HEALTH SERVICES IMPROVEMENT PROGRAM

(CR-0120)

EXECUTIVE SUMMARY

BORROWER AND GUARANTOR:	The Republic of Costa Rica	
EXECUTING AGENCY:	The Caja Costarricense de Seguro Social [Costa Rican Social Security Fund] (CCSS), with the cooperation of the Ministry of Health	
AMOUNT AND SOURCE:	IDB:	US$42 million (OC)
	Local counterpart funding:	US$18 million
	Total:	US$60 million
TERMS AND CONDITIONS:	Amortization period:	25 years
	Disbursement period:	4 years
	Interest rate:	variable, subject to financing from the Intermediate Financing Facility (IFF). This financing would be applied to a portion of the loan equivalent to US$28 million
	Inspection and supervision:	1% of the loan amount
	Credit fee:	0.75% on the undisbursed balance

OBJECTIVES: The principal purpose of the program is to support institutional reforms in the health sector that will make it possible to improve efficiency and effectiveness in the provision of services in the context of public-sector reform. The program's specific objectives are to: (i) design and implement institutional reforms to enable the Ministry of Health (MINSA) to discharge its functions as the sector's lead agency and ensure a more rational pattern of resource allocation, one that avoids duplications among institutions and programs; (ii) consolidate primary health care programs to achieve a more efficient coverage of services; and (iii) reduce inequalities in the access to basic health services by giving priority to physical investments to strengthen the functional capabilities and efficiency of the health services network in the country's low-income areas.

DESCRIPTION:

The funding for the program would be used to finance the following components: (i) restructuring of the Ministry of Health as lead agency to develop its ability to plan, conduct, monitor and evaluate the sector's activities; (ii) the integration of primary care services, which consists of: (a) transferring all health centers and stations to the CCSS to eliminate duplication in primary services and administrative structures; (b) consolidating the primary care services by expanding, remodeling, and/or replacing 119 health stations (25% of the network) and 11 health centers (10% of the network) in underserved areas of the country; (c) enhancing the efficiency of the hospital system by replacing the Alajuela Hospital; and (d) strengthening the CCSS financially to provide it with the funding required to operate the facilities transferred to it.

The sector reforms outlined above are an integral part of the government reforms to be instituted by the Costa Rican authorities. The government reform program is aimed at improving the efficiency of the public sector through a restructuring of institutions engaged in duplicate activities and through the privatization of public enterprises and services which are not regarded as vital to the performance of public functions. In addition, the reform program seeks to reduce redundant public-sector personnel by approximately 20% during 1991-1994. The government reform program will be supported by the World Bank's structural adjustment program III (PAE III) and the IDB's public sector reform program (CR-0025).

It should be noted that the operation proposed herein is a fundamentally important input for World Bank support in the health sector. The World Bank is considering a sector program to complete health-sector reforms in the following areas: (i) readjustment of institutions' financing systems (other than MINSA's); (ii) improvement of the sectoral information system (other than MINSA's); (iii) adjustment of the CCSS's health-care model; and (iv) administrative decentralization of the CCSS.

ENVIRONMENTAL CLASSIFICATION:

The Environmental Management Committee, at its meeting of November 5, 1990, classified this as a Category III operation.

BENEFITS:

The program is expected to generate the following benefits: (i) better resource allocation and avoidance of duplication in activities and administration as a result of the institutional reforms; (ii) wider population coverage and greater efficiency in the

delivery of services as a result of integration of direct health services to individuals; (iii) improved service to users as a result of tighter quality controls by the lead agency; and (iv) greater equity in the health-care delivery system because of a sharper focus on low-income population groups.

RISKS:

The main risks of the program are: (i) that the process of public-sector reform bogs down because of a lack of political consensus and the reforms envisaged are not implemented; and (ii) that the government fails to make timely delivery of the funds required to enable the CCSS to absorb the transfer of health centers and stations.

These risks are expected to diminish, however, since, as stated above, the reforms proposed under this operation are also an integral part of the government reforms supported by PAE III, currently being considered by the World Bank, and of the IDB's public sector reform program (CR-0025). Accordingly, the restructuring of MINSA and the consolidation of services are to be implemented as part of the government reforms. Moreover, the government has already started the reform process in the health sector by integrating the health services in various regions of the country.

In order to make certain that the CCSS has adequate resources at its disposal for operating the health centers and stations efficiently, clauses committing the government to making the necessary transfers of funds will be included in the loan contract.

THE BANK'S COUNTRY STRATEGY:

The Bank's strategy for Costa Rica seeks to support reactivation of the country's economy through: (i) consolidation of commercial and financial liberalization with emphasis on removal of sectoral obstacles to private investment, definition of new fields for private-investment participation, and rehabilitation and expansion of transport infrastructure for exports and marketing; (ii) improvement of the levels of attention to basic social needs, with consideration given to a sharper focus on social spending under decentralized systems and strengthening of the public-investment planning system; and (iii) adjustment of employment-absorption conditions, with due consideration for a new salary-regulation framework and labor-force training and skill-enhancement programs.

The health services improvement program is responsive to this strategy, inasmuch as it would: (i) support

the implementation of institutional reforms in the sector that would strengthen the ministry's ability to plan, direct and evaluate the use of sector resources and provide retraining to appropriate staff for this purpose; (ii) accord priority to investments to benefit the country's lowest-income population; and (iii) supplement the administrative decentralization efforts currently being made by the CCSS and MINSA.

SPECIAL ASPECTS: As of the date of approval of the operation, program-related expenditures will have been incurred in connection with the preparation of the Ministry of Health reorganization component. In this regard, up to US$100,000 of the expenditures pertaining to the design studies on this component will be financed retroactively (see paragraph 3.29).

In addition, expenditures totaling up to the equivalent of US$500,000 incurred for preparation of the final designs for the Alajuela Hospital will be recognized as part of the local counterpart contribution (see paragraph 3.30).

I. FRAME OF REFERENCE

A. Introduction

1.1 The proposed operation is a core element of the national health sector reform plan and of the government reform program, both of which seek to make more efficient use of the sector's resources and improve its operations.

1.2 The activities to be financed by the Bank under the proposed operation would support the implementation of reforms aimed at bringing about an orderly arrangement of the roles and operation of the principal health-sector institutions by making the Ministry of Health (MINSA) responsible for sectoral policy-making and coordination and transferring responsibility for the operation of primary health care services to the Caja Costarricense de Seguro Social (CCSS). It is hoped that these reforms will make it possible to avoid functional duplications and to ensure the creation of conditions that would raise productivity and equity in the delivery of health services. The integration-of-services component, including repair and replacement of infrastructure, will enable the sector to improve the efficiency of health facilities in counties *[cantones]* of the country to which priority is given. 1/

B. Recent economic conditions

1.3 The economy's overall performance during 1991 was subject to contrasting trends. The deficits in the external and public sectors were reduced substantially as a result of various economic adjustment measures. In addition, the country's international reserves increased significantly and arrearages in the payment of the foreign public debt were eliminated or restructured in the Paris Club. Conversely, however, the rate of growth of the GDP was the lowest since 1985 and inflation rose.

1.4 The external sector showed a notable improvement in 1991, with the current account deficit being cut by more than half. This improvement was associated with a major growth in exports, principally the traditional ones. Imports, on the other hand, declined owing to a slowdown in the growth of the domestic economy and the application of more restrictive policies: a 2%-12% surcharge effective as of December 1990 and an increase in deposits required for foreign-exchange requests for imports.

1/ The priority counties are a group of 30 counties identified by the Ministry of Planning as disadvantaged in relation to the rest of the country by virtue of the low socioeconomic level of the population.

1.5 The nonfinancial public-sector deficit, for its part, also declined in 1991, to a level of 0.1% of GDP. Nevertheless, the Central Bank of Costa Rica (BCCR) suffered losses amounting to 2% of GDP. The improvement in the fiscal deficit was due essentially to real adjustments in the rate schedules of government-operated companies and to the surplus recorded by the rest of the nonfinancial public sector, principally the CCSS. On the other hand, the reduction in spending occurred primarily in public investment, which fell by 7.2% as a result of the government's inability to make further headway in its efforts to curtail current expenditures. Current expenditures, together with transfers, accounted for 90% of total spending by the central government.

1.6 In an effort to finance the public deficit, the central government resorted in 1991 to the sale of bonds on the financial market. The public sector's demand for funds, together with private sector demand, was a factor in raising nominal interest rates to levels above 45% throughout the year. High interest rates were in fact the principal obstacle to private investment, which declined by 14% in 1991.

1.7 As a result of the displacement of private investment, the reduction of public investment and the international recession, the economy's rate of growth in 1991 was only 1%, the lowest level since 1985. And as a consequence of the low rate of economic activity, the rate of unemployment rose to 5%.

1.8 Inflation remained high in 1991 (29%) as a result of monetization associated with the inflow of foreign capital (related to the high interest rate), increased prices and rate schedules in government-run enterprises, and inflationary expectations stemming from the speedy process of devaluations. To bring inflation under control, the government, in August 1991, instituted a price freeze and reduced the pace of the devaluations. The result of this was a high but controlled inflation that began in early 1992 with a level of 4% per month.

Prospects

1.9 The process of adjustment of the Costa Rican economy continues in 1992. The government has liberalized access to the exchange market for current and capital account operations of the balance of payments. The rate of exchange is being determined by foreign-exchange supply and demand forces.

1.10 The standby program agreed upon with the IMF in 1991 had the following goals: (i) reducing the overall fiscal deficit to 0.5% of GDP; (ii) reducing the balance-of-payments current account deficit to less than 4% of GDP; and (iii) building up an accumulation of net international reserves in the Central Bank.

1.11 Compliance with the goal of fiscal adjustment was waived by the IMF in April 1992. However, in view of the fact that substantial headway had been made in the stabilization measures in the areas of exchange and capital-account openness and that the international reserves had risen, the standby agreement was extended to September 1992. The new fiscal adjustment goal is to reduce the overall fiscal deficit to 1.0% of GDP and achieve a rate of inflation not exceeding 15% per annum. The rate of growth of GDP is expected to range from 2.5% to 3% in 1992.

1.12 The government is negotiating a new standby program with the IMF for the period from October 1992 to December 1993.

C. Government reform program

1.13 The Costa Rican authorities have determined that in order to achieve a sustained level of economic development it will be necessary to keep the fiscal deficit under control, thereby eliminating the distortions created in the economy by the existence of a public deficit. This, in turn, requires a curtailment of public expenditures and an improvement in tax collection efficiency. Furthermore, in an effort to enhance the efficiency and fairness of public-sector operations, the authorities have decided to undertake a reform of the government based on the understanding that the present government apparatus is oversized, inefficient and costly. The reform program is supported by the World Bank sector adjustment program III and the IDB's public sector reform program (CR-0025), each of which will be submitted to the respective board of directors in December 1992.

1.14 The principal objective of the government reform program is to enhance the efficiency of the public sector through the restructuring of institutions engaged in duplicate activities and through the privatization of public enterprises and services which are not regarded as vital to the conduct of public functions. The reform program seeks also to reduce redundant public personnel by approximately 20% during the period from 1991 to 1994. The institutional reform will cover five of the 13 ministries: Housing, Agriculture, Health, Transportation, and Social Security. Sector working groups were established to determine the measures to be taken in each sector. Each of these groups developed a sectoral diagnosis which served as a basis for the design of actions to improve efficiency and of action plans for their implementation.

1.15 The analysis done by these working groups indicates that the following reforms are needed in the five sectors mentioned above: (i) a rational distribution of functions among the agencies of the sector to maximize the effectiveness of public resource utilization; (ii) strengthening of budgetary control under the new program-budgeting process; (iii) creation of technical capability for the formulation of sectoral policies; and (iv) legal and administrative support for implementing the new ministerial functions.

1.16 The basic legal underpinnings of the proposed reforms for the curtailment of current expenditures are: (i) the Commissioning of Public Works Act, which encourages privatization in the construction of public works; (ii) the Economic Democratization Act, which regulates the privatization of public services; and (iii) the Supplemental Pensions Act, which fosters open competition in the insurance area.

1.17 The Supplemental Pensions Act has been approved by the Legislative Assembly. The bills on the commissioning of public works and economic democratization have been submitted for consideration by the Legislative Assembly. Approval of the Commissioning of Public Works Act is a condition precedent to submittal of the public sector reform program (CR-0025) to the Bank's Board of Directors, while approval of the Economic Democratization Act is one of the conditions precedent to the first disbursement under that operation.

1.18 The health-sector diagnosis that follows is based on an analysis done by the working group on government reform and on the work of the project team for this operation.

D. The health sector

1. Diagnosis of the sector

1.19 While Costa Rica's health care system has helped the country to achieve and sustain health levels which are among the highest in the region, the sector's present structure does not allow the institutions to provide an adequate response to the population's health problems.

1.20 The past decade has witnessed an accentuation of the following problems: (i) inequalities of access to and the quality of health services at the expense of the country's most sorely underserved groups; (ii) inconsistencies between the epidemiological profile resulting from demographic change and the health care model; (iii) an imbalance among sector institutions by virtue of the weakened role of the Ministry of Health as lead agency and the duplication of services and administrative structures; and (iv) a deterioration of capabilities for the prevention and solution of problems as a result of the low efficiency of health care services.

1.21 One of the major features of demographic change in Costa Rica has been the aging of the population, which has entailed rises in the incidence, prevalence and mortality attributable to chronic diseases (e.g. arterial hypertension, diabetes, cancer, heart diseases) and accidents, including work-related accidents and injuries. This broad epidemiological transformation calls for increasingly complex preventive and curative services at a time when significant levels of infectious and parasitic diseases and

deficiencies, 2/ along with complications of pregnancy and childbirth, persist among marginalized groups in the priority counties.

1.22 The sector analysis shows the following to be the major deficiencies in the sector: 3/

a. There is no procedure to govern the overall planning of substantive activities of the various institutions, or any level of authority for comprehensive monitoring and evaluation of the sector. While current legislation provides for MINSA to assume a leadership role in the sector, this has not been possible because the ministry has put more emphasis on the delivery of services than on leading the sector by developing its policies. The ministry has no instruments for the effective exercise of leadership, i.e. for sectoral coordination of autonomous institutions (CCSS and AyA) or for sectoral planning or allocation and control of sectoral financing.

b. Organizational fragmentation exists as a result of an overabundance of legal regulations and an insufficiency of consistent and appropriate managerial procedures, but there are no administrative and legal standards to facilitate an operational and administrative decentralization of health services.

c. There is overlapping in population coverage and duplication in services and administrative structures (MINSA health centers and CCSS clinics), even within particular health centers where the CCSS and MINSA operate jointly.

d. The study of the hospital network indicates that there are urgent needs for partial re-equipping of certain facilities and for replacement of the Alajuela Hospital, which represents the only significant investment needed in the existing system (see chapter II, section B.2).

e. There is no clear process for the determination of human resource policies, standards and procedures in the areas of salaries, incentives, recruitment and selection, distribution of health personnel, training and administration. This suggests that employees in some institutions do not measure up to the educational profile needed to perform the work entrusted to them.

2/ Recent studies (1990, 1991) show that one out of every five preschoolers exhibits some degree of malnutrition (3.7% are moderate or severe cases), one in four children is anemic, and one of nine suffers from iodine deficiency.

3/ For further details on the sector, see Annex I-1.

f. Budget management in the sector has adhered to rigid traditional procedures without reference to any analysis as to whether resources are being used where they are most needed or to any effective monitoring of expenditures against actual costs or against compliance with stated objectives.

g. There is no broad involvement of communities in the promotion and protection of their health or in the definition, execution and evaluation of programs offered by institutions.

1.23 To address the sector's identified weaknesses, the Costa Rican authorities have proposed a series of measures aimed at finding solutions to them and reorganizing the sector as needed. These measures are part of the health sector reform program and involve fundamental changes leading to an improvement of public health.

2. Sector reform program

1.24 The essential features of the health sector reform proposed by the authorities are as follows:

a. Strengthening of the Ministry of Health to enable it to assume a leadership role in the sector by taking charge of sectoral planning, leadership, control and evaluation. This will give the ministry a broader view of the sector as a basis for a more rational approach to the use of resources, one in which duplication of efforts between institutions and programs is avoided and there is a more effective control over compliance with policies and the quality of services.

b. Integration of preventive services and health promotion and development with treatment and rehabilitation as a means of expanding and improving coverage and ensuring a more rational use of resources. In order to improve efficiency in the delivery of services, a harmonious operation within the health services network (health posts and centers, 4/ outpatient clinics, and general and specialized hospitals) is needed. Consequently, consolidation of the primary health care program will involve a transfer of all health posts and centers from MINSA to the CCSS.

4/ Health centers are facilities at the general level that conduct promotional, preventive and treatment activities, offer pharmaceutical and laboratory services and provide technical and administrative support to health stations. Health stations are smaller units responsible for a health area with approximately 3,000 residents that provide preventive medicine, health education, immunizations, first aid and chronic disease control.

c. Effective administrative and functional decentralization based on strengthening the regional and local levels, relieving the central level and facilitating decision-making at the CCSS.

d. Development of new health-care and financing models to facilitate the delivery of services by third parties in the context of the Economic Democratization Act, which is part of the government reform program.

e. Introduction of program-budgeting in sector institutions. This will make it possible to control expenditures and to allocate resources in keeping with actual requirements.

f. Transfer of occupational risks from the Instituto Nacional de Seguros [National Insurance Institute] to the CCSS. This will avert duplication of services and paperwork.

g. Establishment of a sectoral information system to facilitate decision-making and sector leadership.

3. Support for sector reform

a. Proposed operation

1.25 The health services improvement program (CR-0120) will assist the sectoral reform process by providing support for the restructuring of MINSA as lead agency, which is regarded as the essential stage, inasmuch as it will unleash the other needed sector adjustments. The mechanisms and capability needed for the planning, implementation, control and evaluation of sector activities will be created as part of this activity. This will provide a broader view of the sector and, consequently, will facilitate a more rational use of resources.

1.26 As part of this restructuring of the ministry, all primary health care posts and centers will be transferred to the CCSS. To make such a transfer feasible, it has been found necessary to rehabilitate badly run-down facilities located in priority counties. Physical and functional improvement of such facilities will make it possible to regain adequate efficiency levels in the delivery of primary services in marginalized areas of the country.

1.27 Bolstering the efficiency of the national hospital system requires the replacement of Alajuela Hospital, since its badly deteriorated infrastructure and equipment are obstacles to any efficient operation of the system, which has a very limited capacity to address the health problems of patients discharged from peripheral hospitals. This problem leads to lengthy waiting periods for specialty and subspecialty consultations. Replacement of the Alajuela Hospital building will enable this facility to discharge its regional role of addressing and meeting the needs of its service area on terms commensurate with their level of complexity.

b. Supplemental World Bank operation

1.28 The restructuring of MINSA, with the consequent transfer of services to the CCSS, is a vitally important input for the operation being developed by the World Bank, which will make it possible to complete the health-sector reform in the following areas: (i) readjustment of the system of financing for health-sector institutions (other than MINSA); (ii) improvement of the sectoral information system (other than MINSA); (iii) adjustment of the CCSS health care model; and (iv) administrative decentralization of the CCSS. This operation, estimated at US$50 million, is scheduled for approval at the end of 1993.

c. Other operations

1.29 Hospital equipment shortcomings in the sector would be financed with proceeds from a US$30 million loan currently being negotiated with the Government of Spain.

1.30 Expansion and strengthening of the health services system in the Huetar Atlántica region will be carried out with financing from the Central American Bank for Economic Integration (CABEI), whose loan for US$8 million will be used for the reconstruction of health posts and centers hit by the February 1991 earthquake. The eligibility criteria for selection of the works included under this financing are consistent with the thrust of the sector reform program and compatible with the Bank's own criteria.

E. Strategy of the Bank in Costa Rica

1.31 The Bank's strategy in Costa Rica calls for supporting the country's economic recovery through: (i) consolidation of commercial and financial openness, with emphasis on the removal of sectoral obstacles to private investment, identification of new fields for private-investment participation, and rehabilitation and expansion of transport infrastructure for exports and marketing; (ii) improvement of the levels of attention to basic social needs, with consideration given to a closer focus on social expenditures under decentralized systems and strengthening of the social-investment planning system; and (iii) adjustment of employment-absorption conditions, with due consideration for a new salary-regulation framework and workforce training and skill-enhancement programs.

1.32 The proposed health services improvement program fits within the Bank's strategy in Costa Rica, since it would support the implementation of health-sector institutional reforms that would make it possible to improve the quality of health services and deliver them more efficiently. The operation under consideration would also include a development training subcomponent for MINSA staff to enable the ministry to discharge its new functions. In addition, the investment subcomponent would improve basic health care in poor

rural areas and the efficiency of the national network of hospital services, through the replacement of the Alajuela Hospital.

F. The Bank's experience in the sector

1. Loan 439/SF-CR

1.33 In 1975, the Bank approved loan 439/SF-CR in an amount of US$20 million to finance the national health services project. The purpose of the operation was to improve preventive and curative services in the rural areas, to which end three regional hospitals, three maternal and child health centers and 12 clinics were built and equipped.

1.34 Technical cooperation program ATN/SF-1395-CR in the amount of US$284,000 for institutional strengthening of the Caja Costarricense de Seguro Social was approved along with that loan. This component called for the improvement of the CCSS administrative and accounting procedures, the institution of modern hospital-administration methods, and staff training in technical and administrative areas. The objectives of this technical cooperation program were achieved and its recommendations were implemented.

1.35 The operation has yielded highly positive socioeconomic impacts and the expected results of the project were amply attained. Substantial benefits were provided to approximately 500,000 low-income rural residents through the regionalization of medical services. Higher-than-anticipated socioeconomic benefits – in terms of improved distribution of health services, savings in travel expenses, and fewer lost workdays – materialized in the service areas of the facilities built as part of the project. With regard to the basic indicators of the project's impact at the countrywide level, an appreciable reduction of the rate of hospitalization has been achieved because of the greater availability of outpatient facilities, leading to an increase in the average number of outpatient consultations from 2.2 visits per person in 1973 to more than 3 visits per person in 1990.

2. Technical cooperation program ATN/SF-2443-CR

1.36 In 1984, the Bank approved technical cooperation program ATN/SF-2443-CR for US$741,000 to strengthen the Sistema Integrado de Mantenimiento de los Servicios de Salud [Integrated Health Facilities Maintenance System] (SIMSS). The purpose was to establish an integrated infrastructure-maintenance system.

1.37 As a result of the operation, SIMSS was set up with subsystems for the following purposes: administrative and operational maintenance, development of policies on preventive maintenance and building repair, management information, and procurement of equipment and replacement parts for preventive maintenance and

repair, all of which has helped to protect the investments made in the health sector.

1.38 In addition, information and experience in the maintenance area have been transferred to a total of 1,923 officials, including 1,307 from the CCSS and 542 from the ministry, who have received training.

1.39 Lastly, a computerized inventory of equipment and buildings taken as part of this technical cooperation program provided the basic data for the preventive maintenance and repair programs.

II. THE PROGRAM

A. Purpose

2.1 The chief purpose of the program is to provide support for institutional health-sector reforms aimed at improving efficiency and effectiveness in the delivery of services in the context of public-sector reform.

2.2 This purpose would be attained through: (i) the determination and implementation of reforms to enable the Ministry of Health to exercise its role as leading institution in the sector and achieve a more rational approach to resource allocation, thereby averting duplications between institutions and programs; (ii) consolidation of the primary health care programs to improve efficiency in the coverage of services; and (iii) reduction of inequalities in the access to basic health services by giving priority to physical investments that strengthen the functional capabilities and efficiency of the health services network in the country's low-income areas.

B. Description

2.3 In keeping with the purpose of the program, the funds from the proposed operation will be used to finance restructuring of the Ministry of Health and the integration of health services.

1. Restructuring of MINSA

2.4 The areas of activity to be supported by this component are:

a. Development of the ministry's strategic functions.

b. Organizational structure, financing and budget of MINSA.

c. An institutional development program.

2.5 The strategic functions of the ministry will include: (i) health planning and monitoring; (ii) determination of policies and inter-institutional coordination; (iii) regulation of policy compliance and the quality of services; (iv) health promotion; and (v) the protection of public health.

2.6 MINSA's operational functions, organizational structure, financing system and budgetary structure will be worked out in detail on the basis of the strategic functional profile and sectoral interaction model selected.

2.7 The financing model calls for the establishment of standards and procedures for improving the collection, distribution, control and

evaluation of resources, as well as levels of authority for the identification and adoption of new sources of financing.

2.8 A budgetary structure consistent with the financing model and the functional and structural profile adopted for the ministry will be established to eliminate existing gaps and rigidities and allow a more flexible and decentralized pattern of financial management, supported by modern formulation and control mechanisms.

2.9 Following up on the results of the earlier stages, the present operation is aimed at formulating and implementing an institutional development program to make optimum use of information systems and resources and adapt them to a new functional and organizational profile. This program will include training of human resources and the installation of an information system.

2. Integration of health services

2.10 This component calls for: (i) the transfer of all health posts and centers; (ii) consolidation of the integration of primary care services through the expansion, remodeling, and/or replacement of health posts and centers in marginal areas; (iii) the improved efficiency of the hospital system through the replacement of Alajuela Hospital; and (iv) the financial strengthening of the CCSS so that it has the resources necessary to operate the facilities transferred.

2.11 Transfer of the MINSA health posts and centers to the CCSS will eliminate duplication of primary services and make possible an expansion of preventive and curative responsibilities. In addition, the problem of dual administrative structures will be resolved by setting up a single administrative body in each facility.

2.12 In order to make this transfer feasible, the need to repair, expand and/or replace health posts and centers in poor areas of the country has been identified. The most pressing investment needs are considered to include 119 health posts and 11 centers.

2.13 Replacement of the Alajuela Hospital building is another essential requirement for the operation of the national hospital network, given its advanced state of deterioration, particularly since the earthquake in late 1990. From the analysis conducted on the hospital system, it was determined that Alajuela Hospital was the system's priority investment.

2.14 The hospital's very limited capacity to address health problems in its service area is reflected in the low percentage of patients (40%) referred to it by the national hospitals, a situation that contributes to overcrowding and higher patient-care costs in the latter. The Alajuela Hospital is similarly unable to meet the referral demand of peripheral institutions of the system to which it belongs.

2.15 The new regional Alajuela Hospital will cover 90% of the demand from its service area and will have a total of 365 beds in replacement of the existing hospital's 220. It will offer inpatient and outpatient services in 25 specialties. In addition, it will offer diagnostic services (clinical laboratory, endoscopy, electrocardiography and others) and therapy (physical rehabilitation, respiratory and occupational therapy) on a more sophisticated level than is available in peripheral hospitals of the service area.

2.16 Given that all primary care services are to be transferred to the CCSS, the present scheme of financing needs to be adjusted to provide the CCSS with the funding to cover those functions.

2.17 The government has proposed a financial cleanup program covering both the existing debt and future revenue flows of the CCSS (see chapter IV and chapter V, section A).

C. Determination of the size of the program

2.18 In determining the proposed size of the program, consideration was given, on the one hand, to the financing requirements for the MINSA restructuring component and, on the other, to the financial implications of the integration of primary care services.

2.19 In determining the scale of the MINSA restructuring component, the following requirements were taken into account: consultants to assist the executing agency in the design for restructuring the ministry; requirements for training human resources to enable the ministry to implement the restructuring; and the requirements for computer equipment for developing systems needed by the ministry for the exercise of its functions as the sector's lead agency.

2.20 The following activities and needs were considered in working out the scale of the integration component: (i) transfer and rehabilitation of health posts and centers. All of these facilities are to be transferred and, accordingly, the amount of funds to be transferred was estimated as the sum total of their operating expenses; (ii) primary network rehabilitation requirements; since it would not be possible to rehabilitate the entire system in stage one, it was decided to select the areas with greatest health risks; in addition, a representative sample consisting of 30% of the health posts and centers located in priority counties was identified and the service supply and demand in each of them was analyzed; and (iii) replacement of the Alajuela Hospital in response to the need to improve the efficiency of the hospital system. A comprehensive study of supply and demand in the hospital's service area was done with a view to replacement of the present hospital, the plant and equipment of which are in an advanced stage of obsolescence.

2.21 The impact of the works to replace the hospital is estimated at 5% of available installed capacity in the case of hospital infrastructure (number of beds), 10% in the case of health centers, and 25% in that of health posts.

D. Cost and financing

1. Cost

2.22 The total cost of the program is estimated at the equivalent of US$60 million, the breakdown of which, by source of financing and investment category, is shown in the following table:

TOTAL COST AND FINANCING OF THE PROGRAM
(in US$ thousands equivalent)

INVESTMENT CATEGORY	IDB-IFF	IDB-OC	LOCAL	TOTAL	%
1. Engineering and administration	430	0	1,046	1,476	2.4
1.1 Final designs	0	0	626	626	1.0
1.2 Works supervision	335	0	0	335	0.5
1.3 Administration	95	0	170	265	0.4
1.4 Hospital transition	0	0	250	250	0.4
2. Direct costs	21,683	10,353	1,528	33,564	55.8
2.1 Civil works	10,326	4,412	0	14,738	24.5
2.2 Facilities	1,211	1,419	0	2,630	4.3
2.3 Equipment and tools	10,146	4,522	1,108	15,776	26.4
2.4 Working capital	0	0	420	420	0.7
3. Concurrent costs	2,005	0	14,802	16,807	28.0
3.1 Consultancies	1,300	0	318	1,618	2.6
3.2 Human resource training	705	0	195	900	1.5
3.3 Operating costs	0	0	14,289	14,289	23.8
3.3.1 Alajuela Hospital	0	0	2,289	2,289	3.8
3.3.2 Posts and centers	0	0	9,000	9,000	15.0
3.3.3 Payroll increase	0	0	3,000	3,000	5.0
SUBTOTAL	24,118	10,353	17,376	51,847	86.3
4. Unallocated costs	2,536	1,939	153	4,628	7.7
4.1 Contingencies	1,729	1,078	153	2,960	4.9
4.2 Escalation	807	861	0	1,668	2.8
5. Financial costs	1,346	1,708	471	3,525	5.9
5.1 Interest	1,066	1,568	0	2,634	4.4
5.2 Credit fee	0	0	471	471	0.8
5.3 Inspection and supervision	280	140	0	420	0.7
TOTAL	28,000	14,000	18,000	60,000	100.0
PERCENTAGE	46.7	23.3	30.0	100.0	

HEALTH SERVICES IMPROVEMENT PROJECT (in US$ thousands)					
CATEGORY	INTEGRATION		MINSA REORGA-NIZATION	EXECUTING UNIT	TOTAL
	ALAJUELA HOSPITAL	POSTS AND CENTERS			
1. Engineering and administration	1,085	126		265	1,476
Final designs	500	126			626
Works supervision	335				335
Administration	0			265	265
Hospital transition	250				250
2. Direct costs	26,323	5,539	1,702	0	33,564
Civil works	10,520	4,218			14,738
Facilities	2,423		207		2,630
Equipment and tools	12,960	1,321	1,495		15,776
Working capital	420				420
3. Concurrent costs	2,289	12,000	2,468	50	16,807
Consultancies and information systems			1,568	50	1,618
Human resource training			900		900
Operating Costs	2,289	12,000			14,289
Alajuela Hospital	2,289				2,289
Posts and centers		9,000			9,000
Payroll increase		3,000			3,000
TOTAL BASE COST	29,697	17,665	4,170	315	51,847

2. Cost analysis

2.23 The estimate of the costs of the program was based on prices on May 31, 1992, for civil works and equipment and on proposals submitted by the CCSS and MINSA, for review and adjustments by the project team. The engineering and administration costs were estimated on the basis of personnel costs and other costs attributable to the operation of the executing unit of the program (see chapter III, section A).

2.24 The direct costs of the program include civil works to rehabilitate health posts and centers; works related to the new hospital, and equipment and tools for the facilities covered by the program.

2.25 The unit cost for constructing and equipping the Alajuela Hospital is US$1,200 per square meter (US$87,000 per bed), a figure which is

within the range of other projects in the region and is comparable to those for similar construction works in Costa Rica.

2.26 The designs for the hospital were subjected to a special type of evaluation ("evaluative engineering") in an effort to identify alternative means of further trimming the physical investment. This resulted in a savings of approximately US$1.8 million (report available in PRA files).

2.27 The unit cost for a health post is US$43,000 (US$34,000 for construction and US$9,000 for equipment) or US$450 per square meter. The cost of a health center was estimated at US$260,000 (US$175,000 for construction and US$85,000 for equipment) or US$354 per square meter. The higher cost for health posts is explained largely by their isolated location.

2.28 The concurrent costs comprise those for consulting services, human-resource training and information systems for the Ministry of Health and operating costs. The consulting services item calls for 180 person/months in the areas of health planning and administration, organizational development, financial management, human resources, chemical and pharmaceutical product control, health services quality control, information systems and technological development, to assist in the restructuring of MINSA.

2.29 The funds allocated for human-resource training will be used to retrain MINSA staff for the ministry's new role as lead agency. It is estimated that the project will finance 175 fellowships (95 at the master's level and 80 at the undergraduate level) for studies in Costa Rican or foreign universities in the areas of public health, public administration, strategic planning, epidemiology and sanitary engineering.

2.30 The information system will include a network of eight microcomputers for the executing unit and an integrated system for the central unit and MINSA's seven regional units. The cost of this component includes remodeling of the premises to be occupied by the information technology center and the applications programs for the entire system.

2.31 The program includes financing to cover the incremental operating expenses under the following headings during its execution period: (i) increases in the levels of activity of health posts and centers; (ii) a 15% increase in the payroll costs for staff to be transferred from MINSA to the CCSS as part of the transfer of responsibility for primary care; and (iii) the incremental operating costs of the Alajuela Hospital for the first year of operation.

2.32 Contingencies and escalation were figured in accordance with the Bank's procedures and in keeping with the trendlines for Costa Rican inflation and exchange rates. They were calculated by DES.

3. Financing of the program

a. Bank financing

2.33 The Bank will finance the equivalent of US$42 million (70% of total program cost) with resources from the ordinary capital. The equivalent of US$28 million will be subject to an interest-rate subsidy to be provided from the Bank's Intermediate Financing Facility (IFF).

2.34 The terms and conditions applicable to the loan would be as follows:

Source of funds:	Ordinary capital (OC)
Loan amount:	US$42 million
Term for initiation of works:	Three years from the effective date of the contract
Disbursement period:	Four years
Amortization period:	25 years
Grace period:	Four years
Interest rate:	Variable, subject to financing from the Intermediate Financing Facility (IFF). This financing would be applied to a portion equivalent to US$28 million.
Credit fee:	0.75% on the undisbursed balance per annum
Inspection and supervision:	1% of the loan amount charge

b. Local contribution

2.35 The borrower will finance the equivalent of US$18 million, which would be transferred to the CCSS through budget allocations and will be used primarily to cover engineering and administration expenses, direct costs of program components, and concurrent costs.

III. EXECUTION OF THE PROGRAM

A. Institutional framework

3.1 The responsibility for executing the program will be borne by the *Caja Costarricense de Seguro Social* [Costa Rican Social Security Fund] (CCSS), which will exercise it through its Institutional Planning Directorate and in coordination with MINSA. The program executing unit (PEU) will be established within the aforesaid bureau.

1. Program executing unit

3.2 The PEU will be headed by the Director for Institutional Planning and will report directly to the Central Coordination Council, which will consist of the Minister of Health, the Executive President of the CCSS and the Minister of Planning and Economic Policy.

3.3 The council will be the highest policy-making authority and its membership structure will ensure proper coordination between reform planning and actual performance. The council is charged with: (i) reviewing the progress made in the execution of the program; (ii) coordinating the efforts of the various participating institutions in support of the work of the PEU; and (iii) making the necessary policy decisions on matters pertaining to institutional reforms proposed under the program.

3.4 The establishment of a Central Coordination Council with the responsibilities outlined above is to take place prior to the first disbursement. 5/

a. Organization of the PEU

3.5 The basic structure of the PEU will consist of two operational units in charge of executing program components and two support subunits, one in charge of programming and control area and the other in charge of administration and support services.

3.6 The operational units will be composed of the pertinent offices of the CCSS and MINSA, e.g. the CCSS's Architectural Directorate and MINSA's Health Systems Development Directorate. Employees will be assigned on a full-time basis to each operational unit and will form a central group reporting directly to the director of the PEU through the coordinator of the pertinent unit. These units will be supported by consultants funded by the program to assist in the design and implementation of the various components.

5/ See proposed resolution, clause 8(c)(i).

3.7 The principal function of the programming and control subunit will be to provide technical liaison between the director of the PEU and the offices in charge of executing the various components. Consultants will be hired with program funds to assist the executing unit in the economic evaluation of health posts and centers scheduled for rehabilitation and in the design of an oversight and control system. It is recommended that the executing unit hire the experts in the areas mentioned above within 12 months of the effective date of the contract. 6/

3.8 The administration and services subunit will be responsible for administering the loan proceeds and local counterpart funds. It will also be in charge of all administrative and accounting procedures, personnel administration and logistical support.

3.9 An interinstitutional executive committee will be established at the operating level in order to facilitate technical and operational coordination among the various institutions. The membership of this committee will include the director of PEU (as its secretary), the managers of the Medical and Operations Divisions of the CCSS, MINSA's General Director of Health, the coordinators of the programming, control, and administration and finance areas, and the persons specifically in charge of the operational units. This committee will meet once a month to review the progress of the program.

3.10 The structure of the executing unit, its legal aspects, the accounting system it proposes to use, its contracting procedures for goods and services, and its internal control and external audit mechanisms were the subject of a special review and are deemed to be satisfactory. A table of organization reflecting the basic structure of the executing unit is presented in Annex III-1.

3.11 As a condition precedent to the first disbursement from the proposed loan, the borrower is to submit evidence that the PEU has been set up with the necessary staff for the performance of its duties. 7/

B. Progress of the program

1. Restructuring of the Ministry of Health

3.12 The project team, working together with officials of the Systems Development Directorate of the Ministry of Health, has prepared a detailed proposal for implementing this component. The key activities included in the component are presented in chapter II, section B.

6/ See Recommendation 3(b).
7/ See proposed resolution, clause 8(c)(i).

3.13 Defined objectives and contents are available for each activity, as are detailed cost data, terms of reference for all consultants and implementation timetables. In the case of the MINSA information systems, staff training, and support services subcomponents, equipment and consulting requirements and cost data are also available. 8/

3.14 In order to expedite the preparation of this component and provide support to the PEU, consultants in the financial, administrative and health-planning areas have been hired with Ministry of Planning funds - which will be repaid from the loan (see Section E on retroactive financing) - to assist the operational unit in the design phase of the reform. The operational unit of the PEU has begun the initial stage of execution of the component and, according to the preliminary timetable of activities, the MINSA restructuring proposal should be available in approximately six months.

3.15 As a condition precedent to the first disbursement, the borrower, through the executing agency, is required to submit the proposal on restructuring MINSA and optimizing the use of its resources, including the pertinent budgetary allotment and an institutional development program as agreed upon with the Bank together with the plan of action for implementing it. 9/

2. Integration of services

3.16 With respect to the integration of primary care services, MINSA and the CCSS have signed an agreement setting forth the intention of making the CCSS responsible for providing these services.

3.17 The responsibility for operation of the health posts and centers must be transferred to the CCSS in order for service integration to be able to accomplish its goals. The operational unit of PEU in charge of this component is now preparing a timetable for this transfer (see chapter IV, section B).

3.18 For the health posts and centers to be rehabilitated, expanded, or replaced, a representative sample of projects has been completed and final designs are available for every such facility. These establishments were selected on the basis of the following set of criteria: (i) integration of services and administration; (ii) a priority county; (iii) minimum population coverage; (iv) minimum and maximum amount of investment and equipment per project; (v) maximum unit cost; and (vi) least-cost technical solution.

3.19 Designs for the Alajuela Hospital that meet Bank requirements are now available. Construction of the new Alajuela Hospital building is to be supervised by a consulting firm. Given the complexity and

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8/ See Annex III-2.
9/ See proposed resolution, clause 8(c)(ii).

scale of the work, it is recommended that the executing unit submit evidence within a six-month period from the effective date of the contract, that the above-mentioned consulting firm has been hired. 10/

3.20 In order that the present hospital building may be replaced as soon as the new one has been completed and put in service, it is recommended that the borrower undertake to submit evidence, within 12 months after completion of the new hospital, that the old building has ceased to function as a hospital. 11/

3.21 The construction works to be undertaken as part of the program do not require the use of particularly complex methods unfamiliar to local and international contractors. Work schedules have been established by stages to make a reasonable continuity of services possible.

3.22 The CCSS and MINSA hold title to most of the proposed construction sites. Nonetheless, the borrower, through the executing unit, is to submit evidence, prior to each bid, of legal possession of the land on which the pertinent health post or center or the Alajuela Hospital will be constructed. 12/

C. Execution timetable

3.23 Based on a detailed analysis of the principal activities to be carried out in executing the program, an average execution period of three years is estimated, with construction of health posts and centers requiring no more than one year. The term for initiation of works will be three years, and the term for disbursement, four years. 13/ The execution timetable for the program is as follows:

10/ See Recommendation 3(a).
11/ See Recommendation 5.
12/ See Recommendation 1(b).
13/ See proposed resolution, clause 7.

HEALTH SERVICES IMPROVEMENT PROGRAM EXECUTION TIMETABLE					
COMPONENTS AND ACTIVITIES	1992	1993	1994	1995	1996
A. Restructuring					
Proposal	xxx	xxxxx			
Implementation		xxxxx	xxxxxxxxx	xxxxx	
B. Integration					
Transfer and rehabilitation of the primary network		xxxxx	xxxxxxxxx	xxxxxxxxx	xxxxx
Replacement of Alajuela Hospital		xxxxx	xxxxxxxxx	xxxxxxxxx	xxxxx
Financial strengthening of the CCSS		xxxxx	xxxxxxxxx	xxxxxxxxx	xxxxx
C. IDB evaluations		x	x	x	x

3.24 According to the above timetable, the works started in the third year of program execution can be completed within the fourth year. The next table shows the estimated schedule of disbursements for implementing the program.

DISBURSEMENT SCHEDULE (in US$ thousands)					
	YEAR I	YEAR II	YEAR III	YEAR IV	TOTAL
IDB	6,610	12,592	19,381	3,417	42,000
LOCAL	1,487	2,392	4,612	9,509	18,000
TOTAL	8,097	14,984	23,993	12,926	60,000
%	13.5	25.0	40.0	21.5	100

D. Contracts for works, goods and services procurement

3.25 Construction and equipping of the Alajuela Hospital will be bid in a single package. The works and equipment contracting for the hospital will be accomplished by international public bidding with prior prequalification of construction firms, in accordance with the Bank's policies. The bidding documents for equipment will require warranty and maintenance clauses, including provisions for spare parts for sophisticated or costly equipment and start-up training for complex equipment or equipment involving new technology.

3.26 The bidding on construction of health posts and centers will be done yearly for the group to be constructed during the year in question. Given the wide dispersion of the works throughout the country, the operational unit of the PEU will have the flexibility

of awarding the works for each year separately. Construction contracting will be accomplished by public bidding in accordance with the Bank's policies.

3.27 The general notice of procurement was agreed upon by the Bank and the executing agency during the analysis mission. It will be published in accordance with the current instructions in this regard.

3.28 In the selection and contracting of consulting services to be financed in whole or in part with proceeds from the loan, the procedures agreed upon with the Bank and set forth in Annex C of the normative documents are to be applied. Accordingly, no provisions or conditions may be established that would restrict or preclude the participation of consultants from member countries of the Bank.

E. Retroactive financing

3.29 It is expected that, as of the date of approval of this operation, program-related expenditures will have been incurred in connection with preparation of the Ministry of Health reorganization component. With this in view, it is recommended that the borrower be reimbursed from the loan for up to the equivalent of US$100,000 to cover expenditures pertaining to design studies on the MINSA reorganization component incurred over the 12-month period preceding the approval date of the proposed loan. 14/

F. Recognition of expenditures

3.30 It is estimated that, as of the date of approval of this operation, expenditures totaling up to the equivalent of US$500,000 will have been incurred for preparation of the final designs for the Alajuela Hospital. The project team recommends that these expenditures be recognized as costs chargeable to the local financing. 15/

G. Maintenance of the works

3.31 The Maintenance Division of the CCSS was strengthened in 1989 under IDB technical cooperation program ATN/SF-2443-CR (see chapter I, section F). At present, the maintenance system is adequate at the central, regional and local levels and the division has sufficient staff and financial resources to attend to all building and equipment maintenance requirements, including those arising from this program.

3.32 To make certain that the works and equipment financed with funds from the loan are adequately maintained in accordance with generally accepted technical standards, the executing agency is to

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14/ See proposed resolution, condition 8(d).
15/ See Recommendation 2.

present to the Bank, within the first quarter of each calendar year for 10 years following completion of the first of the works under the program, the annual plan for maintenance of the program works and equipment for that year and a report on the state of maintenance of such works and equipment. 16/

H. Environmental impact

3.33 The program was classified by the Environmental Management Committee (CMA) as a category III operation because it includes replacement of a hospital building by a new structure, with the consequent potential risks associated with the construction per se and with the generation of liquid and solid wastes. In the course of program preparation, an environmental impact assessment was done with a view to the development of environmental mitigation measures. On September 28, 1992, the CMA approved the environmental impact assessment and the solutions adopted therein.

3.34 According to the assessment, the measures envisaged in the design for the new Alajuela Hospital (wastewater and hazardous solid-waste treatment plants), as well as the measures contemplated for the health posts and centers, are adequate to reduce potential liquid-and-solid-waste related hazards to their minimal level. No negative impacts attributable to the construction stage are anticipated. The aquifers under the chosen site, forming part as they do of a protected aquifer reserve (the Puente de Mulas Aquifer Reserve), are subject to control measures which are required by law but which would not affect the anticipated volume of water supply for the hospital.

3.35 Major risks are not expected during the construction phase, since the new structure will be built on a vacant lot, presently grass-covered, which is far enough away from the residential areas of Alajuela that construction-related noise and traffic would not create major disturbances.

3.36 It is worth noting that the contribution made by primary-care facilities to environmental protection through programs of sanitation, food inspection and health education has a positive impact which is considered to more than offset the minimal hazards that some of the works might pose.

I. Natural disasters

3.37 The town of Alajuela has been hit by five tremors of intermediate magnitude and superficial origin over the past century. The earthquake of December 22, 1990, originating in the Corpija fault in Puriscal, with a magnitude of 5.9 on the Richter scale, severely damaged the structures of the existing hospital in Alajuela. The

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16/ See Recommendation 4.

entire central valley is fractured and frequent seismic activity is predicted for all areas close to the Firebelt that parallels the Pacific coast along the entire length of the American continent and where a process of energy release is beginning. The Alajuela fault is 14 kilometers long but does not traverse the new hospital site. In any event, the seismic safeguards adopted in the new hospital designs are adequate to withstand high-intensity movements, according to assessments by the Bank's engineering specialists in earthquake-proof structures and construction. The pertinent provisions of Costa Rica's current building code, which have been tested in many buildings that have managed to withstand tremors recorded in the country over many years, have been taken into account in the designs for the hospital and in the prototype designs for the health posts and centers.

J. Advance of funds

3.38 The nature of the program and the anticipated pace of construction render advisable the establishment of an advance of funds equal to 10% of the loan to cover estimated expenses for a period of 120 days.

K. Supervision of the program

3.39 The program will be supervised by the Country Office in Costa Rica with the assistance of the project team. To effect this oversight, it is recommended that a joint annual review be conducted by the borrower and the Bank beginning in 1993. It is recommended in this regard that a meeting with the Bank be held no later than November 30 of each year to examine, *inter alia*, the results achieved in executing the program during the current year, including: (i) an assessment of the progress made in restructuring and strengthening MINSA and optimizing the use of its resources; (ii) advances in the transfer of health posts and centers and the allotment of government resources to the CCSS; (iii) advances resulting from improvements in the system of collection of revenues for the CCSS (see chapter IV, section B); (iv) an evaluation of compliance with the obligations of the government to the Health and Maternity Insurance System (see chapter V, section A); and (v) an evaluation of the CCSS investment portfolio (see chapter IV, section B).

3.40 Compliance in all the areas mentioned above will be rigorously monitored by the Bank. In the event that performance in any area is considered to be less than satisfactory, the borrower, through the executing agency, will be required to indicate, within 60 days following the date on which the Bank states its objections, the remedial measures it proposes to take and the schedule for undertaking such measures. If the remedial measures mentioned above are not satisfactory, the Bank may take such other steps as it deems

appropriate in accordance with the provisions set forth in the loan contracts. 17/

L. External audit of the program

3.41 The financial statements of the program are to be audited by a firm of external auditors acceptable to the Bank during the program's execution period. 18/

M. Women in development

3.42 The status of low-income residents in the 30 priority counties also impacts on women of reproductive age. This group, after children, will be the chief beneficiary of the improved services to be made available in those counties through the proposed program.

N. Ex post evaluation

3.43 The ex post evaluation will be aimed at examining the program's impact in terms of the following objectives: (i) reform process; and (ii) improvements in the efficiency and equity of the services.

3.44 The executing agency will be responsible for evaluating the program. To this end, it will collect the data on each component in accordance with the ex ante methodology used for this document. This data will be appended to the evaluation report. For these purposes, the borrower shall: (a) present to the Bank, six months after the effective date of the loan contract, an initial report including: (i) initial baseline data by component; (ii) a description of the methodology to be used to collect and process the information for comparisons between the baseline data and the results; and (b) in order to secure information for use in measuring the impact of the program and attainment of its targets, the borrower shall also collect information on:

1. Reorganization of MINSA

a. Number and professional characteristics of the human resources.

b. Overall budget and its breakdown by categories.

c. Type of activities planned and implemented.

d. Evaluation of the human resource training program.

17/ See Recommendation 7.
18/ See Recommendation 9.

2. Alajuela Hospital

a. Number of discharges, by service and year, since inception.

b. Number and type of consultations, by specialty and year, since inception.

c. Efficiency indicators: anticipated and actual occupancy level, by service; other indicators.

d. Overall costs, by category, by type of discharge, by type of consultation and by service.

e. Study of inpatient and outpatient referrals to and by the hospital.

3. Health posts and centers

a. Operating costs, by health post or center; cost per home and office visit, annual, anticipated and actual.

b. level of population coverage in the program area.

c. low-income survey, by facility (including the hospital).

3.45 The data outlined above will be used to prepare an ex post evaluation two years after the date of the last disbursement. This evaluation will include but will not be limited to: 19/

a. An analysis of the institutional reform of MINSA.

b. Targets reached in the integration process (MINSA-CCSS).

c. Efficiency and equity improvements achieved in the delivery of services.

d. Conclusions and recommendations.

19/ See Recommendation 8.

IV. THE BORROWER AND THE EXECUTING AGENCY

A. Borrower and executing agency

4.1 The borrower will be the Republic of Costa Rica, and the executing agency the Caja Costarricense de Seguro Social [Costa Rican Social Security Fund] (CCSS) in cooperation with the Ministry of Health (MINSA). The borrower will transfer the loan funds on a nonreimbursable basis, as well as the local counterpart funds, to the CCSS under an agreement to be submitted as a condition precedent to the first disbursement from the proposed loan. 20/

B. Caja Costarricense de Seguro Social

1. Legal framework

4.2 The origins of the CCSS, as well as its source of revenue, are rooted in article 73 of Costa Rica's constitution. "Universalizing Social Security" is the basic conceptual and juridical scheme that underlies the effort to extend social security in Costa Rica, an effort that signifies instituting a system to cover all sectors of the Costa Rican population, irrespective of ability to contribute.

4.3 The institution covers 2.5 million insured persons (84% of the population) under its health and maternity program. This coverage includes, in addition to medical care for victims of common diseases and accidents, health care programs for well children, comprehensive care for adolescents, and internal medicine. The CCSS has 30 hospitals with a combined total of close to 7,000 beds representing the country's public-sector installed capacity, along with 240 clinics. These facilities are staffed by a workforce of approximately 21,000.

4.4 At the present time, the CCSS is managing two entirely independent systems in its financial structure: the Health and Maternity Insurance System and the Disability, Old Age and Survivors Insurance System. The revenues for these systems are based on a payment (the social security tax) which is applied as a percentage of wages and which is contributed by employees, employers and the government. These percentages are applied as shown in the following table:

20/ See proposed resolution, clause 8(c)(iii).

SOCIAL SECURITY CONTRIBUTIONS				
CONTRIBUTION	EMPLOYER	EMPLOYEE	GOVERNMENT	TOTAL
Health and Maternity Insurance	9.25%	5.50%	0.25%	15.00%
Disability, Old Age and Survivors	4.75%	2.50%	0.25%	7.50%
TOTAL	14.00%	8.00%	0.50%	22.50%

4.5 The CCSS also receives contributions from the Social Welfare Board of San José for operation of the hospitals and revenue from the sale of medical services to the Instituto Nacional de Seguros [National Insurance Institute] (INS).

2. Overall organization

4.6 The highest authority in the CCSS is its board of directors, consisting of nine members appointed by the Executive Branch, i.e., three representatives for the central government, three for employers, and three for employees. The board of directors has full authority over the institution's plans and programs, which are implemented by the Office of the Executive President and the offices of four technical managers for the medical, financial, administrative and operations areas. These managerial offices are monitored by an internal audit office.

4.7 General administration is conducted through the managerial offices and the various units reporting to them (directorates, departments, sections and units).

4.8 For operational and service-delivery purposes, the CCSS has decentralized its substantive activities into seven regions. Its regionalization arrangements include: branches and agencies, which report to regional administrative directorates attached to the financial manager's office; and hospitals and clinics, which report to regional medical directorates and the office of the medical division manager.

3. CCSS-MINSA integration

4.9 In 1986, with the adoption of the 1986-1990 National Development Plan, the process of administrative decentralization and integration and coordination of health posts and centers received increased impetus as a result of joint programming between the Ministry of Health and the CCSS. The two agencies have been working in parallel fashion since 1986 to bring about the integration of medical services throughout the country with the primary object of averting duplication of activities and using resources rationally. In spite of existing policies, however, the integration of health posts and centers has yet to materialize.

4.10 In 1992, the CCSS and MINSA signed an agreement setting forth general guidelines for integrating the primary care services by transferring operation of the health posts and centers to the CCSS.

4.11 A recent evaluation of the integration process found that: (i) the integration mechanisms had been set up; (ii) 31 health centers throughout the country (35% of a total of 89) had been physically (but not administratively) integrated; (iii) nine centers were under unified control; (iv) strengthening and training were needed at the post and center levels; and (v) improvements were needed in the areas of local planning, supervision and control, and community participation. This strengthening is to be accomplished by the CCSS using resources of its own.

4.12 The proposed program seeks to bring about the functional integration of all 89 health centers and 419 health posts. Prior to the first disbursement, the borrower, through the executing agency, is to submit a timetable for implementation and transfer of posts and centers including year-by-year targets for functional and organizational consolidation of the primary care services. The timetable should also provide detailed information on the administrative and managerial strengthening components (including their costs) for the health posts and centers. 21/

4.13 It is further recommended that, prior to issuing the yearly calls for bids for the health posts and centers, the borrower submit evidence of having adhered to the timetable agreed upon with the Bank for services consolidation and restructuring of MINSA. 22/

4. Institutional-financial diagnosis

4.14 The analysis conducted on the CCSS identified certain institutional and financial issues that will have to be resolved to improve the institution's administrative efficiency.

a. Structure and organization

4.15 Since 1986, the organization of the CCSS has been undergoing a process of decentralization (regionalization) and strengthening of the central and regional organization that will allow it to make the operation of its health services more efficient. This process has been financed with the institution's own resources and with a grant from the Government of Sweden in the amount of US$1.3 million. In addition, resources are required to strengthen certain specific aspects of the central administration and organization.

21/ See proposed resolution, clause 8(c)(iv).
22/ See Recommendation 1(c).

b. Human resources and information systems

4.16 The institution lacks a system of incentives to reward productivity and quality services. Further, the present information system of the CCSS does not provide support for timely decision making. Accordingly, the operational processes need to be automated to take advantage of currently available technological advances.

c. Financial features of the CCSS

4.17 Following is a description of the salient financial features of the CCSS:

a. Its collection system is centralized and based on inefficient administrative procedures, and it has not developed an information system on production costs by type of service and production unit.

b. On the revenue side, it exhibits problems of tax evasion via the noninsurance route. This problem involves nearly 40% of total private sector employees (equal to 14% of the total statutory revenues of the CCSS).

c. Its investment portfolio has very low yields. The national treasury has settled its debts to the CCSS in the past with bonds. As of December 31, 1991, the value of central government bonds in the hands of the CCSS came to 9,529 million colones (US$70.4 million), which accounted for 25.7% of the institution's total securities portfolio. Most of the nominal rates of such bonds are lower than the rates available in the financial market. As of the same date, it is estimated that 64% of the bonds included in that bonded debt had lost approximately 94% of the purchasing power they had on their respective issue dates.

d. The central government had a cumulative debt of 18.46 billion colones (US$135.7 million) to the CCSS as of July 31, 1992, stemming from unpaid balances arising from government obligations contracted as government and employer.

e. Finally, there has been noncompliance by the government with its obligations as employer to the Health and Maternity Insurance Program, with the extent of arrears running as high as 88% for 1991.

4.18 In response to the need to improve the efficiency of the CCSS, the health-sector reform program includes a strengthening component to support the efforts of the CCSS in the areas of organization and administration. This component will be financed by the World Bank. It provides for a review of existing collection and inspection mechanisms, with emphasis on the control systems, and for the training of staff in the Inspection Department of the CCSS.

4.19 In order to streamline the revenue collection process, it is recommended that the Ministry of Finance and the CCSS establish a committee to arrange for reciprocal support in their inspection and audit functions. As a condition precedent to the first disbursement, the committee is to submit an agreement between the ministry and the CCSS including provisions for mechanisms for improving the collection of CCSS revenues. 23/

4.20 With respect to the investment portfolio (bonded debt), the following measures contemplated in the multisector investment and credit program (CR-0032) under consideration by the Bank should improve the yield on the CCSS portfolio: (i) determination of the balances owed by the Treasury to the CCSS; (ii) negotiation and early issuance of letters of intent outlining a financial solution acceptable to both the Treasury and the CCSS; and (iii) preparation of contracts, including an implementation schedule, for signature by the government and the CCSS. In addition, the government will review the investment policy of the CCSS with a view to improving its investments by placing its funds in instruments yielding returns commensurate with current market conditions.

4.21 An analysis of the financial situation of the Health and Maternity Insurance Program (SEM) and nonfulfillment of the government's obligations to it is provided in section 7 below, and the solution to this problem is discussed in chapter V, section A, on the financial feasibility of the program.

4.22 The government has adopted the following scheme for settlement of its accumulated debt to the CCSS: (i) transfer the following funds to the CCSS on a nonreimbursable basis: US$30 million for replacement of the Alajuela Hospital, the proceeds of the US$8 million loan from the Central American Bank for Economic Integration for Atlantic area infrastructure, and the proceeds of the US$30 million loan from the Government of Spain for the purchase of hospital equipment, thereby reducing the indebtedness by US$68 million; and (ii) any difference between the total owed by the government to the CCSS and the sum of the debts it assumes will be settled by the issuance of treasury bonds with maturities not longer than 13 years and at interest rates varying with the market.

5. Administrative decentralization

4.23 The CCSS has managed to instill a fair degree of institutional awareness to the need to decentralize its internal operation. This is reflected in its institutional objectives and policies for 1991-1994, which emphasize the importance of technical and administrative decentralization via the strengthening of local health systems, and in advances already made in budgetary decentralization toward the regional level.

23/ See proposed resolution, clause 8(c)(v).

4.24 Similarly, in the human resource field, the CCSS is taking the pertinent steps to delegate authority and allocate responsibilities. Advances in this field have included, notably, the delegation of staff-appointment authority and the expansion of direct local purchasing and of minor assets.

4.25 Insofar as the maintenance and upkeep of physical infrastructure and equipment is concerned, the institution's policy is also aimed at decentralizing management of these operations so that the various units may absorb the pertinent costs within their respective budgets. Maintenance of the Alajuela Hospital and the health posts and centers is not expected to pose any problems, since this area was strengthened by the Bank through technical cooperation program ATN/SF-2443-CR, under which a maintenance system was set up. The CCSS has maintained its hospital infrastructure in satisfactory fashion.

6. Internal and external control

4.26 The organization of the CCSS includes an internal audit unit reporting directly to the Executive President. This unit will support the executing unit in the work of controlling and monitoring administrative and financial procedures and operations established for the execution of the program. The financial statements for the Health and Maternity and the Disability, Old Age and Survivors Insurance Programs were audited as of December 31, 1990. The external auditors' comments and recommendations on the financial statements are being implemented by the institution.

7. Financial situation of the Health and Maternity Insurance Program (SEM)

4.27 The following table presents a comparative statement of income and expenditures of the Health and Maternity Insurance Program for the years from 1989 to 1991.

HEALTH AND MATERNITY INSURANCE PROGRAM (SEM) CURRENT INCOME AND EXPENDITURES (in US$ thousands) (at the rate of exchange prevailing at the close of each year)			
ITEM	1989	1990	1991
INCOME			
Contributions to social security	230,704	259,508	227,045
Non-tax income	40,947	38,485	21,557
Current transfers	14,102	10,592	4,608
Cash and banks	58,312	52,099	32,601
Other income	1,102	1,162	769
TOTAL INCOME	345,167	361,846	286,580
EXPENDITURES			
Client services	150,712	171,255	145,121
Other services	20,013	23,595	20,563
Materials and supplies	66,174	60,923	69,044
Machinery and equipment	5,032	4,538	5,093
Financial outlays	759	1,275	3,523
Construction additions and improvements	5,830	9,480	6,415
Current transfers	32,158	39,193	33,075
Debt service	5,694	3,429	3,008
TOTAL CASH EXPENDITURES	286,372	313,688	285,842
TOTAL INCOME – EXPENDITURES	58,798	48,158	738

4.28 As may be seen, the SEM's operations fall into typical budget patterns, including outlays in the strict sense as well as resources for investment as well as transfer operations by the insurance program. The comments that follow should not be interpreted as a traditional analysis of "profit and loss" but as an analysis of budgetary financial flows reflecting both an investment yield component (non-tax income) and an expenditures component (a portion of the operating outlays).

4.29 The total amount of resources available for 1991 was US$286.5 million. The contribution to social security is the most representative category, accounting for US$227 million or 79% of total income and reflecting the total amount of employer and worker contributions from all sectors. With respect to the non-tax income category, a total of US$21 million was received from the sale of services, collection fees, and interest on total investments. Current transfers came to US$4.6 million and represented, *inter alia*, the contribution of the government as such, treatment of

patients insured by the government, and income from the share in the profits of the national lottery. "Cash and banks" is the difference between the actual income and actual expenditures at year end.

4.30 Between 1989 and 1991, current income reflected a decline in contributions to social security. The other income items also diminished compared to the previous years' levels. This resulted from: (i) a very drastic decline in contributions by the government in its various roles in relation to the earlier years; (ii) lower investment yields; and (iii) a dropoff in sales of medical services.

4.31 On the expenditure side, the leading item in terms of percentage share was operating costs, defined as necessary costs for the delivery of services and consisting of the sum total of all client services and current transfer outlays. The latter include social-benefit payments figured as a percentage of payroll amounts, as well as payments of contributions to the government and to international agencies. The operating costs for 1991 amounted to US$178.2 million, which was 62% of the year's total expenditures. Another important category is materials and supplies, which accounted for 24% (US$69 million) of total expenditures.

4.32 While the SEM operated at a surplus in all three years, the positive margin fell from US$58.8 million in 1989 to US$700,000 in 1991. This resulted from the declining level of government contributions with respect to its obligations, which led to a greater reliance on existing resources, especially cash and banks. It is worth mentioning that the SEM is a distributional scheme and seeks to return the largest possible amount of the income it receives in the form of medical care. Consequently, reductions in the contributions by the government impairs the quality of the service provided.

4.33 Given the transfer of responsibility for the operation of health posts and centers to the CCSS, a rise is projected in the operating expenses of the SEM. This makes it important to examine the problem of delays in the payment of the government's obligations, since these account for the major share of total income.

4.34 In analyzing the SEM's income, it is highly important to appreciate the distinction between the concepts of "statutory income" and "actual income." The former refers to a theoretical calculation of what the SEM system ought to have received over a given period in accordance with current laws and regulations, whereas the latter refers to the income actually received.

4.35 Noncompliance with the government's obligations to the Health and Maternity Insurance Program has been accentuated significantly in recent years. This is due primarily to the impacts of the stabilization and economic adjustment programs on the structure of total

government expenditures. This economic outlook affirms the need for the CCSS to review the obligations of the government with a critical eye, particularly in regard to the government contribution to the social security programs and the actual possibilities of a timely receipt of the funds needed for the operation of the health posts and centers.

4.36 The characteristics of the revenue structure indicate that the type of obligation in which government noncompliance has the greatest significance is essentially in the payment of premiums for workers insured at government expense, where the extent of arrearage was at levels that went as high as 92% in 1991, as shown in Annex IV-1. In overall terms, the arrearage of the government over the period from 1987 to 1991 averaged approximately 73%, which is one of the principal problems in the finances of this insurance program.

4.37 For the period 1988-1991, yearly noncompliance with government obligations to the SEM, expressed as a percentage of actual to statutory income, averaged less than 27%, as shown in the following table:

HEALTH AND MATERNITY INSURANCE PROGRAM
STATUTORY AND ACTUAL INCOME: 1988-1991
(in US$ millions)

YEAR	STATUTORY INCOME	ACTUAL INCOME	DIFFERENCE	EFFECTIVE RATE (%)
1988	65.9	19.7	46.2	29.9
1989	77.2	25.0	52.2	32.4
1990	90.4	29.1	61.3	32.2
1991	69.3	8.1	61.2	11.6

4.38 If this level of contributions persists, the SEM will experience shortfalls in the years ahead. Alternative for reversing this trend and making the current costs of the proposed program financially bearable are discussed in chapter V, section A.

C. Ministry of Health

4.39 The Ministry of Health, whose origin dates back to 1929, is responsible for the determination and conduct of national health policy and for the planning, regulation and coordination of all public and private activities pertaining to health care, health promotion, sickness prevention and environmental sanitation. It operates 89 health centers, 650 nutrition education centers and comprehensive child care centers and 419 health posts, along with 40 mobile units.

4.40 With these resources and a contingent of 6,000 professionals, technicians and support personnel, the ministry provides preventive health services accounting for 8% of the country's consultations. Of these human resources, approximately 1,250 (21%) are at the central level, 250 (4%) are in the regional supervisory teams, and 4,500 (75%) are local operating staff. Of the latter, roughly 3,000 (50%) are assigned to operation of the individual health care services that would be transferred to the CCSS and another 1,500 (25%) are engaged in programs in the areas of health promotion, environmental health, vector control and nutrition.

4.41 The funding for MINSA comes from general revenues and special assessments (67%) and transfers from the Family Allowance Fund (33%). These revenues were equal in 1991 to 0.7% of GDP and accounted for 11% of total public expenditures.

4.42 The institutional diagnosis of MINSA and resulting restructuring proposal were discussed in previous chapters. The restructuring proposal and implementation scheme designed support the conclusion that the transformation of MINSA as lead agency for the health sector poses no problems.

V. FEASIBILITY AND RISKS OF THE PROGRAM

A. Institutional and financial feasibility

1. Institutional feasibility

5.1 The program to restructure and strengthen the Ministry of Health as lead agency for the health sector is feasible and viable in terms of concept, content and implementation schedule and the design of its program of institutional development to bolster its ability to catalyze the system. The transfer of primary care to the CCSS makes sense in the context of the current array of problems and is consistent with the goals of the national health-sector reform plan. The supervision mechanisms designed will make it possible to finish restructuring and strengthening the ministry and integrating health posts and centers on the basis of contractual conditions.

5.2 The operational mechanisms worked out in the process of developing this program – involving the establishment of a senior-level Central Coordination Council and support from professional staff of MINSA's Health Systems Directorate – will provide both institutions with broad capacity and flexibility to carry out the components of the proposed program. Moreover, an examination of CCSS activities to date shows that the institution has adequate experience in the construction, supervision and administration of hospitals and health posts and centers.

5.3 To ensure efficiency in the execution of the program, the CCSS will received support from an executing unit and from the operational unit of MINSA, the latter to be advised by consultants. In light of the foregoing, no major difficulties are anticipated in implementing the program on a timely basis.

2. Financial feasibility

5.4 The financial feasibility of the program was determined by examining two concepts, which measure both the financial impact and the country's ability to undertake the execution of the program. One is the ability to provide the necessary local counterpart, as measured by the added burden it places on the government's budget. The other concept is based on the use of financial projections to determine the incremental recurrent costs deriving from the proposed program.

a. Local counterpart

5.5 The local counterpart required for the program totals US$18 million, an average of US$4.5 million per year over the program's implementation period. The government will transfer these funds to the CCSS in the form of budgetary appropriations. The high

priority attached by the government to this program, together with the low yearly amount the counterpart contribution represents in comparison to the government's budget, suggest the conclusion that the funds will be available as needed.

b. Incremental recurrent costs deriving from the program

5.6 The present operating costs of all the health posts and centers operated by MINSA total the equivalent of US$16 million per year. In addition, these facilities will incur incremental recurrent costs on account of: (i) improvements in the performance of services at an annual cost of US$4.7 million; and (ii) salary increase for medical staff of MINSA to be transferred to the CCSS, at an annual cost of US$1.6 million. The incremental recurrent costs attributable to the program will therefore come to the equivalent of US$6.3 million, while the total amount of recurrent costs required for the SEM will be on the order of US$22.3 million beginning in 1997 (see Annex V-1).

5.7 To cover these costs during the program's execution period (1993-1996), it is recommended, given that the transfer of posts and centers is to be progressive, that the government transfer the funding currently being allotted to MINSA for the operation of health posts and centers to the CCSS. 24/ It is estimated that transfers will total approximately US$30.4 million (see Annex V-1).

5.8 Once the investments are completed, the total recurrent costs for the SEM, starting in 1997, will be roughly US$25.3 million per year, including the incremental operating costs for the Alajuela Hospital, amounting to US$3 million, and the total operating costs for health posts and centers. As shown in Annex V-1, the SEM program will not be able to absorb this amount unless the government increases its effective rate of contribution. In order for the program and SEM to be financially feasible, it is important that the government meet its commitments to the insurance program as employer, as the government *per se* and on behalf of the self-employed and the indigent.

5.9 To this end, the government has undertaken to institute a scheme for gradual reduction of the arrearage in its payments to the SEM by the percentage levels shown below: 25/

24/ Compliance with these measures will be monitored during the annual meetings referred to in chapter III, section K. See Recommendation 6.

25/ See proposed resolution, clause 8(c)(iii).

Payment of Government Quotas to the CCSS for the Health and Maternity Insurance Program — Payment Schedule	
YEAR	Minimum yearly percentage of payment of past-due government contributions payable to the SEM
1992	60%
1993	65%
1994	70%
1995	85%
1996	95%
1997	100%

5.10 It should be mentioned that the recurrent costs attributable to the transfer of health posts and centers will be covered if the minimum yearly payment of contributions owed by the government to the SEM reaches a level of 75%. Compliance with the government's commitments in the manner indicated above, together with reductions in the rate of tax evasion, will lead to improvements in the quality of the health services provided by the SEM.

B. Technical feasibility

5.11 The proposed program is responsive, in both its institutional-restructuring and its integration-of-health-services-and-investments component, to the country's priority needs in terms of health-sector organization and consistent with the ministry's functional capacity as the sector's lead agency. The institutions participating in the program have the requisite capability to avail themselves of the proposed support and institutionalize the proposed reforms.

5.12 Integration of the primary care services into the CCSS is technically feasible in light of this institution's more than 10 years of experience with the operation of the hospitals transferred to it between 1974 and 1981 and the health centers integrated from 1982 onward, as well as with MINSA-CCSA coordination of preventive programs. The solution of the main technical difficulties is contemplated under existing agreements (MINSA-CCSS) and under contractual commitments related to the program proposed herein.

5.13 The retention of certain preventive programs (collective care and environmental protection) by MINSA will not strongly influence the possibilities of success in the introduction of the reform measures.

5.14 The technical feasibility of the transfer of health posts and centers, as well as the integrity and efficiency of the national hospital network, hinge on the works planned. On the one hand, these works are essential to enable the CCSS to provide an assured minimum level of efficiency in the facilities it receives; on the other, efficient use of the highly sophisticated national hospitals and the peripheral hospitals in the service areas of the Alajuela Hospital will not be possible unless the latter institution regains its problem-solving capacity (through replacement).

5.15 In general terms, the qualifications and size of MINSA's human resources at the central and regional levels (and of some that may be transferred from the CCSS) will – in light of the training envisaged with a view to the reform of MINSA and the present size and make-up of that human contingent – make possible an effective implementation of the leadership functions under consideration and the transfer of the primary services to the CCSS without detriment to the scope and details of the proposal to be evaluated by the Bank before the first disbursement is authorized.

5.16 Morbidity and mortality (among infants, preschoolers and mothers) attributable to infectious diseases may be expected to decline substantially in the next 10 years in what are currently the most disadvantaged areas (30 counties that need to be brought up to the national average). The same applies to mortality and complications attributable to chronic diseases (e.g. heart disease, malignant tumors, diabetes, etc.). This will be possible because by the time the program is completed, MINSA will be in a position to: (i) exercise more efficient and effective epidemiologic surveillance; (ii) formulate and provide for the enforcement of health policies more in keeping with the country's actual conditions (e.g. preventive responsibilities of the CCSS and private health-care providers, quality of public and private curative services, early detection and control of chronic diseases); (iii) take aggressive action for the promotion of healthy lifestyles and work environments; (iv) ensure a more rational utilization of the sophisticated technological resources required for the treatment of chronic pathologies; and (v) exercise more effective control over environmental and public-health hazards.

C. Socioeconomic feasibility

5.17 As explained earlier, the project's long-term impact lies in its support for the structural reforms to the sector, which will contribute, on the economic, level to greater efficiency in the allocation and use of sector resources and, on the social level, to improved equity and quality in the delivery of health services. In addition, and considering the country's financial condition and the proposed public-sector reforms, it is important to optimize the use of the physical investments included in the program in order to ensure that this component, too, will contribute to attainment of the long-term objectives.

1. Integration of primary care services

5.18 The primary care system operates two basic programs: the Rural Health Program, with a coverage of 67% of its target population, and the Community Health Program, with a 49% coverage.

5.19 The objective of the former program is to maintain its coverage at the present level – as a minimum – whereas the latter program's aim is to regain the coverage level of 64% it reached in 1979. These coverage levels are to be reached along with a substantial improvement in quality. One consultation per person and three rounds of visits per household per year are regarded as necessary.

5.20 Consolidation of the CCSS and MINSA services is proposed as a means of attaining these targets. As indicated in chapter II, section B.2, it was determined to be necessary to rehabilitate a substantial number of health posts and centers which had deteriorated as a result of the shortage of MINSA funds for maintenance. Since it will not be possible to rehabilitate the entire network in stage I, it was decided to select priority health areas (those at greatest risk).

5.21 The project therefore identified 30 priority counties on the basis of socioeconomic criteria and relative health conditions, in each of which the state of repair of the facilities was evaluated. A representative sample of 30% was assembled and served as the basis for drawing up a set of eligibility criteria for evaluating the works that were to form the universe of the program. The principal criteria from the socioeconomic standpoint are: (i) determination of the demand for and supply of services by facility; (ii) selection of the least-cost alternative (investment and operating cost) by establishment; and (iii) low-income beneficiaries.

5.22 Based on an analysis of the sample, it was determined that eligible health posts would be those with an annual cost per visit that did not exceed US$7 and eligible health centers those with a cost per visit that did not exceed US$10. These average costs were converted from market prices to efficiency prices using conversion factors and eliminating transfer payments (taxes, social security contributions, etc.).

2. Replacement of the Alajuela Hospital

5.23 The existing Alajuela Hospital forms part of a network of CCSS facilities of rising complexity: peripheral hospitals, regional hospitals, and national or specialized hospitals. The San Francisco de Asís and Valverde Vega Hospitals make referrals to the Alajuela Hospital and the latter in turn to national hospitals: Mexico, San Juan de Dios and the Children's Hospital

5.24 Programming a network on the basis of medical functions makes it possible to determine the level of sophistication, and the supply

of services associated with that level of sophistication, that each facility will be able to supply to meet the overall demand in a given geographical area. Obsolescence of the existing hospital, compounded by the earthquake damages of 1990 that limited its capacity even further, and population growth have sharply curtailed the hospital's ability to play its proper role in addressing the problems of the region.

5.25 As a result, the demand in the service area is being diverted toward facilities at higher levels of sophistication, with the attendant upward pressure on the network's cost per discharge or consultation.

a. Demand and determination of scale

5.26 The proposed scale of the Alajuela Hospital is based on a comprehensive analysis of the demand for (i) hospitalization (hospital discharges); and (ii) outpatient services (consultations) in the hospital's service area 26/ under a service-network approach.

(i) Demand for hospitalization

5.27 Demand for hospitalization in the years ahead in the direct service area was projected by type of service (medicine, surgery, pediatrics, gynecology and obstetrics) in line with predicted population growth by age group. In the absence of the project, 35% of this demand would have to be accommodated in the metropolitan area for want of local capacity.

5.28 With the project, the future Alajuela Hospital will be able to absorb the discharges from its service area as a regional hospital (approximately 90%; the rest would be more complex cases and would be attended to in the metropolitan area). It was also borne in mind that with the project the peripheral hospitals would handle 83% of the discharges from the indirect service area, referring to the new Alajuela Hospital the more complex cases consistent with its new capabilities.

5.29 Admittance demands are projected to grow from 13,980 in 1987 for the four basic services to 26,119 in the year 2005, the year for which the Alajuela Hospital is scaled. This increase (a cumulative rate of 3.47% a year) in the demand for the hospital's services arises mainly in its service area.

26/ The service area as defined for network programming purposes includes the counties of San Mateo, Central Alajuela, Atenas, Poas, Orotina and Garabito, with an estimated population of 200,000, and the indirect service area for similar purposes consists of the counties of San Ramón, Naranjo, Ruiz, Grecia, Palmares and Vega, with a population of 155,000. The service area was adjusted to "actual area" based on observed demand at each facility.

5.30 The increase in demand varies according to service, inasmuch as the low fertility rates anticipated are expected to slow demographic growth at a time when the aging of the population begins to be felt in the years ahead. As a result, the demand for obstetrical services will increase from 5,268 to 6,830 hospital cases or by an average of 1.44% per year from 1987 to 2005, while at the other extreme the demand for medical services and surgery will be rising from 2,346 to 5,319 and from 2,283 to 5,577 hospital cases, respectively, between the same period of years or by average yearly cumulative rates of 4.55% and 4.96%, respectively. It should be noted that in addition there will be a 23% increase in outpatient surgery, a service which is not available at present in the Alajuela Hospital.

5.31 As a means of accommodating the rise in demand and ensuring a higher level of productivity per bed, provision was made for a more rational use of the stays for the various kinds of service and for more stringent levels of average bed occupancy. The justification for the 68% increase in the number of beds in the new hospital (from the present 217 beds to 365) makes allowance for these more stringent parameters.

5.32 The allocation of beds by type of service takes account of the unevenness in the growth of demand. Thus, medicine (120 beds) and surgery (108) are the services slated to receive the largest increases over the present number of beds (90% and 157%, respectively). The number of pediatric beds will rise by less than 10%, mainly as the result of qualitative improvement, since most of the increase is due to the introduction of neonatology beds. The increase in obstetrics arises mainly from the presently inadequate number of beds, improvements in the quality of service and the inclusion of more sophisticated procedures in the future.

5.33 The overall scale of the 365-bed Alajuela Hospital is viewed as conservative because a stringent approach to bed-productivity rates was taken in determining the scale of the new hospital. Historical data on the Alajuela Hospital and the country's hospital network in general shows productivity rates in the various services to be slightly lower than those predicted for the new hospital. If this historical information is taken into account, the lower productivity generates a need for 15% more beds, raising the necessary size to 419 beds in the year 2005.

(ii) Demand for outpatient consultations

5.34 Outpatient consultations are not offered at present in the Alajuela Hospital, except for emergency room service and certain minimal services in a few internal medicine specialties. However, regional hospitals in Costa Rica are responsible for consultation in subspecialties for which they have resources available, depending on the level of decision involved. The new hospital will therefore offer specialized outpatient services. Various subspecialties

involving highly complex procedures will not be offered at the Alajuela Hospital and will continue to be provided at specialized hospitals in the metropolitan area.

5.35 Waiting periods are extremely long for specialized outpatient service, especially for those involving internal medicine, for which the periods can be as long as three to six months or sometimes even more than a year.

5.36 By 1995, the Alajuela Hospital should be handling 79,000 consultations requiring 116 hours of medical services per day and 14 doctor's offices. Two new medical subspecialties, nutrition and clinical psychology, will be added that year to the outpatient workload.

5.37 According to the projections made, by the year 2005 the new hospital's workload should have risen to 178,688 consultations requiring an average of 262 hours of medical services per day and 33 doctor's offices to accommodate all the demand for specialized outpatient services from the hospital's area of influence and the demand for medicine and surgery from the indirect area.

b. Economic evaluation

5.38 The social benefits from the new Alajuela Hospital are expected to arise from: (i) greater efficiency in the hospital system, reflected in a decline of costs per discharge and per consultation as a result of covering the entire demand in its service area and reducing the need for services in the more sophisticated hospitals of the metropolitan area; (ii) cost savings for user as a result of savings in time and transport costs by users who would no longer have to travel away from the service area; and (iii) an improvement in the quality of service as a result of the availability of appropriate technology and the reduction or elimination of waiting periods.

5.39 Once the requisite size of the hospital facilities had been determined on the basis of demand and planning in terms of medical functions, a cost-effectiveness analysis was done. This involved a study of the alternative of continuing with the present hospital ("without project" or intensive maintenance alternative) versus that of building a new hospital ("with project" alternative).

5.40 The costs per discharge and per consultation were determined for each alternative: the costs per discharge under the "with project" alternative are based on the total investment and operating costs for the new hospital, which are distributed by cost center in accordance with a cost allocation model currently being used by the CCSS in most of its hospitals.

5.41 The economic costs per discharge under the "with project" alternative amount to US$255. The average cost is influenced by

the qualitative improvement in obstetrics and gynecology. In actual fact, this quality differential means that the costs are not strictly comparable because the alternative "with project" reflects an improvement of such significance as to make this alternative preferable even if the costs are similar. The costs for the "without project" alternative amount to US$379 and are 37% higher than the "with project" alternative. The "with project" alternative has lower average costs, which makes it eligible versus the "without project" alternative.

5.42 The benefits from cost savings to users have not been quantified because of their complexity. It should be pointed out, however, that the project will allow two types of user-savings benefits: (i) time and transport cost savings for local residents of the direct service area who would no longer find it necessary to travel out of the area; and (ii) savings as a result of shorter waiting periods for certain services.

D. Distributional impact

5.43 To evaluate the project's distributional impact, the number of beneficiaries for each of its components was taken into account. The Alajuela Hospital will have an estimated 194,801 beneficiaries, the number of residents of its service area. The multiple-works component applies to three regions of the country with 180,048 potential beneficiaries (Chorotega, 7,476; Central Pacific, 161,518; and Brunca, 7,476). Finally, the institutional-strengthening component is intended to strengthen the supervisory role of the Ministry of Health and accordingly all of the country's residents are its beneficiaries.

5.44 In order to calculate the impact of the Alajuela Hospital component, a survey of outpatient and inpatient users was conducted over a one-week period in March 1991. This survey (a statistically identified sample that covered a total of 460 forms) showed that 60.9% of the hospital's users had per capita incomes below the poverty line established by the Bank for Costa Rica, a level estimated that month at 7,148 colones per month.

5.45 In the case of the multiple-works component, a survey had to be taken at the various facilities of the post and center sample, and its findings were compared with those from the 1987-1988 household survey conducted by the General Directorate for Statistics and Censuses. The percentage of beneficiaries below the poverty line was estimated in this case at 68.9%.

5.46 The reform component was considered to benefit all the population to an equal extent (MIDEPLAN estimates the total population below the poverty line at 35%). Accordingly, applying the weighted average, a ratio of 59.5% is obtained for the overall program.

E. Risks of the program

5.47 The principal risks of the program are: (i) that the public-sector reform process bogs down in the absence of a political consensus and the reforms envisaged are not carried out; and (ii) that the government fails to make timely transfer to the CCSS of the resources needed for absorbing the transfer of health posts and centers.

5.48 If a political consensus does not materialize on the public-sector reforms, this would result in a continuance of a status quo involving duplication of functions, an absence of comprehensive planning in the sector, organizational fragmentation, and overlapping population coverages and administrative structures, all of which results in inefficient and inadequate primary health care. This risk is reduced by the fact that the government has already initiated the reform process in the health sector as part of the government reforms supported by sector loans, by consolidating the health services in various regions of the country. Moreover, potential resistance by MINSA medical personnel to being transferred to the CCSS will be lessened by a 15% increase in compensation based on benefit adjustments. The fiscal impact of this cost increase will be more than offset by savings stemming from the optimized use of MINSA resources.

5.49 As mentioned previously, the reforms proposed in this operation also form part of the package of government reforms to be supported by structural adjustment program III under consideration by the World Bank and by the IDB public sector reform program (CR-0025). The restructuring of MINSA and the consolidation of services would therefore be implemented as part of the government reforms.

5.50 In order to ensure that the CCSS will have adequate financial resources at its disposal for operating the health posts and centers efficiently, the contract for the proposed loan will include clauses under which the government will assume a commitment to make the pertinent financial transfers.

ANALYSIS OF THE HEALTH SECTOR

I. General context

1.1 The Costa Rican health system, which has been a key player in radical reforms ever since the early 1970s, has helped make possible and maintain a good national level of health. Nevertheless, there are still a number of factors posing obstacles to full enjoyment of good health, among which the following stand out: (i) socioeconomic inequalities; (ii) gaps between the epidemiological profile and service orientation; (iii) an imbalance among the main institutions of the sector and a weakening of the leadership role of the Ministry of Health; (iv) inefficiency and duplication of services and administrative structures; and (v) a marked deterioration in the preventive and curative ability of health care establishments and public services.

II. Demographic and socioeconomic context: inequalities and epidemiological transition

2.1 Costa Rica's population will grow from 3 million inhabitants in 1990 to 4 million in the year 2005. Of these, 2.5 million will be urban residents, with one million in the capital city of San José and the rest in the seven provinces and 81 counties *[cantones]* 1/ that are home to a significant agriculture-based rural population. This growth rate reflects a decrease in the birth, fertility, and death rates, which are tied to the levels of education and employment in Costa Rica, particularly among Costa Rican women. 2/

A. Inequalities in quality of life and health services: priority counties

2.2 Income distribution in Costa Rica (1983) is more equitable than in other countries of the region. However, significantly skewed areas persist. Over half of the national income goes to the top 20% of the population (the top 30% receives 63.2%). Although in the rural

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1/ The *canton* is the basic political-administrative unit in the country. It is further subdivided into districts, wards, and hamlets and is run by a municipal corporation whose members are elected by popular vote and whose administration is the responsibility of a manager appointed by the municipal council.

2/ Only 7.3% of the population is illiterate, and 41% of the economically active population has completed secondary school.

areas land tenure is less concentrated than in other countries, farming of tiny plots (minifundios) is the rule.

2.3 All the works under the proposed program to improve health centers and stations will be executed in the 30 counties identified with indicators of quality of life 3/ that are below the national average. 4/

B. Epidemiological transition

2.4 The increase in life expectancy at birth (76 years) (figure 2) reflects the aging of the population as a consequence of the decrease in mortality (infant mortality is 15 per 1,000 live births) (figure 1) and lower birth rates (28 per 1,000 women of child-bearing age). Already 6.5% of all Costa Ricans are over 60 years of age 5/ and the labor force (15 to 64 years of age) represents 60% of the population, a percentage which will be increasing with the extension of the age for retirement. 6/ This trend in the Costa Rican health situation is the product of the development momentum in the country, effective prioritization of social sectors (health expenditure represents 7% of gross domestic product), the level of education, social security coverage (85%), 7/ and the system of primary care.

2.5 The most important consequence of this demographic shift has been an increase in the incidence and prevalence of arterial

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3/ According to the 1989 MIDEPLAN study based on an aggregate index of mortality indicators (infant mortality, 1 to 4 years, from infectious diseases, parasites, and diarrhea) and social indicators (malnutrition, homes in poor condition, without running water or sewage hookups, illiteracy, and community organization).

4/ 30 priority counties

(1)	Talamanca	(2)	La Cruz	(3)	Buenos Aires
(4)	Guatuso	(5)	Upala	(6)	Limón Centro
(7)	Abangares	(8)	Puntarenas C.	(9)	Turrubares
(10)	Aguirre	(11)	Sta. Cruz	(12)	Liberia
(13)	Cañas	(14)	Los Chiles	(15)	Siquirres
(16)	Golfito	(17)	Sarapiquí	(18)	Osa
(19)	Pococí	(20)	Corredores	(21)	Matina
(22)	Parrita	(23)	Carillo	(24)	Garabito
(25)	Bagaces	(26)	Acosta	(27)	Nicoya
(28)	San Carlos	(29)	Coto Brus	(30)	Guácimo

5/ 4.3% over 65 years of age.

6/ Raised in 1991 from 55 years of age to 59 years 11 months for women and from 57 to 61 years 11 months for men.

7/ 76% percent are directly insured or dependents thereof, plus 7% are indigent insured by the government.

hypertension, diabetes, heart disease (heart attacks, etc.) malignant tumors, and accidents. Moreover, industrialization has increased the incidence of work-related accidents and occupational diseases. This entire epidemiological shift has created the demand for ever more complex preventive and curative services at the same time as the poor groups in the priority counties continue to suffer from significant levels of infectious diseases, parasites, and deficiencies, 8/ as well as complications during pregnancy and labor. The health sector's capacity to respond to this paradox arising from the epidemiological shift has been severely limited.

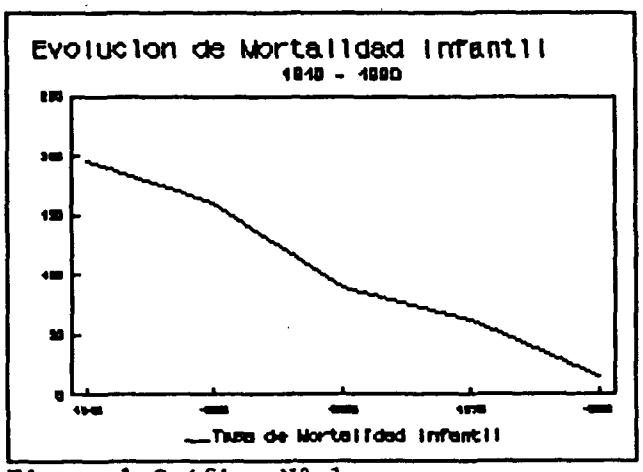

Figure 1 Gráfica Nº 1

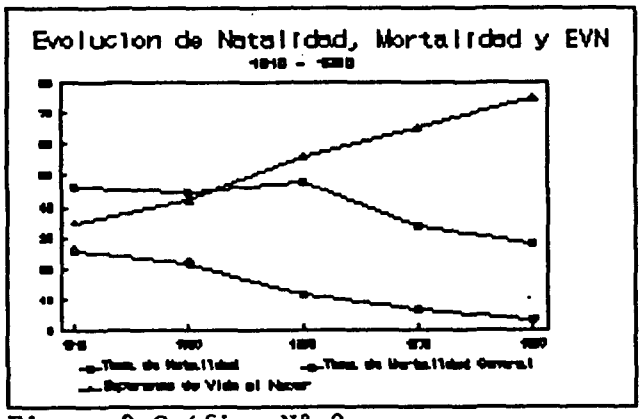

Figure 2 Gráfica Nº 2

8/ Recent studies (1990, 1991) indicate that one out of every five children of preschool age displays some degree of malnutrition (3.7% moderate or severe), one of every four children is anemic, and one out of nine suffers from iodine deficiencies.

1. Health of vulnerable groups

2.6 In spite of the progress that has been made, Costa Rican children are still disproportionately victimized by diarrheic diseases, acute respiratory infections, physical abuse (over 8,500 cases in 1990), measles, cavities, bronchial asthma, and complications in pregnancy and child-birth. Even though 97% of the child-births receive professional attention, women of child-bearing age are also vulnerable. Most cases of maternal mortality (0.2% per 1,000 live births) are the result of post-partum hemorrhaging, gestational toxemia, morbidity resulting from complications in pregnancy, all of which are mainly associated with low prenatal coverage (46 to 50% of the high-risk pregnacies) and post-partum coverage, as well as with maternal anemia (88% of pregnant women and 30% of mothers suffer from iron deficiency). 9/

2.7 Adolescent mothers (10 to 19 years of age) account for 14% of all pregnancies; however, a third of high-risk pregnacies are concentrated in this group, over half of whom receive no prenatal care (and only one-third of those receiving care have more than three visits). Some 39% of the children reported as abused are children of adolescents, 4% of the adolescents use some illegal drug, and this group displays the highest incidence of sexually-transmitted diseases.

2.8 Among the elderly population (over 60 years of age), which represented 6.4% of the population in 1990, chronic and degenerative diseases predominate as causes of death, morbidity, and disabilities, all of which require extended and costly care, but which also are preventable through early diagnosis and timely and appropriate care. Service utilization among this cohort represents 15% of CCSS visits, 13% of the hospital patients discharged, and over one-third (37%) of the adults discharged (over 15 years of age) from medical and surgical services.

2. Environmental situation

2.9 Urban residents enjoy a good level of basic sanitation (93% have access to potable water, but only 40% have sewage hook-ups). By contrast, among the rural population, 93% have water, but for 60% it is not potable; over half (53%) of the homes have sanitary deficiencies. The environmental burden from the 3 million Costa Ricans is equivalent to that of a population of 5.1 million, exacerbated by: (i) the fact that only 30% of the 2,000 metric tons of solid waste generated daily is appropriately disposed of; and (ii) dumping of industrial wastes (coffee, sugar, and others) in the Virilla and Tárcoles rivers, which has already contaminated

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9/ Other studies indicate some prenatal care among 75% to 90% of those who are assisted at the time they give birth.

some aquifers in Valle Central. Among the development projects of likely adverse environmental impact are the Tempisque River Irrigation Project (which would increase the local population from 50,000 to 250,000) and the geothermic electrical project at Miravalles. All these factors pose a significant challenge to the Ministry of Health in its role as lead agency.

C. Inadequate service policy

2.10 The demographic, epidemiological, and environmental considerations are not reflected in the current thrust of service delivery (care model). The services have an institutional, passive and curative focus on acute pathology, rather than taking a preventive or curative approach. A dynamic profile is required with appropriate services to: (i) plan preventive and curative activities for the communities and human environment; (ii) detect, prevent, and control the most prevalent chronic diseases; (iii) respond to the needs of the growing work force and an aging population; (iv) provide high quality prophylactic, diagnostic, and therapeutic responses consistent with rational use of available technologies; and (v) enable the services to adapt to future epidemiological changes under different organizational and financial formats. As a result, the Ministry of Health must be able to provide leadership that makes it possible for services to be redirected accordingly.

2.11 In fact, the current health policy places priority on activities aimed at: (i) reducing preventable infectious diseases and malnutrition; (ii) making prenatal and child-birth care universally accessible; (iii) preventing and controlling chronic diseases, poisoning from insecticides, and traffic accidents; (iv) expanding basic sanitation; and (v) maintaining the infrastructure; and (vi) preparing for natural disasters.

III. Institutional imbalance, service duplication and deterioration

A. Institutional imbalance in the sector and impairment of MINSA

3.1 The sector is made up by: (i) the Ministry of Health (MINSA); (ii) the Costa Rican Social Security Fund (CCSS); (iii) the Instituto Nacional de Seguros [National Insurance Institute] (INS) (Program of Occupational Hazards and other preventive programs, of which the transfer to the CCSS is being arranged); (iv) the Instituto Costarricense de Acueductos y Alcantarillados [Costa Rican Water Supply and Sewerage Administration (AyA); (v) the University of Costa Rica (UCR); (vi) private health care services and related activities; and (vii) community organizations.

3.2 The operational capability of the different entities in the sector for implementing the health policy has been affected by the economic crisis that has hit the country. As a result of adjustment programs, public expenditures for social sectors were cut.

Between 1980 and 1990, real income in the sector grew at a lower rate than that of the population. Per capita health expenditures at the end of the decade dropped by 1,051 colones (16%) compared with 1980. Whereas in 1980, health care expenditures accounted for 8.5% of GDP, they had dropped to 7.8% in 1990. Public expenditure on health care was 6.9% of GDP in 1991, 75% of which (5.2% of GDP) went to the CCSS, with the remainder going to MINSA, ICAA, INS, and the municipalities. This forced the public services to maintain the level of service delivery with fewer resources, which, in turn, was the impetus for the policy of concentrating social spending on low-income groups.

a. Ministry of Health

3.3 The Ministry of Health is responsible for formulating national health policy and for planning and coordinating all public and private activities pertaining to health care, health promotion, disease prevention, and environmental sanitation. It operates 90 health centers, 650 nutrition education centers (CEN) and Early Childhood Comprehensive Care Centers (CINAI), 400 health stations, and 40 mobile units. With these resources and a contingent of 6,000 professionals, technicians, and support staff, the ministry provides mainly preventive services, which account for 8% of the medical visits in the country. Of this personnel, some 1,250 (21%) work at the central level, 250 (4%) work with the regional supervision teams, and 4,500 (75%) work in operations at the local level. Of the last group, some 3,000 (50%) handle the health care services that would be tranferred to the CCSS and another 1,500 (25%) are responsible for programs to promote health, environmental health, vector control, and nutrition.

3.4 Financing for MINSA is currently provided from general revenues and special assessments (67%) and transfers from the Family Allowance Fund (33%). 10/ In 1991, these revenues represented 0.7% of GDP and 11% of public sector expenditures.

b. Costa Rican Social Security Fund

3.5 The Costa Rican Social Security Fund is responsible, under constitutional mandate, for providing 2.5 million participants (84% of the national population) 11/ and indigent persons insured by the government with health recovery and rehabilitation services. It is also responsible for cooperating with the Ministry of Health in promotion and prevention activities. For these purposes, the CCSS has 30 hospitals with a total of almost 7,000 beds,

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10/ This fund is maintained with tax revenues that are determined by law for social services (e.g., children's homes, economic assistance, health services, etc.).

11/ CCSS, Annual Report, 1991, San José, Costa Rica.

representing the lion's share of the country's installed capacity, plus 240 clinics, 30% of which are combined with MINSA health centers. These facilities are operated by a labor force of approximately 21,000 people, who handle 98% of the stays and 70% of the consultations in the country.

3.6 To cover its operations, this system relies on three-pronged financing from employees (5.5% of salary), employers (9.35% of payroll), and the government (0.25% of payroll), as well as contributions from the Social Welfare Fund of San José for operation of the hospitals and revenues from the sale of services to the National Insurance Institute (INS) and other agencies, which account for 13% of the revenues of the Health and Maternity Insurance Fund.

3.7 In addition to caring for those who become sick or are victims of common accidents, the Health and Maternity Insurance Program provides well-baby health care programs, comprehensive adolescent care, and internal medicine. In addition, since early 1992, the CCSS has been negotiating to take over the occupational hazard activities run by the INS. These activities include prevention of accidents in the workplace, prevention of auto accidents and rehabilitation and curative medical sèrvices for accident victims. Coverage for auto accident victims reaches 100% of the population and, for occupational hazards half of the economically active population is covered. The INS operates 16 medical clinics, 1 central office for visits, and 1 rehab center, which altogether account for 3% of the consultations in the country. In addition, it finances the services provided by the CCSS and the private sector.

c. Private sector

3.8 The private sector consists essentially of private clinics and a small hospitalization capacity. These are located mainly in San José and there is little coordination with the public health care system. The private sector only accounts for 10% of the consultations and 2% of the hospital stays in the country. Private practice is overseen by the College of Physicians and Surgeons in accordance with legal provisions and regulations. However, specific standards are lacking for its development, organization, and quality control.

B. MINSA - CCSS imbalance, duplication, and consolidation

3.9 Over the course of the years, the solvency of the CCSS and the fiscal plight of MINSA have led to growing imbalance between the two agencies as well as conflicts and inefficiency. Among the most notable consequences have been the progressive decline in the leadership role of the Ministry of Health, the duplication of (curative) services and administrative structures of local health

services, and the reinforcement of the dichotomy between curative and preventive care.

3.10 Under the law, every health service establishment, in terms of its installation and operation, is subject to the regulatory authority of the Ministry of Health. However, because MINSA has focussed its efforts and resources on providing care, it has not reached the level of institutional development that would enable it to exercise its leadership role. It lacks the information and the effective technical, administrative, financial, and legal tools to do so. Specifically, MINSA has failed to develop a viable capacity to use the different contributions from the government to CCSS as leverage to help ensure the CCSS compliance with health policies and quality standards.

3.11 This imbalance and duplication led the government in the early 1970s to design a process for the progressive merger of the two institutions. In practice, this process has progressed with the absorption by the CCSS of all public-sector hospitals (1973) and the physical merger (1982) of all MINSA and CCSS ambulatory care into the integrated health centers (31 as of now) (which, however, did not change the duplicated administrative structures within the same physical sites). These relationships have been formalized through a series of agreements (1984, 1989, 1992) that have progressively defined the roles and responsibilities of each institution and have established the principal points of the consolidation process that got started two decades ago. As was confirmed in a recent assessment, 12/ solutions still need to be made operational in some practical areas (viz., the unification of administrative and command structures, equalization of wage scales, and imbuing CCSS with a prevention-conscious culture). These are the areas addressed in the proposed operation.

B. Deterioration of the health care system

3.12 The situations described above have been associated with a deterioration in the preventive, curative, and management capacities of the health care system. They have created significant inefficiencies in the use of resources within the sector, which are fundamentally the product of financial, operational, and management constraints on the capacity of the CCSS to take responsibility for personal preventive and assistance care. The constraints include: (i) organizational factors and service delivery that limit user access (e.g., extended waiting times for specialized attention,

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12/ Ministry of Health, "Evaluación del Grado de Desarrollo del Proceso de Integración/Coordinación entre el Ministerio de Salud y la Caja Costarricense de Seguro Social" ["Evaluation of the progress achieved in the consolidation/coordination process involving MINSA and the CCSS"], San José, Costa Rica, 1992.

deficiencies in the physician-patient relationship); (ii) the financial burden of a high component of imported technology and inputs; (iii) weak local management associated with the centralization of administrative and financial authority, notwithstanding certain initiatives to decentralize responsibilities; (iv) deficiencies in the evaluation and control systems; and (v) deficiencies in human resource planning, training, management, and distribution.

3.13 The 1990-1994 National Development Plan establishes the general thrust of the health sector in terms of modernization, reform, and institutional reorganization of the government apparatus and optimization of its resources, in accordance with efficiency criteria that will ensure that the lowest-income groups are given priority in social spending. This view has been spelled out in a health sector reform plan (see chapter I) which reflects a political and technical consensus on critical considerations (i.e., continuation of the consolidation process, new patterns of care). To put these into practice, Costa Rica has requested support from the IDB, the World Bank, and the Pan American Sanitary Bureau.

IV. Service region of the Alajuela Hospital

4.1 The Alajuela Hospital (which dates back to 1883) serves a population of 350,000 people in an area of 9,753 square kilometers, 15 counties, and 107 districts. The population is expected to grow to 500,000 by the year 2005. Its area of direct influence covers five counties (Central, San Mateo, Póas, Orotina, and Garabito) with 56% of the population; the indirect area, where the remaining 44% live, involves another five counties (San Ramón, Naranjo, Palmares, Alfaro Ruíz, and Valverde Vega). The population is mainly rural (60% of the direct and 70% of the indirect areas), with a high level of dispersion (36% in the direct area, 55% in the indirect). The largest growth (1984-1990) took place in the Cantón Central (21.5%), San Pedro Póas (28.1%), San Ramón (12.2%), and Grecia (11.2%), due, among other factors, to important housing projects in two of these counties.

4.2 The relative disadvantage of the counties in the Alajuela Hospital service area in comparison to the rest of the north central region, 13/ of which the hospital is part, is determined by: (i) the high rate of infant mortality (especially in San Mateo, Garabito, and Alfaro Ruíz counties); (ii) low CCSS coverage (in San Mateo, Garabito, San Ramón, Palmares, A. Ruíz, and Valverde Vega); (iii) inadequate basic utilities services for the housing; (iv) high rates of unemployment (9.4%) (Orotina) and illiteracy

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13/ The north central region system has 8 hospitals (including the Alajuela Hospital), 25 CCSS clinics, 27 health centers, and 80 MINSA health stations.

(Orotina, San Mateo, Garabito); and (v) the pollution of the public water system in the central country of Alajuela. The sanitation levels are cause for concern in some zones of the area described, given the presence of 496 shanty towns and as much as 30% of the population lacking potable water.

4.3 The population in the area of reference is mainly an adult population, with important components at the productive age (60%) as well as the elderly (7.4%). The epidemiological profile is consistent with this demographic composition, given the elevated mortality rates there from cardiovascular diseases (8.4 per 10,000), accidents, poisonings and violence, and acute respiratory diseases (1.6). The industrial character of the Alajuela zone contributes to this pathology. (Business and industrial activities that pose health hazards include: a slaughterhouse and a soap factory.)

4.4 The system of health care services is comprised of the Alajuela Hospital, two peripheral hospitals (indirect area), 11 integrated clinics (six direct, five indirect), one CCSS clinic, one health center, one INS clinic, and two health posts. The community actively participates in the activities and concerns of the health sector; there are a large number of health-oriented social action groups.

4.5 The Alajuela Hospital itself suffers from an advanced state of deterioration and obsolescence. The situation became even more urgent when the earthquake that took place in late 1990 caused severe damage to the present hospital. It is important to note that this hospital in fact constitutes a serious environmental hazard; it even had to close down for a time in 1989 because the Alajuela potable water system had become contaminated from damages to the hospital sewage system. These constraints on its curative capacity have been exacerbated by the inadequate distribution of available space, the impossibility of expansion, and low staff productivity. A program to strengthen the Alajuela Hospital administration has been started, with support from PAHO. The corresponding activities could result in an acceptable level of management efficiency in the new building.

4.6 As a result of all of these circumstances, the Alajuela Hospital has been able to meet only 65% of the demand in the direct area (see Annex V-2); it refers 35% of the demand to national hospitals (surgery - 54%, medicine - 48%, pediatrics - 40%). Furthermore, 31% of the hospital stays in the peripheral hospitals (of the indirect area) are directly transferred to the national hospitals (the Alajuela Hospital only cares for 10%). Waiting periods for specialized consultations have now grown to between 3 and 12 months (6 to 12: rehab, urology, peripheral vascular; 3 to 6: cardiology, endocrinology, gastroenterology, neurology, internal medicine, orthopedics, otorhinolaryngology, ophthalmology, psychiatry). Preventive activity is extremely limited.

V. Regions for the sample and the universe of health centers and stations

5.1 The sample covers 11 counties in three regions (Central Pacific, Chorotega, Brunca) and a population of 188,000 (187,849). (Breakdowns available in PRA files.) This population, an average 82% of which (standard deviation of ± 14.2%) lives below the poverty line, resides in the service area of three centers and 23 health posts. All of the other works under consideration in the program (11 centers and 119 posts) are located in the 30 priority counties already identified.

PROGRAM EXECUTING UNIT

The program executing unit was created for the purpose of executing the health services improvement program. It will be located in the Office of the Director of Institutional Planning at the CCSS. The organization and operation of this unit are described below.

The executing unit (PEU) will be the main body responsible for the effective and timely execution of the program; it is to be financed by the IDB and will answer to the Central Coordination Council consisting of the Minister of Health, the Executive President of the CCSS, and the Minister of Planning.

This high-level policy group will have the following responsibilities:

a. Analyze the progress of program execution;

b. Coordinate the efforts of various participating institutions in order to support the work of the PEU and make the necessary policy decisions for appropriate execution of the program.

I. PEU OBJECTIVES

1.1 The main duties of the PEU will be to:

a. Plan, coordinate, execute, and evaluate the program.

b. Coordinate activities with intra- and extra-institutional agencies that are connected with the objectives and execution of the program.

II. PROGRAM MANAGEMENT

Duties of the director of the executing unit:

2.1 The director of the unit will have the following duties:

a. Direct, coordinate, supervise, and be responsible for the technical, financial, and administrative development of the program.

b. Coordinate the execution of the program and supervise compliance with it among the specific operational units.

c. Act as liaison between the IDB, the CCSS, and MINSA in executing the components funded by the IDB.

d. Present the legal, technical, administrative, and financial documents and reports required by the Bank, in terms of component preparation, execution, progress, and evaluation.

e. Present the requests for disbursements to the Bank, in compliance with the provisions set forth in the pertinent loan contracts.

f. Present the requests for disbursements from national counterparts to senior authorities for consideration.

g. Participate in the study of the bidding and invitations to tender, in accordance with the provisions of the IDB contracts, their annexes, and the national laws and regulations on competitive bidding.

h. Prior to issuing calls for biddings, submit for approval by the Bank the final plans for repair or construction of physical infrastructure, the bidding documents and other documents provided for in the contracts for execution of works, procurement of goods and contracting of services.

i. Guarantee a current accounting and financial system that allows appropriate control of the project operations and investment plan.

j. Supervise the execution of the components, the technical support advisory services, the procurement and/or installation of equipment, materials, furnishings, goods, and services.

k. Each semester, present to senior authorities the reports on the execution of the components.

l. Each year, present to the IDB the financial statements of the project, in accordance with the clauses of the loan contracts.

m. Keep the authorities and the Bank informed on the progress of the project in terms of its technical, administrative, and financial aspects.

III. INTERINSTITUTIONAL EXECUTIVE COMMITTEE

3.1 This committee will be the functional liaison body responsible for gathering, adapting, and taking maximum advantage of the execution resources available at the CCSS and MINSA. It will be made up of the Director of the PEU, who will act as Executive Secretary, the Directors of the Medical and Operations Divisions of the CCSS, the General Director of Health (MINSA), and the coordinators in the areas of programming and control, and finance and administration, as well as the specific individuals responsible for the operational units, who will meet once a month.

IV. PROGRAMMING AND CONTROL AREA

4.1 This area will be responsible for acting as the technical liaison between the director of the PEU and the entities tasked with specific execution of the program components. It will be made up of a coordinator, two project specialists, and an economist.

Duties

4.2 Design and implement an ongoing operating system of coordination between the executing unit and the specific operational units of each component.

4.3 Design and implement the methodology for annual and ex post evaluation of the objectives and goals of each of the components of the project and for cost-efficiency evaluation of the selection of health stations and centers for the physical infrastructure component of the Ministry of Health.

4.4 Participate in the drafting of the annual operations plan for the project.

4.5 Draft, in collaboration with the various operational units, the plan for monitoring, control, and evaluation of the project components.

4.6 Present semiannual reports to the project director on the general progress of the program components and on the specific evaluations.

V. ADMINISTRATION AREA OF THE PROGRAM

5.1 This area will be responsible for managing the proceeds of the loan and local counterpart. It will also be responsible for all administrative and accounting functions, personnel administration, and providing the logistical support required for efficient operation of the project.

5.2 It will be made up of the coordinator of the area and two specialists responsible for: bidding and procurement, accounting and payments processing.

5.3 It will receive the support of the internal auditing unit of the CCSS for auditing work.

Duties

5.4 The duties to be performed will be as follows:

a. General services

5.5 Establish appropriate procedures for the procurement of goods and minor services.

5.6 Provide secretarial services and logistical support to the different areas of the PEU.

5.7 Take responsibility for processing per diem payments and requests for vehicles from personnel who have to travel as part of the execution of the project.

b. Bidding and procurement

5.8 Organize the bidding process, procurement and calls to tender, in accordance with the contractual, legal and regulatory provisions.

5.9 Maintain a current list of national and international suppliers.

5.10 Coordinate procurement tasks with the operational units of the project.

c. Financial accounting areas

5.11 Set up the systems of internal control in order to verify the operations undertaken by the PEU, verifying its compliance with specific laws and regulations established for the program with the support of the internal auditing unit of the CCSS.

5.12 Provide external auditors with the information and cooperation that they need to perform their jobs.

5.13 Implement an accounting system and financial records for the project.

5.14 raft the annual financial accounting plan.

5.15 Prepare the requests for project disbursements and set up the revolving fund.

5.16 Prepare the financial statements and the reports concerning the project and/or its components.

5.17 Coordinate with those responsible for areas and operational units of the components on all budgetary matters.

VI. OPERATIONAL UNITS

6.1 The various sections of the CCSS and MINSA will be responsible for executing the components of the project (institutional strengthening of the Ministry of Health as lead agency and physical

infrastructure). These sections have their own functional features and under the program they will be responsible for executing program activities.

6.2 Each operational unit will have public officials who will make up a core group and will be directly assigned to the program on a full-time basis. During this time period they will answer directly to the program director, who will be supported by other officials when it is so required.

VII. OPERATIONAL UNIT OF THE MINISTRY OF HEALTH REORGANIZATION COMPONENT

7.1 This component will be executed by the Office of the Director of Health Systems Development of the Ministry of Health, for which purpose 10 full-time employees have been assigned to act as the core group; they will also receive the support of other MINSA professionals when necessary.

Duties

7.2 Execute the activities indicated in the component.

7.3 Draft an annual activities plan for this component and a corresponding schedule.

7.4 Present semiannual reports on the activities undertaken.

7.5 Provide the information required by programming, control, and administration areas.

7.6 Participate in the meetings of the coordinating committee when required.

VIII. OPERATIONAL UNIT OF THE SERVICE INTEGRATION COMPONENT

8.1 This component will be executed by five officials of the Office of the Director of Architecture of the CCSS and 10 officials from the Ministry of Health. The group from the CCSS will be responsible for all areas related to the construction of the Alajuela Hospital; the Ministry of Health group will be tasked with matters concerning the health posts and centers.

Duties

8.2 Collaborate with the PEU in all matters that may concern the physical execution of the works program.

8.3 Supervise the drafting of the final architecture and engineering plans and their respective specifications, and oversee to ensure full compliance with them.

8.4 Supervise the physical execution of the works.

8.5 Inspect the construction works on a regular basis.

8.6 Coordinate the works in the different regions in which they are undertaken.

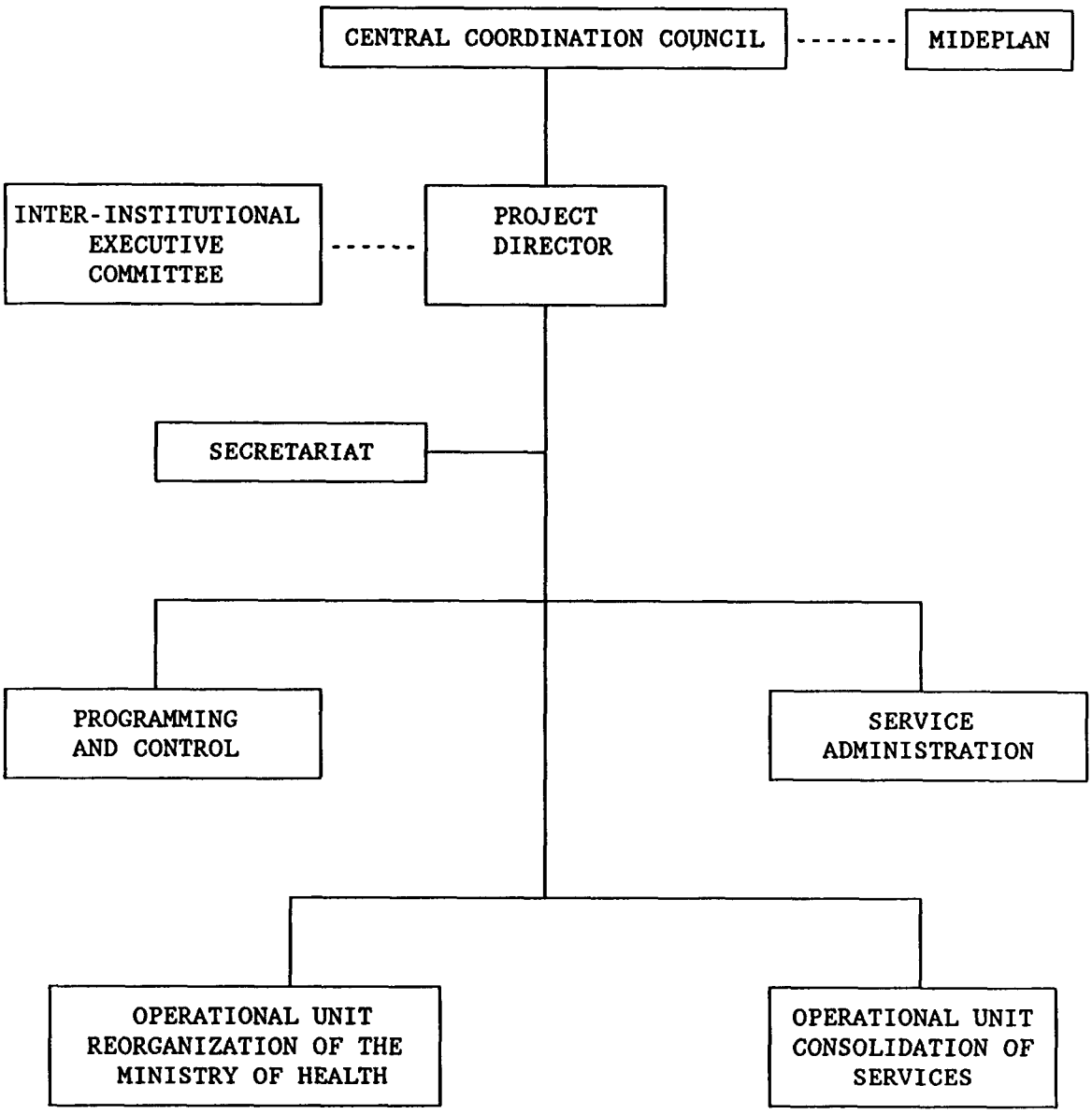
8.7 Review, approve, and control the accounts presented in contracting for any kind of construction related work.

8.8 Collaborate in the preparation of the reports that are to be presented to the IDB. Likewise, draft those that are requested by the PEU areas.

8.9 Make sure that the works investment plan is fulfilled within established deadlines.

8.10 Coordinate with the person responsible for bidding for the procurement and installation of equipment.

PROJECT EXECUTING UNIT
HEALTH SERVICES IMPROVEMENT
JULY 1992



REORGANIZATION OF MINSA

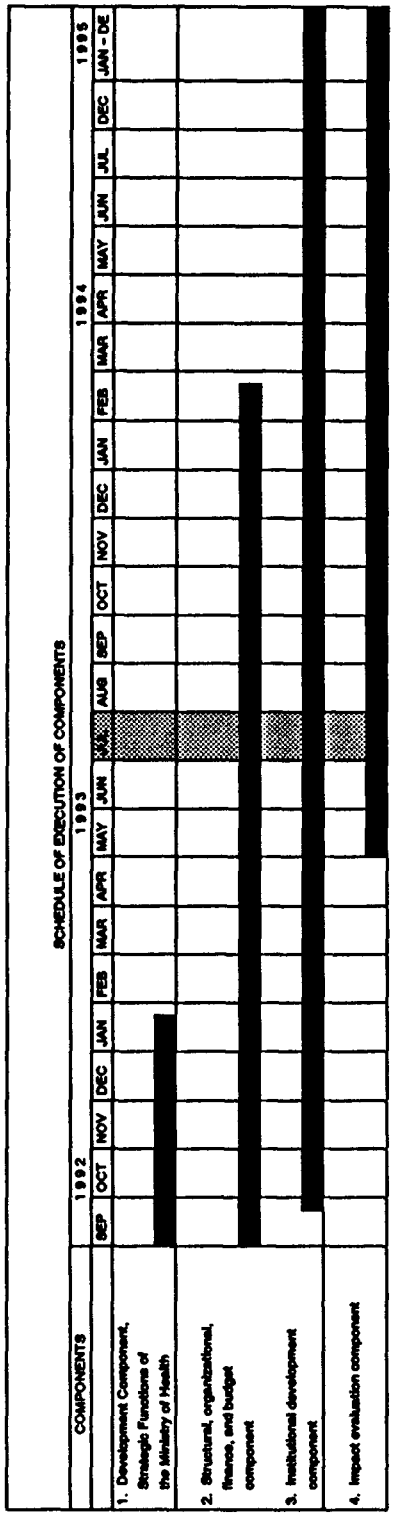
SCHEDULE AND TERMS OF REFERENCE FOR CONSULTANTS

The support for the reorganization of MINSA component will consist of technical assistance (consulting and training) in four central areas of activities, to wit: (i) the **definition of the strategic functions** of the Ministry of Health, and its relations with other institutions in the sector; (ii) the **definition of the operative functional profile**, the organizational **structure**, and the **financial plan** and budgetary structure of MINSA, as well as indispensable **amendments to legislation** in force; and (iii) the **definition of the systems** for leadership of the sector, of the **programs** that the Ministry will continue operating, and of a comprehensive model for the effective coordination thereof and the consolidation and execution of a **plan for institutional development and training** as an operative expression of the proposal for MINSA reform.

A total of 180 person/months of consulting services will be required for these purposes (141.5 national, 38.5 international), as will some 175 scholarships, both national (168) and international (7) at a total estimated cost of US$3.7 million, in accordance with the breakdown in the following table:

BREAKDOWN OF THE DISTRIBUTION OF SCHOLARSHIPS	
TECHNICAL AREA	**NUMBER OF SCHOLARSHIPS**
Master's in Public Health	40
Master's in Public Administration	15
Master's in Sanitation Engineering	7
Master's in Human Resources	8
Master's in Strategic Planning	10
Master's in Business Administration	5
Master's in Epidemiology	3
Master's in Computer Science	3
Master's in Research	2
Master's in Health Economics	2
Degree in Environmental Sanitation	80
TOTAL	175

BUDGET FOR THE REORGANIZATION COMPONENT			
HEADING	**LOCAL GCR**	**IDB**	**TOTAL**
International consultants		393,000	393,000
Consulting fees		193,000	193,000
International travel		38,000	38,000
Domestic travel		12,000	12,000
Per diem		150,000	150,000
National consultants	318,000	857,000	1,175,000
Consulting fees	238,000	847,000	1,085,000
Domestic travel		10,000	10,000
Per diem	80,000		80,000
Printing and publications	2,000	90,000	92,000
Materials and supplies	75,000		75,000
Scholarships and stipends		615,000	615,000
Workshops	118,000		118,000
Computer hardware and software		1,495,000	1,495,000
Physical Plant (refurbishment)		207,000	207,000
TOTAL	513,000	3,657,000	4,170,000


SCHEDULE OF EXECUTION OF COMPONENTS
COMPONENTS
1992
1993
1994
1995
SEP
OCT
NOV
DEC
JAN
FEB
MAR
APR
MAY
JUN
JUL
AUG
SEP
OCT
NOV
DEC
JAN
FEB
MAR
APR
MAY
JUN
JUL
DEC
JAN - DE
1. Development Component, Strategic Functions of the Ministry of Health
2. Structural, organizational, finance, and budget component
3. Institutional development component
4. Impact evaluation component

SCHEDULE OF CONSULTANT CONTRACTING BY COMPONENT

CONSULTANTS	1992					1993											1994								1995
	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN	JUL	DEC	JAN - DE
1. Develop. of Strategic Funct. of Ministry of Health																									
National Consultant (1)	2 months 1/2																								
2. Organizational, financing and budget component																									
2.1 Organizational subcomponent																									
National consultant (2)			2 months			2 months																			
2.2 Financing subcomponent																									
2.3 Budget structure subcomponent																									
National consultant (3)			7 months										6 months												
International consultant (1)					5 months								6 months												
3. Institutional development component																									
National consultant (4)		2 months									2 months 1/2														
National consultant (5)		2 months									2 months 1/2														
National consultant (6)		1 month									2 months 1/2														
National consultant (7)									2 months								22 months								
International consultant (2)		2 months				4 months 1/2					2 months 1/2														
Nacional consultant (8)					3 months																				
National consultant (9)							4 months																		
National consultant (10)						2 months																			
National consultant (11)								2 months																	
Information System																									
National Consulting Firm (1)																									
National consultant (12)											4 months														
National consultant (13)																		6 months							
National consultant (14)																		6 months							
National consultant (15)																		6 months							
National consultant (16)																		6 months							
National consultant (17)																		6 months							
National consultant (18)																		6 months							
4. Impact evaluation																									
National consultant (19)									1 month 1/2			2 months										1 month 1/2			
International consultant (3)									1 month 1/2			2 months										1 month 1/2			
National consultant (20)									1 month 1/2			3 months											3 months		
International consultant (4)									1 month 1/2			3 months											3 months		

I. COMPONENT FOR DEVELOPMENT OF THE STRATEGIC FUNCTIONS OF THE MINISTRY OF HEALTH

NATIONAL CONSULTANT (1)

1. Objective

1.1 Assist the group responsible for the component for the development of Ministry of Health strategic functions in fulfilling the following general objective: present to the group several options or alternatives that make possible coordination and liaison between health sector institutions and the lead agency.

2. Output

1.2 A proposal that will include the definition of the roles, levels of authority and liaison mechanisms between the Ministry of Health and the other health sector institutions: CCSS, ICAA, INS, universities, IAFA, INCIENSA, and MIDEPLAN; at the same time, those institutions of other sectors, such as the Ministry of Science and Technology and the Ministry of Education, which ensures the lead agency of fulfillment of such functions as management, direction, and sectoral coordination.

3. Tasks

a. Review the bibliography on existing studies in areas of organization and performance of ministries of health in their leadership roles, as well as analyze similar experiences of other countries in the field.

b. Design alternatives that offer different liaison mechanisms between health sector institutions and the lead agency to ensure the effective practice of the latter's jurisdiction.

c. Integrate and systematize the results of interviews carried out with key informants with the results of the bibliographic review and the output of the working group in order to identify viable, feasible options, and develop a final proposal that includes liaison mechanisms between the lead agency and the health sector institutions.

d. Present to the executing unit of the project and to the Bank a preliminary report within 15 days of the completion of the consulting services; once remarks from the government and the Bank have been received, present a final report incorporating their responses.

4. Duration

1.3 Two and a half months for the national consultant beginning on September 16, 1992.

5. Professional profile

1.4 Professional in the field of health, the economy, planning, health services administration with 10 years' experience in a senior policy-making position involving programs in the health sector.

II. ORGANIZATIONAL STRUCTURE, FINANCING, AND BUDGET COMPONENTS

A. ORGANIZATIONAL SUBCOMPONENT

NATIONAL CONSULTANT (2)

1. Objective

2.1 Support the national group in the process of drawing up the profile of operational functions of the different units of the Ministry of Health at its central, regional, and local levels of management; also in developing the corresponding organizational structure.

2. Output

2.2 Model describing the operational functions of the different MINSA administrative units, at the central, regional, and local levels, on the basis of the contents of the functional profile drafted in component 1.

2.3 Organizational structure model, on the basis of the description of MINSA operational functions and the corresponding Manual of Organization and Functions, and an Operations Manual for future programs.

3. Tasks

a. Review bibliographic material and other background on existing studies in the Ministry of Health on this topic.

b. Adapt the existing information in the studies that have been carried out according to the contents of component 1 of the project.

c. Draft a proposal for a profile of MINSA operational functions at every management level, the Manual of Organization and Functions and the Operations Manual in order to create future health programs and affiliated institutions.

d. Present a preliminary report to the executing unit of the project and to the Bank within 15 days of the completion of the consulting services; once responses have been received from the government and the Bank, present a final report incorporating the remarks. In addition, if the services are rendered in stages, the consultant will submit applicable reports for approval by the executing unit.

4. Duration

2.4 Four months: two months, from November 1 to December 31, 1992; and two from February 1 to March 31, 1993.

5. Professional Profile

Professional in the areas of administration, planning, or systems engineering, with emphasis on administrative analysis and organizational development, preferably in the public sector; a minimum of 3 years' experience.

B. FINANCING AND BUDGET STRUCTURE SUBCOMPONENT

NATIONAL CONSULTANT (3)

1. Objective

2.5 Support the national group in coordinating with the international consultant in the process of drafting the financing model for the Ministry of Health, ensuring its political viability and technical feasibility, as well as its total alignment and complementarity with the sectoral financing model.

2.6 Support the national technical team in the process of drafting the model for the budget structure of the Ministry of Health at its three management levels, beginning with the start of the program and of the health care model.

2. Output

2.7 Draw up the financial model for MINSA and its relationship to the sectoral financing model; and budget structure model at its three levels of management.

3. Tasks

a. Systematize and study the information on financial administration contained in diagnostics, model proposals, and other such studies.

b. Identify and analyze the viable and feasible revenues needed for the institutional development of the ministry and for exercising its leadership role.

c. Identify the new sources of funding and design the mechanisms and administrative procedures needed to allocate, and control these resources and make them regular.

d. Coordinate with the institutional legal authorities to establish the necessary legal procedures and rules for the effective development of the model.

e. Systematize and analyze the information on the conceptual areas of budgeting and organizational development and the related methodologies.

f. Support the national group in carrying out the study of the current budget structure of MINSA.

g. Identify the strategies used to design the budget structure for MINSA, from the beginning of the program.

h. Support the national group in the design and drafting of the budget structure in accordance with the health care and program initiation model.

i. Design and draw up the subsystems for production, performance, resources, and cost.

j. Participate with the national group in implementing the model of the defined budget structure at the different MINSA management levels.

k. Present a preliminary report to the executing unit of the project and to the Bank within 15 days of the completion of the activity; once responses from the government and the Bank have been received, present a final report that incorporates their remarks. In addition, if the services are rendered in stages, the consultant will submit applicable reports for approval by the executing unit.

4. Duration

2.8 Seven months, from September 15, 1992, to April 15, 1993, and eight months beginning on May 1, 1993.

5. Professional profile

2.9 Professional in economics, with an emphasis in public administration and public sector financial planning, a minimum of three years' experience.

INTERNATIONAL CONSULTANT (1)

1. Objective

2.10 Furnish technical advisory services and support to the national group in coordination with the national consultant, who (s)he will supervise, in order to provide guidance in the process of drawing up the financing model, which will ensure political viability and technical feasibility; to be done in total consistency and complementarity with the sector financing model.

2.11 Furnish technical assistance and support to the national group and the national consultant in the process of drafting the budget structure model for the different management levels of MINSA, beginning with the start of the program and the health care model.

2. Output

2.12 The MINSA financing model and its relation to the sector financing model, and the MINSA budget structure model by level.

3. Tasks

a. Analyze the qualitative and quantitative aspects of the financial resources of the Ministry of Health, beginning with the health care model and the start of the program.

b. Analyze the viability and the feasibility of possible MINSA funding sources, beginning with the health sector financing model.

c. Supervise the tasks and the output of the national consultant in his/her area.

d. Coordinate and give technical support to the national group in designing and drafting different components of the ministry financing model.

e. Design the strategies needed to draw up a budget structure.

f. Draw up, in conjunction with the national group, the budget structure model, under the principles of a flexible decentralized administration.

g. Design and draft the subsystems for production, performance, resources, and costs that allow control and distribution of MINSA resources.

h. Provide the technical support needed to implement the budget structure proposal as designed at the different management levels of MINSA.

i. Advise the group that is preparing the evaluation indicators to gauge the financial and economic impact of the project in its drafting of the evaluation.

j. Present a preliminary report to the executing unit of the project and to the Bank within 15 days of the conclusion of the activity; once the responses from the government and the Bank have been received, present the final report with their remarks incorporated therein. In addition, if the services are rendered in stages, the consultant will submit applicable reports for approval by the executing unit.

4. Duration

2.13 Altogether, the consulting services will last 11 months, divided into two periods as follows: Five months beginning on November 15, 1992, and six months beginning on July 1, 1993. The consultant will have the support of the national group and the national consultant during his assignment.

5. Professional profile

2.14 Professional in finance, with a master's or doctorate in health administration and financial planning; a minimum of 10 years' experience.

III. INSTITUTIONAL DEVELOPMENT COMPONENT

NATIONAL CONSULTANT (4)

1. Objective

3.1 Give technical support to the national group in coordination with the international consultant in drawing up the new conceptual framework and in designing a health monitoring and planning system at different levels.

2. Output

3.2 The system, conceived and designed, for health monitoring and planning.

3. Tasks

a. Review the bibliography on conceptual factors related to the area of health monitoring and planning.

b. Define the methodological and operational concepts (scope of functions) in areas such as: analysis of the health situation, epidemiological monitoring, focus on risks, program strategies; all of which must be keyed to the national epidemiological profile, characterized by transmissible, chronic, and degenerative diseases, accidents, social pathology, and environmental degradation, among others.

c. Define the methodological and operational concepts (scope of function) in such areas as: situational diagnosis, prioritization and ranking of problems, program strategies, feasibility and viability analysis, local planning, control, and evaluation.

d. Design and work out a health monitoring and planning system in the following areas: the operational and functional framework, procedures and mechanisms for the implementation thereof, control and evaluation mechanisms to keep the framework continuously current and updated, determination of information needs and outputs.

e. Present a preliminary report to the executing unit of the project and to the Bank within 15 days of the conclusion of the activity; once the responses from the government and the Bank have been received, present the final report with their remarks incorporated therein. In addition, if the services are rendered in stages, the consultant will submit applicable reports for approval by the executing unit.

4. Duration

3.3 Two months, beginning on October 1, 1992, and two and a half months, beginning on July 1, 1993.

5. Professional profile

3.4 Professional in health or public administration, with emphasis on public health, epidemiology or planning; a minimum of five years' experience working at institutions responsible for health management and leadership.

NATIONAL CONSULTANT (5)

1. Objective

3.5 Provide technical support to the national group in coordination with the international consultant in drawing up the new conceptual framework and in designing a system for regulation, control, and evaluation.

2. Output

3.6 The concept for the system for regulation, control, and evaluation; the terms of reference for the system design, and the designed system.

3. Tasks

a. Review the bibliography and past experience on conceptual factors related to the regulation, control, and evaluation of the public and private health systems.

b. Define the concepts in terms of regulation, control, and evaluation in such areas as: standards for personal and environmental care, for the care and protection of the human environment; the production, use, and distribution of medications, drugs, food, and toxic substances; certification of health establishments and the like, both public and private; research and technological development; social communication concerning health; health economics and financing (cost of medications, access to private health benefits); control over the execution of strategic public health programs of MINSA; assessment of the impact of health programs of public and private health institutions; investments in the development of the health infrastructure; and individual health safety and protection in public building and housing investments.

c. Design and work out the regulatory, control, and evaluation systems in such areas as: the operational and functional framework; procedures; mechanisms for internal and external relations; interface with other systems; information needs and products and the corresponding control and evaluation procedures to keep them current and updated.

d. Instruct the national group in the leadership, administration, and management of the designed system.

e. Present a preliminary report to the executing unit of the project and to the Bank within 15 days of the conclusion of the activity; once the responses from the government and the Bank have been received, present a final report with their remarks incorporated therein. In addition, if the services are rendered in stages, the consultant will submit applicable reports for approval by the executing unit.

4. Duration

3.7 Two months, beginning on October 1, 1992; two and a half months beginning on July 1, 1993.

5. Professional profile

3.8 Public health or health administration professional, or industrial or systems engineer, with emphasis on public health or planning. A minimum of five years' experience working in public and private institutions, preferably in the area of health.

NATIONAL CONSULTANT (6)

1. Objective

3.9 Provide technical support to the national group in coordination with the international consultant in working out a new conceptual framework and in designing a system for research and technological development.

2. Output

3.10 The concept for a system for research and technological, the terms of reference for the system design, and the designed system.

3. Tasks

a. Review the bibliography covering the conceptual and operational factors concerning the subject of research and technological development.

b. Define the methodological and operational concepts (scope of function) in such areas as: scientific and operations research in the fields of health and health services; research planning; health services research and administration; the structure of the subsystem, procedures, and mechanisms for interfacing both within the subsystem and with the others; criteria for planning and prioritizing technological development in health, its scope and content, the structure of the subsystem and its relation to other systems, control and assessment mechanisms to keep the system current. Work out a proposal for the system of research and technological development in conjunction with the international consultant and the national group.

c. Present a preliminary report to the executing unit of the project and to the Bank within 15 days of the conclusion of the activity; once the responses from the government and the Bank have been received, present the final report with their remarks incorporated therein. In addition, if the services are rendered in stages, the consultant will submit applicable reports for approval by the executing unit.

4. Duration

3.11 One month, starting on October 1, 1992, two and a half months, starting on July 1, 1993.

5. Professional profile

3.12 Health professional with emphasis in some field of applied research and a minimum of five years' experience in research and technological development in the field of health.

NATIONAL CONSULTANT (7)

1. Objective

3.13 Advise and lend technical support to the national group in the development of the implementation plan for the information system.

3.14 Provide advice and technical support to the national group in public bidding procedures, at the national or international level, for the provision of computer equipment, in order to guide the process of working out the technical terms for the configuration, evaluation, selection, and installation of the computer, communications and peripheral equipment.

3.15 Supervise the activities and the quality of the products contracted for with the company that will work out and execute the designs, development, and implementation of the information subsystems.

2. Output

a. The Ministry of Health information system, concept, design, development, and implementation.

b. Document on national or international bidding; technical formulation of offers and installation and start-up of MINSA computer equipment.

c. Proposal document on the organization and physical infrastructure of the information technology center.

d. Proposal document for the project portfolio.

3. Tasks

a. Review the bibliography of conceptual areas and experiences concerning health information systems and support systems for the management thereof.

b. Work out the conceptual framework of the health information system, in specific areas such as: use of information,

processing and flow, handling of indicators, frequency scheduling, characteristics of information in areas of biostatistics, medical records, and production; information for fulfilling the leadership role, the relation between this system and the information systems of other public and private institutions belonging to the sector; the size, administration, planning, and control of the system according to the requirements of the lead role functions, systems, the strategic health programs, and the demand at different management levels.

c. Work out the operational framework of the information system in coordination with the national group and the corresponding consulting firm, in such areas as: structure and performance; interface mechanisms between MINSA leadership systems and programs and the sectoral information system.

d. Draw up the national or international bidding documents on the basis of the requirements of the systems to be developed and the computer and communications support infrastructure needed to award the bids.

e. Supervise the process of the design and development of the information subsystems, ensuring that the deadlines and product quality requirements are met.

f. Supervise and monitor the process of installation and start-up of the computer and communication equipment, the system network, the operating systems and the general operating environment for the equipment.

g. Present a preliminary report to the executing unit of the project and to the Bank within 15 days of the conclusion of the activities; once the responses from the government and the Bank have been received, present the final report with their remarks incorporated therein. In addition, if the services are rendered in stages, the consultant will submit applicable reports for approval by the executing unit.

h. Supervise the execution of the policy proposals, the computer-related guidelines, and the guidelines for the organization and physical infrastructure of the information technology center, among others.

4. Duration

3.16 Two months, starting on May 1, 1993; 22 months, nonconsecutively, starting on July 1, 1993.

5. Professional profile

3.17 Professional in engineering or administration with emphasis in computer systems or computer and information sciences; with a minimum of five years' experience in developing information systems for institutions responsible for the management and direction of national and sectoral processes.

INTERNATIONAL CONSULTANT (2)

1. Objective

3.18 Provide technical cooperation, in conjunction with the group of national consultants, to the national group, in working out the conceptual framework of the management systems of the Ministry of Health; and develop the technical capacity within the national group in handling health systems concepts and methodologies, with an emphasis on management.

3.19 Provide technical cooperation in conjunction with the national consultant to the group tasked with developing the synergistic model of systems and programs for the Ministry of Health in conceptual and methodological areas.

3.20 Provide technical cooperation, in conjunction with the national consultant to the national group, for drafting the strategic plan for the institutional development of MINSA and the corresponding control and assessment indicators.

3.21 Provide technical cooperation, in conjunction with the national consultants, to the national group, in working out the management systems for MINSA.

2. Output

a. The conceptual framework of the management systems.

b. A synergistic model of systems and programs for the ministry; develop the technical capacity among the national group tasked with handling the conceptual and methodological aspects of the model.

c. A strategic plan for institutional development with corresponding indicators for control and assessment; development of the technical capacity among the national group tasked with directing and managing the execution of the plan.

d. Design health management systems; develop the technical capacity within the national group in charge of the concepts, content, and management of these systems.

3. Tasks

a. Supervise and coordinate work of the national consultants.

b. Review the conceptual bibliography and experiences concerning the development of systems for performing management functions and strategic public health programs for ministries of health.

c. Work out the conceptual framework for each one of the systems using an integrated and synergistic approach in such specific areas as: content, scope, structure, planning, administration, and relations at the level of each system, between systems, and between these systems and those private and public institutions belonging to the health sector. This conceptual framework must be pertinent and consistent in handling each one of the systems, in order to guarantee the maximum conceptual quality and performance in the framework of systems theory.

d. Present a partial report to the executing unit of the project and to the Bank within 15 days of the conclusion of the activity; once the responses from the government and the Bank have been received, present a partial report with their remarks incorporated therein.

3.22 The following tasks will be performed in two months' time, starting on October 1, 1992.

e. Work out the conceptual framework for the comprehensive synergistic model for the systems and programs of the ministry in specific areas such as: structure, content, liaison mechanisms within the institution and those for interfacing with the environment, performance, specificity for different management levels; strategic analysis and flexible procedures for handling the concepts of the model; definition of the control and assessment mechanisms to guarantee their ongoing timeliness, enabling them to adjust to new requirements that management practice may demand; coherence and correspondence between the management systems and the public health programs at their different management levels.

f. Within 15 days of the completion of the consulting services, present a partial report on the tasks undertaken up to that point to the executing unit of the project and to the Bank. Once the responses from the government and the Bank have been received, present a partial report with their remarks incorporated therein.

3.23 These tasks will be undertaken in four and half months starting on January 16, 1993.

g. Formulate the strategic institutional development plan in such different areas as: the completeness and correspondence among the different components that make up the plan; ensure that the different components are worked out in a strategic fashion, thereby guaranteeing their viability and feasibility for subsequent execution; guarantee the maximum participation of all of the actors committed to the formulation in order to ensure its relevance, consistency, feasibility, and commitment to the execution; guarantee that the strategic focus prevails in the final revision of the plan in order to guarantee to the extent possible, negotiations and consensus among all of the social actors committed to the process of change.

h. Within 15 days of the completion of the consulting services, present a partial report on the tasks undertaken up to that point to the executing unit of the project and to the Bank; once the responses from the government and the Bank have been received, present a partial report with their remarks incorporated therein. These tasks will be carried out over two months beginning on April 1, 1993.

i. Work out the systems of management, coordination, and direction; health monitoring and planning; research and technological development; regulation, control, and evaluation; information; human resources and the internal management systems.

3.24 In such specific areas as: definition of the operational framework at the general level of the aforementioned systems, making the framework explicit for the different levels of management; definition of the basic necessary procedures for the operation of the different MINSA systems; definition of the control and assessment mechanisms for the ongoing updating as required by the exercise of leadership and the management of public health strategic programs.

j. Each task will require training for the national group in the on-the-job training modality.

k. A proposed action plan should be drafted for implementing the systems designed during the consulting period.

l. Present a preliminary report to the executing unit of the project and to the Bank within 15 days of the completion of the consulting services; once the responses from the government and the Bank have been received, present the final report with their remarks incorporated therein.

3.25 These tasks will be performed in two and a half months beginning on July 1, 1993.

4. Duration

3.26 Nine months. These consulting services will be performed in three phases: the first from October 1 to November 30, 1992, the second from January 16 to May 31, 1993, and the third from July 1 to September 15. The consultant will have the support of the national group, the national consultants, and the PAHO advisors.

5. Professional profile

3.27 A health professional or a manager or engineer with a master's or doctorate in public health, health service management, or strategic planning; with broad experience in assisting processes, no less than five years in sectoral reorganization, and development of conceptual frameworks and health systems for management and institutional development.

NATIONAL CONSULTANT (8)

1. Objective

3.28 Provide technical support to the national group in coordination with the international consultant in the review of the bibliography, the drafting of the conceptual framework, the design and adjustments of the synergistic model that will integrate, coordinate, and connect the different MINSA systems and programs with the systems and programs of other health sector institutions at different levels of management.

2. Output

3.29 A synergistic model of the systems and programs of the ministry.

3. Tasks

a. Review the bibliography on conceptual, methodological, and operational areas of health systems with particular emphasis on the leadership agencies and the execution of strategic public health programs.

b. Support the drawing up of the synergistic model that integrates the management, coordination, and direction systems, and those of health monitoring and planning, regulation, control, and evaluation, research and technological development, information, human resources and internal management systems at MINSA, along with the strategic programs of public health, environmental health, food and nutrition, and social improvement. In specific aspects such as structure, content, hierarchy, internal and external liaison mechanisms, administrative guidance, planning, and the control and evaluation procedures with permanent updating and modernization.

c. Training the national group in conceptual, methodological, and managerial aspects of the model.

d. Present a preliminary report to the executing unit of the project and to the Bank within 15 days of completing the consulting services; once responses have been received from the government and the Bank, present a final report that incorporates these remarks.

4. Duration

3.30 Three months, beginning on January 1, 1993

5. Professional Profile

3.31 Systems engineer with a minimum of five years' experience in the development of systems models, preferably applied to public or private health administration.

NATIONAL CONSULTANT (9)

1. Objective

3.32 Offer technical support to the national group in drawing up the occupational and educational profiles by system and program at the different management levels of MINSA. Decide on the human resources required in terms of number, type, and nature, and the requirements for their development. Finally, draft the program of human resource development.

2. Output

3.33 The quantification and qualifications of the human resources desired (image, purpose) at the Ministry of Health and the formulation of the program for human resource development in order to accomplish it.

3. Tasks

a. Work out a methodology to establish real and anticipated occupational and educational profiles for positions at MINSA, in accordance with the health program systems and management levels. Train the national team in the application of these methodologies and participate in the drawing up of these occupational and educational profiles.

b. Define and determine along with the national team the human resources required for the new MINSA in order to achieve appropriate fulfillment of the systems and program functions at all management levels, taking into account the census carried

out, the occupational and educational profiles already drawn up and the descriptive manual of civil service classes.

c. Work out, together with the national team, a proposal for the relocation of existing personnel in the ministry and other institutions of the sector, in accordance with the new systems and leadership functions, according to the level of management; as well as the transformation of existing positions according to the new personnel requirements, taking into consideration the descriptive manual of classes, existing legislation, and the budgets.

d. Work out, together with the national team, a program of human resource development for all levels of MINSA management in terms of motivation, orientation, and training and education to address the leadership functions and the priority programs.

e. Work out, along with the national team, the design of methodological guides and of other materials that will be used in the evaluation and adjustment workshops in the regions and at the central level.

f. Participate as a facilitator in the aforementioned workshops.

g. Work out a proposed plan of action for the relocation of existing personnel.

h. Present to the executing unit of the project and to the Bank a preliminary report within 15 days of the completion of the consulting services; once the responses from the government and the Bank have been received, present a final report, which incorporates the remarks.

4. Duration

3.34 Four months as of February 1, 1993.

5. Professional profile

3.35 Specialists in education, with a minimum of five years' experience in methodological and operational development, diagnostics of training needs, and curriculum design.

NATIONAL CONSULTANT (10)

1. Objective

3.36 Provide technical support to the national group in identifying the new incentive requirements for fulfilling the lead functions and the concrete programs; as well as in the drafting of the incentives

program that will include the definition of stages of execution, legal reforms, and financing studies.

2. Output

3.37 A program of economic and noneconomic incentives for MINSA in its new role.

3. Tasks

a. Define, along with the national team, the types of economic and noneconomic incentives by worker group using geographic criteria.

b. Work out a program of economic and noneconomic incentives and gauge the financial impact on the institution.

c. Formulate an incentive program for MINSA, in accordance with the requirements determined, and assess its financial impact.

d. Prepare an action plan to implement the incentives proposal.

e. Draft, along with the national team, regulations to control, govern, and administer the program of economic and noneconomic incentives.

f. Present to the executing unit of the project and to the Bank a preliminary report within 15 days of the completion of the consulting services; once the responses from the government and the Bank have been received, present a final report that incorporates their remarks.

4. Duration

3.38 Two months, starting on February 1, 1993.

5. Professional profile

3.39 Master's in business administration with an emphasis on human resources, with a minimum of 5 years' experience in the design of systems of economic and noneconomic incentives for civil servants in public administration.

NATIONAL CONSULTANT (11)

1. Objective

3.40 Provide technical support to the national group, in coordination with the international consultant, in the formulation of the strategic plan for institutional development and in working out the

mechanisms, procedures, and indicators for plan control and evaluation.

2. Output

3.41 A strategic plan of institutional development to lead and administer the processes of change in order to fulfill the image of the lead ministry; and indicators for plan control and evaluation that measure efficiency, effectiveness, and impact, and make control over plan execution possible at distinct levels.

3. Tasks

a. Identify and develop the control and evaluation indicators at the different management levels in which the plan will be in place. These indicators must include information sources, comparative standards, frequency of use, fulfillment goals, ranges of deviation from the mean.

b. Integrate all the conceived systems and programs with the identified feasibility and viability strategies, the developed synergistic model, and the designed indicators into a coherent integrated plan, duly scheduled for execution during the execution period of the IDB project.

c. Present a partial report to the executing unit of the project and to the Bank within 15 days of the completion of the consulting services; once comments have been received from the government and the Bank, present a partial report incorporating their responses.

4. Duration

3.42 Two months, beginning on April 1, 1993

5. Professional profile

3.43 Industrial engineer or public administrator, with an emphasis on health services administration, and at least five years' experience in public sector institutional organization and development.

A. INFORMATION SYSTEM

CONSULTING FIRM

1. Objective

3.44 Creation and implementation of an information system, with the corresponding computerized applications, for the health sector of Cost Rica. The system will allow the Ministry of Health to perform its duties of guidance, direction, and coordination, health

monitoring and planning, research and technological development, and the programming, follow-up, control, and evaluation of strategic health programs at the national, regional, and local levels.

3.45 The consulting firm must produce an analysis, design, development, successful test run, adjustment, and start-up of each computer application that forms part of the information system of the Ministry of Health and that will make it possible for the ministry to perform the aforementioned duties.

2. Output

a. Design specifications for the different computer applications of the information system.

b. Develop the application programs on the basis of the systems requirements and the designs for the specifications.

c. Make a test run of the application programs and their implementation.

3. Tasks

a. Design the information systems, taking into account the relations between the information subsystems and their coordination mechanisms.

(i) Define the information and procedures to be computerized: study the current situation and define the information and processing needs. Include entry and exit forms for required information, taking into account those currently in use.

(ii) Designs for data bases and processing models: include the structures and description of the required data files for each information subsystem, data dictionaries, manuals of codes, estimates of the volume of information, passwords, interfaces between files, cross-references between the data files and the modules and submodules that will use them.

(iii) Design and scaling of the information system: include physical and logical flow charts for the current system and the proposed one, the design for control indicators, modules and submodules that make up each information subsystem, and their pseudo-code specifications. Establish, in coordination with the UCP, priorities for design and system development.

(iv) Estimate of the costs of design, development, and implementation for each information subsystem and the complete system.

b. Development and implementation of the computerized information applications

3.46 On the basis of the detailed designs, the same firm should develop the corresponding computer applications, using the development computer equipment purchased by the institution.

c. Make the required flows of information operational for appropriate performance of information systems

3.47 All of the parties involved should, as needed, provide the information required to put into operation, test, evaluate, and correct the information system in its entirety.

4. Duration

3.48 Eighteen months.

5. Professional profile

3.49 Requirements are for the services of a consulting firm specializing in the design, development, and implementation of information systems and computer applications, which has experience in open-ended systems, customer service type systems, fourth generation languages, data base applications, and local and long-distance telecommunications applications. The company must furnish at least 104 person/months of consulting services, distributed as follows: 48 person/months devoted to the analysis and design of the computer applications, and 56 person/months to the development and implementation of these applications.

3.50 The company must provide a team of professionals, with the corresponding documentation, that fulfills the following minimum features: i) an expert in systems integration with a master's in computer or information sciences and at least 8 years' experience in the development of information systems; ii) five experts in development of customer service type applications, fourth generation languages and data base applications, each with a master's in information or computer sciences, systems analysis, or related fields and at least 5 years' experience each in the design and development of complex information systems.

NATIONAL CONSULTANT (12)

1. Objective

3.51 Design, execute, and evaluate curricular content on management as required for the change, for the orientation process and motivation of personnel at the three management levels of the Ministry of Health.

2. Output

a. Indispensable curricular content for the orientation and motivation for change.

b. Teaching and support materials.

c. Educational activities provided.

d. Regular reports and final evaluation of the process.

3. Tasks

a. Work out, with the national team, the appropriate strategies and methodology that will help get underway the program to motivate and guide MINSA personnel at all management levels in order to raise awareness about the process of change.

b. Establish the appropriate content for each one of the activities, taking into account the new duties of the ministry, the systems and programs, as well as the correct context for each one of the groups that will be affected within the motivation program.

c. Formulate the motivation and orientation program for MINSA personnel, using such activities as: workshops with central, regional, and local management teams (regional and local Continuing Education Commissions).

d. Draft the teaching materials required in the program and participate in its execution.

e. Perform follow-up on the process and adjust it whenever necessary, communicating any changes to the executing unit of the project and bringing to its attention any relevant remarks that personnel at different levels have made, thereby facilitating feedback for the overall project.

f. Final evaluation of the impact of the motivation and orientation program, according to the management levels and groups at MINSA.

g. Present to the executing unit of the project and to the Bank a partial report within 15 days of the completion of the consulting services. Once remarks from the government and the Bank have been received, present a partial report incorporating their responses.

4. Duration

3.52 Four months starting on July 1, 1993.

5. Professional profile

3.53 Bachelor's degree in business management or public administration with a master's in human Resources. Minimum of five years' experience in design and development of induction programs.

NATIONAL CONSULTANT (13)

1. Objectives

3.54 Draw up, execute, and evaluate a training program for the personnel of the Ministry of Health, focussing on directing, coordinating, and implementing the process of fulfilling the ministry's lead role.

2. Output

a. Training program on the corresponding subject matter.

b. Teaching and support materials.

c. Educational activities provided.

d. Regular reports and a final evaluation of the training.

3. Tasks

a. Join the team of consultants and public officials responsible for the design and execution of the human resource development program.

b. Draw up a teaching module keyed to the MINSA lead agency function of directing, coordinating, and implementing.

c. Draw up, in coordination with the national consultants and the institutional team, the comprehensive training program for all management and executive levels.

d. Conduct the educational activities in the pertinent area, according to the training program for the different geographic regions of the country.

e. Present a partial report to the executing unit of the project and to the Bank within 15 days of the completion of the consulting services period; once comments have been received from the government and the Bank, present a partial report incorporating their responses.

4. Duration

3.55 Eight months beginning in November, 1993.

5. Professional profile

3.56 Four year university degree in business or public administration, with a graduate degree in management. Five years' experience in teaching. Three years' experience in teaching in the relevant field.

NATIONAL CONSULTANT (14)

1. Objective

3.57 Draw up, execute, and evaluate a training program on monitoring and planning of the lead agency process for Ministry of Health personnel.

2. Output

a. Training program on the relevant subject matter.

b. Teaching and support material.

c. Educational activities provided.

d. Regular reports and a final evaluation of the program developed.

3. Tasks

a. Join the team of consultants and public officials responsible for the design and execution of the human resource development program.

b. Draw up a teaching module on the leadership function, monitoring and planning at MINSA.

c. Work out, with the national consultants and the institutional team, a comprehensive training program for all management and executive levels.

d. Conduct the educational activities for the pertinent area, according to the training program in different regions of the country.

e. Present a partial report to the executing unit of the project and to the Bank within 15 days of the completion of the consulting services; once comments have been received from the government and the Bank, present a partial report incorporating their responses.

4. Duration

3.58 Eight months, as of November, 1993.

5. Professional profile

3.59 Bachelor's degree in health planning with a master's. Minimum of five years' experience in the field of teaching.

NATIONAL CONSULTANT (15)

1. Objective

3.60 Draw up, execute, and evaluate a training program in the regulation, evaluation, and control of the lead agency process for Ministry of Health personnel.

2. Output

a. Teaching and support material.

b. Educational activities provided.

c. Regular reports and a final report on the program developed.

3. Tasks

a. Join the team of consultants and public officials responsible for the design and execution of the human resource development program.

b. Draft a teaching module for the lead agency function in regulation, evaluation, and control at MINSA.

c. Draft, with the national consultants and the institutional team, the comprehensive training program at all executive and management levels.

d. Conduct educational activities in the pertinent area, in the different regions of the country, in accordance with the training program.

e. Present a partial report to the executing unit of the project and to the Bank within 15 days of the completion of the consulting services; once comments have been received from the government and the Bank, present a partial report incorporating their responses.

4. Duration

3.61 Eight months, starting in November, 1993.

5. Professional profile

3.62 Bachelor's degree in public or business administration with a graduate degree in comprehensive quality control. Minimum of five years' experience in the field of teaching.

NATIONAL CONSULTANT (16)

1. Objective

3.63 Work out, execute, and evaluate a program for training all management levels of MINSA personnel in research and technological development.

2. Output

a. Training program in the pertinent subject matter.

b. Teaching and support material.

c. Educational activities provided.

d. Regular reports and a final report on the development program.

3. Tasks

a. Join the team of consultants and public officials responsible for the design and execution of the human resource development program.

b. Draft a teaching module for the lead agency function in research and technological development at MINSA.

c. Draft, with the national consultants and the institutional team, the comprehensive training program at all levels of MINSA management.

d. Conduct educational activities in the pertinent area in the different regions of the country, in accordance with the training program.

e. Present a partial report to the executing unit of the project and to the Bank within 15 days of the completion of the consulting services; once comments have been received from the government and the Bank, present a partial report incorporating their responses.

4. Duration

3.64 Eight months, starting in November, 1993.

5. Professional profile

3.65 Professional in medical sciences with graduate degree in epidemiology; minimum of five years' teaching experience.

NATIONAL CONSULTANT (17)

1. Objective

3.66 Draft, execute, and evaluate a human resource and incentives program for the lead agency process among Ministry of Health personnel.

2. Output

a. Training program in the pertinent subject matter.

b. Teaching and support material.

c. Educational activities provided.

d. Regular reports and a final evaluation of the program developed.

3. Tasks

a. Join the team of consultants and public officials responsible for the design and execution of the human resource development program.

b. Draft a teaching module for the lead agency function in human resources and incentives at MINSA.

c. Draft, with the national consultants and the institutional team, the comprehensive training program at all levels of administration and management.

d. Conduct educational activities in the pertinent areas and in the different regions of the country, in accordance with the training program.

e. Present a partial report to the executing unit of the project and to the Bank within 15 days of the completion of the consulting services; once comments have been received from the government and the Bank, present a partial report incorporating their responses.

4. Duration

3.67 Eight months, starting in November, 1993.

5. Professional profile

3.68 Bachelor's degree in public or business administration with a graduate degree in human resources. A minimum of five years' experience in the field of teaching.

NATIONAL CONSULTANT (18)

1. Objective

3.69 Draft, execute, and evaluate an information program for the leadership process for Ministry of Health personnel.

2. Output

3.70 Training program in the subject matter. Teaching and support material; educational activities conducted; regular and a final evaluation reports of the program developed.

3. Tasks

a. Join the team of consultants and public officials responsible for the design and execution of the human resource development program.

b. Draft a teaching module for the lead agency function in information at MINSA.

c. Draft, with the national consultants and the institutional team, the comprehensive training program at all levels of MINSA management and administration.

d. Provide educational activities in the pertinent area and in the different regions of the country, in accordance with the training program.

e. Present a partial report to the executing unit of the project and to the Bank within 15 days of the completion of the consulting services; once comments have been received from the government and the Bank, present a partial report incorporating their responses.

4. Duration

3.71 Eight months, starting in November, 1993.

5. Professional profile

3.72 Systems Engineer. Five years' teaching experience.

IV. IMPACT ASSESSMENT

NATIONAL CONSULTANT (19)

1. Objective

4.1 Give technical support to the national group, in coordination with the international consultant, in evaluating the sociopolitical impact of the transfer of services and programs between MINSA and the CCSS on the users, pressure groups, the community, and others.

2. Output

a. The evaluation of the sociopolitical impact.

b. Definition of the program strategies to redirect the project.

3. Tasks

a. Identify the critical variables and the indicators for the evaluation.

b. Design a research methodology to evaluate the sociopolitical impact.

c. Carry out the research and corresponding analysis.

d. Consult and adjust the results of the analysis and present them to the MINSA authorities for their approval.

e. Draft program strategies, on the basis of the results of the research on the political and social impact of the project.

f. Consult and adjust the strategies drafted, and present them to the MINSA authorities for their approval and implementation.

g. Present a partial report to the executing unit of the project and to the Bank within 15 days of the completion of the consulting services; once comments have been received from the government and the Bank, present a partial report incorporating their responses.

4. Duration

4.2 One and a half months, beginning on May 15, 1993, and three and a half months beginning in June, 1993.

5. Professional profile

4.3 Professional in health, administration, or sociology, with a master's in political and social sciences, and a minimum of five years' experience in the design and execution of evaluations of sociopolitical impact.

INTERNATIONAL CONSULTANT (3)

1. Objective

4.4 Give technical support to the national group, in coordination with the national consultant, for evaluating the sociopolitical impact of the transfer of services between MINSA and the CCSS on users, pressure groups, the community, and others.

2. Output

a. The evaluation of the sociopolitical impact.

b. Definition of the program strategies to redirect the projects.

c. National group trained in the methodology and processes of evaluating sociopolitical impact.

3. Tasks

a. Identify the critical variables and the indicators for the evaluation.

b. Design a research methodology to evaluate the sociopolitical impact.

c. Carry out the research and corresponding analysis.

d. Consult and adjust the results of the analysis and present them to the MINSA authorities for their approval.

e. Draft program strategies, on the basis of the results of the research on the political and social impact of the project.

f. Consult and adjust the strategies drafted and present them to the MINSA authorities for their approval and implementation.

g. Train the national group in concepts, methodologies, procedures, and evaluation tools of sociopolitical impact.

h. Present a partial report to the executing unit of the project and to the Bank within 15 days of the completion of the consulting services; once comments have been received from the government and the Bank, present a partial report incorporating their responses.

4. Duration

4.5 One and a half months beginning on May 15, 1993, and three and a half months beginning in June, 1993.

5. Professional profile

4.6 Professional in health, administration, or sociology, with a master's or doctorate in political and social sciences, and a minimum of ten years' experience in the consulting field devoted to evaluation of the impact from the processes of change.

NATIONAL CONSULTANT (20)

1. Objective

4.7 Give technical support to the national group, in coordination with the national consultant, in evaluating the financial and economic impact of the transfer of programs and services between MINSA and the CCSS.

2. Output

a. A study containing the quantification and analysis of the financial impact.

b. A study containing the quantification and analysis of the economic impact.

c. The strategies and alternatives that make the change viable and feasible, drawn up on the basis of the studies of economic and financial impact.

3. Tasks

a. Draft the terms of reference for the study to be carried out, the scope of which will be: (i) costing of programs and services that will be transferred between the CCSS and MINSA at each level; (ii) quantification and qualification of the funding of the aggregate cost, its ripple effect on health expenditures, and the funding of the institutions.

b. Carry out the actual studies themselves.

c. Analyze and adjust the results of the study and present them to the health authorities for their consideration, approval, and implementation.

d. Draft the terms of reference for the economic evaluation study, the scope of which will be: (i) an analysis of the impact of the transfer of services and programs on the productivity and efficiency of the overall resources in the sector; (ii) an analysis of the inflationary process and its effect on health service financing.

e. Carry out the actual studies themselves.

f. Analyze and adjust the results of the studies, submit them to the MINSA authorities for their consideration, approval, and implementation.

g. Identify the program strategies and alternatives of the economic and financial impact.

h. Analyze, adjust, and submit the program strategies and alternatives to the MINSA authorities for their approval and implementation.

i. Define the mechanisms and procedures for the execution of the program strategies and alternatives in the economic and financial field.

j. Present a partial report to the executing unit of the project and to the Bank within 15 days of the completion of the consulting services; once comments have been received from the government and the Bank, present a partial report incorporating their responses.

4. Duration

4.8 One and a half months beginning on May 15, 1993, and six months beginning in June, 1993.

5. Professional profile

4.9 Economist with a master's degree in economic and financial analysis, with a minimum of five years' experience in the field of economic and financial impact assessment.

INTERNATIONAL CONSULTANT (4)

1. Objectives

4.10 Provide technical support to the national group, in coordination with the national consultant in the evaluation of the financial and

economic impact of the transfers of programs and services between MINSA and CCSS.

2. Output

a. A study containing the quantification and analysis of the financial impact.

b. A study containing the quantification and analysis of the economic impact.

c. The strategies and alternatives that make the change viable and feasible, drawn up on the basis of the studies of economic and financial impact.

d. Train the national group in the concepts, methodologies, and procedures corresponding to the economic and financial impact in the health field.

3. Tasks

a. Draft the terms of reference for the study to be carried out, the scope of which will be: (i) costing of programs and services that will be transferred between the CCSS and MINSA at each level; (ii) quantification and qualification of the funding of the aggregate cost, its effect on health expenditures, and the funding of the institutions.

b. Carry out the actual studies themselves.

c. Analyze and adjust the results of the study and present them to the health authorities for their consideration, approval, and implementation.

d. Draft the terms of reference for the economic evaluation study, the scope of which will be: (i) an analysis of the impact of the transfer of services and programs on the productivity and efficiency of the overall resources in the sector; (ii) an analysis of the inflationary process and its effect on health service financing.

e. Carry out the actual studies themselves.

f. Analyze and adjust the results of the studies, submit them to the MINSA authorities for their consideration, approval, and implementation.

g. Identify the program strategies and alternatives of the economic and financial impact.

h. Analyze, adjust, and submit the program strategies and alternatives to the MINSA authorities for their approval and implementation.

i. Define the mechanisms and procedures for the execution of the program strategies and alternatives in the economic and financial field.

j. Present a partial report to the executing unit of the project and to the Bank within 15 days of the completion of the consulting services; once comments have been received from the government and the Bank, present a partial report incorporating their responses.

4. Duration

4.8 One and a half months beginning on May 15, 1993, and six months beginning in June, 1993.

5. Professional profile

4.11 Economist with a master's or doctorate degree in an area related to the analysis and evaluation of the financial and economic impact of the processes of change, with a minimum of ten years' experience in the consulting field.2

HEALTH AND MATERNITY INSURANCE
STATUTORY GOVERNMENT CONTRIBUTION
(in thousands of current colones)

CATEGORY	YEAR				
	1987	1988	1989	1990	1991
Employer contribution a/	1,409,067	2,079,469	2,538,919	3,509,770	4,033,432
Supplemental contributions independent workers b/	493,292	497,361	530,700	563,149	705,338
Contributions for participants insured at government expense c/	1,373,144	2,346,780	2,839,695	3,727,846	4,064,626
Contribution of government as such d/	956,572	320,438	382,128	523,509	617,084
TOTAL	4,232,075	5,244,048	6,291,442	8,324,274	9,420,480
EFFECTIVE GOVERNMENT CONTRIBUTION					
Employer contribution a/	557,015	806,503	635,017	1,987,430	605,038
Supplemental contributions independent workers b/	131,004	101,700	153,906	146,061	75,921
Contributions for participants insured at government expense c/	428,409	337,334	876,638	401,598	318,137
Contribution of government as such d/	546,000	320,438	382,128	143,500	104,365
TOTAL	1,662,428	1,565,975	2,047,689	2,678,589	1,103,461
PERCENTAGE OF SHORTFALL IN GOVERNMENT OBLIGATIONS BY TYPE OF COMMITMENT					
Employer contribution a/	60.47	61.22	71.05	43.37	85.01
Supplemental contributions independent workers b/	73.44	79.55	71.00	74.06	89.24
Contributions for participants insured at government expense c/	68.80	85.63	69.13	89.23	92.17
Contribution of government as such	42.92	—	—	72.59	83.09
TOTAL	60.72	70.14	67.45	67.82	88.29

NOTES:
a/ Includes the employer contribution for government retirees.
b/ Includes the supplementary contribution from agreements.
c/ Includes the cost of the medical care program for prison internees.
d/ In 1987, 0.75% of the base contribution was charged; since 1988, only 0.25%.

ANALYSIS OF THE INCREMENTAL COSTS OF THE SEM DERIVED FROM THE TRANSFER OF CENTERS AND STATIONS AND CONSTRUCTION OF ALAJUELA HOSPITAL (in millions of US$)

	SEM General Revenues	SEM Total Expenditures without project	Recurrent Expenses Increment			Operating Expenditures MINSA Centers and Stations	Total Recurrent Incremental SEM	SEM Total Expenditures with Project	SEM Deficit
			Centers and Stations		Alajuela Hospital				
			Efficiency	Payroll					
	(1)	(2)	(3)	(4)	(5)	(6)	(8)	(8)+(2)=(9)	(9)-(1)
1989	345.1	286.6							
1990	361.8	313.7							
1991	286.6	285.8							
PROJECTED									
1992	286.6	285.8						286	0.8
1993	286.6	285.8						286	0.8
1994	286.6	285.8	1.3	0.5		4.4	6.2	292	(5.4)
1995	286.6	285.8	3.0	0.9		10.0	13.9	300	(13.1)
1996	286.6	285.8	4.7	1.6	2.3	16.0	24.6	310	(23.8)
1997	286.6	285.8	4.7	1.6	2.7	16.0	25.0	311	(24.2)
1998	286.6	285.8	4.7	1.6	3.0	16.0	25.3	311	(24.5)
1999	286.6	285.8	4.7	1.6	3.0	16.0	25.3	311	(24.5)
2000	286.6	285.8	4.7	1.6	3.0	16.0	25.3	311	(24.5)

RGII-CR200
CR-0120
Original:Spanish
Appendix I

PROPOSED RESOLUTION [1/]

COSTA RICA. LOAN /OC-CR TO THE REPUBLICA DE COSTA RICA
(Health Services Improvement Program)

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 Costa Rica, as Borrower, for the purpose of granting it a financing to cooperate in the execution of a program to improve health services, hereinafter referred to as the "Program". This Financing shall be subject substantially to the following conditions:

1. Amount and Currencies: Up to US$28,000,000, or its equivalent in other currencies, except that of Costa Rica, which are part of the ordinary capital resources of the Bank, to pay for goods and services acquired through international competition in the member countries of the Bank and for such other purposes as may be specified in the loan contract. Payments of amortization and interest shall be made in the currency or currencies specified by the Bank, in a quantity equivalent to the corresponding amount owed, calculated in units of account in terms of dollars of the United States of America, in accordance with provisions to be included in the loan contract.

2. Source of Funds: The ordinary capital resources of the Bank.

3. Guarantee: The general responsibility of the Borrower.

4. Credit Fee: 0.75% per annum on the undisbursed portion of the Financing, which fee shall commence to accrue 60 days after the date of the loan contract and payable in dollars of the United States of America on the same dates as the interest.

[1/] The provisions contained in this Appendix I and in Appendices II, III, IV and V which follow will be final only when the Board of Executive Directors has approved the loan proposal.

5. Amortization: The Borrower shall amortize the loan in a period of 25 years from the date of the loan contract, by means of semiannual, consecutive and, insofar as possible, equal installments. The first installment shall be paid on the first interest payment date, six months after the date scheduled for the last disbursement of the Financing.

6. Interest: The Borrower shall pay interest semiannually on the daily outstanding balances of the loan. The first payment shall be made six months after the date of the loan contract. The Bank shall determine the rates of interest to be applied during the life of the loan, in accordance with the lending rate policy of the Bank. At the request of the Borrower, resources of the Financing may be used to pay interest during the period of disbursement thereof.

7. Physical Initiation and Disbursement: The term for physical initiation of the works of the Program shall expire 3 years after the effective date of the loan contract, and the term for disbursement of the Financing shall expire 4 years after that same date.

8. Special Conditions:

   (a) The execution of the Program and the utilization of the resources of the loan shall be carried out in their entirety by the Borrower through the Caja Costarricense de Seguro Social (CCSS), hereinafter referred to as the "Executing Agency", which shall in turn act through its Dirección de Planificación Institucional and in coordination with the Ministerio de Salud, hereinafter referred to as "MINSA".

   (b) The resources of the loan, together with the resources of loan _____/OC-CR, shall be used to participate in the execution of a Program the total cost of which is estimated at the equivalent of US$60,000,000. Consequently, the loan contracts shall contain the appropriate provisions to ensure that such additional resources as may be necessary, in addition to the two loans, for the complete execution of the Program shall be duly provided, in an amount estimated at the equivalent of US$18,000,000, in accordance with a schedule of investments satisfactory to the Bank.

   (c) Prior to the first disbursement of the Financing, the Borrower shall present to the satisfaction of the Bank: (i) evidence that the Central Coordination Council and the Program Executing Unit (PEU) have been set up in the Institutional Planning Directorate of the CCSS, with the

organizational structure and staff needed for their functions, as previously agreed upon with the Bank; (ii) a proposal for the restructuring of the Ministry of Health (MINSA) and for optimum use of its resources, including a budgetary allocation and the institutional development program agreed upon with the Bank, with a timetable for its implementation; (iii) evidence that it has concluded an agreement under the terms of which the proceeds of the Financing and the local counterpart resources are to be transferred, on a nonreimbursable basis, to the Executing Agency for the execution of the Program, with the additional undertaking to institute a plan to gradually reduce the arrears in its payments to the Health and Maternity Insurance Fund (SEM), in accordance with the percentages agreed upon in advance with the Bank; (iv) a timetable for completion and transfer of the health centers and posts, including yearly targets for the consolidation of client services from an operations and organizational standpoint, as previously agreed upon with the Bank; and (v) evidence that it has entered into an agreement with the CCSS setting forth the mechanisms to be used to improve the latter's revenue-collection system.

(d) Upon acceptance by the Bank, up to the equivalent of US$100,000 of the resources of the Financing may be utilized to cover consulting expenses with respect to the restructuring of MINSA, incurred within the 12 months preceding the date of this Resolution, provided that requirements substantially similar to those of this resolution and the loan contracts have been fulfilled.

(e) In the acquisition of machinery, equipment, and other goods for the Program and in the awarding of construction contracts, the system of public bidding shall be followed in each case in which the value of such acquisitions exceeds the equivalent of US$250,000 or the value of such contracts for the execution of works exceeds the equivalent of US$1,000,000. The bidding shall be subject to the procedures to be appended as an Annex to the loan contract. This provision shall not apply to acquisitions made with resources from suppliers' credits or other financing resources.

(f) The Bank shall establish such inspection procedures as it deems necessary to assure the satisfactory execution of the Program, and the Borrower shall extend all cooperation which is required for the most effective accomplishment of

this purpose. From the amount of the Financing the sum of US$280,000 shall be allocated for credit to the income accounts of the Bank to meet expenses of general inspection and supervision.

9. Conditional Provision: The contract or contracts which are executed pursuant to the authorization conferred upon the terms of this resolution shall enter into force only when the Board of Executive Directors has determined by means of resolution that the Bank has sufficient resources available in the Ordinary Capital, to cover the loan authorized by this resolution.

PROPOSED RESOLUTION [1/]

COSTA RICA. LOAN /OC-CR TO THE REPUBLICA DE COSTA RICA
(Health Services Improvement Program)

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 Costa Rica, as Borrower, for the purpose of granting it a financing to cooperate in the execution of a program to improve health services, hereinafter referred to as the "Program". This Financing shall be subject substantially to the following conditions:

1. Amount and Currencies: Up to US$14,000,000, or its equivalent in other currencies, except that of Costa Rica, which are part of the ordinary capital resources of the Bank, to pay for goods and services acquired through international competition in the member countries of the Bank and for such other purposes as may be specified in the loan contract. Payments of amortization and interest shall be made in the currency or currencies specified by the Bank, in a quantity equivalent to the corresponding amount owed, calculated in units of account in terms of dollars of the United States of America, in accordance with provisions to be included in the loan contract.

2. Source of Funds: The ordinary capital resources of the Bank.

3. Guarantee: The general responsibility of the Borrower.

4. Credit Fee: 0.75% per annum on the undisbursed portion of the Financing, which fee shall commence to accrue 60 days after the date of the loan contract and payable in dollars of the United States of America on the same dates as the interest.

1/ The provisions contained in this Appendix II, in the preceding Appendix I, and in Appendices III, IV and V will be final only when the Board of Executive Directors has approved the loan proposal.

5. Amortization: The Borrower shall amortize the loan in a period of 25 years from the date of the loan contract, by means of semiannual, consecutive and, insofar as possible, equal installments. The first installment shall be paid on the first interest payment date, six months after the date scheduled for the last disbursement of the Financing.

6. Interest: The Borrower shall pay interest semiannually on the daily outstanding balances of the loan. The first payment shall be made six months after the date of the loan contract. The Bank shall determine the rates of interest to be applied during the life of the loan, in accordance with the lending rate policy of the Bank. At the request of the Borrower, resources of the Financing may be used to pay interest during the period of disbursement thereof.

7. Physical Initiation and Disbursement: The term for physical initiation of the works of the Program shall expire 3 years after the effective date of the loan contract, and the term for disbursement of the Financing shall expire 4 years after that same date.

8. Special Conditions:

   (a) The execution of the Program and the utilization of the resources of the loan shall be carried out in their entirety by the Borrower through the Caja Costarricense de Seguro Social (CCSS), hereinafter referred to as the "Executing Agency", which shall in turn act through its Dirección de Planificación Institucional and in coordination with the Ministerio de Salud, hereinafter referred to as "MINSA".

   (b) The resources of the loan, together with the resources of loan _____/OC-CR, shall be used to participate in the execution of a Program the total cost of which is estimated at the equivalent of US$60,000,000. Consequently, the loan contracts shall contain the appropriate provisions to ensure that such additional resources as may be necessary, in addition to the two loans, for the complete execution of the Program shall be duly provided, in an amount estimated at the equivalent of US$18,000,000, in accordance with a schedule of investments satisfactory to the Bank.

   (c) Prior to the first disbursement of the Financing, the Borrower shall present to the satisfaction of the Bank: (i) evidence that the Central Coordination Council and the Program Executing Unit (PEU) have been set up in the Institutional Planning Directorate of the CCSS, with the organizational structure and staff needed for their functions, as previously agreed upon with the Bank; (ii) a proposal for the restructuring of the Ministry of Health

(MINSA) and for optimum use of its resources, including a budgetary allocation and the institutional development program agreed upon with the Bank, with a timetable for its implementation; (iii) evidence that it has concluded an agreement under the terms of which the proceeds of the Financing and the local counterpart resources are to be transferred, on a nonreimbursable basis, to the Executing Agency for the execution of the Program, with the additional undertaking to institute a plan to gradually reduce the arrears in its payments to the Health and Maternity Insurance Fund (SEM), in accordance with the percentages agreed upon in advance with the Bank; (iv) a timetable for completion and transfer of the health centers and posts, including yearly targets for the consolidation of client services from an operations and organizational standpoint, as previously agreed upon with the Bank; and (v) evidence that it has entered into an agreement with the CCSS setting forth the mechanisms to be used to improve the latter's revenue-collection system.

(d) In the acquisition of machinery, equipment, and other goods for the Program and in the awarding of construction contracts, the system of public bidding shall be followed in each case in which the value of such acquisitions exceeds the equivalent of US$250,000 or the value of such contracts for the execution of works exceeds the equivalent of US$1,000,000. The bidding shall be subject to the procedures to be appended as an Annex to the loan contract. This provision shall not apply to acquisitions made with resources from suppliers' credits or other financing resources.

(e) The Bank shall establish such inspection procedures as it deems necessary to assure the satisfactory execution of the Program, and the Borrower shall extend all cooperation which is required for the most effective accomplishment of this purpose. From the amount of the Financing the sum of US$140,000 shall be allocated for credit to the income accounts of the Bank to meet expenses of general inspection and supervision.

9. Conditional Provision: The contract or contracts which are executed pursuant to the authorization conferred upon the terms of this resolution shall enter into force only when the Board of Executive Directors has determined by means of resolution that the Bank has sufficient resources available in the Ordinary Capital, to cover the loan authorized by this resolution.

RECOMMENDATIONS

A. It is recommended that the following conditions, to be met to the Bank's satisfaction, be included in the loan contracts in addition to those set forth in the proposed resolutions:

1. Unless the parties agree otherwise, prior to issuing each call for public bids, or if there is no need for public bids, prior to the acquisition of the goods or the initiation of the works, the Borrower, through the Executing Agency, shall submit to the Bank: (a) the general plans, specifications, budgets and other documents required for the acquisition or construction, and, where applicable, the specific requirements and other documents necessary for the call for bids; (b) in the case of works, evidence that it has the legal possession, easements or other pertinent rights to the lands required for their construction; and (c) evidence that the targets and timetables agreed upon with the Bank, mentioned in Appendices I and II, Clause 8(c), items (ii), (iii) and (iv), are being adhered to.

2. The Bank may recognize as part of the local counterpart resources of the Program expenditures up to the equivalent of US$500,000 incurred within the 18 months preceding the date of Resolution DE- /92 for the preparation of final designs for construction of the Alajuela Hospital, provided that requirements substantially similar to those set forth in the Resolution and in the loan contract have been fulfilled.

3. The Borrower, through the Executing Agency, shall submit evidence that it has contracted, within the periods established hereunder, reckoned in each case from the effective date of the loan contracts, and in accordance with the terms of reference agreed upon with the Bank, the following consulting services: (a) within 6 months, a consulting firm to supervise construction of the Alajuela Hospital; and (b) within 12 months, experts to advise the Program Executing Unit on the economic evaluation of projects and evaluation and control systems.

4. The Borrower and the Executing Agency shall: (a) assure that the works and equipment involved in the Program will be adequately maintained in accordance with generally accepted technical standards; and (b) submit to the Bank, during the 10 years following completion of the first of the works of the Program, and within the first quarter of each calendar year the annual maintenance report for the works and equipment of the Program for that year as well as a report on the annual maintenance status of such works and equipment, in accordance

with the provisions set forth in Section 7.03 of Appendix IV. If the inspections conducted by the Bank, or reports its receives, reveal that actual maintenance is below the agreed-upon levels, the Borrower and the Executing Agency shall take appropriate action to have the deficiencies fully corrected.

5. The Borrower shall, through the Executing Agency, demonstrate to the Bank, within one year after the completion of construction of the new Alajuela Hospital, that the original premises are no longer being used as a hospital.

6. The Borrower shall transfer to the CCSS the resources needed to defray the operating costs of the health centers and posts, in accordance with the completion and transfer timetable referred to in Appendices I and II, Clause 8(c)(iv).

7. Follow-up activities to assess the achievement of the Program's objectives shall take the following form:

   (a) The Borrower, through the Executing Agency, undertakes to meet annually with the Bank beginning in 1993 and during the execution of the Program, no later than November 30 of each year, to examine and assess, *inter alia*, the results of the execution of the Program during the current year, including: (i) the progress made on restructuring and strengthening MINSA and optimizing the use of its resources; (ii) achievements in the process of transferring health centers and posts, and allocation of government resources to the CCSS; (iii) results obtained following the improvements made in the revenue-collection system of the CCSS; (iv) compliance with the State's obligations to the Health and Maternity Insurance Fund (SEM) referred to in Appendices I and II, Clause 8(c)(iii); and (v) the CCSS's investment portfolio.

   (b) If in the opinion of the Bank the status of execution of the Program is not satisfactory, the Borrower shall, through the Executing Agency, submit to the Bank within 60 days of having received notice from the Bank to that effect, a description of the remedial measures it plans to institute and the timetable for same.

   (c) If the remedial measures referred to in paragraph (b) above are not satisfactory, the Bank may take such other action as it deems appropriate, in accordance with the provisions of the loan contracts.

8. The Borrower, through the Executing Agency, shall submit for the Bank's consideration:

   (a) within 6 months from the effective date of the loan contract: (i) the initial baseline data, by component; and (ii) the description of the procedure to be used to compile and process the annual data which shall be compared to the initial baseline data to evaluate the results of the Program; and

   (b) at the end of the second year from the date of the final disbursement of the Financing, an ex-post evaluation report on the results of the Program, based on the guidelines indicated in paragraphs 8.01 and 8.02 of Appendix IV.

9. The financial statements of the Program, during its execution, shall be presented annually to the Bank audited by an independent public accounting firm acceptable to the Bank.

B. The loan contracts shall include an annex substantially of the tenor of Appendix IV, The Program, of this document.

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Appendix IV

THE PROGRAM

(Annex A to the Loan Contract)

I. Purpose

1.01 The purpose of the Program is to offer support for health sector reforms aimed at improving the efficiency and effectiveness of service delivery, within the framework of Public Sector reforms.

1.02 The specific objectives of the Program are as follows: (i) to provide support for the design and implementation of reforms to enable the Ministry of Health to function effectively as the health sector's policy-making body and target its resources more rationally, so as to avoid duplication between institutions and programs; (ii) consolidate primary health care programs to achieve more efficient coverage of services; and (iii) narrow the gap between levels of access to basic health services, giving priority to material investments that can strengthen the operating capabilities and efficiency of the health services system in low-income areas of the country.

II. Description

2.01 The Program will consist of the following two components:

(a) Ministry of Health Restructuring Component, which is designed to reorganize the Ministry of Health. It calls for consulting services and training to: (i) review and adapt the operating profile and organization of the Ministry of Health to reflect its mandate as policy-making body for the health sector; (ii) train the human resources needed for the Ministry to perform that mandate effectively; and (iii) equip the Ministry with an information system.

(b) Service Integration Component, which includes: (i) the transfer of all the health centers and posts; (ii) the consolidation of the integration of the primary attention services through the rehabilitation, enlargement and/or substitution of health centers and posts; (iii) the improvement of the hospital system's efficiency through the substitution of the Alajuela Hospital; and (iv) the financial strengthening of the CCSS.

III. Cost of the Program and Financing Plan

3.01 The estimated cost of the Program is the equivalent of US$60,000,000. A breakdown of the cost by investment category and source of financing is given in the following table:

TOTAL COST OF THE PROGRAM AND SOURCES OF FINANCING
(US$000 equivalent)

INVESTMENT CATEGORY	IDB-IFF	IDB-OC	LOCAL	TOTAL	%
1. Engineering and administration	430	0	1,046	1,476	2.4
1.1 Final designs	0	0	626	626	1.0
1.2 Works supervision	335	0	0	335	0.5
1.3 Administration	95	0	170	265	0.4
1.4 Hospital conversion	0	0	250	250	0.4
2. Direct costs	21,683	10,353	1,528	33,564	55.8
2.1 Civil works	10,326	4,412	0	14,738	24.5
2.2 Fixtures	1,211	1,419	0	2,630	4.3
2.3 Equipment and instruments	10,146	4,522	1,108	15,776	26.4
2.4 Working capital	0	0	420	420	0.7
3. Associated costs	2,005	0	14,802	16,807	28.0
3.1 Consultants	1,300	0	318	1,618	2.6
3.2 Staff training	705	0	195	900	1.5
3.3 Operating costs	0	0	14,289	14,289	23.8
3.3.1 Alajuela Hospital	0	0	2,289	2,289	3.8
3.3.2 Health centers & posts	0	0	9,000	9,000	15.0
3.3.3 Payroll increase	0	0	3,000	3,000	5.0
SUBTOTAL	24,118	10,353	17,376	51,847	86.3
4. Unallocated	2,536	1,939	153	4,628	7.7
4.1 Contingencies	1,729	1,078	153	2,960	4.9
4.2 Escalation	807	861	0	1,668	2.8
5. Financing charges	1,346	1,708	471	3,525	5.9
5.1 Interest	1,066	1,568	0	2,634	4.4
5.2 Credit fee	0	0	471	471	0.8
5.3 Inspection and supervision	280	140	0	420	0.7
TOTAL	28,000	14,000	18,000	60,000	100.0
PERCENTAGE	46.7	23.3	30.0	100.0	

IV. Procurement

4.01 (a) When goods and services that are either acquired or contracted for the Program including those related to any means of transportation and insurance, are financed, either in whole or in part, with foreign exchange proceeds of the Financing, the procedures and specific conditions of the bidding or other form of contracting shall allow free competition of goods and services from member countries of the Bank. Consequently, the aforementioned specific requirements and procedures shall not establish conditions that preclude or restrict the offer of goods or the participation of contractors from the member countries.

(b) When financing other than the resources of the Financing or the local counterpart funding is to be used in the awarding of contracts and the procurement of goods, the Borrower and the supplier of such financing shall mutually agree on the applicable bidding procedures. If the Bank so requests, however, the Borrower shall demonstrate that the price agreed upon or paid with respect to the awarding of contracts for the procurement of goods, as well as the term and conditions of the financing, are reasonable. The Borrower shall further demonstrate that the quality of the goods so financed conforms to the technical specifications of the Program.

(c) For the purposes of section B, paragraph 3.04, of Annex B to the loan contract ("Tender Procedures"), the system of prequalification or registry of bidders shall be used in calls for bids for the execution of works for the Program corresponding to the construction of the Alajuela Hospital.

V. Consulting Services

5.01 In the selection and contracting of consultants whose services are to be financed, either in whole or in part, with resources of the Financing: (a) the procedures agreed upon with the Bank shall be applied, and (b) no provision or stipulations that would restrict or preclude the participation of consultants from member countries of the Bank may be imposed.

5.02 With respect to the consulting services financed with resources of the local counterpart, the Bank reserves the right to review and approve, before the Borrower formalizes a consulting contract, the names and background of the firms or individual consultants selected, their terms of reference, and the agreed fees.

VI. Eligibility Criteria

6.01 The following criteria shall be observed when selecting health centers and posts for the Program:

(a) Consolidation: The center or post must present an annual joint MINSA-CCSS work program showing: (i) that steps have been taken to ensure that no services will be duplicated and that the resources available will be put to optimum use; (ii) that, in the case of health centers, the management of all health care services has been placed under a single authority; and (iii) that, in the case of health posts, the management of the center to which a post is attached has been consolidated.

(b) District and establishment: The project must be located in one of the 30 districts [*cantones*] identified, exceeding the threshold point rating determined by MINSA on the basis of their situation and socioeconomic indicators of the population served by the establishment.

(c) Population served: The minimum population served must be 500 for health posts and 5,000 for health centers. This target population must reside not more than one hour's travel time from the establishment, by the habitual mode of transportation, and must not have access to another equally or more sophisticated facility within one hour's travel time using the same mode of transportation.

(d) Cost per project: Investment and equipment costs may not, for health posts, be lower than US$5,000 or higher than $45,000, and for health centers may not be lower than US$10,000 or higher than US$300,000, estimated at August 1992 prices and exchange rate.

(e) Maximum unit cost: In the case of health centers, the cost per visit may not exceed US$10. This unit cost will be calculated by adding the annual share of fixed investment for infrastructure and equipment to annual operating expenses and dividing that sum by the target population. For health posts, the cost of visits per dwelling unit may not exceed US$7, estimated at August 1992 prices and exchange rate.

(f) Least-cost technical solution: For each project there must be presented an analysis of alternatives showing that the technical solution proposed is the least-cost alternative. The analysis will compare the investment and maintenance costs for facilities of similar dimensions under an expansion and/or rehabilitation scenario versus construction of a new facility, where such is feasible.

VII. Maintenance

7.01 The purpose of the maintenance will be to conserve the works included in the Program in the operating condition they were in at the time of their completion, at a level compatible with the services they are to provide.

7.02 The first annual maintenance plan shall cover the fiscal year subsequent to that in which the first of the Program works went into operation.

7.03 The annual maintenance plan shall include: (i) a detailed description of the organization responsible for maintenance, the personnel in charge, and the number, type, and condition of the maintenance equipment; (ii) the location, size, and condition of repair and storage facilities and of maintenance camps; (iii) information on the resources to be allocated for maintenance during the current year and the amount to be allocated in the budget for the following year; and (iv) a report on the status of maintenance, based on the evaluation system established by the Borrower.

VIII. Ex-post Evaluation

8.01 For the purposes of Appendix III, paragraph 8(b), the information to be compiled shall include, *inter alia*, the following:

(a) Restructuring of the Ministry of Health: (i) number of staff and their professional qualifications; (ii) total budget, by line item; (iii) types of activities planned and completed; and (iv) evaluation of the human resources program.

(b) Alajuela Hospital: (i) volume and type of expenditures per year since the hospital began operations; (ii) volume and type of visits by specialty, by year, since the hospital began operations; (iii) efficiency indicators; (iv) overall costs; and (v) study of referrals.

(c) Health centers and posts: (i) operating costs by health post and center; (ii) cost per annual visit and per consultation; (iii) coverage of the population in the program area; and (iv) low-income survey.

8.02 The ex post evaluation report referred to in recomendation 8(b) of Appendix III, which shall be prepared on the basis of the information contained in paragraph 8.01 above, shall comprise, among other aspects, the following: (a) the analysis of MINSA's institutional reform; (b) the goals achived in the MINSA-CCSS integration process; (c) the improvement achieved on the efficiency and equality in the provision of services; and (d) conclusions and recomendations.

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Appendix V

PROPOSED RESOLUTION

COSTA RICA. PARTIAL PAYMENT OF INTEREST ON LOAN ____/OC-CR TO THE REPUBLIC OF COSTA RICA
(Health Services Improvement Program)

The Board of Executive Directors

RESOLVES:

1. That the President of the Bank, or such representative as he shall designate, is authorized, in the name and on behalf of the Bank, as administrator of the Intermediate Financing Facility Account (hereinafter referred to as the "Account") to enter into such contract or contracts as may be necessary with the Republic of Costa Rica, as Borrower, and to adopt other pertinent measures to use the resources of the Account to pay a part of the interest due by the Borrower on outstanding balances of the loan authorized by Resolution DE- /9__ for financing part of the cost of the Health Services Improvement Program, hereinafter referred to as the "approved loan". Such part shall represent up to 5% per annum of such outstanding balances.

2. That the Bank shall charge to the Account the amounts due by the Borrower and to be paid by the Account, in the currencies designated by the Bank and available in the Account, on the dates specified for the payment of interest or on the date or dates the Bank receives the payment of the remainder of the interest owed to the Bank by the Borrower (hereinafter referred to as the "Remainder"). Should the Borrower not have paid on the date due the Remainder, as well as any payment of principal or fees, the Bank shall withhold payment of the amount of interest authorized to be paid from the Account to the Bank. In such event, the Borrower shall remain liable for the total amount of the interest due and owed until such time as the Bank has received payment of the Remainder and of the respective amounts for amortization and fees.

3. That to the extent that the Bank receives payments from the Account for interest on the approved loan, the Borrower shall not be liable for the payment of such amounts and, consequently, it shall not be obligated to repay to the Bank any amounts of interest paid from the Account to the Bank.

4. That the Borrower may decide to pay the whole amount of the interest accrued on the outstanding balances of the approved loan either during the life of the loan or only during the amortization period of said loan. In both cases the Bank shall, as soon as possible, reimburse the Borrower for interest paid to the Bank and which may be charged to the Account in accordance with Sections 1 and 2 above.

5. That to the extent that the Bank determines that there are not sufficient resources available in the Account for making the payments referred to in Sections 2 and 4 above, the Borrower shall pay the interest due on the dates and the amounts specified in the loan contract, up to the full amount accrued on the outstanding balances of the approved loan, without obligation of the Bank to reimburse any amount whatsoever.