because of its nature as a basic measurement.

hospital pilot program (PROHOSPITAL) will benefit women and children in the areas served by hospitals taking part in the program since the fund operation restricts investment and civil works to the departments of gynecology, obstetrics, and pediatrics.

F. Risks

4.24 The program's financial and political risks are attributable to the financing with IDB resources of some of the government's expanded coverage goals. To alleviate these risks, the program has been designed to ensure that: (i) it does not replace public spending on health services; (ii) it succeeds in raising spending gradually over time; and (iii) it guarantees the availability of resources in the future for the spending needed to maintain the expanded coverage being financed under the program. To accomplish this aim, the scale of the Bank's financing in terms of beneficiaries and resources is declining. An accounting and technical audit to be conducted concurrently is included as part of the program to verify the spending targets and to make sure that IDB funding is not being used to replace local financing. Also, the program provides for the design and early implementation of an information system to facilitate monitoring of costs and productivity of private providers, thus providing the government with more effective tools for bringing new beneficiaries into the plan and the fiscal resources needed for the expanded coverage program.

4.25 During the program, the Bank conducted a study to determine the fiscal viability of expanded coverage and the rate at which new beneficiaries would join the program in different macroeconomic scenarios. The sizing of the Bank's financing and the addition of new beneficiaries were determined on the basis of this study. The findings are available in the program technical files.

4.26 The financing for the delivery of basic health services entails other risks as well: (i) potential constraints on the supply of private health services; (ii) marginal costs increasing with expanded coverage; and (iii) organizational weaknesses in the NGOs with which the MSPAS has entered into agreements. The experience with phase one shows that the number of beneficiaries has tended to increase on average by 34% each year since 1996 and that the response to this demand was timely. In addition, to alleviate the organizational capacity and supply constraints, the program provides for a gradual increase in coverage, a survey and accreditation of available providers, and flexible execution with annual reviews of the coverage and financing targets. Provision was also made for competitive procurement of health services so that more providers could enter the basic health services market.

4.27 In view of the institutional weaknesses identified in the Ministry, in the hospital sector, and in public health service providers, the program has devised a technical assistance strategy to mitigate such weaknesses (components 1, 2, and 4). The team hopes that a firm of specialized consultants will be hired to administer these

activities and ongoing monitoring of the Ministry, the NGOs, and pilot hospitals targeted under the program.

4.28 The changes put in motion by the IGSS in the last two years are the outcome of a national strategy of health reform and incorporate key elements for modernization of the sector. The participation by the IGSS in phase two of the program is a plus for the program since it guarantees greater levels of sector coordination and common criteria in shaping sector policy. Given the IGSS's surplus position, only technical assistance activities for this entity will be financed under the program.

4.29 The risk of the changes in the insurance function adversely affecting the operation of the IGSS's already weakened pension system will be reduced through the use of an incremental technical assistance strategy for the organization. This stage of the program stresses the gradual introduction of changes to the IGSS management capacity setting the stage for structural reform in the years ahead.

LOGICAL FRAMEWORK
GUATEMALA
HEALTH SERVICES IMPROVEMENT PROGRAM, PHASE II (PMSS-II)

ESCRIPTION	INDICATORS	MEANS OF VERFICATION	MAJOR ASSUMPTI
			Sustainability
rove health status of the uatemala	1.1	1.1.1	a. The government collects suffi resources to maintain spendin b. Other conditions determining do not deteriorate
am			Purpose to aim
d efficiency of health system	1.1	1.1.1	a. b.
			Components to purpose
ervisory and regulatory ngthened	1.1 Percentage of MSPAS current spending on preventive health increases from X% in year X to Y% in year Y	1.1.1 Budget performance report	a. Investment in preventive healt health of population
	1.2 (Public perception of MSPAS indicator)	1.2.1 Surveys conducted in component 7 (communications strategy)	b. Basic care package improves h population
d quality basic health services d improved (through use of	2.1 Y "new" persons are covered by basic health services package by year 4	2.1.1 Concurrent audit of program	c. The contract modality improv and achieves savings to be app expanded coverage
	2.2 90% of pregnancies covered by basic health services package received prenatal care in accordance with established protocols by year 4	2.2.1 Program monitoring report	d. Improvements in IGSS financi raises its capacity to provide h services
nce function strengthened	3.1 Percentage of accounts receivable/payable improves from X to Y by end of program	3.1.1	
	3.2 Percentage of IGSS spending on delivery of basic health services increases from X% to Y% by end of program	3.2.1	

SCRIPTION	INDICATORS	MEANS OF VERFICATION	MAJOR ASSUMPTIO
uctivity and quality	4.1 All pilot hospitals meet targets of productivity, efficiency, quality, and user satisfaction set out in agreements by end of program	4.1.1 Evaluation report	
	4.2	4.2.1	
IMPROVEMENT IN HOSPITAL MANAGEMENT			
			Sustainability
efficiency of health system	1.1	1.1.1	a. b.
			Purpose to aim
uctivity and quality	1.1 All pilot hospitals meet targets of productivity, efficiency, quality, and user satisfaction set out in agreements by end of program	1.1.1 Evaluation report	a. Other conditions determining h do not deteriorate
	1.2	1.2.1	
			Components to purpose
s plan implemented) agement Improvement Fund nd evaluated	1.1 Operating Regulations approved by MSPAS to the Bank's satisfaction 2.1 X% of beneficiary hospital operating budget has been decentralized by year 3	1.1.1 Copy of approved regulations 2.1.1	a. Hospitals with decentralized b autonomy to raise quality
			Sustainability
d efficiency of health system	1.1	1.1.1	a. b.
			Purpose to aim
d quality of basic health nded and improved (through cts)	1.1 Y "new" persons are covered by basic health services package by year 4	1.1.1 Concurrent program audit	a.
	1.2 90% of pregnancies covered by basic health services package received prenatal care in accordance with established protocols by year 4	1.2.1 Program monitoring report	

ESCRIPTION	INDICATORS	MEANS OF VERFICATION	MAJOR ASSUMPTI
			Components to purpose
service contracts with private th quality indicators	1.1 Percentage of basic services budget executed under contract (in accordance with model contract) rises from X% in year X to Y% in year Y (from Q.XXX to Q.YYY)	1.1.1 Budget performance report and copy of contracts	a. Providers fulfill contract term conditions
	1.2 All contracts signed are capitated and include established protocols by year 2	1.2.1 Copy of contracts (or standard format)	b. Component 2 of MSPAS strer project has been fulfilled
r integrated health services plemented	2.1 X networks in operation (based on model established for program) by year 4	2.1.1 Annual technical reviews	c. Public accepts and practices s
educate users of basic health igned, implemented, and	3.1 Information to educate users reaches 70,000 homes by year 3	3.1.1 Evaluation paper of pilot plan	d. Public improves use of health
promote innovation in type of medical services to communities designed and d	4.1 All of the innovations that are rewarded have been processed in accordance with standards established in Action Plan commencing in year 1	4.1.1 Annual technical reviews	e. Innovative practices are adopt service providers

STRENGTHENING OF IGSS INSURANCE FUNCTION

			Sustainability
d efficiency of health system	1.1	1.1.1	a.
			b.
			Purpose to aim
nce function strengthened	1.1 Percentage of accounts receivable/payable improves from X to Y by end of program	1.1.1	a.
	1.2 Percentage of IGSS spending on delivery of basic health services increases from X% to Y% by end of program	1.2.1	
			Component to purpose
, financial, and accounting g of the IGSS implemented	1.1 90% of positions at 3 levels of supervision filled in year 2	1.1.1 Midterm evaluation report	a. Board of directors of IGSS has willingness to proceed with fir restructuring

DESCRIPTION	INDICATORS	MEANS OF VERFICATION	MAJOR ASSUMPTIONS
	1.2 Operating and financial management report by unit functioning and ratified by board of directors in year 2	1.2.1 Management report	b. Members accept adjustments to their contributions to health system
2. Financial information system designed	2.1 Plan for implementation of financial information system approved by IGSS in year 2	2.1.1 Action plan for implementation	c. Financial restructuring of IGSS health insurance system does not cause disruptions in the pension system d. Action plan implemented
INSTITUTIONAL STRENGTHENING OF MSPAS			
Aim			Sustainability
1. Coverage and efficiency of health system improved	1.1	1.1.1	a. b.
Purpose			Purpose to aim
MSPAS supervisory and regulatory capacity strengthened	1.1 Percentage of MSPAS current spending on preventive health increases from X% in year X to Y% in year Y 1.2 (Public perception of MSPAS indicator)	1.1.1 Budget performance report 1.2.1 Surveys conducted in component 7 (communications strategy)	a.
Components			Components to purpose
1. New MSPAS structure implemented	1.1 90% of positions at 3 levels of supervision filled in year 2	1.1.1 Midterm evaluation report	a.
2. Plan for strengthening of health services purchasing function and procurement implemented	2.1 All of agreements in effect upon approval of program have been converted to contracts in 3 departments of the country by year 4	2.1.1 Concurrent annual audit reports	
	2.2 All of the new contracts come under competitive bidding regime by year 2	2.2.1 Idem	
3. Rules implemented for admission, performance and exit from health services provider organizations	3.1 All of organizations contracted with proceeds of program financing comply with rules in effect by year 4	3.1.1 Idem	

ESCRIPTION	INDICATORS	MEANS OF VERFICATION	MAJOR ASSUMPTI
stablished for regulation, and control of cal, food, and cosmetics	4.1 Action plan approved at ministerial level by year 2	4.1.1. Technical review in year 2	
stablished and agreed on for tal regulation, surveillance,	5.1 Action plan approved at ministerial level by year 2	5.1.1 Idem	
systems in operation	6.1 5 reports incorporating human resources, financing, and procurement data have been produced in areas of health and hospitals by year 3	6.1.1 Technical review in year 3	
tions strategy implemented	7.1 All of the activities contained in action plan have been implemented by year 4	7.1.1 Annual technical reviews	
demiological surveillance tioning	8.1 29 field epidemiologists trained and performing their functions in health area by year 3	8.1.1 Annual technical review, year 3	
onent of the national disaster nd prevention plan prepared	9.1 National plan tested at three levels of MSPAS in each health area by year 3	9.1.1 Annual technical reviews	
and evaluation of health nd policies implemented	10.1 Evaluation reports prepared in accordance with TOR agreed on with the Bank	10.1.1 Copy of reports	

HEALTH SERVICES IMPROVEMENT PROGRAM, PHASE II

PROCUREMENT SCHEDULE

MPONENT/PROCUREMENT	ESTIMATED BUDGET	QUANTITY	FINANCING	METHOD	PREQUALIFATION	DATE (FIRS HALF AN
. Institutional strengthening of MSPAS						
es	2,480,000	7	90% IDB	ICB	Yes	I-2000 /
es	4,371,700	43	90% IDB	LCB	No	I-2000 /
es	1,021,970	38	90% IDB	PS	No	I-2000 /
	737,330	2	90% IDB	ICB	Yes	I-2000 /
	452,500	6	90% IDB	LCB	No	I-2000 /
	136,500	10	90% IDB	PS	No	I-2000 /
2. Financing of basic health services						
es	2,440,000	3	100% IDB	ICB	Yes	I-2000 /
es	120,000	2	100% IDB	LCB	No	I-2000 /
es	186,050	16	100% IDB	PS	No	I-2000 /
alth service providers	31,370,000		70% IDB	ICB/LCB/PS	Yes	I-2000 /
	152,560	1	100% IDB	LCB	No	I-2000 /
	15,000	4	100% IDB	PS	No	I-2000 /
3. Development of IGSS insurance capacity						
es	2,160,650	22	90% IDB	LCB	No	I-2000 /
es	1,416,100	66	90% IDB	PS	No	I-2000 /
	229,000	14	90% IDB	PS	No	I-2000 /
4. Modernization of hospital management						
es	3,007,500	9	90% IDB	ICB	Yes	I-2000 /
es	1,840,875	18	90% IDB	LCB	No	I-2000 /
es	223,675	13	90% IDB	PS	No	I-2000 /
biomedical equipment and infrastructure	5,627,500	10	90% IDB	ICB	Yes	I-2000 /
	570,450	3	90% IDB	ICB	Yes	I-2000 /
	320,000	2	90% IDB	LCB	No	I-2000 /
	43,000	3	90% IDB	PS	No	I-2000 /

tional competitive bidding
ompetitive bidding
hopping (at least 3 quotations)

RGII-GU219P
GU-0125
Original: Spanish

PROPOSED RESOLUTION

GUATEMALA. LOAN ___/OC-GU TO THE REPUBLICA DE GUATEMALA
Health Services Improvement Program - Second Stage

The Board of Executive Directors

RESOLVES:

That the President of the Bank, or such representative as he shall designate, is authorized, in the name and on behalf of the Bank, to enter into such contract or contracts as may be necessary with the República de Guatemala, as Borrower, for the purpose of grant it a financing to cooperate in the execution of the Health Services Improvement Program - Second Stage. Such financing will be for the amount of up to fifty five million four hundred forty thousand dollars of the United States of America (US$55,440,000) from the resources of the Single Currency Facility of the Bank's Ordinary Capital, and will be subject to the "Financial Terms and Conditions" and the "Special Contractual Conditions" of the Executive Summary of the Loan Proposal.