

## ARGENTINA

### Health Infrastructure Rehabilitation Program (AR-0045)

#### INDEX

	<u>Page</u>
I. INTRODUCTION .....	1
A. Background .....	1
B. Request and priority .....	2
C. Missions .....	2
D. Conclusion .....	2
II. FRAME OF REFERENCE .....	4
A. Argentine public sector resources and organization .....	4
1. Territorial political division .....	4
2. National government .....	4
3. The provincial level .....	5
B. Level of health .....	6
C. The health sector .....	9
1. The public subsector .....	9
2. The social work subsector .....	11
3. The private subsector .....	12
D. Physical resources .....	13
E. Human resources .....	14
F. Production of services .....	15
G. Health policy .....	17
H. Bank activities in the health sector .....	19
I. Summary and conclusions .....	19
III. THE PROGRAM. ITS COST AND FINANCING	
A. Conceptual framework .....	21
B. Programa objectives .....	22
C. Description of the Program .....	22
1. Goals of the Program .....	23
2. Selection criteria .....	23
3. Dimensioning criteria .....	29
4. Equipment and construction subprogram .....	30
5. Institutional strengthening subprogram .....	32

	<u>Page</u>
D. Cost and financing .....	33
1. Engineering and administration .....	34
2. Direct costs .....	35
3. Concurrent costs .....	36
4. Financial costs .....	36
5. Financing Program .....	36
E. Recurrent costs .....	38
 IV. EXECUTION OF THE PROGRAM	
A. Execution procedure .....	40
B. Creation of the Program .....	40
C. Organization for execution .....	41
1. Central Executive Unit .....	41
2. The Provincial Executive Units .....	43
D. Plan for execution of the Program .....	44
1. Execution of the construction and equipment subprogram .....	44
2. Execution of the institutional support subprogram .....	46
E. State of Preparation of the Architectural projects .....	47
F. Eligibility criteria .....	47
G. Acquisition of land .....	49
H. Bid and procurement Program .....	49
I. Procedure for contracting of goods and services .....	50
J. Schedule of investments .....	51
K. Advance payment of funds .....	52
L. Acknowledgment of expenses .....	52
M. Operation of the hospitals .....	52
N. Maintenance of the works .....	53
O. Utilization of appropriate technologies .....	53
P. Ex-post evaluation .....	54
Q. Inspection and monitoring .....	55
 V. BORROWER AND EXECUTOR	
A. Institutional aspects.....	56
1. Borrower.....	56
2. Executor.....	56
3. Secretariat of Health.....	56
4. Provincial Secretariats of Health.....	60

	<u>Page</u>
B. Financial analysis.....	61
1. Republic of Argentina.....	61
2. Ministry of Health.....	63
3. Secretariat of Health.....	67
4. National Health Support Program (PAS Funds).....	69
5. Analysis of the Budgetary execution of the provinces	70
 VI. PROGRAM JUSTIFICATION	
A. Technical feasibility.....	73
B. Institutional feasibility.....	75
C. Financial feasibility.....	75
1. Local matching funds for implementation.....	76
2. Operations and maintenance revenue and expenditures.	77
D. Socioeconomic Analysis.....	80
1. Introduction.....	80
2. Target population. Health care.....	81

## A N E X O S

- II-1 Situación Económica Reciente
- II-2 Distribución de camas a nivel de país de las Provincias del Programa, del aglomerado y del sector público
- II-3 Datos Básicos de Población de las Provincias Participantes
- II-IV Indicadores de Salud en las Provincias Participantes
- III-1 Guía del Contenido de los Programas Médicos de los Hospitales
- III-2 Localización y Servicios de los Terrenos
- III-3 Listado de Equipos y Costos por Hospital y Rubros Principales
- III-4 Dimensionamiento de los Hospitales en Base a Programa Médico
- III-5 Detalles de Costos del Subprograma de Fortalecimiento Institucional y Términos de Referencia.
- III-6 Niveles de complejidad: clasificación de establecimientos de salud
- III-7 Presupuestos Detallados UEC y UEP
- III-8 Situación de los hospitales a reemplazarse
- IV-1 Modelos de Convenios a firmar con Provincias Participantes
- IV-2 Organización de la Unidad Ejecutora Central (UEC)
- IV-3 Organización Ejecutiva del Programa
- IV-4 Organización de las Unidades Ejecutoras Provinciales (UEP)
- IV-5 Plan de Ejecución del Programa
- IV-6 Calendario de Actividades (PEP Preliminar)
- IV-7 Procedimiento de Licitaciones
- IV-8 Reglamento de Contratación de Consultores
- V-1 Organigrama de la Secretaría de Salud
- VI-1 Costos de Operación y Mantenimiento de los Hospitales de reemplazo
- VI-2 Factores de Recuperación de las Obras Sociales de las Provincias
- VI-3 Derivación del Déficit de Servicios Hospitalarios en las Areas de Influencia del Programa
- VI-4 Eficiencia de la utilización de los Hospitales



## I. INTRODUCTION

### A. Background

- 1.01 The Health Infrastructure Rehabilitation Program which is being proposed would contribute to the start up of a sectoral modernization process based on the development of a system of health services on the provincial level. Two components are envisioned: (a) construction and equipping of 11 hospitals which together would contain approximately 3,000 beds. Ten hospitals would be of a general nature with the four basic services of: medicine, surgery, obstetrics-gynecology and pediatrics; and with some medical and surgical specialties depending on the needs of the provinces. Moreover, a general hospital would be built for child care. The hospitals basically would be located in the major cities of the province and would replace hospitals that are physically and functionally obsolete. The other component, (b) institutional strengthening, aims at optimizing operational capacity of the hospitals and the service network within their area of influence.
- 1.02 Argentina is one of the most urbanized countries in Latin America. In 1980, 83 percent of its population lived in urban areas. This process has been gradual and has occurred since the start of the century when approximately 57 percent of the population of the country lived in urban areas. Traditionally, the urban population is concentrated in Buenos Aires and its area of influence. However, since 1960, and in particular since 1970, the degree of concentration in the Regional Capital has declined from 47 to 43 percent of the country's urban population. Medium-sized cities, particularly provincial capitals, have grown more rapidly than the Buenos Aires Metropolitan Region. In 1947, only nine medium-sized cities were in existence with populations greater than 100,000 inhabitants which combined contain 20 percent of the country's urban population and none of them had more than 500,000 inhabitants. In 1980, the cities of the interior that had more than 100,000 inhabitants numbered 17 and five of them had populations of more than half a million. Combined, the 17 medium-sized cities in 1980 contained 27 percent of the country's urban population. The most dynamic cities are situated in the North and South of the country and at present show the highest demand for investments in infrastructure and urban services.
- 1.03 The recessionary situation characterizing the Argentine economy in recent years has reduced the capacity of provincial governments to satisfy demand for investments in the size required to replace the principal hospitals. They have concentrated their efforts in the health sector in expanding the first level services network and construction and health centers and smaller hospitals. The Argentine Government, aware of this situation, has proposed the program under analysis in this document. It would allow replacing hospitals which on average are 82 years old and whose individual age fluctuates between 61 and 105 years.

- 1.04 Formulation of the Program was assigned to an interdisciplinary working group appointed in mid 1985 and consisting of doctors, architects, economists, sociologists and administrators, who acted under the direct supervision of the Secretariat of Health of the Ministry of Health and Social Action. The Bank, through the program, together with the Pan American Health Office (PAHO), provided technical cooperation consisting in the contracting of seven consultants for a period of 27 consultant months for the purpose of cooperating and formulating the Program.

B. Request and priority

- 1.05 On July 8, 1986, the Ministry of Economy presented the request for credit and ratified the priority that the government has granted to strengthening the health sector on the provincial level as one of the means for attaining social equity and improving the standard of living of the population. The Development Plan of 1985-1990 identifies as a top priority the improvement of public health services and highlights the Program which is the subject of this report.

C. Missions

- 1.06 The Bank, in taking cognizance of the priorities and interests of the government in financing the Program, in July and in December 1985 and in February 1986, sent three orientation missions to cooperate with the authorities in conceptualization and structuring of the Program. In addition, under the IBD-PAHO agreement, a number of missions have been sent for orientation in specific aspects of the medical programming, maintenance and administration of hospitals. The Bank sent an analysis mission on August 25, 1986 which returned to Argentina on September 29 to wrap up an analysis of the operation.

D. Conclusion

- 1.07 The operation which is being presented has a total cost equivalent to US\$300 million and will contribute to improving the health conditions in 11 provinces in the interior by replacing 10 hospitals which have reached physical and functional obsolescence and by constructing a new one. In selecting the provinces, taken into account has been the combination of different criteria, particularly the degree of physical obsolescence of the hospitals and population having basic needs unsatisfied on the basis of which a determination was made for demand for medical services. Personnel that would provide services in the new hospitals would basically be those presently in the current hospitals with some particularities depending on each province and which have been provided for in the Program through actions for their training in technical and administrative aspects required for operation and efficient maintenance of the new hospitals. As a result of the analysis that was carried out, it is believed that the Health Infrastructure Rehabilitation Program that is being proposed is feasible both from a technical point of view as well as from a social

and economic, financial and institutional point of view, as indicated in the following chapters. Consequently, it is recommended approving its financing through a loan in the amount of US\$125,000,000 from the ordinary capital of the Bank, of which an amount equivalent to US\$120 million will be in foreign exchange and an amount equivalent to US\$5.0 million in local currency.

## II. FRAME OF REFERENCE 1/

### A. Argentine public sector resources and organization

- 2.01 By virtue of the fact that the program which is the subject of the present document is based in large measure on the autonomous capability that the provinces have in acting as well as on distribution of income between the nation and the provinces, it is important to note the federal system of the country. Given herewith are the most significant aspects of the public sector and highlighted among them is decentralization of political-administrative organization in Argentina and division of general work between the various levels of government.

#### 1. Territorial political division

- 2.02 The Argentine Government is divided into three political-administrative and territorial levels: national, provincial and municipal. These three levels correspond to a federal organization in which government responsibilities originate with the provincial states which delegate them to the National Government. As a result, the provinces are autonomous entities which stipulate their own constitutions. The municipalities, in turn, are organized as part of the provincial system. At present, the Argentine Federal System encompasses 22 provinces, the Federal Capital and National Territory of Tierra del Fuego, Antarctica and the South Atlantic Islands.

#### 2. National Government

##### (a) Organization

- 2.03 On the basis of the delegation of powers by the provinces, the National Government has responsibilities of seeing to the broad general necessities of Argentine society and providing common interests for the various territorial subdivisions. The powers delegated to the National Government are all those indicated in the National Constitution. Moreover, there are "concurrent powers" provided by the Constitution, both for the Central Government as well as the provinces, and even to the municipalities through provincial delegation.
- 2.04 The National Executive Power is carried out by the President who is responsible for the general administration of the country. The present executive system arises from Law 23.023 of December 1983 which organizes the central administration into eight Ministries: Interior, Foreign Relations and Cult, Defense, Economy, Public Services and Works, Education and Justice, Labor and Social Security and Health

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1/ See annex No. II-1 "Argentina: The Recent Economic Situation and Prospects."

and Social Action 1/ constituting the National Cabinet. The Ministries are entrusted with drawing up national objectives and policies, as well as implementation of plans, programs and projects in accordance with directives imparted by the Central Executive Power. In fulfillment of their responsibilities, Ministries consist of Secretariats, Undersecretariats and Directorates.

(b) Resources and their co-sharing

- 2.05 The resources of the National Government depend on the constitutional provisions which assign powers exclusively to the Federal Government or concurrently with the provincial governments. According to these provisions, the Nation has the following: (i) resources allocated exclusively and permanently (external taxes on foreign commerce and postal revenues); (ii) resources allocated on a concurrent and permanent basis with the provinces (in domestic taxes); and (iii) resources allocated temporarily or transiently on a concurrent basis with the provinces (direct taxes in the event of national emergencies).
- 2.06 Beginning in 1935, a system for unifying and co-sharing of taxes was set up between the Nation and the provinces. Through this system, the Federal Government collects taxes throughout the national territory. Of the total collected, 3 percent is set aside for the Regional Development Fund and the rest is distributed in equal parts between the Nation and the provinces combined. Among the provinces, in turn, 65 percent of the funds are distributed in a directly proportional manner to the population of the provinces, 25 percent proportioned to the development gap between each province and the most developed area and the remaining 10 percent between provinces whose populational density is less than the national average.

3. The provincial level

(a) Organization

- 2.07 Provinces define their own constitution laws, create their own local institution and elect their authorities without the intervention of the Federal Government. The Central Government guarantees the autonomy of the provinces since they meet the conditions laid down in the National Constitution. The legislatures of the provinces, therefore, do not stipulate all the laws governing their territories since private law legislation and some public law legislation (Civil, Commercial, Penal Codes, etc.) is the subject of the National Congress. The provincial governments are responsible for administrative and financial organization within their territories including general power for internally regulating safety and welfare of the population. Among the responsibilities of the provinces that are not delegated is including the provision of the population with health services.

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1/ Would be responsible for the Program through the Health Secretariat.

- 2.08 Institutional organization of the provinces respects division of responsibilities laid down in the National Constitution giving rise to an Executive Power, a Legislative Power and a Judicial Power. The first is carried out by a governor who is assisted by a group of ministers. The Legislative Power is carried out by the provincial legislature and there are three judicial courts that are established.

(b) Resources

- 2.09 The provinces' resources come from a number of sources. On the one hand, resources are obtained through tax collection within the provincial territory (own resources). Secondly, provincial revenues consist of resources collected by the National Government nationwide through the federal co-sharing system. Finally, provincial resources consists of other national transfers outside of the system of co-sharing, included among these is the Health Support Program (HSP Funds), with capital contributions for investments in the sector.
- 2.10 The principal own resources of the provinces arise from tax, stamp taxes, taxes on profit generating activities or on gross incomes and on automobiles. In different provinces, payments received from national organizations on the basis of royalties for extraction of minerals, fuels, or production of hydroelectric energy represent an important source of resources. In general terms, provincial resources consist of approximately 50 percent of own income, 40 percent of co-shared resources and 10 percent of other revenues.

B. Level of health

- 2.11 The country, on the basis of the 1980 national census, on that date had 27,947,466 inhabitants with the following demographic characteristics:
- (a) urban population (living in localities of 2,000 and more inhabitants) was 83 percent; 90 percent of which live in localities of more than 10,000 inhabitants; conspicuously, Greater Buenos Aires (Federal Capital and urban cone of Buenos Aires) had 9,969,826 inhabitants live there in 1980 meaning 35.6 percent of the population of the country;
  - (b) other characteristics are: the female population was 50.8 percent; the economically active population was 50 percent; population with basic needs unsatisfied was 27.7 percent; population younger than 15 years, 30.3 percent and older than 65, 8.2 percent; and
  - (c) demographic density was 10.1 inhabitants per square kilometer.
- 2.12 Rate of growth demographically has shown a decline since 1914 when it was 36 per 1,000; attaining 16 per 1,000 in the 1960-1970 decade. However, in the 1970-1980 decade for the first time, there has been an

increase going up to 17.9 for each 1,000 inhabitants. For 1982, the birth rate was 23.4 per 1,000 inhabitants; and the mortality rate was 8.4 per 1,000 reflecting a natural growth rate of 15 per 1,000. Life expectancy at birth in 1980-1985 was 69.7 years.

- 2.13 In brief, Argentina has an urban population; distributed in many urban concentration centers; with an average age of 27.3 which expresses a certain aging of the population if we compare it with the 24.8 percent in existence in 1947. An important percentage of the latter has basic needs that are unsatisfied. This identifies the population exposed to the risk of suffering transmissible diseases (gastroenteritis - acute respiratory illnesses); as well as nontransmissible diseases (degenerative, cancer, etc.). The demographic projections to the year 2000 based on 1980 census data are:

Year:	1985	1990	1995	2000
Millions of Inhabitants:	30.5	32.9	35.1	37.2

- 2.14 General mortality has declined from 1970 (9.5 per thousand) to 1980 (8.6 per thousand) as a national average. Logically, there are differences among the various provinces with the following data for 1980: Neuquen 5.3 per thousand (minimum); and federal capital: 12.9 per thousand (maximum). The percentage of medically certified death is 98.9 percent for 1981 and the general mortality structure showed the following first five causes of death: (a) heart disease: 29.0 percent; (b) malignant tumors 17.3 percent; (c) cerebro-vascular diseases 9.5 percent; (d) accidents 5.1 percent; and (e) arteriosclerosis 4.8 percent.

- 2.15 A comparison of the mortality data with indicators from other group "A" countries is as follows:

<u>Indicator</u>	<u>AR</u>	<u>BR</u>	<u>ME</u>	<u>VE</u>	<u>Observations</u>
Life expectancy	69.7	63.5	65.7	69.2	in years
General mortality	8.4	8.8	7.1	4.9	per thousand inhabitants
Infantile mortality	33.6	87.3	53.0	29.8	per thousand live births
1-4 year old mortality	1.5	3.8	2.6	1.7	per thousand children
Maternal mortality	0.7	1.3	3.5	0.5	per thousand live births

Source: Argentina-Loan Request Document. Other countries: PAHO - Official Document 201, Director's Report, 1984.

- 2.16 The principal causes for hospitalization in 1981 were: (a) pregnancy, delivery and birth, 29.5 percent of total discharges; (b) respiratory infections, 10.5 percent; (c) traumas, 8.4 percent; (d) infectious diseases and parasitic diseases, 8.2 percent; (e) circulatory system diseases, 5.9 percent. Institutional care for birth is 90 percent. Indicators for coverage (immunization, environmental protection, medical and nutritional care for 1983) also show a good level of health in their national averages as indicated in the following table:

<u>Indicator</u>	<u>AR</u>	<u>BR</u>	<u>ME</u>	<u>VE</u>	<u>Observations</u>
Immunization: DPT	62.0%	65.0%	—	71.8%	under one year
Polio	91.0%	95.0%	—	91.6%	under one year
Measles	60.0%	87.5%	—	45.0%	under one year
Tuberculosis	61.0%	59.4%	53.3%	73.5%	under one year
Population with drinking water	69.0%	93.7%	71.0%	90.0%	urban population
Population with sewage disposal	79.2%	60.4%	50.7%	78.2%	urban population
Doctor visits/inhabitants/year	* 6.2%	* 1.5%	1.4%	1.8%	
Dismissals per 100 inhabitants <sup>1/</sup>	11.4%	—	3.7%	5.5%	
Beds per 1,000 inhabitants	5.4%	4.3%	0.8%	2.7%	
Availability of calories	3,380	2,578	2,890	2,646	per capita per day
Availability of proteins	112.7%	59.4%	74.9%	71.2%	grams per capita per day

\* Only metropolitan area.

Argentina Loan Request Document. Other countries.

Source: PAHO - Official Document 201. Director's Report, 1984.

- 2.17 National averages for health indicators are satisfactory even though it is appropriate to note the existence of certain differences on the provincial level as well as identify a morbidity-mortality mixed structure which share risk of becoming sick and dying among nontransmissible diseases (cardiopathies, neoplasies, etc.); as well as transmissible diseases;
- 2.18 Among the latter, acute gastroenteritis constitutes one of the five causes of morbidity and mortality in those younger than five years of age. The same thing can be said of "acute respiratory diseases" (pneumonia and influenza). Malaria has an endemic area in some border provinces; and Chagas' disease still has significant prevalence in certain provinces of the northeast of the country. (Catamarca, Chaco, Formosa, etc.). Although the health level on average is good, the existence of programs, services and technology is necessary which has a problem solving capability both for control of transmissible diseases as well as nontransmissible diseases.
- 2.19 As regards nutrition, although the Argentine food diet is one of the highest, there does exist a rather unequal distribution in food consumption which produces regional differences. Hence, in the specific studies carried out in Salta, Resistencia and Santiago de Estero, there was detected a percentage of malnutrition in those younger than five years of age varying between 30 and 43 percent.

<sup>1/</sup> The rate of 11.4 dismissals per 100 inhabitants is the second highest in Latin America and the fifth on the American continent and shows demand for internment which historically has had an ascending projection in Argentina.



C. The health sector

- 2.20 Within the health sector structure, three subsectors are identified: public, social works and private. Owing to the fact that its political organization is Federal, the provinces and municipal power have considerable autonomy in organizing and carrying out health actions. The combination of these aspects gives rise to the configuration of a differential health system for various groups of the population of the country which varies depending on place of residence, occupational position and levels of income. On the other hand, each subsector shows significant differences in its organizational and internal operation.

1. The public subsector

- 2.21 The public subsector provides its services through three jurisdictions: national, provincial and municipal. Up until 1970, the public subsector had the greatest capacity for technological solving of problems but after that date the situation began turning around and its contribution diminished. At present, it has 42 percent of total internment establishments and 63 percent of total beds in the country. The public subsector is responsible for taking care of the population with smaller income and patients with "acute" pathology as well as emergencies and a good percentage of chronic infections with little or no assistance on the part of the other subsectors.
- 2.22 Users of the public subsector are of three types: (a) small income groups not covered by any other sector; (b) groups that are theoretically covered by other social works but which practice the fact that they do not have their economic contribution may be a limiting factor for their access, and (c) groups residing in geographic areas where there do not exist establishments of their own organization or, if they do exist, they do not have the required technical services. These situations make it difficult to specify the population currently responsible for this subsector.
- 2.23 Operationally, the health services network of the public subsector is structured into three "attention levels" depending on the relation existing between resources and health requirements to be met.
- (a) The first level is identified with those establishments which do not possess patient internment facilities (health centers); and whose functions are based particularly on development of activities at the external visit level for preventive-promotional actions and health curative actions.
  - (b) The second level is constituted by general or multi-purpose hospitals that have basic services (medicine, surgery, pediatrics, obstetrics, gynecology) and some specialties. These services are carried out both on an external visit level as well

as an internment level; and many of the establishments also have a specific number of beds for chronic hospitalization of certain illnesses such as pulmonary tuberculosis which with present technology no longer requires a lengthy stay for its internment.

- (c) The third level of care reflects hospitals and special institutions generally located in the three or four main cities of the country.
- 2.24 Health services in Argentina have been classified by "Levels of Complexity", based on the fact that the complexity of a service does not depend necessarily on having a larger number of beds or more doctors or patients taken care of but on the organization, equipment and degree of training and specialization of the human resources as well as the degree of development of the activities that they carry out or the services that they provide. Hence, there are nine different levels of complexity.
- 2.25 The public subsector presently has a series of institutional and operational problems affecting its efficiency. The Ministry of Health with relatively little technical capability for directing, and coordinating the health actions both on an intra as well as an inter-sectoral level as well as attaining adequate compatibility of nation and province within the federal and decentralizing context. To this effect, some critical aspects have been identified: capability for managerial conduct; administration of financial and accounting system; data and health statistic system; personnel policies. Operationally, health problems are more relevant on the secondary care level (hospitals).
- 2.26 The public sector infrastructure is of large scope but it must be recognized that it is a loss of the protagonistic role of the public hospital in its triple aspect: care, teaching and research. This deteriorating situation shows itself through a series of critical aspects constituting factors which negatively determine adequate medical and hospital care. Among these we may mention: (a) limitations on hours of operation of services; (b) poor quality in provision of services: not providing medicines to external visit patients; shortage of medical and surgical equipment; (c) low "personnel per bed" indices in provincial hospitals; and lack of training; (d) poor maintenance conditions for physical resource, particularly installations that are obsolete and largely deteriorated; (e) structured hospital organization level on the basis of patient internment without taking into consideration other preventive promotional methods and recovery methods which together can increase hospital efficiency and have a more positive effect on the health of the population.
- 2.27 One of the problems with Argentine medical care is to incorporate the public hospital into a new social works system, allowing its participation in the demand and financing currently existing. This

situation will be solved with the implementation of the General Health Plan. For that purpose, it is indispensable the rehabilitation of the provincial hospitals.

2. The social work subsector 1/

- 2.28 The social works subsector was established in 1944 through the impetus of social solidarity. In 1970, the National Social Works Institute (INOS) was established as an authority for applying social works. This subsector comprises 337 organizations, 292 of which (86.6 percent) are coordinated by INOS and the remaining 45 (13.3 percent) correspond to provincial social works, municipal social works, and those of the Judicial Power, Congress, and those of the Armed Forces and Security. Social works at present have a limited infrastructure of their own: they possess 5.4 percent of the total beds and basically behave as fundamentally financing organizations since they basically contract with the private subsector for practically all of the services that they offer.
- 2.29 The social works subsector had as affiliates 22,337,656 inhabitants in 1980 (80 percent of the country's total) corresponding to 62 percent for INOS; 14 percent for social works for the provinces and municipalities and 4 percent for social works for the Armed Forces. Of the 292 organizations under the responsibility of INOS, most (200) belong to unions (68.5 percent) and the remainder (92): are state, province or municipal.
- 2.30 The social works subsector is characterized by a multiplicity of institutions by its lack of orderliness and its internal inequity. This situation is due in large part to the fact that social works were structured by the professional union and the latter by branch of production of the country's economy with the following characteristics:
- (a) programming of services provided to their affiliates are established for each social work,
  - (b) providing services is different according to each social work, because of the different resources of each one determined by the hierarchy of the social work in terms of the importance of its union and the number of its affiliates. This aspect is of extreme importance since it can differentiate at least three large sorts of social works: (i) a type having many resources but also many affiliates (bank employees, railroad employees) who, because of their volume, have a significant network of services of their own with different levels of complexity and also use the private subsector; (ii) another sort, having greater

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1/ Social works are, basically, labor associations for health and other welfare services called "obras sociales" in Argentina.

economic resources and a relatively reduced number of affiliates (executives) which contract services with the private subsector infrastructure especially at the level of large cities (Buenos Aires, Cordoba, Rosario, Mendoza); (iii) the third sort of social works with a relatively small number of affiliates and with low levels of income and distributed over various provinces of the country. These social works have limited supply capability and in practice and for the most part his affiliates use public services (retirees, farm folk, public employees, etc.)

- (c) Another aspect which is differential for social works is determined by the geographic spread of the affiliates; since even though they are workers in one and same union and have the same economic contribution they may receive different quality of care depending on the locality where they reside.

### 3. The private subsector

- 2.31 The private subsector is shaped by two large groups: professionals who practice their profession independently on private patients affiliates with social works or prepaid systems, and care establishments contracted by social works. In this subsector, there are group solidarity institutions generally having no profit purposes such as ethnic community hospitals. The private subsector holds 31.4 percent of the country's beds, generating 44.7 percent of total discharges; particularly those of short duration; and it has 50 to 60 percent of the most sophisticated equipment (extracorporeal pumps; axial tomography; intensive care, etc.) located in an estimated 2,000 establishments of different complexity particularly in the large cities (Buenos Aires, Cordoba, Rosario, Mendoza).
- 2.32 In summary, it will be noted that the health sector has almost complete care coverage but has serious problems of inequity with respect to users and deficiencies in quality of medical care provided. The "Social Works" subsector are basically financing organizations. The public subsector in reality is taking care of a population which lacks resources and that affiliated to social works without charging the latter for the services that are provided. This situation leads the public subsector to be caring for the population of other subsectors because these have different forms of inaccessibility: economic, geographic or pathological. The provincial hospitals on the second level which are the least efficient in providing services and this impacts on the poor performance of the entire services network by not providing the support corresponding to the primary level of care. The services which the public hospital offers are, in general, free to the population since for the most part the users are citizens with limited resources. The private subsector has more specialized services for the care of "acute" pathology patients basically located in cities with greater availability of resources: Buenos Aires, Cordoba, Rosario and in part Mendoza.

D. Physical resources

- 2.33 According to the 1980 survey, the country had 9,642 establishments, 6,456 of which were primary level services (67 percent) and 3,186 were in patient health services (33 percent) and an average of 47 beds per establishment. In this general index (47 beds), on average 70 beds reflect the public subsector, 70 the social works and 27 the private subsector. The institutional distribution of the physical resources is as follows:

	<u>Public</u> <u>subsector</u>	<u>%</u>	<u>Social works</u> <u>subsector</u>	<u>%</u>	<u>Private</u> <u>subsector</u>	<u>Total</u>	
Establishments	5,123	53.1	374	3.9	4,145	43.0	9,642
Establishments with beds	1,334	41.8	114	3.6	1,738	54.6	3,186
Establishments without beds	3,789	58.7	260	4.0	2,407	37.3	6,456
Beds	94,588	63.2	8,079	5.4	47,048	31.4	149,715

- 2.34 Distribution of beds depending on the stay of the patient (acute up to 30 days; chronic and convalescents over 30 days) is as follows:

<u>Beds</u>	<u>Public</u> <u>subsector</u>	<u>%</u>	<u>Social works</u> <u>subsector</u>	<u>%</u>	<u>Private</u> <u>subsector</u>	<u>%</u>	<u>Total</u>
Acute	70,572	59.1	7,668	6.4	41,002	34.3	119,242
Chronic	24,016	78.8	411	1.3	6,046	19.8	30,473
Total	94,588		8,079		47,048		149,715
	=====		=====		=====		=====

- 2.35 Geographic concentration of the 149,715 beds is as given below; comparing percentage of population. (See annex II-2)

<u>Federal Capital and</u> <u>Province of Buenos Aires</u>		<u>Rest of</u> <u>Provinces</u>	
<u>No. of Beds</u>	<u>% Country</u>	<u>No. of Beds</u>	<u>%</u>
72,285	48.3	77,430	51.7
Population	49.3		50.7

- 2.36 The rates of beds per 1,000 inhabitants is given below as compared with other Group "A" countries.

<u>Resource</u>	<u>AR</u>	<u>BR</u>	<u>ME</u>	<u>VE</u>	<u>Observations</u>
Bed	5.4	4.3	0.8	2.7	Per 1,000 inhabitants

Source: PAHO. Official Doc. 201. Director's Report, 1984.

- 2.37 Although the number and rate of beds is acceptable, it should be pointed out that the conditions of the latter, particularly in provincial hospitals is unsatisfactory because of the degree of deterioration because of the age of the hospitals. Distribution of beds by province is as given in annex II-2.
- 2.38 The primary care network is constituted by 6,456 health establishments that do not have inpatient facilities and which carry out activities for the promotion of health, prevention of disease and recovery medical attention on the level of the external office visit.
- 2.39 These establishments receive different names with respect to the particularities of each province (health center; peripheral clinic, etc.) and in the private subsector they are mostly diagnostic services (clinical laboratories; x-ray diagnostic offices; imaging diagnostics, etc.). Geographic distribution is as indicated below, it shows the large percent concentration in provinces where such services perform activities on the basis of priority programs for mothers and infants and use health promoters in addition to other basic human resources:

	<u>Federal Capital</u> <u>Province of Buenos Aires</u>	<u>Remainder</u> <u>of Provinces</u>	<u>Total</u>
No.	1,938	4,518	6,456
%	30.0	70	100

- 2.40 Through the public subsector primary care network, a series of programs is carried out on a national level including: (a) National Food Program (NFP). This program has as its purpose to combat the food emergency which the infant population is undergoing and consists in delivering food to families of limited income particularly those with pregnant women and children younger than six years of age; (b) Self-Supply Farms Program, promotes food self-sufficiency through development of family type farms and gardens; (c) Medical Assistance Fund, provides basic medicines to economically and socially unprotected groups and is oriented towards taking care of specific pathologies: parasitosis, gastroenteritis, acute respiratory illnesses, etc.; and (d) Health Education Programs, aimed at improving basic environmental cleanliness conditions and habits.
- 2.41 The public primary care network has a rather good performance, being limited by a lack of resolution of reference on the secondary care level.

#### E. Human Resources

- 2.42 In 1980 the country had 46,353 medicine doctors (603 inhabitants per doctor); 13,808 nurses; 39,480 nurse's aides (524 inhabitants per nursing personnel) and 6,416 dentists (4,356 inhabitants per dentist). These resources were geographically distributed as follows:

<u>Resources</u>	<u>Federal Capital and Province of Buenos Aires %</u>	<u>Remainder of Provinces %</u>
Doctors	54.2	45.8
Nurses	44.5	55.5
Nurse's Aides	51.8	48.2
Dentists	<u>53.9</u>	<u>46.1</u>
Population %	49.3	50.7

- 2.43 Medicine doctors and nurses rates per 10,000 inhabitants are given below as compared with other Group "A" countries.

<u>Resource</u>	<u>AR</u>	<u>BR</u>	<u>ME</u>	<u>VE</u>	<u>Observations</u>
Doctors	16.6	8.6	8.2	12.1	Per 10,000 inhabitants
Nurses	5.8	1.0	4.9	8.1	Per 10,000 inhabitants
Nurse's aides	8.9	25.2	6.1	23.4	Per 10,000 inhabitants

Source: PAHO. Official Doc. No. 201. Director's Report for 1984

- 2.44 Training of the human resource is carried out at different levels: (a) University: national universities, provincial and private universities offer careers for the training of professionals, technicians and aides. At this level, there are twenty universities, four of which are in the Federal Capital and Province of Buenos Aires and the other 16 are in the provinces of Catamarca, Cordoba, Corrientes, La Rioja, Mendoza, Misiones/Salta, San Juan, San Luis, Santa Fe, Santiago de Estero and Tucuman. Of these twenty universities, nine have medical training; seven trained dentists; ten trained biochemists; seven trained pharmacists; six trained registered nurses; twelve trained nurses. (b) Nurses and technicians. Nurses training is offered in schools that fall under the national universities or the provincial or municipal jurisdictions. There are also private schools associated generally with private hospitals. There is a total of 57 institutions in charge of training nurses and 114 for training of nurse's aides. As regards nurses, in 1984, 369 professionals were turned out and 1,387 nurse's aides on the national level showing an excess training of doctors with respect to nursing personnel.

#### F. Production of Services

- 2.45 In 1980 on the national level, 3,181,584 discharges were produced signifying a rate of 11.4 discharges per 100 inhabitants. Distribution by subsectors is as indicated below:

	<u>Public</u> <u>Subsector</u>	<u>%</u>	<u>Social Works</u> <u>Subsector</u>	<u>%</u>	<u>Private</u> <u>Subsector</u>	<u>%</u>	<u>Total</u>
Discharges	1,583,459	(49.8)	176,020	(5.5)	1,422,105	(44.7)	3,181,584
Discharges per bed	16.7		21.8		30.2		21.2

As regards the distribution we may note that the Federal Capital and Province of Buenos Aires provided 48.4 percent of total discharges.

2.46 The structure of the discharges by jurisdiction for 1980 is as indicated below:

<u>Jurisdictions</u>	<u>Total</u>	<u>Public</u>	<u>Social Works</u>	<u>Private</u>
Federal Capital	100	20.9	10.0	69.1
Buenos Aires	100	59.8	2.7	37.5
Catamarca	100	59.7	1.1	39.2
Cordoba	100	30.7	2.7	66.6
Corrientes	100	93.7	1.4	4.9
Chaco	100	64.0	0.8	35.2
Chubut	100	64.5	12.0	23.5
Entre Rios	100	66.7	2.9	30.4
Formosa	100	78.6	0.9	20.5
Jujuy	100	75.1	0.9	24.0
La Pampa	100	90.7	0	9.3
La Rioja	100	76.4	10.1	13.5
Mendoza	100	59.9	8.9	31.2
Misiones	100	81.1	0	18.9
Neuquen	100	78.4	12.6	9.0
Rio Negro	100	65.0	9.5	25.5
Salta	100	64.1	6.3	29.6
San Juan	100	57.8	10.8	31.4
San Luis	100	70.7	3.7	25.6
Santa Cruz	100	73.0	23.0	4.0
Santa Fe	100	50.6	7.5	41.9
Santiago del Estero	100	81.1	2.2	16.4
Tucuman	100	55.2	8.2	36.6
Tierra del Fuego	<u>100</u>	<u>90.7</u>	<u>0</u>	<u>9.3</u>
Total	100 ===	49.8 ===	5.5 ====	44.7 =====

2.47 As regards medical visits for 1980, there was a rate of 6.2 visits per inhabitant per year for the metropolitan region of Buenos Aires. On the national level and for 1984, within the public subsector there were the following yields: turnover of beds: 22.8; percentage of occupation of 70; and average stay of 11.2 days.



G. Health policy

- 2.48 In 1984, the Ministry of Health and Social Action drew up the General Health Plan, establishing the lines of the health policy within the process of the country's democratization and which in the context of the sector principally involves: (a) making equitable possibilities for access to better quality of health services; (b) guaranteeing broad popular participation and by the various interests sectors in programming and development of necessary activities; (c) overcoming current inequalities and discriminations which requires effective unity of the political leadership to orient the government's action, social works and the private area towards the common social objective which they should fulfill; (d) create a National Health System in order to accomplish coordination of various services and assure better utilization of resources.
- 2.49 These guidelines are based on acceptance of the concept of primary care which requires a reframing of the entire profile of the Health Services System, with the idea of solving at least in terms of complexity and quantity as far as possible in terms of meeting the health requirement.
- 2.50 Other strategy for becoming operational requires the following action lines:
- (a) Active participation of groups and community organizations on the sectoral and extrasectoral level.
  - (b) Real and effective decentralization consolidating provincial health systems.
  - (c) Full utilization of resources by means of prioritizing the services network whether public or social work assuring adequate mechanisms of referral.
  - (d) Incorporation on the first level of care of a programmatic content giving greater emphasis to health promotional preventive activities.
- 2.51 The General Health Plan aims at coming up with an answer allowing full exercise of the right to health through access and utilization of services on the basis of health requirements. For this purpose, the following conceptual framework has been identified:
- (a) In terms of doctrine, the need is indicated of shifting the axis for the care system from sickness to health emphasizing primary preventive actions and early diagnosis.
  - (b) Strategically, assumed as a nondelegatable function of the government is management of the system integrating under the same Ministry of Health and Social Action the National Social Works Institute (INOS) as well as other related social areas.

- (c) Tactically, expression is given to the intention of initiating a process of recuperation and modernization of public establishments in order that they can be incorporated under equality of terms into a health network system.
  - (d) Operationally, an attempt is made to produce basic changes such as: availability of services without time limits; simplification of administrative paperwork; adequate terms of care through improving of buildings, equipment and necessary input; and equality of care for all users.
- 2.52 The General Health Plan includes the following programs: (i) leadership; (ii) regulation and control; (iii) activities regarding persons and medium; (iv) prioritization of resources; (v) support for health (PAS) and (vi) emergency and national coverage programs. The Health Support Program (Fondos PAS) includes national assistance activities for provincial health programs, aiming at accomplishing a homogeneous development of the health area in the federal structure of the country and is the programmatic context in which hospitals in the Program will operate. The General Health Plan includes other programs of national coverage aimed at improving health conditions of the population among which are the following: (i) national food program (ii) gardens and farms program for self-supply; (iii) medicine assistance fund; and (iv) women, health and development program.
- 2.53 Financing of health services is done through the budget for the Ministry of Health and Social Action by means of the Secretariat of Health with funds coming basically from the General Fund of the Nation. As regards operational outlays, this Secretariat has budgetary allocations specific for national programs (food, medicines, etc.), control of endemic diseases (Chagas, etc.). Environmental programs, medical care programs, health services and the health support (PAS), among others. In 1983, 1984, 1985 and 1986, the Health Secretariat had significant budget increases going from US\$227 million in 1983 to US\$382 in 1986. This shows the importance given to the social sectors.
- 2.54 The National Government is engaged in gradually orienting health services towards establishment of a system, having consolidated financing, through structuring of the National Health Insurance in order to guarantee full enjoyment of the right to health for all inhabitants without social, economic, cultural or geographic discrimination. The National Health Insurance would adapt its actions to policies spelled out by the Ministry of Health and Social Action.
- 2.55 The National Health Insurance calls for articulating health activities of public services social works and private services in a single health services network respecting their individuality on the basis of the following principles: (i) comprehensive coverage; (ii) solidarity; (iii) pluralism; (iv) participation; and (v) federalism.

- 2.56 The authority for applying the National Health Insurance will be the Health Secretariat. Within its scope and replacing the current National Social Works Institute (INOS), the National Health Insurance Administration (ANSSAL) would become operative, as a organization in public right having a legal personality and authority and financial and administrative individuality.
- 2.57 The Draft of the "National Health Insurance Law" is being debated in Congress in the House of Representatives of the Nation and aims at ensuring financing for the System for personal care, prioritization of demand for services and creation of a network of coordinated services, among which recovery of the public hospital plays a preponderant role on the basis of accreditation and approval of their standards.

H. Bank activities in the health sector

- 2.58 Thus far, the Bank has not financed health programs and has only participated with funds from the Social Progress Trust Fund (SPTF), providing technical cooperation for monitoring and possible eradication of endemic diseases (Chagas, leprosy and Argentine hemorrhaging fever).

I. Summary and conclusions

- 2.59 The principal conclusions regarding the health situation are:
- (a) A health situation considered satisfactory in its national averages but having marked differences in the various provinces. See annex II-4, Health Indicators for the Provinces in the Program.
  - (b) An uncoordinated health sector having a public, private structure and social works structure. The public subsector has a broad network of services infrastructure but a secondary level (provincial hospitals) showing marked deterioration because of the degree of their obsolescence and an appropriate quality of health services with basic responsibility for caring for populations with limited incomes. The private subsector has considerable technology and is frequently located in the principal cities of the country. The social works subsector is characterized by a multiplicity of institutions and with internal inequalities in services offered to their affiliates.
  - (c) An appropriate magnitude of physical resources although it does exist especially in the public subsectors, but marked deterioration of their provincial hospitals.
  - (d) Adequate quantity of human health resources with acceptable provincial distribution but noting probable excess in terms of medicine doctors training.

- (e) Health policy which through its general plan, aims at strengthening decentralization by consolidating provincial health networks through integral (physical and functional) recovery of the public hospital. A change with greater focus on promotional and preventive activities radiating out from the hospital as the center of the system; and coordination among different subsectors for the purpose of better utilizing the resources, improving access to services, meeting demand, and obtaining better quality of medical care.

### III. THE PROGRAM. ITS COST AND FINANCING

#### A. Conceptual framework

- 3.01 As analyzed in chapter II, the country's services infrastructure in quantitative terms is adequate. But there do exist problems of poor performance, especially on the secondary level of the services network which is determined by the degree of obsolescence of the provincial hospitals and their inadequate organization of services. The Program which is proposed would contribute to improve performance of hospital care on a secondary level by strengthening its operational capability and improving the quality of care. It would be basically carried out on the provincial level although offsetting resources which would be used would come from the National Budget, from allocations already earmarked for provinces for implementation of works in the sector.
- 3.02 The Program is based on application of a series of guidelines which allow structuring a care model for physically and functionally rehabilitating the public hospital making it efficient and effective. This Program model depends on availability of full time personnel and will be organized on the basis of progressive care for the patient by developing new methods of care which would limit the upward trend towards traditional inpatient care, without causing risk to the patient.
- 3.03 The Program emphasizes strengthening operational capability and organization of new methods of care to meet demand and improve quality of services through providing medications, vaccinations and other inputs for the purpose of offering integral care (preventive and curative), most particularly to low income populations which provides no incentive for being cared for by the private sector.
- 3.04 These new methods of care would make it possible to increase coverage, without necessarily signifying an increase in the number of beds or inpatient patients since in some cases requirements for internment would be reduced and in other cases the average stay would be reduced by lessening waiting times both for diagnosis as well as for use of operating rooms. "Outpatient surgery" programs would substantially reduce the average stay of the patient to 48-72 hours for a good percentage of surgeries (hernioraphy; tonsillectomy, cataracts, etc.). Likewise, the "Day Hospital" system would mean fewer traditional intakes of patients who could receive their treatment in 12 hours even without using a traditional hospital bed (dialysis; anti-cancer therapy application; mental health problems, etc.).
- 3.05 The Program is focused on the level of general hospitals since it is considered that the primary care network is taken care of satisfactorily by the provinces and that the basic problem is encountered in referral hospitals which show marked physical and functional obsolescence (82 years of age on average). Although the rest of the primary network also calls for improvement, it was considered

absolutely essential to improve hospitals situated in the principal provincial cities for them to become normative and referral centers for the latter and to supplement health services which the private sector provides. The Program which is proposed is the beginning of the activities of a more complete process which in future will take in other provinces and would be the basis for establishing norms and guidelines for the health plan.

B. Program objectives

- 3.06 The Health Infrastructure Rehabilitation Program has as its objective to contribute to the start up of a process of hospital modernization, based on progressive development of a system of provincial health services improving the quality of care and assuring comprehensive coverage. Under this general objective, an effort is made to accomplish other objectives such as: (a) recover the physical health resource and adapt its organization and performance to meet demand and improve quality of care by reducing risk factors for the population; (b) strengthen the provincial health services network, especially establishments on a secondary level and with medium complexity; (c) develop a process for training the human health resource to optimize performance of services contributing to improvement in operational capability of health establishments; and (d) cooperate with the process of decentralization of services and health programs.

C. Description of the Program

- 3.07 The Program has two principal components: (a) construction and equipping of 11 provincial hospitals, for the care of short stay patients. One of the 11 hospitals is new (Neuquen) and 10 are replacements for present hospitals marked by their outstanding obsolescence and an average age of 82 years; and (b) institutional strengthening to improve performance of hospitals and operational capability of the Health Secretariat. The hospitals and the Program have the following characteristics:
- (a) Structurally all possess a common modular system in their standards with the same design standards: flexibility (nondifferentiated beds), functionability (progressive care for the patient, technological concentration), and possibility for future expansion with 30 percent as maximum;
  - (b) Organizationally, there are three medical care models with respect to the characteristics of each province (existing supply and demand);
  - (c) Functionally they have the same programming system: full time doctors; yields of four visits per doctor hour; bed turnover of 29.2 discharges; 80 percent occupation and 10 day average stay; and

(d) Operationally they all have an important institutional strengthening component to assure training of personnel and realize integral effectiveness of the establishment and its network of influence through programming of new methods of care (day hospital; home visit; outpatient surgery).

- 3.08 To carry out the Program, two subprograms have been proposed, one for construction and equipment and the other for institutional strengthening which are described after the criteria for selection and dimensioning, in numerals 4 and 5 of this section.

Pursuant to the Bank's policy, the hospital construction subprogram was treated as a global multiple-works program since its target goals do not depend on the number of hospitals built; and independent of each other; have similar economic and financial, operating and technical characteristics; and their final participation in the Program depends on compliance with previously determined eligibility criteria.

#### 1. Goals of the Program

- 3.09 The Program includes construction and equipment of 11 provincial hospitals with a approximate total of 3,000 beds.
- 3.10 As regards size of the establishment, the Program calls for there not to be fewer than 120 beds nor more than 350 in terms of the characteristics of each province and for the purpose of adapting the physical resource for process of effective management.
- 3.11 With respect to utilization of services, the Program calls for different yields than those currently in terms of national averages as follows:

<u>INDEX</u>	<u>Present hospitals National Average</u>	<u>Program Hospitals</u>	<u>Observations</u>
Occupation	70	80	Percent
Average stay	11.2	10	Days
Bed turnover	21.5	29.2	Discharges/year
Visits per doctor hour	2.5	4.0	Visits
Personnel per bed	2.4	2.7	Employees
Doctor's schedule	4 h	8 h	Per day

#### 2. Selection criteria

- 3.12 For selection of the cities where the hospitals will be located in the Program, basically three criteria were identified, moreover, taken into consideration were three determining factors.

3.13 The criteria include:

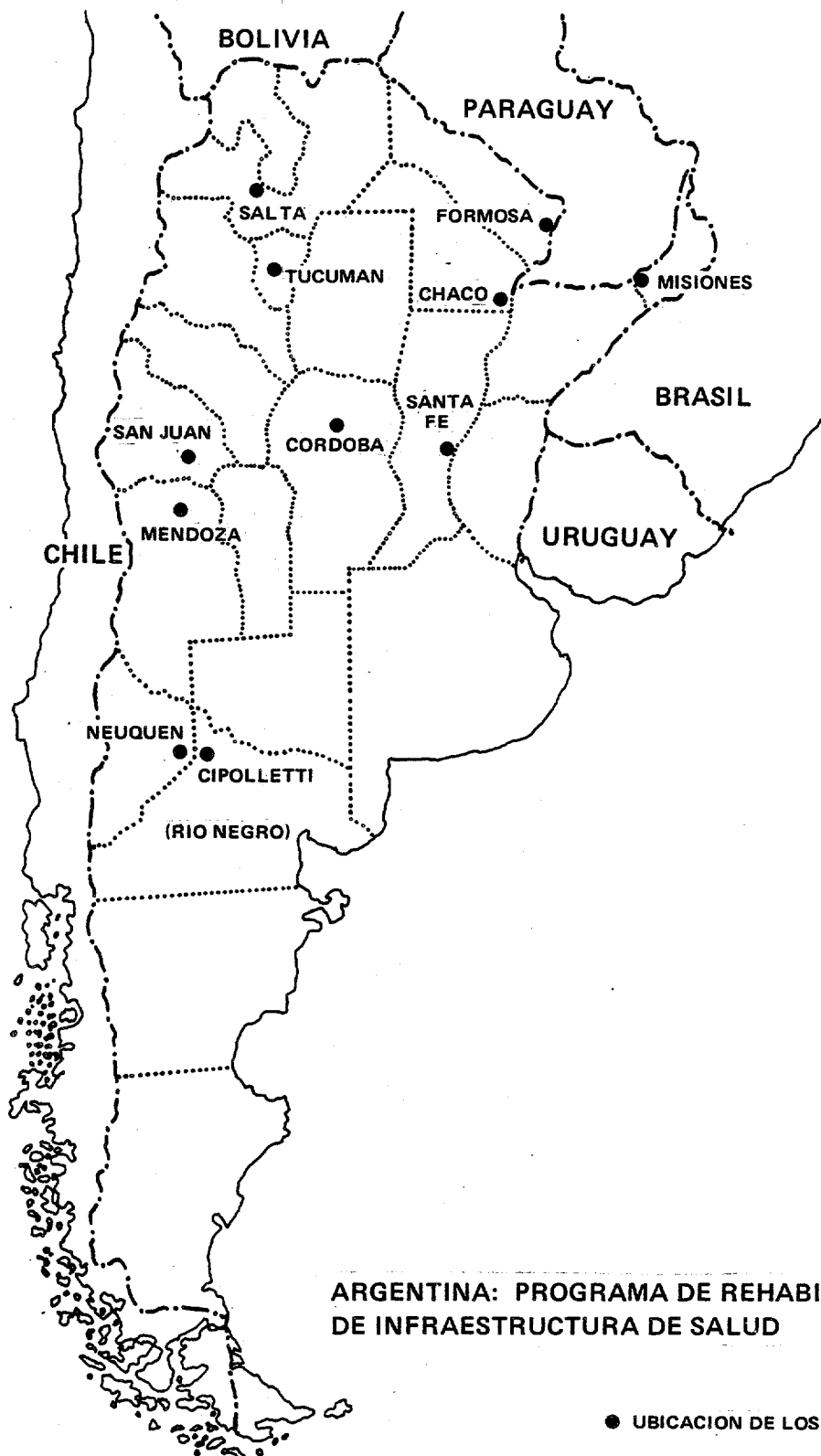
- (a) Physical and functional obsolescence of hospitals which showed marked deterioration in their physical plant and installations measured on the basis of their age and current operational situation.
- (b) Population having limited resources in the province. For this determination, a source that was used was INDEC data for 1980 showing household rates for a population having basic needs unsatisfied (BNU). The BNU criteria interrelates variables for: housing, health conditions, school assistance and general economic conditions of the family; and it was found that on the national level 22.3 percent of households at BNU, which meant that 27.7 percent of the population of the country did.
- (c) The third criterion was location in provincial main cities or in cities having greater development on the provincial level. This criterion was adopted on the basis of the fact that the new hospital should be capable not only of supplying demand but influence in the entire services network for the province in normative aspects, in the development of programs and training of human resources in services. On the other hand, adoption of this criterion allows and encourages development of the provincial health system as a product of health decentralization.

3.14 Among the determining factors that were taken into account were: (a) amount of population of the province and its capital; (b) demographic growth rate and that of the city and province; and (c) infant mortality rate.

3.15 All the provinces were arranged (except Buenos Aires and the Federal Capital) on the basis of the criteria abovementioned and the following priorities were arrived at: (1) Chaco, (2) Salta, (3) Misiones, (4) Tucuman, (5) Formosa, (6) Rio Negro, (7) Mendoza, (8) San Juan, (9) Santa Fe, (10) Cordoba, (11) Neuquen, (12) Chubut, (13) Jujuy, (14) Corrientes, (15) Catamarca, (16) Santiago del Estero, (17) La Rioja, (18) Entre Rios, (19) La Pampa, (20) San Luis, (21) Santa Cruz, (22) Tierra del Fuego.

3.16 At first, the initial 16 provinces were defined as being a subject for the Program and after the financial size was analyzed for the possible Program this was reduced to 12 by eliminating Jujuy, Corrientes, Catamarca and Santiago del Estero, whose hospitals did not show physical conditions of as great deterioration as the first 12. Afterwards, Chubut was eliminated which was a hospital that had been programmed for 90 beds and where the province in 1985 had begun the process of bidding for civil construction. The provinces that have been selected in principle reflect the following regions: (a) Northeast, three provinces: Chaco, Formosa, Misiones; (b) Northeast, two





provinces: Salta and Tucuman; (c) Cuyo, two provinces: San Juan and Mendoza; (d) Pampa: two provinces: Neuquen and Rio Negro as indicated in the map on the following page.

3.17 Given below are data for the 11 provinces that were selected:

Province	Order of priority	Population 1/	% with B.N.U. 2/	Current age of hospital to be replaced 3/	Current hospital beds 4/	"Acute" beds	"Chronic" beds 5/
Chaco	1	701,392	51.3	76 years	529	459	70
Cordoba	10	703,571	32.3	92 years	208	208	
Formosa	5	295,887	53.8	61 years	283	255	28
Mendoza	7	1,196,228	24.0	90 years	200	200	-
Misiones	3	588,977	44.7	70 years	310	296	14
Neuquen	11	243,850	38.3	new	-	-	-
Rio Negro	6	383,354	38.0	85 years	77	77	-
Salta	2	662,870	26.4	102 years	576	526	50
San Juan	8	465,976	22.6	66 years	536	526	10
Santa Fe	9	2,465,546	22.0	82 years	418	418	-
Tucuman	4	972,655	31.0	105 years	453	446	7
TOTAL		8,680,306		82.9	3,590	3,411	179

- 1/ Thirty one percent of population directly and indirectly benefited. The population of Cordoba is the least in 15 years.
- 2/ Only 3 of the 11 provinces have values below the national average (Cordoba, Tucuman and Santa Fe).
- 3/ Average age of the 10 hospitals to be replaced is 82.9 years with minimum values in Formosa (61) and maximum in Tucuman (105 years).
- 4/ Mendoza hospital was destroyed by the 1985 earthquake. At present it does not have a single bed.
- 5/ Of total "chronic" beds, 112 are for tuberculosis, 40 for psychiatry, 20 for convalescence and 7 for dermatology (leprosy).

The hospitals in the provinces selected are complexity VI establishments except for Rio Negro which is complexity IV.

3.18 The health physical resources situation in the 11 provinces in 1980 is as indicated in next page:

Province	Rate of beds per 1,000 inhabitants	Number of beds by subsectors			Total
		Public	Private	Social works	
Chaco	4.1	1,871	991	12	2,854
Cordoba	6.8	9,774	5,870	674	16,318
Formosa	3.4	718	280	-	998
Mendoza	4.5	3,431	1,464	507	5,402
Misiones	3.9	1,249	1,049	6	2,304
Neuquen	6.3	996	404	147	1,547
Rio Negro	5.1	1,302	586	74	1,962
Salta	5.8	2,758	922	177	3,857
San Juan	3.9	1,481	218	140	1,839
Santa Fe	5.5	7,018	6,031	641	13,690
Tucuman	4.6	2,910	1,208	355	4,473
Total		33,488	19,023	2,733	55,244
		=====	=====	=====	=====
Percentage		60.7%	34.4%	4.9%	100%

3.19 In general, the hospitals in the public subsector show poor performance because of their obsolescence; and they are usually the ones with the largest amount of beds in the cities taking care of "acute" and "chronic" patients. Private subsector establishments usually are small (on average 40-50 beds) and especially intended for caring for patients with "acute" illnesses or of short stay and located in the principal cities.

3.20 The hospitals that are to be replaced were constructed by systems of 30 patient wards in common rooms; wards separated from one another with uncovered circulation for the most part and exposed to climatological conditions. The 1985 earthquake completely damaged the hospital of Mendoza which was demolished; and it partly damaged the hospital of San Juan. The hospital of Cipolletti (Rio Negro) suffered damaged in 1985 to its physical plant and patients had to be located in three separate houses with areas that had been adapted but were completely nonfunctional. All the hospitals have a proven obsolescence and a brief description of these is given in annex III-8.

3.21 As regards production of the hospitals to be replaced, the present table indicates the comparative situation with hospitals in the Program.

<u>INDEX</u>	<u>Current hospitals 1984 average</u>	<u>Program hospitals</u>
Visits	1,607,670	2,696,960
Visit per hour	3.0	4.0
Beds	3,471	2,977
Discharges	91,434	86,929
Bed turnover	23.8	29.2
% occupation	75	80
Average stay	11.5	10
Personnel per bed	2.2	2.7
Hours per doctor per day	4	8

3.22 An important aspect to be noted in the operation of the hospitals to be replaced is the type of services. By not providing medicines or having available appropriate methods for diagnosis and treatment, these place at risk care for the patient. In this regard, the high rate of hospital mortality noted is indicative since according to 1984 data, eight of the hospitals showed indices surpassing the value which is considered normal (4 percent) and some of them showed frankly high rates of 7.6 percent, 8.2 percent and up to 13.6 percent.

3.23 This leads us to two considerations: on the one hand, since they are hospitals of more complexity in the provinces, they receive the most complex and serious cases of the entire province which, logically, those most exposed to the risk of dying; but the other consideration is that the rates are so high because they probably are due to the poor performance of services because of the exposed conditions of current physical and functional obsolescence.

3.24 As regards future use of the nine current buildings, four will be demolished, the other five will be partly used: three (Chaco, Santa Fe and Rio Negro) for care of the chronically ill. Two (Formosa and Misiones) will be used for administrative and technical offices of other agencies of the Provincial Health Ministry. It was agreed that in the provincial participation contracts will be established that the old hospitals are not to be continued in use, with the following exceptions. Given below is an explanation of the three that will have medical care for the chronically ill (psychiatry, geriatrics, convalescence):

<u>HOSPITAL</u>	<u>BEDS</u>	<u>ANNUAL EXPENSE</u>	<u>RESPONSIBILITY</u>
Chaco	40	176,550	Ministry of Health and Social Welfare
Santa Fe	30	128,325	Ministry of Health and Social Welfare
Rio Negro	<u>30</u>	<u>128,325</u>	Ministry of Health and Social Welfare
Total	100 ===	433,200 =====	

Fifty of the 100 beds will be for geriatrics, 35 for psychiatry; and 15 for convalescence.

- 3.25 As regards use of current equipment, it is estimated that 20-25 percent could be used in the new hospitals since this is equipment that was acquired during the past two years. The rest will be redistributed (if possible) in other health services in the interior of the provinces.

### 3. Dimensioning criteria

- 3.26 Once location has been defined for the eleven hospitals in the Program, dimensioning of the establishments was undertaken in accordance with:
- (a) analysis of demand carried out on the basis of: services deficit projections for the city and area of influence for 1995 and 2000; use of demographic projections of the INDEC on the basis of the 1980 course; and estimate of other hospitals within the area of influence.
  - (b) Formulation of a "functional medical" program for each establishment which would constitute a response to the health necessities of the population.
- 3.27 The dimensions for each of the eleven hospitals were established in the light of those criteria. A cost-efficiency was made for six of them that would be located in three of the five participating regions. In four of those six hospitals mentioned, including the pediatric hospital at Cordoba, the costs, and final architectural and engineering designs were analyzed. For the seven remaining hospitales included in the Program, the preliminary architectural designs and plans (at final stage) were analyzed to determine the costs thereof. The figures cited indicated that a representative sample of the Program was analyzed in terms of: demand (100%); cost and architectural design (40% at final level and 60% at preliminary design level); equipment (100%); and cost-efficiency analysis (55%).
- 3.28 The medical program which was formulated for each hospital is the instrument which first determined: (a) the number of beds, external offices, auxiliary diagnostic services, treatment services and technologies, general services and support services; (b) requirements for specific dimensioning for internment, outpatient, laboratory, x-ray, surgery center, obstetrics center, intensive care, newborn, and other services (laundry, nutrition and dietetic, etc.); (c) basic elements with surfaces and standards for drawing up the architectural design so as to assure maximum functionability possible. In annex III-1 is given a guide to the contents of the functional medical program for each province.

- 3.29 In this way, three models could be structured relating on the one hand the number of beds of the establishment, on the other, the complexity of the services. Basically, the models are: "A" 300 to 350 beds; "B" 200 to 300; and model "C" 100 to 200 beds (see annex III-4).
- 3.30 As regards the number of beds and complexity of each hospital in the Program, the following table gives us the following data:

<u>Hospital</u>	<u>Beds</u>	<u>Type</u>	<u>Complexity</u>
Chaco	338	general	VIII
Cordoba	293	pediatric	VIII
Formosa	304	general	VIII
Mendoza	220	general	VIII
Misiones	322	general	VIII
Neuquen	120	general	VI
Rio Negro	120	general	VI
Salta	322	general	VIII
San Juan	338	general	VIII
Santa Fe	288	general	VIII
Tucuman	312	general	VIII
Total	2,977		
	=====		

#### 4. Equipment and construction subprogram

- 3.31 This subprogram consists in constructing and equipping 11 hospitals, 10 of which are replacement establishments and one is new (Neuquen). As regards the assistance which they provide, 10 are general hospitals with the four basic specialties (medicine, surgery, pediatrics, obstetrics and gynecology) and having medical and surgical specialties. One of the 11 is a general hospital for the care of children (Cordoba).
- 3.32 The architectural design of each hospital was based on the requirements of the medical program and structures the different units or hospital services with a spatial distribution which allows: functionality; flexibility; future growth possibility of 30 percent as planned; and technological concentration in areas of progressive patient care.
- 3.33 This design was programmed for a maximum of 350 beds providing for expansions of two or three inpatient modules thus avoiding the establishment of institutions having more than 400 beds which are complex and difficult to administer. The inpatient module that is used has 34 beds on the basis of 16 rooms with two beds each with a bath shared by two rooms; and two individual rooms for specific isolation situations.

- 3.34 The design was done on two levels (floors) 1/, including in general terms the following functional areas: (a) first floor: front section: administrative services; medical records; social service; external offices. middle section: diagnostic services; treatment services and special units (surgical center; obstetrical center; intensive care; emergency; newborn). Back section: differentiated access; general services; laundry, kitchen, cellar; (b) second floor: as far as possible, all inpatient services.
- 3.35 Although they are not prototypes, the designs do have in common the "primary areas of the hospital" (diagnostic and treatment areas); with the hospitalization units varying depending on the bed requirements of the medical programs of each province. Characteristics of the designs that have been developed take into account weather, seismic conditions and availability of materials and technology in each province.
- 3.36 As regards location of the sites where the hospitals are going to be built, the following variables exist: (a) sites on a new location independent of the current hospital in six locations: Cordoba, Formosa, Neuquen, Rio Negro, Santa Fe and Tucuman; (b) location of sites adjacent to current hospital and two localities: Chaco and Misiones; and (c) location on same site of current hospital in three locations: Mendoza, Salta and San Juan. In annex III-3, a more specific description is provided of the conditions of each site.
- 3.37 The architectural program for each hospital has the following dimensioning and direct costs:

<u>Hospital</u>	<u>Beds</u>	<u>Surface in M2</u>	<u>Cost of construction*</u>	<u>Cost M2</u>	<u>M2 per bed</u>	<u>Cost per bed (\$000)</u>
Chaco	338	24,573	15,057	613	72	44.5
Cordoba	293	21,718	13,082	602	74	44.6
Formosa	304	20,357	12,339	606	66	40.6
Mendoza	220	18,562	11,024	594	84	50.1
Misiones	322	20,730	12,479	601	64	38.7
Neuquen	120	8,913	5,421	608	74	45.2
Rio Negro	120	8,913	5,421	608	74	45.2
Salta	322	21,044	12,690	603	65	39.4
San Juan	338	26,394	16,279	617	78	48.2
Santa Fe	288	19,733	11,810	598	68	41.0
Tucuman	312	25,300	15,544	614	81	49.8
Total	<u>2,977</u>	<u>216,237</u>	<u>131,146</u>	<u>606</u>	<u>72</u>	<u>44.1</u>
	=====	=====	=====	=====	=====	=====

\* Not including costs of: boilers; generators; telephone exchanges; elevators; air conditioning.

1/ Cordoba is the only design which because of characteristics of the elevation of the terrain will have a design including two levels and a mezzanine.

- 3.38 As regards equipment, the Program will acquire an estimated 75-80 percent of the hospital equipment because of the fact that in the current hospitals there are medical and nursing instruments as well as some diagnostic components that have been acquired in the past two years and are still within their useful operational life.
- 3.39 Program resources will be used to acquire basic equipment which necessarily will have to be replaced and which has been classified into 30 categories organized into the following groups:
- (a) Fixed equipment, installed during the civil construction basically including: elevators, boilers and pumps, generators, telephone exchanges, air conditioning, transformers, etc. (built into the construction).
  - (b) Fixed medical equipment including x-ray units, surgical tables, overhead lights, anesthesia equipment, gas installations, autoclaves; etc. (see annex III-3).
  - (c) Mobile medical equipment including beds, stretchers, wheelchairs, laboratory equipment, intensive care equipment, stainless steel tables, incubators, etc.
  - (d) Equipment for administrative services and general equipment including: various furniture, typewriters and calculating machines, minicomputers, cleaning equipment, vehicles, etc.

5. Institutional strengthening subprogram

- 3.40 The institutional strengthening subprogram aims at optimizing operational capability of the hospital and the network of services under its influence; and improve quality of care, by adjusting physical resource with functionability of the establishment. Through this component, duly articulated with that of the physical resource, the aim is to achieve modernization of the provincial public network services. This modernization will be accomplished through technological transfer and training afforded through consultancies, courses and seminars, national level scholarships, short term scholarships (maximum four months) in other countries with similar situations.
- 3.41 The institutional strengthening subprogram would be developed on two levels: on the level of the 11 provinces (with an approximately 90 percent of resources); and on the central level with an estimated 10 percent of resources for training on the level of the Health Secretariat (see annex III-5).
- 3.42 On the provincial level, the following training areas have been identified:
- (a) Maintenance, to assure operation of installed capability.



- (b) Organization of Health Services including activities to organize: opening of hospital and all its services, external office, inpatient, surgical center, laboratory, x-ray, administration, etc.
  - (c) Hospital administration to train personnel in aspects of management conduct.
  - (d) Health statistics and data systems for design of a production, collection, tabulation, presentation and distribution process for data to be converted into hospital indicators that are reliable and operational for making decisions. And the developing of records for patient identification.
  - (e) Operational health service technologies to analyze the operation of the hospital and the services network in its entirety. Utilization of services and improvement of quality of hospital medical care.
  - (f) An accounting and financial system to update and modernize the entire accounting process (account books, costs, etc.) and develop a financial statement by health programs and activities.
  - (g) Medical and paramedical training to update knowledge for residents, doctors, nurses and technicians.
- 3.43 The institutional strengthening component will be developed (at 10 percent of the allocation of resources) for improvement of operational capability of the Health Secretariat at the central level in the following areas: accounting and financial systems, managerial systems, and health services systems.

D. Cost and financing

- 3.44 The total cost of the Program is estimated at the equivalent of US\$300 million. A summary is provided of the budget broken down by the different investment categories and sources of financing is the following table:

COST AND FINANCING  
(In millions of US\$) 1/

	Loan		Supplier	Local	Total	%
	F.Exch.	L.CURR.	credit	contribution		
1. <u>Engineering and administration</u>	-	0.80	-	10.44	11.24	3.75
1.1 Central executive unit	-	0.80	-	6.08	6.88	
1.2 Provincial executive units	-	-	-	4.36	4.36	
2. <u>Direct costs</u>	96.58	-	28.42	111.40	236.40	78.80
2.1 Constructions	82.58	-	-	73.69	156.27	
2.2 Equipments for buildings	14.00	-	-	-	14.00	
2.3 Medical and hospital equipment	-	-	28.42	37.71	66.13	
3. <u>Concurrent costs</u>	0.80	3.64	-	18.01	22.45	7.48
3.1 Institutional strengthening	0.80	3.64	-	4.29	8.73	
3.2 Endowment in medicines and materials	-	-	-	7.88	7.88	
3.3 Increase costs of operation	-	-	-	5.84	5.84	
4. <u>Financial outlays</u>	22.62	0.56	-	6.73	29.91	9.97
4.1 IDB Interests	21.42	0.51	-	-	21.93	
4.2 IDB commitment commission	-	-	-	4.02	4.02	
4.3 FIV	1.20	0.05	-	-	1.25	
4.4 Supplier credit interest	-	-	-	2.71	2.71	
Total	120.00	5.00	28.42	146.58	300.00	100.00
Percentage	40.0	1.67	9.47	48.86	100.0	

3.45 Below is described the basis on which were computed costs for each component of the budget.

1. Engineering and administration (US\$11,240,000)

3.46 To determine these costs, account has been taken of: (a) outlays made by the UEC in preparing the draft projects and final designs for the four sample projects from July 8, 1986, the date on which the request for the loan was made, and the expenditures that will have to be made

1/ Prices are for June 1986 and the rate of exchange that was used was US\$1 = 0.928 australs.

in order to complete final designs for the architectural drafts for the seven hospitals not yet in final designs. (b) The expenses that the UEP will make during the period of construction for the hospitals for inspection and supervision of the construction work determined on the basis of the costs for managerial, administration and engineering personnel that will be contracted specifically for the project; and (c) administrative costs by the UEC which include those for supervision and consultancy for the participating provinces in the aspects mentioned under paragraph (b) above. The costs were determined on the basis of wages that those personnel shall receive on per diems and travel expenses and general administrative expenses of the executive units, in annex III-7 the itemized budgets for the same are presented.

2. Direct costs (US\$236,400,000)

3.47 The Program has the following dimension relative to direct construction and equipment costs:

<u>Hospital</u>	<u>Construction cost</u>	<u>Cost of equipment in buildings</u>	<u>Cost of hospital medical equipment</u>	<u>Total</u>
Chaco <u>1/</u>	17,847	1,600	7,804	27,251
Cordoba <u>1/</u>	15,498	1,290	6,587	23,375
Formosa <u>1/</u>	14,722	1,290	6,084	22,096
Mendoza	13,199	1,200	4,861	19,260
Misiones <u>1/</u>	15,610	1,420	6,414	23,444
Neuquen	6,804	670	3,600	11,074
Rio Negro	6,804	670	2,777	10,251
Salta	15,654	1,420	6,018	23,092
San Juan	18,933	1,600	8,098	28,631
Santa Fe	14,109	1,420	5,580	21,109
Tucuman	17,090	1,420	8,307	26,817
Total	<u>156,270</u>	<u>14,000</u>	<u>66,130</u>	<u>236,400</u>
	=====	=====	=====	=====

3.48 Construction costs were estimated on the basis of itemized costs for the three hospitals in the architectural sample Chaco, Formosa and Misiones which have definitive designs. Moreover, the costs for construction of the hospital of Cordoba was estimated on the basis of itemized costs. This analysis resulted in an average per square meter which is reasonable for this type of construction in Argentina. This unit cost was adjusted for escalation and contingencies at 12 percent in estimating the equivalent of US\$170.27 million for the costs of the 217,180 square meters of construction required for the 11 hospitals including equipment for the building.

1/ Projects from the architectural sample and Cordoba Hospital have a direct total cost equivalent to US\$96.2 million representing 40.7 percent of total cost.

- 3.49 Costs for hospital equipment were determined on the basis of the itemized list drawn up for each hospital in the Program according to the items listed in annex III-3 using recent specialized international catalogs, PAHO experience and recent purchases made in the country. Moreover, the costs were adjusted at 15 percent for contingencies, 8 percent for escalation and 5 percent for internal transportation, storage and installation. The total cost of equipment for hospitals is estimated at the equivalent of US\$66.13 million.

3. Concurrent costs (US\$22,450,000)

- 3.50 Concurrent costs have three basic components: (a) institutional strengthening including (i) training for personnel in the provinces who will be responsible for the hospitals and improvement of provincial health systems; with such effects being estimated at a cost of US\$5.5 million and training in financial, accounting and managerial matters at the level of the Health Secretariat at a cost of US\$0.5 million; and (ii) is the cost for personnel and other services required to develop the administrative and accounting systems and to start them up during the process of delivery of the 11 hospitals by the UEC to the provinces estimating the cost for this component at the equivalent of US\$2.73 million. Costs were estimated by using fees currently being paid to national and international consultants in the country. In annex III-5, itemized costs are given for the training component and itemized costs for the start up component in both cases 10 percent was added for contingent costs; (b) the inventory of medicine and hospital materials totaling six months supplies of medicines and other materials for each hospital have a total amount equivalent to US\$7.88 million; and (c) incremental operational costs required by the hospitals of Cordoba, Misiones, Neuquen, Rio Negro, Santa Fe and Tucuman during the period for implementation of the project, estimated at US\$5.84 million on the basis of the time table for implementation and anticipated costs increase.

4. Financial costs (US\$29,910,000)

- 3.51 Financial costs were estimated on the basis of the time table for disbursement of the loan from the Bank estimating interest at 8.0 percent to the resources in foreign exchange of the Ordinary Capital and other financial outlays in accordance with what has been indicated in paragraph 3.54 in this chapter.

5. Financing program

(a) Bank loan

- 3.52 It is proposed a loan for a total amount of US\$125,000,000 resources of the Ordinary Capital, of which US\$120,000 will be in foreign currency and the equivalent of US\$5,000,000 will be in local currency. The foreign currencies of the loan that is proposed reflects 40 percent of the cost of the Program. This percentage is the maximum

that is authorized for projects in the Urban Development and Social Infrastructure Sector in Group A countries and will be used to partially finance construction contracts for the hospitals, payment of international consultants and foreign scholarships envisioned in the institutional strengthening subprogram, payment of interest and the corresponding Inspection and Oversight Fund (FIV) of the Bank.

3.53 The Ordinary Capital resources, in local currency, will be used to contract national consultants, make outlays for training of personnel in the country and payment of interest and corresponding FIV.

3.54 The terms that are proposed for financing are:

<u>Currency</u>	<u>Foreign currency</u>	<u>Local</u>
Total amount (millions)	US\$120.0	Eq. US\$5.0
Period of amortization	25 years	25 years
Period of disbursements	5 years	5 years
Grace period	5 years	5 years
Interest	Variable <u>1/</u>	4% annually
Commission	1 1/4% annually <u>2/</u>	--
FIV (on total amount)	1%	1%

(b) Supplier financings

3.55 Provision has been made for supplier financings for acquisitions of required imported equipment and it is estimated that it is possible to obtain financing for 85 percent of total amount of said acquisitions with a guarantee from the Ministry of Economy. The Executor has received various proposals from interested firms. However, it is proposed that any loan contracts contain provisions such that before first pay out the lender through the executor presents the Bank with an updated documented report containing offers received and regarding the possibility of financing by suppliers and/or export agencies or alternatively provide another source of financing (see Draft Resolution).

(c) Local contribution

3.56 The local contribution reflects budget funds of the Executor and the allocation of funds from the Health Support Program (Fondos PAS) earmarked for investments in the participating provinces during the period for the implementation of the Program. Financed with such resources are: (a) all engineering and UEC costs; (b) part of the costs for

1/ Interest will be adjusted in accordance with Bank policies.

2/ The Commitment Commission would be collected on the portion of the loan not disbursed.

construction of the hospital; (c) part of the equipment imported in all nationally manufactured equipment required for hospitals; (d) start up costs for the hospitals included in the institutional strengthening component; (e) supplier credit interests and (f) Bank commitment commission.

E. Recurrent costs

- 3.57 An itemized study was made of the operational costs for the purpose of measuring the effect of recurrent costs of the Program on the budgets of the participating provinces based on the standardized model described in the conceptual framework item and the goals of the Program. The Program establishments will need an operational budget which in total for the 11 hospitals amounts to US\$42,675,374 annually distributed as follows:

<u>Hospital</u>	<u>Personal services</u>	<u>Non-personal services</u>	<u>Medicines and materials</u>	<u>Food-stuffs</u>	<u>Maintenance</u>	<u>Total</u>
Chaco	3,033,732	503,000	1,317,127	243,390	212,000	5,309,249
Cordoba	2,567,344	313,000	1,063,739	208,350	160,000	4,312,433
Formosa	2,836,535	496,000	979,088	223,530	267,000	4,802,153
Mendoza	1,745,705	259,000	678,394	158,410	124,000	2,965,509
Misiones	2,067,845	496,000	1,143,638	231,110	172,000	4,110,593
Neuquen	1,444,105	155,000	467,380	83,950	88,000	2,238,435
Rio Negro	1,444,105	155,000	467,380	83,950	88,000	2,238,435
Salta	2,488,850	391,000	1,157,746	231,110	224,000	4,492,708
San Juan	2,170,740	303,000	1,317,127	243,390	172,000	4,206,257
Santa Fe	2,401,620	309,000	863,714	208,350	176,000	3,958,684
Tucuman	1,987,826	317,000	1,338,824	225,270	172,000	4,040,920

- 3.58 Presented below is the expected production based on standardized specifications of the medical program.

<u>Hospital</u>	<u>Beds</u>	<u>Doctors Offices</u>	<u>Discharges</u>	<u>Out Patients Visits</u>
Chaco	338	40	9,870	313,600
Cordoba	293	36	8,556	282,240
Formosa	304	29	8,877	227,360
Mendoza	220	20	6,424	156,800
Misiones	322	36	9,402	282,240
Neuquen	120	18	3,504	141,120
Rio Negro	120	18	3,504	141,120
Salta	322	40	9,402	313,600
San Juan	338	40	9,870	313,600
Santa Fe	228	24	8,410	188,160
Tucuman	312	32	9,110	337,120
Totals	2,977	344	86,929	2,696,960
	=====	====	=====	=====

3.59 On the basis of the data in the preceding tables, allotments for outside office visit and for inpatient care are obtained as well as unit cost per visit and discharge.

<u>Hospital</u>	<u>Total budget</u>	<u>Allocated for visit</u>	<u>Allocated for in-patient</u>	<u>Cost of visit</u>	<u>Cost of discharge</u>
Chaco	5,309,249	1,858,237	3,451,012	5.92	349.65
Cordoba	4,312,433	1,509,352	2,803,081	5.34	327.61
Formosa	4,802,153	1,680,754	3,121,399	7.39	351.62
Mendoza	2,965,509	1,037,928	1,927,581	6.62	300.05
Misiones	4,110,593	1,438,708	2,671,885	5.10	284.18
Neuquen	2,238,435	783.452	1,454,983	5.55	415.23
Rio Negro	2,238,435	783.452	1,454,983	5.55	415.23
Salta	4,492,706	1,572,447	2,920,259	5.02	310.59
San Juan	4,206,257	1,472,190	2,734,067	4.70	277.00
Santa Fe	3,958,684	1,384,540	2,573,144	7.36	305.96
Tucuman	4,040,920	1,414,322	2,626,598	4.20	288.32

#### IV. EXECUTION OF THE PROGRAM

##### A. Execution procedure

- 4.01 The Ministry of Health and Social Action will be the executing agency of the Program, through the Secretariat of Health Care. The Secretariat does not have any recent experience nor personnel trained in planning, constructing and putting into operation a large number of hospitals of the complexity of those proposed in this case; however, it has contracted a working group which will help in drafting the Program, and this working group will be assisted by personnel having experience in: management, work supervision and personnel training, for the purpose of making up the Central Executive Unit (CEU). The Secretariat has engaged personnel who have experience in designing and constructing hospitals for the final designs of the works, and some of the architects and engineers who participate in the design work are planned to remain with the Unit to supervise the execution of the Program.
- 4.02 The construction of the works will be contracted for by means of international public requests for proposals, and the contracts will be supervised by the Provincial Executive Units (PEU), which are to be set up by engaging personnel with specialized qualifications and using personnel, having construction experience, in the Secretariats of Health Care and/or Public Works from each province participating in the Program, under the supervision of the Central Executive Unit. The equipment for the hospital will be acquired by the Central Executive Unit through public requests for proposals and/or supplier financing at reasonable prices. Institutional support is basically to be provided by national and international consultants engaged by the CEU, who are to prepare the basic designs for management and accounting systems for the new hospitals, provide service training, hold specific short-term seminars and assist in putting the hospitals into operation. In addition, plans have been made to send management personnel, and personnel specializing in maintenance, to spend short periods of time in hospitals in the country and abroad; these personnel are to join the staffs of the new hospitals which are to be built.

##### B. Creation of the Program

- 4.03 Formally, the Program will be instituted through a Decree of the National Executive Power which is to approve the loan contracts of the Bank and to establish the Central Executive Unit of the Program within the framework of the Secretariat of Health Care of the Ministry of Health and Social Action, and in addition a special account will be created in the national budget to administer the resources of the Program. This special account is to be administered by the Central Executive Unit and is to have independent and detailed accounting; the



funds from the bank loans and the local counterpart are to be deposited in it. The special account will be separated from the funds of the general account for purposes of financial and accounting control, and its resources are to be allocated by the treasury section of the Secretariat of Health Care solely for the specific expenses of the Program.

- 4.04 Chapter II explained the autonomy which the provinces have from the Federal Government; consequently, there has to be an agreement between each participating province and the Ministry of Health and Social Action for the execution of the project. While the Program was being drawn up, discussions were held among the parties, and a draft agreement was made according to the model which is to be signed, which is presented in Annex IV-1, and the main characteristics of which are: (a) the province pledges to: cede in commodate the land for the construction of the hospital, to monitor and supervise the contracts for the work, to assign the personnel for training to operate and maintain the projected hospital according to the general accepted standards; and to agree that the contributions for the Expenses of the Health Care Support Program (PAS Funds), which the Federal Government is to make for five years or more, are intended to be a local contribution to the construction and outfitting of the hospital; and (b) the Ministry of Health pledges to: construct and outfit the hospital with medical equipment, provide technical assistance in and supervision of the execution of the works, provide institutional support and deliver the hospital in operational condition to each participating province.
- 4.05 The signing of the agreements with the provinces is to be done after the financing is approved and it is recommended that, as a prior condition for the first disbursement, the loan contract include a clause which states that the borrower submit the final contract signed with one of the provinces, which is to be basically in conformity with the model in Annex IV-1. It is also recommended that within a period of 18 months starting as of the date of the loan contract, the executor submit evidence to the bank that all of the participating provinces have signed the participation agreement (see the draft of the Resolution and Recommendations).

C. Organization for execution

1. Central Executive Unit (CEU)

- 4.06 The CEU is to be directly subordinated to the Secretary of Health, is to be headed by an executive manager appointed by the Secretary of Health and is to be staffed by permanent personnel assigned exclusively to the Program. The director of the CEU will be responsible for the general scheduling of activities, management of resources and coordination of the execution of the Program with the participating provinces. Annex IV-2 shows the organization of the CEU, which is summarized in the following sections and is described in Annex IV-3.

- 4.07 The CEU is to have three permanent advisors; and two operational departments, which are to be responsible for the execution of the construction and equipment subprogram and the institutional support subprogram, respectively; and a management and programming department; their functions are presented in detail in Annex IV-3 and are summarized below.
- 4.08 The three permanent advisors to the Executive Director of the CEU are to be: (a) legal advisor who are to be responsible for providing advice on the contracts and agreements with the provinces participating in the Program; (b) health care policy advisor, who are to advise on the medical aspects of the Program; and (c) evaluation advisor, who will advise on the progress of the Program, make Ex-ante economic evaluation of the hospitals which are to be included in the Program, draw up the operating procedures and coordinate the information needed for the evaluation ex-post of the hospitals which are constructed.
- 4.09 An Advisory Committee to the CEU is to be established which will be headed by the Secretary of Health Care and integrated by the head of the CEU and the heads of the Provincial Executive Units. This committee will meet periodically for the purpose of jointly reviewing the development of the Program, exchanging experience with respect to its execution and coordinating the training aspects which are being carried out jointly in different provinces.
- 4.10 The Department of Construction and Equipment is to have three units, which are to be: (a) Architecture and Engineering; (b) Bid Submission and Contract Management; and (c) Hospital Equipment. The department is to be responsible for carrying out the construction and equipment subprogram. For this purpose, it is to have the following main functions: (a) preparing the bid documents for the civil engineering works of the hospitals and for the medical equipment; (b) carrying out the cause for quotations: prequalification, request for proposal, negotiation and preparation of the contracts for the execution of the works and purchase of the equipment; (c) monitoring the progress and quality of the works which are being carried out and programming and monitoring of the contracts; (d) solving the design and execution problems which may arise during construction; (e) endorsing the payments to the contractors issued by the Provincial Executive Units (see section 4.14); and (f) receiving and installing the medical equipment procured for the hospitals.
- 4.11 The Health Care Services Department is to be responsible for carrying out the entire institutional support subprogram; its director is to be an expert in hospital administration and would be the person who handles the basic training Program in the area of management and administration. The department is to have the following functions: (a) developing the detailed terms of reference for all of the individual consultants; (b) selecting and engaging the consultants;

(c) approving the instruction programs which are to be used in the training seminars; (d) coordinating the short courses and seminars which it is to hold on the national level, for which purpose it is to be given the support of the Health Care Services Subsecretariat; (f) supporting the provinces in the short courses and seminars which are to be held in each of them; (g) coordinating the training visits and trips which selected officials are to make in Argentina and abroad; (h) designing the Program for putting each hospital into operation, in coordination with the corresponding Provincial Executive Unit; (i) exerting technical control over the Institutional Support Subprogram.

- 4.12 The Management and Programming Department is to have three sectors: Management, Data Processing and Financial Programming. It will be responsible for: (a) providing administrative support to the Executive Manager of the CEU; (b) programming the various activities of the project, monitoring the progress thereof and identifying any deviations which may arise; (c) keeping the account ledgers, preparing disbursement requests and maintaining detailed control over the budget; (d) setting up the information systems which are required for management; (e) preparing the progress reports on the activities being carried out and (f) managing the personnel of the Central Executive Unit.
- 4.13 In view of the need to have a fully established and completely settled Central Executive Unit, for the start of the works in the Program, it is proposed that the loan contract should have provisions which require that, before the first disbursement is made, the borrower must present evidence that the CEU has been set up and staffed with the key personnel for its operation. <sup>1/</sup> The key personnel are to be: (a) Executive Director; (b) the three advisors; (c) the department heads; (d) five professionals in each of the following units: engineering and construction, bidding and contract administration, management and programming; and ten administrative officers. Key personnel should demonstrate vast experience on the functions they are about to perform.

## 2. The Provincial Executive Units (PEU)

- 4.14 In each participating province a unit to execute the project will be set up; each such unit is to begin operation three months before the start of the construction of the works and is to be directly subordinated to the Provincial Minister or Secretary of Health Care. This Provincial Executive Unit is to be headed by an official who is appointed for a full time (dedication) and who is to be the person of direct contact with the Central Executive Unit. Annex IV-4 presents the organization proposed for the Provincial Executive Units, and their main functions are described below: (a) the construction unit

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<sup>1/</sup> See the Draft Resolution.

is to responsible for supervising the execution of the contract for construction of the hospital, will measure the work completed and is to be responsible for the quality control; (b) the management unit is to be responsible for verifying and updating the unit prices for the works and for preparing the payment orders for the contractor, as well as submitting them to the head of the Provincial Executive Unit for review; (c) the training unit is to be responsible for coordinating the courses and seminars to be held in the province, will submit the names of the candidates for courses outside of the province and will coordinate with logistic support for trips outside of the province associated with the Institutional Support Subprogram. In view of the importance of the Provincial Executive Units, it is recommended that a contractual condition be established which requires that evidence be submitted that this type of unit has indeed been created and staffed with the necessary personnel, who are acceptable to the Bank, before the call is made for bids on the works for each hospital in the Program (see the Recommendations).

D. Plan for execution of the Program

- 4.15 The plan for execution of the Program and the schedule of activities of the preliminary plan for execution of the Program are presented in Annexes IV-5 and IV-6, respectively. Below are presented the provisions which were considered for each of the main components:

1. Execution of the construction and equipment subprogram

- 4.16 The preliminary architectural plans of the hospitals and the final designs of the three projects of the sample were drawn up by the Central Executive Unit, with the support of national personnel specifically engaged for this design work; this work was also carried out in consultation with the medical authorities and architects responsible for the provincial projects. The Cordoba Hospital was designed in the province, and the development of the architectural designs of the other seven hospitals will be carried out mainly at the Central Executive Unit; however, in exceptional cases it may be possible to draw up the final designs of some of the hospitals at the corresponding Provincial Executive Unit following the technical specifications of the preliminary plans which have already been approved.
- 4.17 The construction of the hospitals in the Program and the procurement of the hospital equipment are to be contracted for by the Central Executive Unit using the bid procedures approved by the Bank. For the construction bids, a Bid Committee is to be set up, which will have a representative appointed by the Provincial Executive Unit for whose hospital the bid is to be let. Committees are also to be set up for the equipment bids and purchases, prequalification being waivable. The committee will analyze the documentation submitted by the companies for their prequalification and will prepare a corresponding report with their recommendations for the given case. Once the

Executive Director of the Central Executive Unit approves the prequalification report, it will be sent to the Bank for its approval and remarks before it is submitted to the Secretary of Health Care for his approval.

- 4.18 Once the prequalification is approved, the prequalified firms will be summoned by mail and through the press, with notice being given of the dates on which the documents are to be delivered and the proposals received.
- 4.19 The prequalified firms will have a period of at least 45 calendar days to submit their offers starting on the date when the documents are made available to them. Through the Bid Committee, the Central Executive Unit will make a technical-economic analysis for the purpose of evaluating the offers which meet the conditions requested and for the purpose of comparing them. It will send a report with its recommendations to the Executive Director of the Central Executive Unit and, with express indication of the recommended bidder. The report will be sent to the Bank so that it can make any remarks that it sees fit to make; after that the report will be sent to the Secretariat of Health Care for his approval and the announcing of the results of the bids.
- 4.20 Before the call is issued for each construction bid, the Central Executive Unit will have to show the Bank that: (a) it has legal possession of the land; and (b) it has the bid specifications, designs, plans and works budgets needed for the call for bids (see Recommendations).
- 4.21 Inspection of the execution of the construction contracts is to be the responsibility of the corresponding Provincial Executive Unit under the supervision of the CEU; this unit will verify the quality of the works and will make the necessary measurements to evaluate the payment requests from the contractors, as well as adjusting the prices, in accordance with the standards set forth in the corresponding construction contract.
- 4.22 Each work evaluation will be monitored by the head of the Provincial Executive Unit and by the architect in charge of the works at the Central Executive Unit, and such evaluation will also be approved by the head of the Construction and Equipment Department of the Central Executive Unit before it is submitted to the Management and Programming Department in order to make up the payment order.
- 4.23 Acceptance of the works on the hospital in each province will be carried out jointly by the Provincial Executive Unit and the Central Executive Unit; a test will be made on the hospital under vacant conditions, and a document is to be drawn up with the participating of the contracting company on the repairs and modifications which has to be made to the works and equipment in the building if necessary; this document will also set forth the deadlines and time periods for final

acceptance. Acceptance of the equipment will be carried out by the Hospital Equipment Unit and a representative of the corresponding Provincial Executive Unit; the equipment will be installed and put into operation during the process of delivery of the hospitals to the provinces.

2. Execution of the institutional support subprogram

- 4.24 The activities of this subprogram will be administered by the Central Executive Unit through the Institutional Support Department which is to be set up, in coordination with the Provincial Executive Units. In the agreements on the participation of the provinces, clauses have been inserted, which specify that the provinces appoint the hospital personnel, with enough lead time, to allow them to be trained in their new jobs and in the activities which they will be performing.
- 4.25 A preliminary schedule of courses, seminars and apprenticeships has been submitted for the execution of the subprogram; these courses, etc., will be held on the national and provincial level once the number of consultants that have to be engaged is determined; however, due to the very nature of the Program, the training activities will be planned annually, as explained in the following section.
- 4.26 The execution of the training Program will have to begin in each province once the work on the hospital has begun, and will continue until it is finally delivered to the provincial authorities. The execution and monitoring of this subprogram are to be carried out through annual work plans which will be submitted during the second quarter of each year starting in 1988, when it has been planned that this component is to be initiated. Starting in the second year of execution, the annual institutional support plans will submit an analysis of the extent to which the planned measures have been completed in the previous year (see Recommendations).
- 4.27 The annual work plans are intended to make it possible to review the programmed measures based on the experience which is obtained during the execution of the project and are supposed to contain the following:
- (a) Participation goals, to be carried out during the next year in each province, in the different courses and seminars which are to be held;
  - (b) Probable dates on which consultants will be engaged and detailed terms of reference for each of them;
  - (c) Numbers of short courses and seminars which are to be offered, dates and places where they are to be held, numbers of officials to attend them, objectives to be achieved by each activity, procedure for evaluating the activity conducted and team responsible for the activity;

- (d) Plan to send management personnel elsewhere in the country and abroad for training, numbers of people to be sent, training sites, dates of initiation and termination of the trips, method for evaluating the activity;
- (e) Apprenticeship plan for personnel specializing in maintenance, numbers of people who are to be sent, exact objectives to be achieved, dates and places when courses are to be held, and method of evaluation of the activity.

E. State of Preparation of the Architectural Projects

- 4.28 The architectural sample for three hospitals (Chaco, Formosa and Misiones) which represents 30.6% of the cost of construction, and for the Cordoba Hospital, which represents some 9.9% more, are at the level of an architectural project, wherein the following information is available: (a) descriptive report; (b) layout diagram on a scale of 1:200; (c) architectural plans which include floor plans, cross sections and views; (d) plans of structures and foundations; (e) infrastructure plans (hot and cold water, sewers, power, air conditioning and heating, pavement; and special services for fixed hospital equipment); and (f) calculations of amount of works and budgets.
- 4.29 The bid documents with all of the plans and details of the above-mentioned sample are to be completed on the first quarter of 1987. It should be pointed out that the available information has made it possible to evaluate the construction costs and that, both with regard to their functional diagrams and to technical construction, layout and availability of land, the hospitals are adequate for the proposed hospital medical Program.
- 4.30 The seven additional hospitals which the Program is supposed to construct have architectural designs at the preliminary plan level and represent 59.5% of the planned construction costs. The available information for these hospitals is: (a) descriptive report; (b) layout diagram; and (c) architectural plans on a scale of 1:200 of the ground floor, the upper floor, two cross sections and views of two different fronts. This makes it possible to define the characteristics and costs of the hospitals with sufficient precision due to the fact that a work procedure has been employed which utilizes modular design units.

F. Eligibility criteria

- 4.31 The Program was conceived as multiple works; however, in order to determine the total cost, the costs of the 11 provincial hospitals which are to be financed were estimated. On the basis of the analysis of the pattern of three hospitals which have complete designs (Chaco, Formosa and Misiones) and of the hospitals of Neuquen and Rio Negro (Cipolletti), eligibility criteria for determining the inclusion of the other hospitals in the Program, or the possible replacement of some of them by hospitals in other provinces, should any of the provinces originally selected decide not to enter the Program.

4.32 The eligibility criteria which were used to elect the hospitals in the pattern will also be used to determine the other hospitals in the Program; they are:

- (1) Location criteria: The hospitals will have to be located in areas where: (a) on the basis of a supply-and-demand shortages of in-patient services and out-patient consultation are identified. In order to estimate the shortages, it will be necessary to identify the following in the area of influence of the hospital: (i) the installed capacity, the occupancy rate of the hospital infrastructure, average number of days of stay, production of expenses by type of service and consultation, and population serviced in each of the existing hospitals in the public, private and social work subsectors; and (ii) other projects which are to be carried out, with the schedule, location, number of rooms, expenses and consultations and population to be covered being indicated; (b) there is easy access to the hospital by means of public transportation which is commonly used by the low income population; (c) all of the public services required for the construction and operation of the hospital are available.
- (2) Complexity criteria: The hospitals will have to be able to conduct activities of various levels of complexity depending on their respective medical programs; three indicative models have been defined. In Model C, Complexity (Level) VI, it will have the following services: (a) out-patient services including general outside consulting, day time hospital and emergency services; (b) in-patient capability with 70% to 80% of the rooms undifferentiated; (c) special services including a clinical laboratory, a pathological anatomy service, an x-ray diagnostic service, and surgical center and an obstetrics center; (d) general services with emphasis on maintenance; and (e) administrative services. In Model B, Complexity VIII, in addition to the services of Model C it will have the following additional services: (a) outside specialized consulting; (b) hemotherapy; (c) neonatology; (d) intensive care; (e) dialysis; and (f) a differentiated surgical center. In addition to the services of Model B, Model A, Complexity VIII could have the following additional services: (a) a burn unit; (b) an imaging diagnostic center; (c) nuclear medicine; and (d) differentiated intensive care wards.
- (3) Criteria of dimensioning and design: (a) For each hospital a demand analysis will have to be made using the procedure agreed upon with the Bank, and the size of the hospital must not exceed the demand projected for the next ten years; (b) the hospitals will have to be designed on the basis of the respective medical Program which is produced by the study of demand by services and they are to provide adequate traffic capacity for patients, personnel and material; (c) the hospitals will have to have a coordinated future expansion plan to a maximum of 30 percent of



their initial capacities; they will have to have the flexibility needed to be able to make changes in the future in response to technological progress without modifying their basic structure; and the initial size of the hospital will have to be no less than 120 beds and no more than 350.

- (4) Evaluation criteria: A cost-efficiency analysis will have to be performed for each hospital. To do this, a cost by type of expense, patient-day, consultation and emergency for each hospital will have to be compared with the costs corresponding to a representative sample of hospitals which operate efficiently and which offer services comparable to those of the hospitals in this project. The unit costs of the hospitals must not exceed the following costs (in US dollars): (a) cost per discharge US\$650; (b) cost of a patient-day US\$65; (c) cost for consultation US\$8. These costs are expressed in 1986 dollars based on the exchange rate, prices and salary levels of July 1986. In the future these costs are to be adjusted to the same base using the same technical and operating parameters which were applied for the projects of the pattern.

G. Acquisition of land

- 4.33 The tracts of land where the hospitals are to be constructed have been completely identified, they are the property of the participating provinces and they are included in the execution agreements which are to be signed before them and the Ministry of Health their transfer in "commodato" for the construction of the hospital. The foregoing notwithstanding, it is recommended that in each case before the call for bids is made for a hospital, the borrower should have to show, through the Central Executive Unit, satisfactory proof to the Bank that it has legal possession of the tracts of land needed for the construction of the works and that these tracts have the public services necessary for the start of the work. In addition, will also have to be presented the agreement with the public utilities to the effect that, six months before the completion of the works, all of the necessary services for the operation of the new hospital will have been completed (see Recommendations).

H. Bid and procurement Program

- 4.34 The bidding on each of the eleven hospitals will be done individually, because they are too disperse throughout the country. For each hospital a construction firm will be engaged which has experience in the execution of similar work. A study has been made of the possibility of soliciting joint bids for some items of equipment such as elevators, boilers and air conditioning systems which are to be installed in all of the hospitals; these would be delivered to the contractor for installation, thus ensuring: (a) uniformity of the items of equipment and a stock of spare parts in the country; (b) economies of scale and (c) a logical staggering in the production and delivery of these items of equipment; the decision on this matter will depend on what the actual savings that can be achieved turn out to be.

The construction bids will be carried out for the first 20 months of execution, to insure that all of the hospitals can be physically started two years after the loan contracts are signed. Since this is an overall multiple works Program, it is recommended that this term of two years for the actual initiation of the works be included in the loan contract (see the Draft Resolution).

4.35 The following bids have been planned:

<u>Year</u>	<u>Framework</u>	<u>Number</u>	<u>Item</u>	<u>Basic amount in millions of US\$ per bid 1/</u>
1	International	3	Construction of hospitals	16,500
1	International	3	" "	13,600
2	International	2	" "	6,000
2	International	2	" "	13,600
2	International	1	" "	17,000
1	National	2	Procurement of hospital equipment 2/	2,500
1	International	1	" " "	4,000
2	National	2	" " "	2,000
2	International	1	" " "	3,000
1	National	1	Procurement of equipment and tools 3/	5,000
1	International	1	" " "	9,000
2	National	1	" " "	5,000
2	International	1	" " "	7,000
2	National	2	Procurement of furniture	2,000
3	National	2	" "	2,000
4	National	2	" "	1,000

#### I. Procedure for contracting of goods and services

4.36 The works and items of equipment which are to be financed with the resources of the Program will be contracted for and procured by the Central Executive Unit in accordance with the bidding procedure agreed upon with the authorities of the Ministry of Health, which is presented in Annex IV-7. In the procurement of the items of equipment and in the contracting for works which are to cost the equivalent of US\$200,000 or more to the resources of the Program, public bids will be used, and those which are financed in full or in part with foreign currency resources from the loan, if granted, will be made using the international public bid system (see the Draft Resolution).

1/ This does not include unexpected items nor cost escalations; the amounts indicated for the hospitals include the items of equipment mentioned in the previous section.

2/ This is fixed items of equipment.

3/ These are semifixed items of equipment and instruments and tools.

- 4.37 In accordance with the standards of the Bank for the procurement of specialized laboratory instruments, books and publications, it will be possible to dispense with the required bid, provided that the borrower makes a request to this effect and justifies it properly to the Bank and indicates the procedure which it intends to follow in accordance with the goals of the financing (see the Draft Resolution). In any case, the procurement procedure, as for any purchase or contracting action which individually exceeds the amount of US\$25,000 or the equivalent, is to require the prior approval of the Bank.
- 4.38 The procurement of items of medical equipment for the hospitals which are not financed by the resources of the Bank or the local contribution will have to be governed by the procedures which the laws of the country permit in these cases. These procedures will have to be consistent with the technical requirements of the Program and will have to ensure that the costs of the goods and the financial conditions of the loans are reasonable (see Appendix III-Annex A).
- 4.39 To engage the consultants who are to participate in the institutional support subprogram, the procedure agreed upon with the authorities of the Ministry of Health will be used, whereby this procedure will be essentially the same as that presented in Annex IV-8 of the present report. The majority of the consultants who are to be engaged utilizing the resources in national currency of the OC loan, are to assist the Central Executive Unit in the execution of the Program and in the preparation of the specific seminars in the participating provinces; consequently, it was not considered necessary to include in this document the terms of reference for each of the consultants individually whom it was planned to engage. Annex III-5 presents an example of the terms of reference which are to be used as a pattern for the preparation of the terms of reference for the consultants to be engaged.

J. Schedule of investments

- 4.40 The schedule of investments has been determined on the basis of the plan for execution of the Program; this schedule is presented in the following table:

(in millions of US\$)

	<u>0</u>	<u>1</u>	<u>2</u>	<u>3</u>	<u>4</u>	<u>5</u>	<u>TOTAL</u>
Engineering and Admin.	0.40	1.82	2.14	2.57	2.52	1.79	11.24
Direct costs	-	32.76	25.63	58.61	81.82	37.58	236.40
Concurrent costs	-	1.09	2.57	1.39	7.59	9.81	22.45
Final costs	-	1.95	3.18	4.79	8.19	11.80	29.91
	<u>0.40</u>	<u>37.62</u>	<u>33.52</u>	<u>67.36</u>	<u>100.12</u>	<u>60.98</u>	<u>300.00</u>

- 4.41 The forecast of disbursements for the investments for each source of funds and for each year is presented in the following table:

(in US\$ million)

<u>Year</u>	<u>IDB LOAN</u>		<u>Suppliers</u>	<u>Local contribution</u>	<u>TOTAL</u>
	<u>Foreign exchange</u>	<u>Local currency</u>			
1986	-	-	-	0.40	0.40
1987	14.37	.66	-	22.59	37.62
1988	13.08	1.57	-	18.87	33.52
1989	29.54	.91	8.00	28.91	67.36
1990	40.90	.99	17.37	40.86	100.12
1991	<u>22.11</u>	<u>.87</u>	<u>3.05</u>	<u>34.95</u>	<u>60.98</u>
Total	<u>120.00</u>	<u>5.00</u>	<u>28.42</u>	<u>146.58</u>	<u>300.00</u>
%	40.0%	1.67	9.47	48.86	100.00

K. Advance payment of funds

- 4.42 In view of the nature of the Program, it is recommended that advance disbursements of funds be provided with the resources of the loan, up to an amount equivalent to the actual anticipated payments for a period of no more than 120 days and up to amount of no more than 10% of the total amount of the loan.

L. Acknowledgment of expenses

- 4.43 The Central Executive Unit has incurred and plans to incur expenses in the equivalent amount of US\$400,000 between the date of the request, July 8, 1986, and mid-December 1986. These expenses basically involve the drafting of the architectural design and the preparation of the support information for the analysis and execution of the Program. It is recommended that these expenses be recognized as local counterpart resources, provided that requirements which are essentially similar to those called for in the loan contracts have been met. (See Recommendations).

M. Operation of the hospitals

- 4.44 The operation of the hospitals will be handled by the participating provinces. There will be a start-up period of some six months during which the Central Executive Unit is to be directly involved and the

personnel of the hospitals are to be trained in the services, in order to ensure adequate utilization of the services and equipment. A provision has been included in the agreement which the Secretariat of Health Care is to sign with the participating provinces to the effect that the hospitals will be administered and operated in accordance with generally accepted technical standards and that six months before the final transfer takes place, the hospitals are to submit an operating plan with their respective budgets, which are to meet the requirements of the Secretariat. The borrower will in turn pledge to the Bank that the works will be operated and maintained efficiently and that the necessary measures will be taken to ensure that the annual budgets of the hospitals include the items necessary for these purposes. (See Recommendations).

N. Maintenance of the works

- 4.45 During the visits paid to the provinces, different levels of maintenance were found in the hospitals to be replaced, varying from acceptable to very inadequate. The institutional support subprogram which is proposed calls for two important efforts to correct the deficiencies noted: the first is comprehensive training of the hospital administrators, and the second is training of the personnel in performing the necessary preventive maintenance and minor repairs on the works and equipment to be financed by the Program. Consideration has also been given to equipping maintenance workshops with the necessary tools and most common spare parts required for the maintenance of the equipment. The foregoing notwithstanding, it is recommended that a pledge from the borrower be included for the submission of an annual maintenance Program for the components of the Program. (See Recommendations).
- 4.46 The maintenance plans have been considered in the agreements which the Ministry of Health and Social Assistance is to sign with the participating provinces, which is presented in Annex IV-1. In the agreement the provinces are to pledge to submit a hospital maintenance Program each year within the first three months of the calendar year, for a period of ten years from the date that the hospital is delivered and, starting in the second year of operation, to provide reports on the results of this Program during the previous year. (See Recommendations)

O. Utilization of appropriate technologies

- 4.47 The design of each hospital considers the use of materials which are abundant and commonly used in the provinces, and during the construction of each hospital will be used technologies which require the intensive use of labor. Regarding the complexity of the hospitals, it is considered that it will be of levels VIII and VI in two provinces. Their equipment is being designed to provide the most common diagnostic and medical-care services in each province, and in them an attempt has been made to select modern equipment appropriate to the needs, which is easy to maintain and is available at reasonable cost.

P. Ex-post evaluation

- 4.48 In order to evaluate the impact of the project, the Ministry of Health and Social Action will collect annual statistics and, on the basis thereof, will submit to the Bank the corresponding ex-post evaluation report. To do this, within 24 months of the date that the loan contract takes effect, the executor will submit for the consideration of the Bank a description of the system which is to be used in collecting, processing and analyzing the data associated with the evaluation and the basic initial data with which the project data, to be submitted annually, will be compared.
- 4.49 The basic data to which the previous section refers are: (a) general data on the area of influence of each facility in the Program: total population, low income population, population covered by "obras sociales" and by private medical insurance; (b) hospital supply in the area of influence of each facility in the Program, including public, private and social work subsectors: existing hospitals, specialties, ages, number of GMP rooms, plans for new facilities or replacements; (c) provision of services in facilities in the Program: annual data on the numbers of rooms, occupancy rates, number of discharges, average stay per service and turnaround for each of the hospitals in the Program, as well as the number of days per year with the capacity of 100% or more than, 90% or more and 80% or more per service; (d) total cost per type of service and unit costs per discharge by type of service and by out-patient consultation for each hospital in the Program and for a representative sample of other public and private hospitals; (e) data on the operational and personnel budgets in each of the facilities in the Program; (f) provision of services in other facilities in the area of influence of each facility of the Program: number of average discharges, out-patient services, occupancy rate, average stay per service, rates of referral and mortality; and (g) prevailing rates and fees, admittances for recovery by plan; number of users not obligated to pay, amounts of fees allowed to be collected under this plan, and socio-economic data on the exempt users.
- 4.50 The annual comparative data will include the same categories indicated in the basic data (except for items (a), (b) and (d), in which up dates will be required only when major changes occur and during the last year of the evaluation), and following as well: (a) changes made in the original list of facilities in the Program and changes in size, design or location; (b) actual investment costs and schedules and date when each facility in the Program goes into operation, as well as a comparison thereof with the corresponding forecasts.
- 4.51 The annual comparative data will be presented in such a way that they make it possible to examine both the fulfillment of the measures of the Program and the changes compared to the previous situation.
- 4.52 The ex-post evaluation report which is to be presented within three years of the date of the last disbursement, will be executed with the

method used in the ex-ante analysis of the Program, supplemented and expanded with the previously indicated additional information. In particular, the final evaluation will have to include the following:

- (a) Analysis of demand: Determining the shortage of hospital services in each built-up area according to the method used in the ex-ante evaluation of this operation but including in the ex-post evaluation, in addition to the public subsector, the private subsector and social services and identifying the population served by each subsector.
- (b) Cost-efficiency analysis: Determining the effectiveness of the investment services by each of the four major areas of production (surgery, pediatrics, medicine and tocogynecology) and the emergency services and out-patient facilities of each of the hospitals. To do this, it will be necessary to compare the costs by type of discharge, patient/day, consultation and emergency service of each hospital in the Program with the corresponding costs of a representative sample of hospitals which operate efficiently and which offer services which are comparable to those of this Program. This sample will have to include public and private hospitals, as appropriate.
- (c) Distributive impact analysis: Determining the distributive impact in accordance with the procedure recommended by the Bank.
- (d) Operational analysis: Determining the appropriateness of the budgetary allocations and the allocations for personnel and maintenance of the facilities and equipment.
- (e) Conclusions and recommendations:

Q. Inspection and monitoring

- 4.53 The Bank will monitor the execution of the Program mainly through its representative in Argentina. The hospitals are to be approved by the Bank.

## V. BORROWER AND EXECUTOR

### A. Institutional aspects

#### 1. Borrower

- 5.01 The Borrower would be the Republic of Argentina. The Ministry of the Economy, acting as the financial agent of the Republic, would receive the loan funds, make the transfers from the loan and provide local counterpart funds for program implementation, and will be responsible for servicing the debt.

#### 2. Executor

- 5.02 The Ministry of Health and Social Welfare, through the Secretariat of Health, would be responsible for program implementation. Toward that end, the Secretary will set up a Central Implementation Unit (CIU), which will program, coordinate and supervise program implementation on the national level. The Offices of the Secretariats of Health in each participating province will set up Provincial Implementation Units (PIU) which will supervise and monitor the hospital project in their respective provinces according to the guidelines set forth by the CIU and in accordance with national policies, requirements and specifications stipulated in the loan contract and in the participation agreements that would be drawn up by the Office of the National Secretariat of Health and the Secretariats of Health of the participating provinces.

#### 3. Secretariat of Health (National)

##### (a) Organization (see organization chart, annex V-1)

- 5.03 The Secretariat of Health is part of the Ministry of Health and Social Welfare and is comprised of the Secretary of the Federal Health Council and four under secretaries as follows: Health Programs, Health Resources, Regulation, Control and Coordination, and finally, Services. Different directorates, which are actually support units, and the National Institute of Social Work (INOS) (with its decentralized administration) are under them. Their major functions are accomplished as follows:
- 5.04 The Secretariat of the Federal Health Council, whose objective is to develop the technical and administrative support policies of the Federal Health Council (COFESA). It consists of representatives of all of the provinces and includes actual coordination of the member jurisdictions on the national and regional levels.
- 5.05 The Under Secretariat for Health Resources promotes health, recovery and rehabilitation policies, as well as prevention of illnesses in order to achieve optimum health conditions for the people.



- 5.06 The Under Secretariat for Health Programs carries out policies for which the Secretariat is responsible in the areas of training and educating health personnel. It also takes part in the process of human resources development with a view to achieving health conditions commensurate with national health realities.
- 5.07 The Under Secretariat for Regulation and Control deals with policies related to the standards and application of health laws for health policies in execution of legal and regulatory standards as well as the laws in effect, in order to contribute to achieving adequate health conditions for the people.
- 5.08 The Under Secretariat for Coordination and Services has the objective of providing assistance to the Secretariat of Health in the management of technical support as well as legal, administrative, bookkeeping and financial services. Finally, he also provides assistance in the areas of general coordination and liaison among the different departments within the office of the Secretariat.

(b) Staff

- 5.09 The permanent staff of the Secretariat of Health totals 15,851 employees. Of that figure, 3,548 are employed in administrative and professional capacities, and 12,303 are employed as professionals, technicians, maintenance staff and production and general services staff.

Secretariat of Health

Permanent Staff - General Summary

	<u>Admin.</u>	<u>Prof.</u>	<u>Serv.</u>	<u>Prod.</u>	<u>Maintenance and service General</u>	<u>Total</u>
Secretariat of Health						
Unit	349	39	261	49	165	863
Under Secretariat for Health						
Programs	567	217	1,250	274	609	2,917
Under Secretariat for Health Resources	840	86	5,314	1,005	1,203	8,448
Under Secretariat for Regulation & Control	500	317	483	62	129	1,491
Under Secretariat for Coordination of Services	<u>568</u>	<u>65</u>	<u>1,337</u>	<u>70</u>	<u>92</u>	<u>2,132</u>
Total	<u>2,824</u>	<u>724</u>	<u>8,645</u>	<u>1,460</u>	<u>2,198</u>	<u>15,851</u>

- 5.10 The staff of the Secretariat of National Health is primarily involved in programming, planning, regulating and evaluating health services.

As central headquarters personnel, this staff is not significantly involved in operational activities. These activities are carried out by units in the different provinces which deal with health programs. At the central level, the standards, procedures and methodologies are developed and then, in turn, used in the different programs in the country, making it possible to maintain or increase health goals and conditions.

- 5.11 The Secretariat of Health is the executing agency responsible for project implementation and has a large staff at this time. Nevertheless, due to the government's policy which aims to limit government expenditures, the staff level has been frozen by Order #983 of May 31, 1985 and Order #2.256 of November 25, 1985. These Orders and other austerity measures limit salary increases to the point that the wages are not competitive with those of the private sector. Therefore, the Secretariat does not have available all the necessary staff who have the qualifications required to properly carry out the stages of project design, supervision and control.
- 5.12 Creation of the Central Implementation Unit (CIU), with additional staff who are paid competitive wages in order to ensure the proper number of qualified professionals, is imperative for completing the program. Toward this end, the authorization for creating the above mentioned CIU must be signed. Moreover, an exception must be made to the rules in effect for limiting government expenditures, so that the salary levels required to attract qualified staff are authorized.

(c) Financial administration

- 5.13 The bookkeeping system in the Ministry of Health and Social Welfare has been implemented in accordance with the rules established by the Comptroller General. A resolution enacted by the Ministry in 1983 approved the assignment of tasks and responsibilities of the various agencies of the Directorate of Data Processing Systems of the Technical Under Secretariat and Administrative Coordination was approved. This Directorate is comprised of three departments: the Department of Research and Development, the Systems Department and the Data Processing Department.
- 5.14 The primary functions of the departments are as follows: (i) the Department of Research and Development is responsible for developing software programs and hardware as well as training staff in uses and applications; (ii) the Systems Department is responsible for developing, maintaining and controlling computer programs; (iii) the Data Processing Department is responsible for processing data from the information system. Among the large number of information programs developed, the applications are as follows: a Budget Implementation and Control System; a Construction Cost Index; Project Operation; a Housing Investment and Recovery System (FONAVI); and an Integrated Public Administration Budget Accounting System.

- 5.15 In general, the accounting systems are intended for budget control by purpose and economic itemization under comprehensive headings. The budgetary control books were outdated and no account catalogue is available which is sufficient for recording the program's financial transactions. This is due to the various sources of funding and complications arising from the requirement of controlling implementation in eleven provinces. Because of the work load and a lack of staff and equipment, it is felt that the existing systems would not make it possible to maintain the books in the manner required during program implementation. In order to ensure financial control of the project, we foresee the assignment of additional staff to the Central Implementation Unit in order to set up accounting systems based on a catalogue of accounts designed to control investments in accordance with the requirements of the Bank.

(d) Internal control

- 5.16 Internal auditing is basically carried out in accordance with the obligations set forth in Art. 76 of the Accounting Law. The Internal Control Unit, as a component of the Comptroller General, works on a full time basis controlling not only the financial, accounting and legal aspects, but it also assesses operational administrative management, i.e., it checks to see that the goals are achieved with efficiency, economy and effectiveness.
- 5.17 As part of its work method, based on an annual program, the activities are as follows: (i) auditing the books, preparing reports and financial statements; (ii) auditing the internal control system; (iii) assessing the efficiency of the use of human, material and financial resources as part of the policies and legal regulations of the institution; and (iv) recommending and advising corrective actions that must be taken in order to improve the performance of the institution's programs.
- 5.18 We foresee a role being played by the Internal Control Unit as a representative of the government during program implementation, in order to ensure that the legal requirements, policy of the Secretariat of Health and the contractual requirements of the loan are fulfilled.

(e) External audit

- 5.19 Article 85 of the Accounting Law prescribes the direct involvement of the National General Accounting Office (Tribunal de Cuentas de la Nación) in overseeing out external audits of all the administrative actions of each jurisdiction without prejudice to the supervision of legal representatives or delegations.
- 5.20 The standards which govern the performance of audits are included in the "General Bookkeeping Regulations and Procedures for Legal and

Bookkeeping Audits," approved by Resolution #1658/77 of the National General Accounting Office. This Office does not take part in external audits in accordance with the Bank's requirements in this area. For this reason, the project's financial statements will be audited during project implementation by an independent auditing firm or institution and the Bank will approve the firm before the first disbursement. (See Draft Resolution.)

#### 4. Provincial Secretariats of Health

- 5.21 The Provincial Secretariats of Health are part of the Provincial Ministries of Health. Basically, they are organized in a manner similar to that of the national level. Each Secretariat of Health in those provinces which participate in the project would be responsible for the follow-up, control and monitoring of the project in their respective jurisdictions below the supervision of the CIU.
- 5.22 In general, the Provincial Secretariats of Health are responsible for providing assistance to the provinces and localities for carrying out the national health policies. Their activities necessitate that they act as coordinators of public services in order to organize and manage the provincial health establishments. In general, the Provincial Secretariats of Health are responsible for promoting and protecting health through education and medical care in order to ensure that the people's demands for medical care are covered on a permanent basis in their areas of influence.
- 5.23 Each province follows the same austerity policy for staff (freezing the positions included), yet they have more flexibility in applying the policy as long as they comply with the directives for required staff if justified in each particular case.
- 5.24 The financial administration of the provinces is centralized and its overall accounting system for income and expenditures is divided among the Secretariats. The Provincial Ministry of the Economy (Hacienda), in some cases processes payments of wages and does not itemize according to activity. This makes it impossible to allocate the expenditures to said activity. Furthermore, the Provincial Secretariats of Health make wholesale purchases of drugs and inputs in order to obtain lower prices. These inputs and medicines are distributed to the health centers, clinics and hospitals free of charge to each final user. The Ministry of Public Works of the provinces repairs and makes additions to the hospitals and health centers, the costs of which must be accounted for in its own books.
- 5.25 In order to meet the actual cost of the health sector, these costs must be reconciled with expenditures made for other provincial entities. To resolve this problem of cost determination by activity, an institution-building program has been set up to promote development of cost accounting systems for the hospital to be built in each

province, to provide better control, and to develop information on the operating and maintenance costs. The hospital staff would take part in developing the system and would receive training in the use of the system, which would be based on the use of computers to be included in hospital equipment.

- 5.26 The development and design of accounting systems would make it possible for each hospital to control its own income and expenditures and would depend upon the degree of decentralization. This has been discussed with the provincial health authorities, which are totally in agreement. They would include this in the agreement between the National Secretariat of Health and the Provincial Secretariats of Health (see annex IV-1). This process is prescribed as a pilot program for decentralizing other health units in order to improve the level of control and operation.

B. Financial analysis

- 5.27 Summaries of the budget and budget implementation of the Republic of Argentina, the Ministry of Health and Social Welfare, the Secretariat of Health and the provinces which will participate in fiscal years 1983, 1984, 1985, as well as the 1986 budget, are presented below. In order to compare like figures, the values have been adjusted to 1986 prices in Argentinean currency (pesos and australes), and converted into U.S. dollars using the official exchange rate of US\$1.00 = As 92.8, in effect as of June 30, 1986.

1. Republic of Argentina

- 5.28 An analysis of Table #1 of the following page shows that total expenditures between 1983 and 1984 decreased by US\$ 1,054.4 million (7.2%). In 1985 the operating expenditures increased by US\$2,827.8 (27.3%) compared with 1983, mainly as a result of wage adjustments in the civil service. On the other hand, capital expenditures fell dramatically, from US \$4,210 million to US\$ 1,308.2 million (69%) in 1984, and US\$ 1,762.5 million (58%) in 1985 compared to 1983 expenditures. These decreases reflect the austerity measures taken by the government due to the economic situation of the country.

Table # 1

Historical Budget of the Republic of Argentina

	<u>1 9 8 3</u>			<u>1 9 8 4</u>			<u>1 9 8 5</u>			<u>1986</u>
	<u>Bud.</u>	<u>Actual</u>	<u>%</u>	<u>Bud.</u>	<u>Actual</u>	<u>%</u>	<u>Bud.</u>	<u>Actual</u>	<u>%</u>	<u>Budget</u>
<u>EXPENDITURES</u>										
Operations	10,976.4	10,364.6	94.4	12,344.9	12,212.0	98.9	13,778.5	13,192.4	95.7	13,300.2
Capital	4,483.7	4,210.0	93.9	2,014.0	1,308.2	64.9	2,024.7	1,762.5	87.0	2,109.8
Total	<u>15,460.1</u>	<u>14,574.6</u>	94.3	<u>14,354.9</u>	<u>13,520.2</u>	94.2	<u>15,803.2</u>	<u>14,954.9</u>	94.6	<u>15,410.0</u>
<u>Changes from the base year</u>										
Operations					+17.8%			+27.3%		+28.3%
Capital					-68.9%			-58.1%		-49.9%
					-7.2%			-2.6%		+5.7%

Table #2

Republic of Argentina - Budgeted and Actual Execution - Itemization by Purpose

	<u>1983</u>	<u>Actual Share</u>	<u>1984</u>	<u>1985</u>	<u>1986</u>	<u>Partic.</u>	<u>Bud.</u>	<u>Partic.</u>	<u>Bud.</u>	<u>Partic.</u>	<u>Bud.</u>	<u>Partic.</u>
	<u>Bud.</u>		<u>Partic.</u>									
Total	15,460.1	14,574.6	100.0	14,354.9	13,520.2	100.0	15,803.2	14,954.9	100.0	15,410.0	100.0	
Central Administ.	2,883.9	2,816.3	19.3	2,523.4	2,425.4	17.9	3,690.6	3,633.1	24.3	3,600.1	23.4	
Defense	1,452.7	1,435.9	9.9	1,227.6	1,193.7	8.8	1,081.3	1,059.6	7.1	1,164.5	7.6	
Security	499.6	472.9	3.2	443.8	427.7	3.2	399.0	374.1	2.5	418.3	2.7	
Health	281.5	247.9	1.7	358.4	306.3	2.3	361.5	300.5	2.0	580.4	3.8	
Culture & education	1,126.7	1,072.8	7.4	1,236.2	1,181.3	8.7	1,108.9	1,044.6	7.0	1,264.3	8.2	
Economic development	7,290.9	6,758.9	46.4	5,124.7	4,648.7	34.4	4,899.2	4,388.2	29.3	4,546.2	29.5	
Social welfare	1,623.6	1,484.3	10.2	2,257.2	1,702.8	12.6	2,632.3	2,559.1	17.1	2,758.7	17.9	
Science & technology	283.1	236.1	1.6	255.2	205.3	1.5	276.7	242.0	1.6	331.1	2.1	
Public debt	18.1	49.5	0.3	928.4	1,429.0	10.6	1,353.7	1,353.7	9.1	1,178.1	7.6	
Savings	-	-	-	-	-	-	-	-	-	(432.7)	(2.8)	

5.29 A more in-depth analysis based on Table # 2 shows the change and emphasis of the new government which came into power in 1984. Reviewing expenses by purpose it can be seen that expenditures for Defense, Security and Economic Development have decreased in absolute and relative terms. However, the other expenditures over this period increased in the social sectors of Health, Culture, Education and Social Welfare. For example, Health received a large increase in funding: US\$332.5 million (134.1%) compared to expenditures of US\$ 247.9 million in 1983 and the budget of 1986, US\$ 580.4 million. In 1984 a significant increase in expenditures related to the public debt can be observed as a result of the fact that the government took on the burden of the debts of state-owned companies in 1983.

## 2. Ministry of Health

5.30 When the new government came into power it was confronted with the historical delay of allocating resources to the social sectors. Governmental expenses directed toward these sectors gradually decreased during the previous government. The objective of the current government in this area is to encourage significant changes in the composition of its total expenditures, and as has already been mentioned, the social sectors experienced a clear recovery since the start of the new government. This restructuring of the public expenditures was reflected in the budgetary policies of the Ministry of Health and Social Welfare, as can be seen in Table #3.

Table #3

### Ministry of Health - Historical Expenses (in millions of US\$)

	<u>1983</u>	<u>1984</u>	<u>1985</u>	<u>1986</u>
Operating Costs	467.3	665.5	776.4	901.1
Capital Costs	589.5	116.2	588.4	576.8
	<u>1,056.8</u>	<u>781.7</u>	<u>1,364.8</u>	<u>1,477.9</u>
Exchange Ratio Compared to Base Year				
Operating Costs		+42.4%	+66.1%	+92.8%
Capital Costs		-80.3%	- 0.2%	-2.2%
Total		<u>-26.0%</u>	<u>+29.1%</u>	<u>+39.8%</u>
<u>Total Expenses</u>				
Central Government	14,574.6	13,520.2	14,954.9	15,410.0
Ministry of Health and S.A.	1,056.8	781.7	1,364.8	1,477.9
Relation between the Expenses of the Ministry and Central Government	7.3%	5.8%	9.1%	9.6%
Ratio of Change Compared to the Base Year		-1.5%	+1.8%	2.3%

- 5.31 An analysis of the changes in budget and loan implementation in 1986 by the Ministry illustrates that the expenses, except for 1984 when the government changed, as was the case for total expenses, increased by 29.1% for 1985. The increase was in operating expenditures as a result of an increase in wages and transfers to special programs and to the provinces in order to implement health services programs. Capital expenditures decreased in 1984 and in 1985 returned to a level equal to that of 1983. It is important to note that transfers and contributions to the provinces on some occasions are used for capital expenditures. In terms of sharing national expenditures, the Ministry will increase its share from 7.3% of the national budget to 9.1% in 1985 and 9.6% in 1986, which indicates that the Ministry's budget has begun to recover its importance in the national budget.
- 5.32 An analysis of Table # 4 illustrates that the budgets and expenses incurred by the decentralized agencies and jurisdictions which comprise the Ministry demonstrate with a few exceptions a tendency to increase operating expenses. The capital expenditures do not demonstrate a clear tendency except for the decrease of expenditures of the Secretariat of Housing.



Table # 4

Ministry of Health and Social Welfare  
Historical Budget and Actual Expenditures  
(in millions of \$US)

Operations	1983			1984			1985			1986
	Budget	Actual	%	Budget	Actual	%	Budget	Actual	%	Budget
Central Administration	115.8	109.3	94.3	191.1	167.8	87.8	263.3	240.5	91.3	309.6
Secretariat of Health	150.6	137.2	91.1	232.6	190.1	81.7	232.3	183.2	78.9	261.7
Secretariat of Recreat.	9.0	8.5	9.4	17.9	15.1	84.3	15.3	14.9	97.4	19.3
Secretariat of Social Development	-	-	-	79.7	78.8	98.9	59.4	56.4	94.9	82.9
Secretariat of Human Development	24.7	20.7	83.8	30.7	25.2	82.0	30.6	25.7	84.0	36.3
Secretariat of Housing	27.0	24.6	91.1	26.1	8.3	31.8	34.6	25.6	74.0	42.4
Decentralized agencies	70.0	37.5	53.5	85.9	85.9	100.0	82.3	81.5	99.0	119.3
Special expenses	145.7	129.5	88.9	96.5	94.3	97.9	173.8	148.6	85.5	29.6
Total operations	542.8	467.3	86.1	760.5	665.5	87.5	891.6	776.4	87.0	901.1
<u>Capital Expenditures</u>										
Ministry of Central Admin.	8.5	6.1	71.8	4.8	1.5	31.3	6.6	3.9	59.1	7.1
Secretariat of Health	36.8	18.5	50.3	31.5	15.9	50.5	21.7	15.0	69.1	26.0
Secretariat of Recreation	3.3	0.6	18.2	3.3	0.8	24.2	5.2	4.7	90.3	0.8
Secretariat of Social Development	-	-	-	0.1	0.1	100.0	0.1	0.1	100.0	0.2
Secretariat of Human Development	0.4	0.2	50.0	0.9	0.0	5.6	0.3	0.1	32.7	0.8
Secretariat of Housing	542.7	542.7	100.0	505.4	70.5	14.0	539.1	538.8	99.9	519.2
Decentralized agencies	23.3	21.4	91.8	27.7	27.4	98.8	25.9	25.8	99.7	22.7
Total capital	615.0	589.5	95.9	573.7	116.2	20.3	598.9	588.4	98.2	576.8
Total expenditures	1,157.8	1,056.8	91.3	1,334.2	781.7	58.6	1,490.5	1,364.8	91.5	1,477.9

5.33 Table # 5 illustrates in relative terms the share of the Ministry of the jurisdictions and decentralized agencies in the budget.

Table # 5

Ministry of Health and Social Welfare  
Costs according to Purpose  
(percentages)

	<u>1983</u>	<u>1984</u>	<u>1985</u>	<u>1986</u>
<u>Operations</u>				
Central Administration	23,4	25,2	31,0	34,4
Secretariat of Health	29,3	28,6	23,6	29,1
Secretariat of Recreation	1,9	2,3	1,9	2,1
Secretariat of Social Devel.	-	11,8	7,3	9,2
Secretariat of Human Devel.	4,4	3,8	3,3	4,0
Secretariat of Housing	5,3	1,2	3,3	4,7
Decentralized agencies	8,0	12,9	10,5	13,2
Special expenses	<u>27,7</u>	<u>14,2</u>	<u>19,1</u>	<u>3,3</u>
Total operations	<u>100,0</u>	<u>100,0</u>	<u>100,0</u>	<u>100,0</u>
<u>Capital Expenditures</u>				
Ministry of Central Adm.	1,0	1,3	0,7	1,2
Secretariat of Health	3,1	13,7	2,5	4,5
Secretariat of Recreation	0,1	0,7	0,8	0,1
Secretariat of Social Devel.	-	-	-	-
Secretariat of Human Devel.	-	-	-	0,1
Secretariat of Housing	92,1	60,7	91,6	90,2
Decentralized Agencies	<u>3,7</u>	<u>23,6</u>	<u>4,4</u>	<u>3,9</u>
Total Capital Expenditures	<u>100,0</u>	<u>100,0</u>	<u>100,0</u>	<u>100,0</u>

5.34 An analysis of the previous table reveals that the operating expenditures of the Central Administration, the Secretariat of Health, decentralized agencies and special expenses, i.e., transfers to other institutions and provinces, consume to a great extent the funds allocated to the Ministry. The Secretariat of Housing uses an average of 91% of the funds allocated to the Ministry for capital expenditures.

### 3. Secretariat of Health

5.35 Table # 6 illustrates the budget and actual historical expenditures for fiscal years 1983, 1984 and 1985 and the 1986 budget for the Secretariat of Health. The Secretariat reports his activities by program under operating and capital expenditures.

Health Secretariat  
Historial Budget and Actual Expenditures by Program  
(in thousands of US\$)

	1983			1984			1985			1986
	<u>Budget</u>	<u>Ejec.</u>	<u>%</u>	<u>Budget</u>	<u>Ejec.</u>	<u>%</u>	<u>Budget.</u>	<u>Ejec.</u>	<u>%</u>	<u>Budget.</u>
<u>GASTOS FUNCIONAMIENTO</u>										
Central Adm.	12.583	12.023	95,6	15.002	12.965	86,4	18.764	16.577	88,3	21.573
Delivery of Asist.	16.544	15.717	95,0	78.875	74.762	94,8	72.971	65.707	90,0	94.990
Medical care services	50.588	45.980	90,9	-	-	-	-	-	-	-
Health-related constr.	10.384	9.477	91,3	1.691	1.555	92,0	874	782	89,4	223
Drugs	18.685	15.254	81,6	15.125	9.258	61,2	23.295	20.315	87,2	25.375
Regulation and control	6.862	6.339	92,4	11.287	8.594	76,1	7.564	6.211	82,1	6.943
Chagas control	4.803	4.750	98,9	3.592	2.935	81,7	-	-	-	-
Health	21.843	21.843	100,0	61.678	61.678	100,0	67.148	67.148	100,0	69.520
Environment	2.305	1.026	44,5	-	-	-	4.082	3.739	91,6	5.435
Pharmaceuticals research	20	13	65,2	38	13	34,2	-	-	-	-
Health education	5.917	4.810	81,3	25.021	15.007	60,0	-	-	-	-
Border area devel.	-	-	-	3.351	3.351	100,0	-	-	-	-
Drugs assistance	-	-	-	16.911	-	0,0	37.607	2.687	7,1	40.467
Urban planning/CENARE	-	-	-	2.532	2.532	100,0	825	795	96,4	834
Total operating exp.	<u>150.534</u>	<u>137.232</u>	91,2	<u>235.103</u>	<u>192.650</u>	81,9	<u>233.130</u>	<u>183.961</u>	78,9	<u>265.360</u>
<u>CAPITAL EXPENDITURES</u>										
Central adm.	307	228	74,2	1.532	1.161	75,8	172	98	57,1	59
Medical care services	5.167	3.396	65,7	-	-	-	-	-	-	-
Health-related const.	27.526	12.339	44,8	17.000	5.624	33,1	12.771	8.165	63,9	15.237
Drugs	220	66	30,1	667	309	46,3	1.412	882	62,5	1.617
Regulation and Control	951	566	59,5	3.986	2.058	51,6	1.507	768	50,9	1.464
Chagas control	100	80	80,0	116	80	68,9	-	-	-	-
Environment	89	29	32,6	-	-	-	-	-	-	-
Pharmaceutical research	47	11	23,4	71	22	31,0	-	-	-	-
Health education	1.322	1.007	76,2	1.620	1.329	82,0	-	-	-	-
Urban planning/CENARE	-	-	-	3.743	3.743	100,0	7	3	42,9	8
Delivery of health care.	1.058	813	76,9	-	-	-	-	-	-	-
Total capital expend.	<u>36.787</u>	<u>18.535</u>	50,4	<u>28.735</u>	<u>14.326</u>	49,9	<u>15.869</u>	<u>9.916</u>	62,5	<u>18.385</u>
Total Gastos	<u>187.321</u>	<u>155.767</u>	83,2	<u>263.838</u>	<u>206.976</u>	78,4	<u>248.999</u>	<u>193.877</u>	77,9	<u>283.745</u>

- 5.36 An analysis of the table shows the emphasis that the current government has placed on health sector programs of the Secretariat. This is confirmed by increases in the various programs. The operating expenditures incurred will increase by 40.4% in 1984 and by 34.1% in 1985 compared to 93.4% for 1983. In terms of actual expenditures, the Secretariat has succeeded in implementing the approved budget only by an average of 84.0% in relative terms. In absolute terms, applied operating expenses have increased by US\$ 55.4 million in 1984 and US\$46.7 million in 1984 and the budgeted amount of US\$ 128.1 million in 1986 compared to fiscal year 1983.
- 5.37 An analysis of the operating expenditures of the Secretariat shows that expenditures for Central Administration have increased, mostly as a result of wage adjustments. Other programs which have shown substantial changes are:
- (a) Health assistance services which include the direct delivery of general and specialized health services. This program shows an increase of US\$59.0 million in 1984 and US\$50.0 million in 1985 compared with 1983 expenditures. The budget amounts to US\$94.9 million, which represents the greater amount allocated to this program during the period under consideration. This program has consolidated the activities of medical care service and chagas control. The totals of these programs illustrate changes of US\$66.4 million in 1983 to US\$77.7 million in 1984, to US\$65.7 million in 1985. The 1986 budget is US\$94.9. In relative terms of the total expenditures of the Secretariat, these consolidated programs indicate decreases from 29.2% in 1983 to 28.3% in 1984; 24.9% in 1985; and 24.8% in 1986. This is compensated by distribution of the funds for the provinces as part of these and other projects.
  - (b) The Health Support Project (PAS funding) represents transfers made by the Secretariat of Health to the provinces of the country for operating and capital expenditures. The increase over the last years has been significant, from US\$21.8 million in 1983 to US\$61.7 million (183%) in 1984 and US\$67.1 million (208%) in 1985 and US\$69.5 million (219%) budgeted in 1986. This illustrates the emphasis placed on assistance programs for the provinces and the improvement of health services in general. Paragraph 5.39 looks at the distribution of HSP funding among the provinces.
  - (c) The Drugs Program includes the production and distribution of drugs to provinces at the national level. The drugs complement those used in the health centers and hospitals for correcting general health problems and are not considered to be substitutes for the total requirements of the provinces.

- 5.38 On the other hand, capital expenditures have decreased largely as a result of the current government's strategy of decentralizing the allocation of capital resources which appear as operating expenditures in the Health Support Project funded by HSP.

4. National Health Support Program (PAS Funds)

- 5.39 The National Health Support Program, funded by PAS, are transfers from the Secretariat of Health to the provinces of the country. These transfers are divided into current and capital expenditures and are negotiated each year with the provinces according to their needs and demonstration of programs in progress. The provinces which would take part in the Program will transfer to an extrabudgetary special account the funds which correspond to capital expenditures during the period of 1986 and are implemented as part of the local counterpart funds for the project.
- 5.40 PAS funding is directed toward the following programs on the national level: (a) Support for the Central Health Management; (b) Support for the care of individuals at the Primary Care Level; (c) Support for the care of individuals at the Specialized Level; and (d) Support for the improvement of the health conditions of the Environment. The provinces use and apply these funds with a certain flexibility and autonomy according to their specific needs.
- 5.41 Table # 7 presents the expenditures for the Program during fiscal year 1985 and the budget for 1986. An analysis of the Table makes it possible to illustrate how program expenditures have developed, from US\$67.1 million in 1985 to US\$107.7 million budgeted for 1986. The 1986 budget has taken into account an increase in the items for operating and capital expenditures for each province. The budgets approved since 1983 for this program have been spent in total for each year studied.

Table # 7

NATIONAL HEALTH SUPPORT PROGRAM (Funded by PAS)  
Budget Spending in 1985 and Budget for 1986  
(in millions of \$US)

<u>Province</u>	<u>1985 Expenses</u>			<u>1986 Budget</u>		
	<u>Operations</u>	<u>Capital</u>	<u>Total</u>	<u>Operations</u>	<u>Capital</u>	<u>Total</u>
Buenos Aires	290,1	123,4	413,5	450,2	191,8	642,0
Catamarca	1.198,9	782,1	1.981,0	1.919,3	1.212,3	3.131,6
Chaco	2.733,0	612,0	3.345,0	4.493,9	948,8	5.442,7
Chubut	1.142,2	1.662,5	2.804,7	1.842,6	2.574,6	4.417,2
Córdoba	5.035,8	465,2	5.501,0	8.257,5	722,0	8.979,5
Corrientes	2.229,4	391,9	2.621,3	3.671,8	606,9	4.278,7
Entre Ríos	1.999,9	538,6	2.538,5	3.330,0	835,4	4.165,4
Formosa	1.459,1	2.419,5	3.878,6	2.371,2	3.748,5	6.119,7
Jujuy	2.036,0	416,9	2.452,9	3.305,0	645,3	3.950,3
La Pampa	723,7	465,2	1.188,9	1.160,6	722,0	1.882,6
La Rioja	1.128,9	636,9	1.765,8	1.792,6	987,2	2.779,8
Mendoza	2.112,7	855,4	2.968,1	3.486,7	1.325,7	4.812,4
Misiones	3.094,9	855,4	3.950,3	4.980,8	1.325,7	6.306,5
Neuquen	1.245,6	1.735,9	2.981,5	1.997,7	2.688,0	4.685,7
Río Negro	1.582,5	2.176,1	3.758,6	2.569,6	3.370,0	5.939,6
Salta	2.708,0	612,0	3.320,0	4.417,2	948,8	5.366,0
San Juan	1.840,9	2.151,1	3.992,0	2.951,5	3.331,7	6.283,2
San Luis	892,1	1.027,2	1.919,3	1.435,7	1.592,5	3.028,2
Santa Cruz	510,3	440,2	950,5	812,1	682,0	1.494,1
Santa Fe	3.855,2	1.662,5	5.517,7	6.481,6	2.574,6	9.056,2
Sgo. Estero	2.186,1	1.027,2	3.213,3	3.603,5	1.592,5	5.196,0
Tucuman	2.292,8	2.096,0	4.388,8	3.826,9	3.246,6	7.073,5
Tierra de Fuego	303,5	1.394,0	1.697,5	480,2	2.159,4	2.639,6
Totals	<u>42.601,6</u>	<u>24.547,2</u>	<u>67.148,8</u>	<u>69.638,2</u>	<u>38.032,3</u>	<u>107.670,5</u>
Distribution	63,4%	36,6%	100,0%	64,7%	35,3%	100,0%

5. Analysis of the budgetary execution of the provinces

- 5.42 The expenses for fiscal year 1985 for seven provinces have been studied, including the forecasts for participants in this program. The provinces studied are representative in terms of population, financial resources and geographical distribution. Table # 8 which follows illustrates the financial activity of the provinces and the relative share of the Secretariat of Health of each one for fiscal year 1985.

Table # 8  
Expenses of the Secretariat of Health by Province  
1985  
(in thousands of US\$)

<u>Province</u>	<u>Total</u> <u>Expenses</u> <u>by</u> <u>Province</u>		<u>Expenses of the Secretariat of Health and</u> <u>relation to total provincial expenses</u> <u>expenses in percentages</u>					
			<u>Operations</u>	<u>%</u>	<u>Capital</u>	<u>%</u>	<u>Total</u>	<u>%</u>
Misiones	172,674	16,952	9.8	1,341	0.8	18,293	10.6	
Rio Negro	199,535	26,492	13.3	2,593	1.3	29,085	14.6	
Neuquen	216,910	20,578	9.5	1,906	0.9	22,484	10.4	
Chaco	246,656	33,067	13.4	1,343	0.5	34,410	12.9	
Formosa	160,315	17,920	11.2	2,770	1.7	20,690	13.5	
Cordoba	501,342	66,450	13.3	1,034	0.2	67,484	13.5	
Santa Fe	606,907	71,507	11.8	4,379	7.2	75,886	12.5	

5.43 As can be seen, the relative share of operating expenditures of the health sector as opposed to the total costs of the provinces varies between the lowest, Neuquen, with 10.4% of the highest, Rio Negro, 14.6% with an average of 12.6%. The capital expenditures vary between the lowest, Cordoba with 0.2% and Chaco with 0.5% of the highest; and Santa Fe with 7.2% of the share. In absolute terms of capital expenditures, the applications vary between US\$1 million in Cordoba to US\$4.4 million in Santa Fe. In operations, the absolute expenditures vary between US\$71.5 million for Santa Fe to US\$16.9 million in Misiones.

5.44 Table # 9 illustrates the impact of PAS funds on the budgets of the seven (7) provinces studied. Compared to total expenses of the Secretariat of Health for 1985, the applications of PAS funds has a greater impact in provinces with lower income. This concept is observed when the applications of PAS funds is analyzed in the expenditures of the following provinces: Misiones, (21.6%); Rio Negro, (12.9%); Neuquen, (13.3%); and Formosa, (18.7%). In terms of capital expenditures, HSP funds cover a large share of the investments of all of the provinces, from 38% for Santa Fe, to 91% for Neuquen. The PAS funds, which represent a large amount of income, still do not have as much impact on the operating expenditures, which vary from 5.4% for Santa Fe to 18.3% for Misiones. It is noteworthy that with PAS funds being allocated by participating provinces to the program,

it would be necessary to allocate other resources from the provinces to the capital expenditures of the Secretariats of Health for other programs.

Table # 9

FUNDING FOR THE NATIONAL HEALTH SUPPORT PROGRAM (PAS)  
Share of Expenses of the Secretariat of Health by Province  
1 9 8 5

(in thousands of \$US)

	Total Funds <u>PAS</u>	Total Secy. of Health	%	PAS Funds <u>Capital</u>	Secy. of Health <u>Capital</u>	%	PAS Funds <u>Operations</u>	Secretariat of Health <u>Operations</u>	%
Misiones	3,950.3	18,293.2	21.6	855.4	1,341.1	63.8	3,094.9	16,952.1	18.3
Rio Negro	3,758.5	29,085.4	12.9	2,176.1	2,593.1	83.9	1,582.5	26,492.3	6.0
Neuquen	2,981.5	22,483.8	13.3	1,735.9	1,905.7	91.1	1,245.6	20,578.1	6.1
Chaco	3,345.0	34,410.1	9.7	612.0	1,342.8	45.6	2,733.0	33,067.3	8.3
Formosa	3,878.6	20,690.0	18.7	2,419.5	2,769.7	87.4	1,459.1	17,920.3	8.1
Cordoba	5,501.1	67,483.6	8.2	465.2	1,033.9	45.0	5,035.8	66,449.7	7.6
Santa Fe	5,517.8	75,886.3	7.3	1,662.5	4,379.3	38.0	3,855.2	71,507.0	5.4



## VI. PROGRAM JUSTIFICATION

### A. Technical feasibility

- 6.01 The proposed Program would make it possible to begin to fulfill the General Health Plan in participating provinces by contributing to: a) decentralization of health services; b) the possibility of access to the possible care; and, c) reorganization of the provincial service network, strengthening operational capacity and improving the quality of service delivery.
- 6.02 The proposed Program would replace hospitals that manifest: (a) a marked degree of deterioration because of age, degree of conservation and excessive use of the physical plant, installations, and equipment; and, (b) clear deterioration of hospital care stemming from lack of resources and inadequate organizational, diagnostic, and treatment technologies. This is expressed in the low yields observed and especially in the high rates of hospital mortality in most of the establishments examined. In addition to the above, the new hospitals would establish norms for and serve as reference centers in each province. As a group they would have a positive impact on other provinces of the country.
- 6.03 The proposed operational concept would make Program hospitals effective and efficient since they would: a) have improved administration and hospital organization based on use of full-time staff and on the availability of technology of proven effectiveness; b) reduce hospital mortality rates using the new technological resources and the new organization of these resources; c) improve yield and use of services by means of the new modes of care proposed.
- 6.04 The new hospitals with the hospitalization modules described would be very flexible thus differentiating them from hospitals traditionally structured by medical speciality: (medicine and medical specialties, surgery and surgical specialties, pediatrics, and obstetrics and gynecology). The latter structure is a limiting factor to adequate use of hospital beds, resulting in low rates of use being observed (i.e., 60-70% in use). This factor has conditioned situations in obstetrical services in which bed use is over 100% (e.g., cots are placed in corridors); in other services occupancy is 40-50%, depending on the case. In order to prevent this situation, the new hospitals are being programmed to have an average of 80% of their beds "undifferentiated", meaning that at a given moment a room with four beds may be used to practice medicine with male patients and at another time it may be used for surgery on female patients. In this way the organizational rigidities of truly impervious compartments found in traditional hospitalization (beds for general surgery, otorhinolaryngology, ophthalmology, etc.) is avoided and better care is provided.

- 6.05 The Program emphasizes its purpose of reinforcing installed capacity by improving its use and quality of care, not be increasing the number of beds. The yields will be greater on the basis of the following average standardization:

<u>INDICATOR</u>	<u>NEW HOSPITAL</u>	<u>OBSERVATIONS</u>
Doctors	8 hours	per day
Staff	2.7	per bed
% Occupancy	80.0	of all beds
Length of Stay	10.0	days per patient
Turnover of beds	29.2	patients per year
Doctors' hours	4.0	hourly consultations

These yields planned for the new hospital are reasonable within the norms of hospital administration and are acceptable for the conditions and complexity of the hospitals in the Program once they are fully operational.

- 6.06 No problems are anticipated with regard to human resources given the large supply of existing basic staff. However, needs were detected in staff training for the new organizational, diagnostic, and treatment technologies that the new hospitals would use. Therefore an important component of institutional strengthening is programmed to guarantee technical feasibility in an integral fashion, complementing the hospitals' adequate organization and functioning in their provincial contexts.
- 6.07 By improving the hospitals' installed capacity, the program would provide them with conditions needed for them to be accredited and qualify as social assistance service delivery institutions in each province.
- 6.08 Final architectural designs are available for four of the projected hospitals; preliminary designs have been drawn up for the other seven in the Program. A team of architects and engineers with the skills to prepare the detailed plans that are lacking are ready and it will be available, the documentation needed to open bidding on the four hospitals upon signing of the loan contract. No difficulties are foreseen in terms of developing the preliminary designs on time so as to start construction in the proposed period.
- 6.09 As regards unit costs, an index of 72 square meters of construction per bed at a cost of US\$606 per square meter yields and average direct construction cost of US\$44.100 per bed. These averages are acceptable and reasonable taking into account the nature of hospital infrastructure and the fact that the overall "per bed" index includes the costs of space built for outpatient services.

6.10 The direct cost of equipment (estimated at US\$66 million) amounts to 50.3% of direct construction costs, which is a satisfactory index. Equipment has been organized in four main categories: a) fixed equipment in construction: 21.2%; b) fixed medical equipment: 25.1%; c) mobile equipment and instruments: 39.4%; and d) furniture and linens: 14.3%.

6.11 With regard to operating costs, the unit costs are as follows: (a) Outpatient services: Average cost of US\$5.54 with a minimum of US\$4.20 and a maximum of US\$7.39. These costs are acceptable given the complexity of services delivered. It is important to note that at the present outpatients (with some exceptions) are not given drugs, but they are provided in Program hospitals. (b) Discharges: with regard to discharges average costs amount to US\$319, with a minimum of US\$277 and a maximum of US\$415. This maximum value occurs at the two hospitals with the least number of beds (Neuquen and Rio Negro), which is acceptable. The average value of US\$319 is equivalent to a daily expenditure per patient amounting to US\$31.90, which is reasonable given the complexity of services delivered.

#### B. Institutional feasibility

6.12 The Health Secretariat has the legal and administrative guidelines necessary for planning and building the facilities to be included in the Program. However, it does not have experienced personnel to implement the program due to limitations in the number of staff, low salaries, and the fact that this will be its first experience in implementing a Program at the proposed level.

6.13 It is believed that the establishment of the Central Implementation Unit staffed with experienced and capable personnel is essential to guarantee implementation of the Program. The Implementation Unit, as designed, and staffed with qualified and experienced personnel, will have the operational and technical capacity to adequately implement the proposed Program. Nonetheless, the operational and technical capacity of the hospitals' future managements need to be strengthened in order to adopt new health service techniques, fully use the equipment, and implement administrative and information systems to increase productivity of health services and establish the hospital system. For this purpose, an institutional strengthening component will be included, incorporating design and training programs in: health services organization; maintenance programs; hospital administration; information systems; research on service operations technologies; financial accounting systems and costs; and medical/paramedical training.

#### C. Financial feasibility

6.14 Program impact in terms of resources needed to attend to the counterpart in a timely fashion and incremental operational costs, functioning, and maintenance of the program's health facilities, were examined on the basis of a projection of national resource needs as explained below.

1. Local matching funds for implementation

- 6.15 The total amount required as the local counterpart is drawn from the national budget, and excluding commercial credit for equipment during the implementation period, would come to a total of US\$137.5 million as shown in the following chart:

Impact of local matching funds on the Central Government's capital expenditures budget (in U.S. million of dollars)						
	<u>1</u>	<u>2</u>	<u>3</u>	<u>4</u>	<u>5</u>	
National Budget for 1986						
Capital Expenditures	<u>2.109,8</u>	<u>2.109,8</u>	<u>2.109,8</u>	<u>2.109,8</u>	<u>2.109,8</u>	
National sources for the						<u>Total</u>
program						
PAS funds	17.7	18.4	19.3	20.5	21,9	97,8
Additional funds	<u>5.2</u>	<u>0.5</u>	<u>9.6</u>	<u>20.4</u>	<u>4,0</u>	<u>39,7</u>
Total	<u>22.9</u>	<u>18.9</u>	<u>28.9</u>	<u>40.9</u>	<u>25,9</u>	<u>137,5</u>
Ratio to 1986 National						
Capital Budget	<u>1.1%</u>	<u>0.9%</u>	<u>1.9%</u>	<u>1.2%</u>	<u>1,2</u>	

- 6.16 The amounts required for program implementation from the national budget derive from its basic sources: The National Health Support Project (FONDOS PAS); and additional funds from the total budget. PAS funds would cover 66.7%, and additional funds from the general budget would cover the remaining 33.3%. PAS funds are transfers from the Central Government through the Health Secretariat for health programs in the provinces. These funds would be deposited in a special extrabudgetary account to be used as local matching funds for the program. Moreover, additional funds would be required from the central government to complete the local matching funds not covered by PAS funds. The local counterpart's resource allocation amounts to a yearly average of 1.4% of the 1985 capital expenditures budget. The required amounts are considered to be within the country's financial capability. The budget's behavior, with significant increases in the health budget, the high priority accorded to this sector by the present government, and the high level of interest the provinces have shown in the Program -- given the agreement to allocate PAS funds -- all suggest that there will be no problem in local contributions being made on a timely basis.

- 6.17 The above analysis does not include commercial credit resources for purchase of equipment for Program hospitals, due to the external nature of these resources. These resources are considered to be local contributions, but they are not treated as direct transfers from the

national budget. These totals are estimated at approximately US\$28.5 million, equivalent to 16.1% of the required local contribution; they represent 9.5% of the program's total cost.

## 2. Operations and Maintenance Revenue and Expenditures

- 6.18 The Participation Agreement to be entered into by the National Health Secretariat and the Provincial Health Secretariats states that the provinces will take responsibility for hospital operations and maintenance. The medical assumptions under Chapter III, paragraphs 357-359, will be used to calculate operations and maintenance revenues and expenditures. The chart on the next page compared the hospitals' historic expenditures (except the hospital in Neuquen, which is brand new) and projected operations and maintenance expenditures. In addition, the chart shows the impact that operations and maintenance expenditures would have in the Ministry of Health's budget for each province (Annex VI-1 shows this in greater detail).
- 6.19 Operations and maintenance costs would be reduced in six provinces, since in some cases two hospitals are being consolidated, in other the number of hospitals beds is being reduced, and there would be increased operational efficiency. In Chaco, Formosa, and Salta two hospitals are being consolidated into one. In Chaco, Salta, San Juan, Santa Fe, and Tucuman the number of beds is being reduced. It should be noted that the decrease in hospitals beds does not necessarily reduce costs proportionately, because of the improvement and complexity of services offered by the new hospitals.
- 6.20 The increases in the hospitals' operations and maintenance expenditures is due primarily to the high level of complexity and expansion of services in the new facilities. Personnel expenditures have increased due to: The extension of doctors' schedules from part-time to full-time; the correction in salary policy to make wages more attractive; and compensation for loss of income that had been earned through other activities. Non-personnel expenditures are related to energy needed for air conditioning and heating, use of diagnostic equipment and lengthening of the hours of operation. Drugs and Materials expenditures have increased due to a policy change of providing needed drugs, expenditures relating to complementary diagnostic and treatment services such as X-rays, laboratory services, dialysis, mammography, etc. Food expenditures were only projected for hospitalized patients and medical personnel on call, a departure from some provinces' policy of providing food to all staff as an additional benefit. Maintenance expenditures reflect the adoption of policies established within the terms of the Participation Agreement and the application of systems developed within the institutional strengthening program.
- 6.21 With the construction and equipping of the new Program hospitals it is expected that the Provinces will be able to participate in the national and provincial "Obras Sociales" health program. In order to

participate in the "Obras Sociales" programs, any public or private health entity must demonstrate the capability to offer health services of acceptable quality. These standards of quality establish that the minimum requirement for health entities is an infrastructure that meets up to norms of sanitation, hygiene, and comfort and that the quality of their medical services comply with the national norms. It is considered that the program being studies would meet or surpass all the minimum requirements by virtue of its new buildings and modern equipment, and training and development of medical and technical staff so as to provide the services required by social assistance.

HEALTH IN ARGENTINA  
PROJECTIONS OF REVENUES AND OPERATIONAL COSTS  
(In thousands of US\$)

	New Costs	Actual Costs	Gross Increase Decrease	REVENUES				Net Increase Decrease	Health	Increase Decrease %
				SOCIAL ASSISTANCE	1986 Province	Budget				
%	Consul- tations	Hospita lization	Total							
Chaco	5309	5907	-598	-10.12	95	117	212.00	-810	34410	-2.35
Cordoba	4312	2486	1826	73.45	56	70	126.00	1700	67484	2.52
Formosa	4802	6963	-2161	-31.04	133	165	298.00	-2459	20690	-11.88
Mendoza	2966	5223	-2257	-43.21	73	89	162.00	-2419	32684	-7.40
Misiones	4111	2216	1895	85.51	50	64	114.00	1781	18293	9.74
Neuquen	2238	0	2238	100.00	67	83	150.00	2088	22484	9.29
Rio Negro	2238	1946	292	15.01	47	58	105.00	187	29085	0.64
Salta	4493	5784	-1291	-22.32	94	117	211.00	-1502	42297	-3.55
San Juan	4206	5337	-1131	-21.19	88	109	197.00	-1328	13783	-9.64
Santa Fe	3959	3815	144	3.77	83	103	186.00	-42	75886	-0.06
Tucuman	4041	2916	1125	38.58	85	105	190.00	935	34853	2.68

- 6.22 Each social assistance program varies in terms of its conditions and remunerations for services procured. However, all require co-participation in payment on the part of the user. In most cases, "Obras Sociales" covers 70% of service costs, while the user contributes 30%. Disbursements to the entity providing health services is based on an agreement defining conditions and regulations of participation for both parties. Remuneration is based on the use of a National or Provincial Standardized List. The national list (Nomenclador) used in most cases because it is more thorough and standardized.
- 6.23 The greatest difficulty in providing "Obras Sociales" services is the public health sector's inability to identify the users as affiliates of "Obras Sociales". Furthermore, the provision of health services to the Argentinian population, whether they can or cannot pay, is

national policy. Consequently, some beneficiaries are reluctant to identify themselves as "Obras Sociales" affiliates upon seeking public sector services so as not to pay their co-participation fee. The result, since people tend not to identify themselves as affiliates, is that the user receives public sector health services without paying, and the service provider is not paid by "Obras Sociales"; thus, public health services end up subsidizing "Obras Sociales" indirectly.

- 6.24 This problem has been the subject of intense debate for several years, and no viable solution has been found due to the lack of a system for identifying "Obras Sociales" affiliates. The Program will provide resources for the design and future application of an identification plan for all patients in the future hospitals and to incorporate the Public Employees' "Obras Sociales" within agreement with the Province. This measure renders such participation viable if the hospitals enter into an agreement with "Obras Sociales". In taking it will recover at least 70% of cost of services provided to members of the corresponding "Obras Sociales", which would proportionally reduce the provincial subsidy.
- 6.25 Income projections for the program are based on the hypotheses that the public sector affiliates of the hospital's area of coverage would be incorporated as potential users and would recover 70% of costs associated with consultation and hospitalization services. Appendix VI-2 establishes the distribution of recovery factors for each province based on estimates for the two types of services.
- 6.26 In summary, the financial feasibility of the hospitals' operations and maintenance expenditures included in the program is based on: improvement of services; correcting the obsolescent conditions found in the present hospitals; big expectations in terms of reducing the death rate; the great complexity of services; and the high priority placed on providing acceptable health services in the country. Of the participating provinces operations and maintenance costs are reduced in six of the hospitals from .06% in Santa Fe to 11.9% in Formosa. In three hospitals the increase is insignificant, ranging from .64% in Rio Negro to 2.68% in Tucuman. In three, cost increases range from US\$935 thousand (Tucuman) to US\$1.7 million (Cordoba), with a nominal impact on the Provincial Health Budgets. Operational costs for the new hospital in Neuquen were projected at US\$2.2 million. In Misiones the cost increase for the Health Budget is 9.7%; however, the impact on the provincial budget, which is US\$173 million, is of only nominal significance. On the other hand in the course of the analysis it was found that in Misiones historic expenditure levels were significantly below the norm with 2.2 staff per bed, while 2.8 per bed, the projected figure, is considered acceptable.

D. Socioeconomic Analysis

1. Introduction

- 6.27 The Program analyzed consists of the building, equipping, and institutional strengthening of eleven provincial hospitals (2.977 beds in all) including a new hospital, Neuquen, and ten hospitals to replace present hospitals with an average age of eighty two years. In the present situation, outdated establishments, shortage of equipment and only partial dedication of doctor's time, are factors causing inadequate care for patients, poor quality of services, unnecessary extension of hospital stays, and increase in inpatient discharge costs. The main criteria for selection of provinces for the Program (paragraph 4.31) were: obsolescence of hospitals and level of demand of the critically poor population (NBI population). 1/
- 6.28 With the program the absolute number of public subsector GPM beds 2/ (Appendix VI-2) in the catchment areas coverage would decrease by 15%. Flexibility of hospital design, institutional strengthening, provision of adequate equipment, and the increase of doctors hours are expected to cause increased output (i.e. increased utilization rates of beds and decrease in average patient down-time) so as to compensate for the negative impact of the reduction of the absolute number of beds on the overall potential supply. Considered as a whole, when the program is fully operational, it is expected that the capacity for hospitalization will be maintained, and the hospital's capacity for outpatient consultations (71%) increased. Such an increase would, in the absence of other parallel projects in the catchment areas, be less than the increase in required services (due to population growth) to maintain in 1995 the rate of discharges and consultations per inhabitant of the public subsector at the 1985 level. Considered separately, the following table indicates that the capacity for hospitalization (i.e. supply of discharges) decreases with the project in 5 of the 11 hospitals fundamentally by reducing the number of beds. In addition to the increase (in extent and quality) of traditional supply, the program proposed to increase the establishments' level of resolution and offer new highly complex services to attend to both the population presently unprotected (low income bracket and other low income sectors) and present beneficiaries of "Obras Sociales" (covered population).

1/ Estimated according to indices of unsatisfied basic necessities from the INDEC study "Poverty in Argentina" based on the 1980 census data. The indices include overcrowding, sanitary condition of the home; school attendance of dependent minors. Of the 11 provinces, in 8 the percentage of population in the low NBI category is above the national average while in three (Cordoba, Mendoza and Santa Fe) it is below.

2/ General, pediatric, and maternal beds.



Comparison of Discharges and Number of Beds  
with and without project

Hospital	O U T P U T S			NUMBER OF BEDS		
	With	Without	Difference	With	Without	Diff.
	Project 1995	Project 1985	With Without	Project 1995	Project 1985	With Without
Chaco	9.870	11.758	-1.888	338	529	-191
Cordoba	8.556	5.371	+3.185	293	208	+ 85
Formosa	8.877	8.090	+ 787	304	287	+ 17
Mendoza	6.424	0	+6.414	220	0	+220
Misiones	9.402	10.448	-1.046	322	324	- 2
Neuquen	3.504	0	+3.504	120	0	+120
Rio Negro	3.504	1.727	+1.777	120	54	+ 66
Salta	9.402	16.930	-7.528	322	560	-238
San Juan	9.870	17.323	-7.453	338	606	-268
Santa Fe	8.410	9.324	914	288	499	-211
Tucuman	9.110	6.807	+2.303	312	453	-141
TOTAL	86.928	87.778	- 859	2.977	3.520	- 543

\* In Mendoza a 200-bed hospital destroyed by the 1985 earthquake is being replaced. In Neuquen a new hospital is being built.

2. Target population. Health care

- 6.29 The provincial population of the eleven projects' areas of coverage in 1985 is estimated at 9.6 million; 35% of these are critically poor population (NBI). 1/ Total GPM beds (40,632) (Appendix II-2, p.3) are distributed among the public subsector (58%) and the private subsector together with "Obras Sociales" (42%), for an average of 5.0 beds per thousand inhabitant. In the Program's catchment areas (areas with most direct access to the hospitals) the ratio of beds (14,349) to population affected (3.2 million) is 4.42; 51% are public subsector beds, 9% correspond to "Obras Sociales", and 40% are of the private subsector (Appendix II-2, p.4).

1/ The indicators for the low NBI population apparently underestimate the country's poverty since they do not include population on ranches. Given the economic situation in recent years the percentage of poor population could have increased with respect to the 1980 indicators. The low income bracket indicators are used in this analysis to indicate critically poor population.

- 6.30 The installed capacity is 4.42 beds per thousand inhabitants. Nevertheless, given the hospitals' physical obsolescence, their real capacity to offer assistance could be less than the figure indicated. The program would replace 48% of the public subsector beds in all of the 11 targeted catchment areas.
- 6.31 The Argentine health system consists of three subsectors: Public, Private, and "Obras Sociales" (which are separate social funds formed originally by labor unions to offer medical care plans to their affiliates to "Obras Sociales" in 1985). In all, it is estimated that approximately 73% of the population of the 11 provinces is affiliated to "Obras Sociales". Of these, INOS has approximately 5.5 million and COSSPRA 1.9 million affiliates. "Obras Sociales" attends to its members through private health care providers, channeling most of its funds to the private subsector, and only occasionally to the public subsector. By contract with the private subsector "Obras Sociales" is committed to pay the health provides 70% of the value (according to a standardized price list) of the service rendered to the affiliate. The remaining 30% (co-insurance) is paid directly by the patient. Thus the affiliate is free to choose, from the list of "Obras Sociales" health agents, the doctor and/or establishment for his care. The financing of "Obras Sociales" is based fundamentally on payroll deduction equivalent to 3% of employ employee's salary and employer contribution equivalent to 4.5% of employee's wages.
- 6.32 The population of the provinces receiving assistance within the public subsector is the low income population (paragraph 6.50), mostly NBI population. A percentage of this population, ranging from 23% to 38% according to the hospital, is affiliated to "Obras Sociales". Nevertheless, it is assisted (despite the deterioration of the establishments and the quality of the services) in public hospitals which, not having any agreement with Social Work and not charging for their services, they are subsidizing the Social Work and the patient. Due to its very low income, those populations have very limited access to the private subsector, either because it is not affiliated to the Social Work or even being affiliated, it has not capacity to afford the charge to the patient (coinsurance) imposed by the private subsector. In the present situation, with very few exceptions, the low income population is the most important consumer of the public subsector, thus constituting the main population object of this Program. This population receives hospital services of inadequate quality. When analyzing the efficiency in the use of the present public infrastructure on the basis of a sample of 4 of the 11 hospitals (Annex IV) it was found that due, partly, to lack of flexibility, the hospitals operate, in some services, with rejection levels unacceptable because of insufficient capacity.
- 6.33 The socioeconomic analysis of this Program consists of three sections. The first analyses hospital sizes in relation to the demand of eleven hospitals, including the three sample projects and eight others that may be eligible for participation in the Program. The second section

analyzes the economic feasibility of six hospitals that represent the three basic models of the medical programs, a pediatric hospital, and a hospital that is not a replacement. The six hospitals analyzed are situated in three of the five regions that may be eligible for the Program. The last section consists of a low-income impact analysis including characteristics of Program's beneficiaries, their capacity to pay, and investment recovery options.

(a) Program dimensioning

- 6.34 The concept of "demand" which is applied in the analysis is based on the aggregate relationship of target population and services delivered within the public subsector. For each of the 11 hospitals, actual demand is defined on the basis of statistical information on population and services in the respective catchment area. This area is determined in accordance with the analysis of patients' place of residence based on a sample of 6 of the present hospitals. It concludes, with some exceptions, the capital city, where the hospital is located, and urban centers that grow up around the provincial capital in a geographical area called the "aglomerado".
- 6.35 The dimensioning of the Program and of each of the 11 hospitals was determined as a function (of projections) of hospital services deficit in 1995: Three main factors determine deficit size: (i) the present level (1985) of health care delivery of the public subsector in the total of the catchment area 1/ measured by the number of inpatient (or consultations) of the public subsector per capita per year; (ii) population growth in the project's catchment area; 2/ (iii) potential supply in the catchment area (assuming an estimated potential utilization rates of beds) of other public hospitals functioning at present, and other parallel projects, which are projected to be operational during the course of the Program. The analysis (Appendix VI-3), due to lack of information on (the extent and characteristics of) supply and demand of other health services providers, is based on quantitative information from the public subsector only and some hypotheses on the behavior of the private subsector (Appendix VI-3, p.2). The main hypothesis is that the private subsector will grow in the future at the rate needed to maintain its present coverage per capita per year. Nonetheless, the conclusions of the analysis indicate that if this hypothesis were reversed, the public sector demand would be even greater than estimated in this study. The estimated of the analysis are presented in Appendix VI-3, pp.3-6, and the conclusions in tables 6-1 and 6-2 below.
- 6.36 In 1985 the rate of inpatient (public subsector average) in the 11 catchment areas was six discharges per 100 inhabitants; assuming that total average inpatient (public and private) per inhabitant per year in the target provinces were equal to the national average (11 discharges per 100 inhabitants), the other subsectors would have an average participation of five discharges per 100 inhabitants. Total

potential demand of the public subsector per catchment area (Appendix VI-3, p.4) can be determined by holding participation of the public subsector constant at the 1985 level (Appendix VI-3, p.3) and projecting the populations for each area.

Table 6-1  
Inpatient services  
Potential demand hospitalization for hospitals

	Deficit of Discharges 1985	Project Discharges	Beds required to cover deficit	Project beds
Chaco	15,707	9,870	538	338
Córdoba	7,676	8,556	263	293
Formosa	10,932	8,877	374	304
Mendoza	17,786	6,424	609	220
Misiones	14,052	9,402	481	322
Neuquen	8,272	3,504	283	120
Río Negro (Cipolletti)	2,607	3,504	89	120
Salta	21,558	9,402	738	322
San Juan	20,060	9,870	687	338
Santa Fé	15,512	8,410	531	288
Tucumán	19,829	9,110	679	312
TOTAL	153,996	86,928	5,273	2,977

TABLE 6-2  
POTENCIAL DEMAND (Outpatient Consultation)  
FOR HOSPITALS

	Consultation deficit 1985	Project Consultations	Outpatient Depts. re- quired to cover deficit	Project Outpatient Depts.
Chaco	363,894	313,600	89	40
Córdoba	251,901	282,240	59	36
Formosa	222,108	227,360	42	29
Mendoza	221,708	156,800	159	20
Misiones	250,196	282,240	40	36
Neuquen	186,208	141,120	59	18
Río Negro	154,680	141,120	24	18
Salta	671,226	313,600	160	40
San Juan	341,862	313,600	82	40
Santa Fe	219,478	188,160	85	24
Tucumán	296,675	337,120	106	43
TOTAL	3,179,937	2,696,960	905	344

- 1/ The rate of participation is held constant in the projection of demand. The figures (1985) were provided by the Ministry of Health and Social Action.
- 2/ INDEC's population projections based on the 1980 census.

- 6.37 If other projects are not carried out during the period in consideration, the conclusions in this analysis indicate that the dimensioning of these hospitals is rather conservative, except Cordoba and Rio Negro which, due to certain particular characteristics, require specific analysis.
- 6.38 In the case of Cordoba, the new children's hospital could attract, as a specialized hospital, additional demand outside of the present reference network. This demand, which has not been considered in this analysis, could arise from "Obras Sociales" and the private sector. The hospital that is substituted in Cipolletti, Rio Negro (54 beds) does not have the capacity to fully cover local demand. Part of this demand is diverted to the Neuquen Central Hospital. According to the analysis of the place of residence of Central Hospital users, <sup>1/</sup> 3% of inpatient and 14% of consultations at the hospital were to provide care for inhabitants of Rio Negro. On establishing an adequate hospital in Rio Negro, the demand would probably cease to be diverted to Neuquen or other provinces, rendering the project feasible. In any case, if it is found in the final studies on the basis of the selection criteria (paragraph 4.32) that Cordoba Hospital or Rio Negro Hospital would be oversized, it would be possible to adjust the design given its flexibility.
- 6.39 With respect to the potential demand for outpatient consultations, in none of the hospitals would the estimated demand exceed the deficit projected for 1985.

(b) Economic Feasibility

- 6.40 As is observed in Appendix III-4, the three basic models of the medical program are: a) 338 beds; b) 293 beds; and, c) 120 beds. The level of complexity of the first two would be VIII, and the complexity of Model C would be VI, as defined in paragraphs 2.24 ff. Considering that the unit costs and services offered by the hospitals of each level are similar, since they serve the same segment of the population and provide the same type of health care, a sample was analyzed which includes the three basic models: a) Chaco; b) Formosa; and, c) Rio Negro. In addition, Cordoba has been analyzed, since it is the only pediatric hospital, and Neuquen, since it is not a replacement hospital. The hospitals of the sample are located in 3 of the 5 regions that would participate in the Program. For the analysis it was considered that technically the physical and functional state of obsolescence of the hospitals does not permit the alternative of repair. Using the available information the analysis compares the alternatives with and without the program for the replacement hospitals. In addition, the costs of the proposed services in the project are compared with the corresponding costs of two public hospitals functioning at present in Buenos Aires and Neuquen which have similar levels of complexity.

<sup>1/</sup> Carried out for 1985 based on a sample of 2,308 hospitalized patients, equivalent to 24% of all patients that year.

- 6.41 The methodology used consists of: a) comparison of current unit costs with and without the project; and, b) comparison of total unit costs with the project as opposed to current costs without the project. The following exercise makes it possible to determine the efficiency that would achieve by replacing the hospitals, although it does not compare homogeneous products. If, despite the superior quality of the project's services, costs are less than those of the present hospitals, the difference would indicate the savings for the economy and the project's cost-effectiveness.
- 6.42 The annualized investment cost of the sample of five hospitals, using a discount rate of 12% and a use life of 40 years for the buildings and 20 years for the equipment, and discounting all items that do not reflect real costs to the economy, is presented in Table 6.3, as follows:

Table #6.3  
Prototype Hospitals  
Annualized Investment Cost  
(in thousands of US\$ to June 1986)

Province	Number of beds Model of hospitals	Annualized Investment Cost
Chaco	338 A	2,298
Córdoba	293 B Pediátrico	2,040
Formosa	304 B	1,931
Misiones	322 A	1,950
Neuquen	120 C	850

- 6.43 The operations and maintenance cost of all the Program's hospitals are presented in paragraph 3.57. to analyze the efficiency of the hospital's operations, the hospitals' average cost per inpatient and per consultation (with the project) is compared with the equivalent costs of the present hospitals (without the project). The results are shown in Table 6.4, which shows that the direct operations and maintenance costs per inpatient are less in all the hospitals, except that of Misiones (paragraph 6.20), considering that the increases in efficiency are fundamentally due (in the cases of Chaco, Formosa, and Río Negro) to economies of scale that result from merging of two or more hospitals in a single hospital, and the consolidation of pavillion establishments into single compact hospitals. The economies result mainly from savings in fixed personnel costs and are reflected in lower unit costs. In Cordoba, the per unit cost is reduced because of increases in production.

Table #6.4

Comparison of Unit Costs of Operations and  
Maintenance for a Sample of Hospitals  
(June 1986 US\$)

Hospital province	Cost per Discharge			Cost per Consultation		
	With Project	Without Project	Dif- ference with/ without	With project	Without project	Dif- ference with/ without
Chaco	350	402	-52	6	6	0
Córdoba	328	370	-42	5	3	+2
Formosa	352	689	-337	7	10	-3
Misiones	284	170	+114	5	3	+2
Neuquen	415	644	-229	6	6	0
Río Negro	415	901	-486	6	4	+2

6.44 Table 6.5 illustrates total unit costs (investment plus operations and maintenance) and compares them with operations and maintenance costs of the existing hospitals. Despite the fact that the present hospitals have no investment cost, the comparison is useful for putting into perspective the extent of the change.

Table #6.5  
Comparison of Costs for a Sample of Hospitals  
(June 1986 US\$)

	COST PER INPATIENT					COST PER CONSULTATION				
	With project invest- ment cost	With project current cost	With project total cost	Without project current cost	Total cost with 1/2 current cost without	With projet invest- ment cost	With project current cost	With project total cost	Without project current cost	Total cost with 1/2 current cost without
Chaco	210	350	560	402	1,39	,73	6	6,73	6	1,12
Córdoba	251	328	543	370	1,47	,72	5	5,72	3	1,92
Formosa	196	352	548	689	0,80	,85	7	7,85	10	0,79
Misiones	187	284	471	170	2,77	,69	5	6,69	3	2,23
Neuquen	218	415	633	644	0,98	,60	6	6,60	6	1,10
Río Negro	218	415	633	901	0,70	,60	6	6,60	4	1,65



- 6.45 The results show that three of the six hospitals, Formosa, Neuquen, and Río Negro, would obviously be cost-efficient (i.e. the current cost of operations and maintenance per inpatient is actually greater than the unit cost of investment plus operation and maintenance of the project). The increases in hospitalization costs of the other hospitals, except for Misiones, appear to be reasonable if one takes into account the increase quality of the service.
- 6.46 Present discharges from the Misiones hospital have levels of prescriptions for drugs and medical-surgical equipment that are unacceptable for proper care. Moreover, the hospital operates with 2.2 staff per bed, which is also considered technically insufficient. With the project, the cost per inpatient increases substantially because of increases in drugs, medical-surgical equipment, and the increase in staffing, which would be on the order of .5 per bed.
- 6.47 In October 1986, at the Bank's request, the Ministry of Health and Social Action carried out a cost analysis of two public hospitals (Central Hospital of Neuquen, and the Ramos Mejía Hospital of Buenos Aires) that offer services of a complexity comparable to those of the program. The cost per inpatient of the Central Hospital (US\$644) is greater than that of two hospitals of the program whose degree of complexity is similar to the Central Hospital (Neuquen and Río Negro). The cost per inpatient at the Ramos Mejía Hospital (US\$625), whose degree of complexity is similar so that of the other four projects, is superior to their cost per inpatient, even though medical salaries in Buenos Aires are lower than in three of these provinces (Chaco, Córdoba, and Formosa). In Misiones, medical salaries are 13% less than in Buenos Aires, and the total cost per inpatient of the Misiones project (including investment costs) is 25% less than the operations and maintenance costs per inpatient of the Ramos Mejía Hospital. Compared to Neuquen's Central Hospital and Buenos Aires's Ramos Mejía Hospital, the costs per discharge of the sample of projects appear to be reasonable.
- 6.48 As regards outpatient consultations, the costs increase in all the hospitals (except for Formosa) due to the fact that the project proposes as a new mode of operation providing drugs free of charge to outpatients. With the exception of the Central Hospital of Neuquen, none of the hospitals analyzed currently provide drugs to outpatients. With the Project, the average cost of drugs is US\$1 per consultation. Excluding this cost so as to allow for a less heterogeneous comparison, the Project's current cost in Chaco, the same in Neuquen, and would increase by 25% in Río Negro and 33% in Córdoba and Misiones. The average cost per consultation at the Ramos Mejía Hospital (excluding drugs) is US\$3.67, and at the Central Hospital of Neuquen (including drugs), US\$6. The increase in cost per consultation with the Project is due to technical reasons (paragraph 6.20).

(c) Analysis of the Program's Beneficiaries

(i) Characteristics

- 6.49 Analysis of the Program's beneficiaries was done on the basis of a survey <sup>1/</sup> carried out by the Ministry of Health and Social Action in four of the Program's hospitals (Charco, Formosa, Misiones, and Córdoba) and two public hospitals (Neuquen and Mendoza) not part of the Project. In the present situation, the patients of the Chaco, Formosa, and Misiones hospitals typically have low incomes and very limited educational levels. Results of the analyses of low incomes among these three hospitals' patients are illustrated in Table 6.6.

TABLE #6.6

Distribution of Family Income of the Public Hospital Patients

Monthly Family Incomes (in Australes)	CHACO			FORMOSA			MISIONES		SAMPLE TOTAL			
	%	%	Accumm.	%	%	Accumm.	%	% Accumul.	%	% Accum.		
Less than - 50	19,40		19,40	24,50		24,50	8,50		18,00		18,00	
50 - 99	42,10		61,50	32,40		56,90	33,60		42,10		36,00	54,00
100 - 149 <u>1/</u>	22,10		83,60	26,20		83,10	44,80		86,90		31,00	85,00
150 - 199	9,50		93,10	7,10		90,20	7,60		94,50		8,00	93,00
200 - 249	4,20		97,30	1,90		92,10	4,70		99,20		3,00	96,00
250 - 299 <u>2/</u>	1,50		98,80	4,40		96,50	0,40		99,60		2,00	98,00
More than - 300	1,20		100,00	3,50		100,00	0,40		100,0		2,00	100,00

<sup>1/</sup> Incomes under 149 are less than 1/2 of the Bank low income level for 1986.

<sup>2/</sup> Incomes under 299 are below the Bank low income level for 1986.

Sources: Surveys done in 1986 in the sample hospitals.

<sup>1/</sup> The survey covered 1.694 patients selected at random: 280 in Chaco; 292 in Formosa; 263 in Misiones; 324 in Córdoba; 245 in Neuquen; and 290 in Mendoza. The patients surveyed are distributed as follows: approximately 20% in emergency care, 40% in outpatient consultations, and 40% hospitalized.

- 6.50 As the above table indicates, 98% of all users of these hospitals are members of families that declared their monthly incomes to be below the low income level set by the Bank 1/ and 85% state their incomes to be less than half the Bank low income level. The survey also reveals that 86% of the heads of household are either self-employed (33%), have private (36%) or public (11%) sector jobs, are domestic workers (7%), or have no income (11%). The sectors of the economy in which the users are employed include: services (56%), manufacturing (18%), commerce (14%) and agricultures (12%). The 14% of heads of households who do not work are either unemployed (6%), retired (4%), or housewives (4%). Most of the patients are unskilled workers. Of the sample population, 57% are women, 68% are over 15 years of age, 40% have had no education, and 55% have completed only their primary education.
- 6.51 In September 1986, at the Bank's request, the Ministry of Health carried out a survey over a three-day period to determine the income levels and other characteristics of public hospital users. The group of other hospitals presented below includes the Pediatric Hospital of Córdoba and two public hospitals that are not part of the Project (Central Hospital of Neuquen, and Lago Maggiore Hospital of Mendoza). Comparing them with the users of the first sample, the make-up of the population of these other hospitals does not vary significantly as regards employment levels, sector of employment, and patients ages (except in Córdoba). 2/ Nonetheless, the educational levels are higher (over 10% of the patients have at least a secondary education. The survey also reveals that in some of the hospitals the groups of patients with incomes above the Bank low income threshold increases. Table 6.7 illustrates that both the percentage of the Bank population with incomes below half the Bank low income level, as well as the percentage of the low-income population in general, is lower than among the patients making up the first sample population, perhaps indicating relatively less participation on the part of the low NBI population. In sum, the sample results for the six hospitals show that on average over 90% of the patients' incomes are below the Bank low income bracket.

1/ The annual per capita low income level as of March 1986 was 813 australs (318 australs per family assuming an average of 4.7 members per family). <sup>/month</sup>

2/ The Córdoba hospital is for children. Some 99.7% of the patients are in the 0-14 age group.

Table #6.7

Distribution of Family Incomes of  
Public Hospital Patients

Monthly family incomes (in australs)	PROVINCES Neuquen		Cordoba		Mendoza	
	%	% Accumm.	%	% Accummul.	%	% Accummul.
Less than - 50	4,30	4,30	3,50	3,50	1,10	1,10
50 - 99	10,50	14,80	18,60	22,10	16,20	17,30
100 - 149	21,40	36,20	33,40	55,50	28,20	45,50
150 - 199	20,50	56,70	19,90	75,40	18,10	63,60
200 - 249	13,30	70,00	14,20	89,60	15,20	78,80
250 - 299	9,50	79,50	3,80	93,40	11,90	90,70
More than - 300	20,50	110,00	6,60	100,00	9,30	100,0

a/ The hospitals are the Castro Rendón (Neuquen), the Pediatric (Córdoba), and the Lago Maggiore (Mendoza).

Sources: Survey done in 1986 at the corresponding hospitals.

(ii) Payment Capacity of the Beneficiaries and Recovery of the Investment.

6.52 According to the analysis of the survey done in the six hospitals, all of the present patients of public hospitals are attended to without them making any direct payment to the hospitals for services rendered. Average transportation time to the hospitals is approximately one hour, except in Formosa. 1/ As a percentage of the average per capita monthly income, the transportation cost varies from 2% in Mendoza to 7% in Formosa. Setting aside the transportation cost, the cost of a single outpatient consultation in one of the Program's hospitals would absorb more than 13% of the monthly per capita income of 98% of the

1/ The average transportation time to the hospital is 4 hours.

patients in Chaco, Formosa, and Misiones, and of 80% of the population for the other public hospitals. Given the low incomes of this population, it is not feasible to obtain significant recovery of the investment through direct charges to the patients.

- 6.53 Information from INOS and the Ministry of Health and Social Action supplies to the Bank indicates that in the provinces public employees, retirees, and some private sector employees have to be affiliated with "Obras Sociales". On the basis of this information those users whose type of employment was considered to be covered when they were working in the private sector were chosen from the survey (by occupational code), along with all public employees and retirees. The results of this selection process indicate that part of the population attended to in the public hospitals (see Table 6.8), varying from 22.8% in Chaco to 37.5% in Neuquen, is affiliated with "Obras Sociales". This population is served free of charge in the public subsector, and without identification of affiliation and thus with no charge to "Obras Sociales", thereby constituting a subsidy (of 70% of the service fees) of the public subsector to the benefit of "Obras Sociales".

TABLE #6.8  
Percentage of Hospital Patients who are  
affiliated with Social Assistance

	Retirees	Public Sector Employees	Private Sector Employees	Total Population Affiliated with Social Assistance
Chaco	3.9	8.2	10.7	22.8
Formosa	5.5	13.4	7.5	26.4
Misiones	2.7	5.7	15.6	24.0
Córdoba	1.7	7.2	17.6	26.5
Mendoza	6.6	10.0	12.4	29.0
Neuquen	7.3	13.1	17.1	37.5

Source: Estimates from 1986 survey of a 1,694 patient sample.

- 6.54 Results of the analysis of beneficiaries indicate that while the total of funds that could be recovered by directly charging the low-income population is not very significant, identification of "Obras Sociales" affiliates and commitment to pay for such affiliates would allow for recovery of part of the investment by charging "Obras Sociales" for the population covered.

(d) Conclusions

- 6.55 The Programs demand and the hospital's sizes were analyzed based on estimates of hospital service deficits in eleven Argentine provinces. The sizes of the 3 sample projects hospitals in the sample appear to be adequate, and the remaining projects will be subjected to the analysis specified in the eligibility criteria (paragraphs 4.31 and 4.32). The analysis assumed that technically the state of physical and functional obsolescence of the hospitals does not allow for the possibility of repairs. Not having carried out minimum cost studies on replacement alternatives, the Program's economic feasibility was analyzed (for a sample of (6) hospitals, including three basic models of general hospitals, one pediatric model, and one hospital that is a replacement hospital, in three of the five target regions) comparing the hospital's current unit costs under present circumstances and under the project. The Project's unit cost were also compared with two of the country's public hospitals similar in complexity to those of the Program. Based on the analysis carried out, the 3 sample Projects' current unit costs appear to be reasonable. The remaining projects will be analyzed following criteria specified in paragraphs 4.31 and 4.32. The Program's distributive impact is substantial given that approximately 90% of the hospital users are from low income sectors.

A R G E N T I N A

SITUACION ECONOMICA RECIENTE Y PERSPECTIVAS

A. Situación Económica Reciente

- 1.01 La evolución de la economía argentina se caracterizó por un cambio significativo durante 1985. El Gobierno lanzó a mediados del año un plan drástico de estabilización denominado el "Plan Austral", con el objetivo primordial de lograr la estabilidad de precios en una economía con un largo período de inflación creciente, que en junio de 1985 se hallaba al borde de la hiper-inflación.
- 1.02 El Plan Austral contó con el apoyo generalizado de la población y cumplió con su objetivo de reducir significativamente la inflación y las expectativas inflacionarias. La tasa de inflación se redujo del 28% mensual en mayo-junio de 1985, a un ritmo de sólo 2,9% por mes entre julio de 1985 y febrero de 1986, en tanto que los precios mayoristas aumentaron a una tasa promedio de tan solo 0,5% en ese mismo período.
- 1.03 Esta brusca reducción de la inflación estuvo acompañada de una gradual recuperación de la producción en los últimos meses de 1985, después de haberse producido una notoria contracción al inicio del Plan, que se reflejó en una gran eliminación de existencias. Sin duda alguna el Plan ha contribuido significativamente a la estabilidad en la economía y la confianza en el exterior.
- 1.04 En materia fiscal, ha habido una mejora sustancial desde la adopción del Plan Austral. El déficit consolidado del sector público no financiero se redujo considerablemente en 1985 al equivalente de 4% del producto interno bruto (PIB), del 12,5% en 1984 y 15,7% en 1983. Desde el segundo semestre de 1985 el financiamiento del déficit se hizo sin recurrir al crédito del Banco Central. Esta mejora se logró a través del mejor comportamiento de los ingresos, que resultó de los ajustes efectuados en junio de 1985 en los impuestos locales y las tarifas de servicios públicos y también por el efecto de la estabilidad de precios en la recaudación. Por el lado del gasto, la congelación de los salarios y la reducción del nivel de inversiones públicas explican el comportamiento señalado.
- 1.05 En el sector externo el déficit de la cuenta corriente de la balanza de pagos se redujo en 1985 cerca de un 60% con relación al del año anterior. Esto fue posible mediante el logro de un mayor excedente comercial, principalmente a base de la reducción de las

importaciones y en parte por el mayor volumen exportado de cereales, a pesar de la caída de precios internacionales de dichos productos. Asimismo ha habido un menor egreso por servicios, por efectos combinados de la reducción de tasas de interés internacionales, renegociación de la deuda, y menores transacciones de bienes. A fines de 1985 se registró una ligera mejora de la posición de reservas internacionales brutas del país.

- 1.06 Dado su elevado nivel de deuda externa, la economía argentina se vio afectada durante 1985 por la situación económica internacional, en particular por la evolución desfavorable de los términos de intercambio y por las políticas fiscales y monetarias de los países desarrollados.
- 1.07 Estos factores que generan elevados niveles de las tasas internacionales de interés en términos reales para la economía argentina han producido los siguientes efectos sobre la actividad económica general : (a) una caída del PIB del 4,4% durante el año 1985, debido principalmente a la disminución del producto industrial y del comercio mayorista y minorista; (b) una nueva caída del nivel de inversión (la inversión bruta interna cayó un 16,8% en 1985 con respecto al año anterior); (c) una reducción del número de horas trabajadas debido al menor nivel de actividad productiva durante el año 1985. El nivel general de horas obrero trabajadas en la industria manufacturera cayó alrededor del 8% con respecto al año 1984. Este fenómeno se reflejó en un aumento de la desocupación y fundamentalmente del subempleo. La tasa de desempleo se elevó del 4,6% en 1984 al 6,1% mientras la subocupación aumentó del 5,6 al 6,9% y (d) una declinación en el ingreso real de la población. El nivel general del salario por trabajador industrial cayó en términos reales alrededor de 15% en 1985 con respecto al año anterior. Esta baja en el ingreso real de la población derivó en una disminución del consumo.
- 1.08 El comportamiento del sector agropecuario fue favorable en el primer semestre de 1985 por la buena campaña agrícola 1984-85 de cereales, cuya producción alcanzó a una cifra sin precedente de 44 millones de toneladas, de las cuales 13 millones correspondió a la cosecha de trigo. En la campaña agrícola 1985-86, sin embargo, hubo una gran merma debido tanto a la reducción del área sembrada, como a adversas condiciones del clima y de la severa inundación de noviembre de 1985 que afectó principalmente la zona triguera de la Provincia de Buenos Aires. Se estima que la producción de trigo para el año agrícola 1985-86 se reduzca a 8,5 millones de toneladas, con un excedente exportable de sólo 3,5 millones de toneladas. En el subsector pecuario, en cambio, no se registró mayor variación con relación al comportamiento del año anterior.
- 1.09 La industria manufacturera continuó deprimida en 1985, con una fuerte reducción en su nivel de actividad como resultado de la eliminación de existencias. Los mayores retrocesos se dieron en las ramas de textiles, maquinarias y equipos y minerales no



metálicos. En general, los artículos manufacturados fueron afectados por el deterioro de los ingresos de la población. Sin embargo, a partir de septiembre de 1985 ha habido indicios de una lenta recuperación en la demanda de productos manufacturados.

- 1.10 La construcción continuó manifestando un comportamiento negativo fundamentalmente por la inactividad de obras públicas, a raíz de la política de austeridad fiscal. La construcción privada por su parte se mantuvo deprimida ante la dificultad de mercado para viviendas por falta de crédito y el alto costo de financiamiento. En efecto, persistió el problema de la alta tasa de interés, que en cierto modo frenó el desenvolvimiento de los sectores productivos y de la construcción.
- 1.11 No obstante, a partir de la aplicación del Plan Austral desde mediados del año 1985 y en particular durante el último trimestre de ese año, comenzó a evidenciarse una recuperación de la actividad productiva. El PIB mostró un crecimiento del 4,7% durante el cuarto trimestre de 1985 con respecto al trimestre anterior debido principalmente al crecimiento del producto en la industria manufacturera que fue del 13,1%. En el primer trimestre de 1986, el PIB creció 0,4% en relación al mismo período del año anterior, destacándose en los resultados el incremento de 5,7% en la producción industrial y la declinación del 8,4% en la actividad agropecuaria.

#### B. Políticas económicas

- 1.12 Durante el primer semestre de 1985 se continuó con la política de ajuste gradual iniciado en 1983, caracterizada por la acentuación de los controles de precios. Sin embargo, el esquema recesivo de las medidas alentaba mayores expectativas inflacionarias y tropezaba con los objetivos de reducir el déficit fiscal. Posteriormente, se trató de flexibilizar el control de precios para aliviar la distorsión existente y se impuso una limitación cuantitativa de ajuste salarial al 90% de la inflación del mes anterior. Se aplicó también una reforma financiera con mayor intervención del Gobierno en el mercado monetario, hecho que ocasionó una nueva alza de la tasa de interés en términos reales.
- 1.13 En junio de 1985, la inflación anual con respecto al mismo mes del año anterior sobrepasaba los 1.100%, con una caída del nivel de actividad, aumento de desempleo, reducción de las inversiones, empeoramiento del desequilibrio fiscal y una situación de incertidumbre generalizada. En estas circunstancias y ante la posible ineficacia de adoptar una estrategia de cambio gradual, el Gobierno anunció el 14 de junio una política de choque conocido como el "Plan Austral".
- 1.14 Los principales elementos del Plan consistieron en: (a) congelación de precios y salarios por tiempo indefinido, excepto los precios de los bienes y servicios de oferta estacional como

frutas y hortalizas; (b) la reforma monetaria y la creación de un nuevo signo monetario, el "austral", equivalente a 1.000 pesos argentinos y la implantación de una paridad fija de 0,80 australes por un dólar estadounidense; (c) el financiamiento sano del gasto y del crédito público y la reducción del déficit del sector público consolidado a alrededor del 2,5% del PIB, en el segundo semestre de 1985, del 12,5% en el primer semestre. Paralelamente se dio a conocer un nuevo memorándum de entendimiento con el FMI, que permitió aliviar el problema de pagos externos, conjuntamente con un acuerdo de financiamiento y renegociación del pago de servicio de la deuda vencida y a vencer en 1985 con los bancos comerciales.

- 1.15 Cabe señalar también que, antes de congelar los precios, se dispuso un alza de la paridad cambiaria, un aumento de los impuestos para aumentar los ingresos fiscales y un fuerte ajuste tarifario (el nivel general de precios y tarifas de las empresas públicas creció 5,5% y 5,1% en términos constantes durante los meses de mayo y junio de 1985, respectivamente).
- 1.16 La aplicación de estas medidas bajo el esquema adoptado logró un significativo éxito, y creó un ambiente de confianza en la población. Los logros más sobresalientes del Plan Austral han sido la importante reducción de la tasa de inflación y el equilibrio fiscal, además de la relativa estabilidad en los tipos de cambio oficial y paralelo.
- 1.17 Desde el inicio del Plan el Gobierno sostuvo que el congelamiento de precios y salarios sería de carácter temporal, y hacia fines de 1985, anunció un ajuste general de salarios del 5% para los trabajadores tanto del sector público como del privado, con vigencia a partir de enero de 1986. Se otorgó también un ajuste del 50% de asignaciones familiares, y se les permitió a las empresas un aumento adicional del 5% en los salarios durante 1986, sólo por incrementos en la productividad.
- 1.18 En febrero de 1986 el Gobierno solicitó una prórroga para finalizar el acuerdo vigente con el FMI, concretado en julio. Asimismo, se espera negociar un nuevo acuerdo con la citada institución en el transcurso del segundo semestre de 1986, que sería complementado con financiamientos de otros organismos internacionales como el Banco Mundial y el BID.
- 1.19 En abril de 1986 el Gobierno anunció nuevas pautas sobre el sistema de precios y salarios. El congelamiento de precios se sustituyó con precios administrados que se fijarán de acuerdo con los costos de insumos. Los incrementos de salarios serán negociables durante el remanente del año entre el 18 y 21% para el sector público, con un aumento instantáneo del 5% para la administración pública. Se acordó también aumentos en las tarifas de gas y electricidad del 6%, con incrementos mensuales del 2% para el resto del año y la gasolina subió en 8%. Asimismo, a

partir de abril se autorizaron una serie de mini-devaluaciones del austral, el cual en la primera semana de octubre llegó a US\$1 = A 1,07.

- 1.20 Con estos cambios el Plan Austral entró durante 1986 en una fase de reorientación de política hacia la consecución de los objetivos de crecimiento económico con estabilidad relativa de precios. Con esta premisa, la política del Gobierno busca la promoción de las exportaciones, la reactivación de la construcción, la modernización y la transferencia de empresas públicas al sector privado y una mayor participación de éste en actividades de exploración petrolera.

### C. Perspectivas

- 1.21 En 1986 la actividad económica se desarrolla dentro de las premisas dadas a conocer como la segunda fase del Plan Austral con la introducción de medidas estructurales encaminadas a consolidar el esfuerzo de estabilización y a la vez promover el crecimiento económico. Asimismo, las señales de una lenta recuperación en las actividades productivas que se vienen observando desde fines de 1985 indican que el país está saliendo gradualmente de la recesión, por lo que se puede prever que habría un moderado crecimiento en 1986. Los incrementos observados en los precios durante abril-junio de 1986 indican, sin embargo, que la inflación anual sería superior a la del 28% proyectada por el Gobierno, pudiendo llegar a alrededor del 60%.
- 1.22 Por su parte, el sector externo está íntimamente vinculado al comportamiento futuro de la economía. La caída de precios internacionales de las principales exportaciones argentinas y un leve aumento de las importaciones reducirá el excedente comercial en 1986. A su vez, la magnitud de la deuda externa seguirá imponiendo severas restricciones a la economía, dado que el pago de intereses de la deuda representa una proporción importante del ahorro interno. Las condiciones anteriores podrían, por lo tanto, producir presiones sobre las políticas fiscal y cambiaria, si no hay un aumento compensatorio en el financiamiento externo.
- 1.23 La tendencia que ha seguido la recaudación tributaria desde el lanzamiento del Plan Austral continuaría en el corto plazo. Sin embargo, para acompañar a los objetivos de la reactivación económica se requerirán cambios estructurales en la organización del sector público y en particular en la administración del gasto público. Con ese fin, el Gobierno propone una racionalización y modernización de las actividades del sector, al mismo tiempo que ha anunciado la iniciación de un proceso de traslado al sector privado y de saneamiento de las empresas públicas.
- 1.24 En este contexto, el año 1986 será un año de transición entre la primera fase del Plan Austral, que fue la de control de inflación, y la segunda etapa, que tiene por objetivo lograr el crecimiento

con estabilidad. El crecimiento de las exportaciones y la creación de un ambiente favorable para aumentar el nivel de la inversión privada serán los aspectos más importantes para el desarrollo y crecimiento futuro del país. La posibilidad de una estabilización sostenida dependerá también de la recuperación del crecimiento real de la economía.

DISTRIBUCION DEL RECURSO CAMA, PAIS - 1980

La Distribución Geográfica y Sectorial de las Camas del País es la siguiente:

PROVINCIA	PUBLICAS	SOCIALES	PRIVADAS	TOTAL
Capital Federal	13.525	2.560	8.722	24.807
Buenos Aires	30.837	1.902	14.739	47.478
Catamarca	894	30	291	1.215
Córdoba	9.724	674	5.870	16.268
Corrientes	2.238	44	750	3.032
Chaco	2.146	12	991	3.149
Chubut	1.147	246	329	1.722
Entre Ríos	5.088	242	1.303	6.633
Formosa	718	-	280	998
Jujuy	2.046	36	612	2.694
La Pampa	850	-	285	1.135
La Rioja	663	54	163	880
Mendoza	3.411	507	1.464	5.382
Misiones	1.249	6	1.049	2.304
Neuquén	996	147	404	1.547
Río Negro	1.302	74	586	1.962
Salta	2.738	177	922	3.837
San Juan	1.461	140	218	1.819
San Luis	767	45	177	989
Santa Cruz	562	101	99	762
Santa Fe	6.948	641	6.031	13.620
Santiago Estero	2.190	86	543	2.819
Tucuman	2.890	355	1.208	4.453
Tierra Fuego	198	-	12	210
TOTAL	94.588	8.079	47.048	149.715

CUADRO N° 14 - Egresos, total por dependencia, por cama y por habitantes -  
Argentina 1978 - 1980

DIVISION POLITICA	EGRESOS				EGRESOS POR CAMA				EGRESOS POR 100 HAB.
	OFICIAL(1)	O. SOCIAL(2)	PRIVADO(2)	TOTAL	OFICIAL	O. SOCIAL	PRIVADO	TOTAL	
TOTAL REPUBLICA	1.583.459	176.020	1.422.105	3.181.584	16.7	21.8	30.2	21.2	11.4
Capital Federal	145.430	68.506	478.916	692.852	10.8	26.8	54.9	27.9	23.7
Buenos Aires	507.453	22.645	318.170	848.268	16.5	11.9	21.6	17.9	7.8
Catamarca	19.007	360	12.490	31.857	21.3	12	42.9	26.2	15.3
Córdoba	111.166	9.794	241.200	362.160	11.4	14.5	41.1	22.4	15.0
Corrientes	47.847	709	2.509	51.065	21.2	16.1	3.3	16.7	7.7
Chaco	40.357	480	22.199	63.036	18.8	40.0	22.4	20.0	9.0
Chubut	18.944	3.511	6.898	29.353	16.5	14.3	21.0	17.0	11.2
Entre Ríos	68.891	2.951	31.448	103.290	13.4	12.2	24.1	15.5	11.4
Formosa	22.602	258	5.894	28.754	31.5	7.8	21.1	29.8	9.6
Jujuy	44.135	513	14.140	58.788	21.4	14.3	23.1	21.7	14.3
La Pampa	29.785	-	3.049	32.834	35.0	-	10.7	28.9	15.8
La Rioja	13.211	1.751	2.339	17.301	19.9	32.4	14.3	19.7	10.5
Mendoza	74.349	11.074	38.707	124.130	21.7	21.8	26.4	23.0	10.4
Misiones	33.379	-	7.782	41.161	26.7	-	7.4	17.9	7.0
Neuquén	19.799	3.188	2.280	25.267	19.9	21.7	5.6	16.3	10.4
Río Negro	(2) 25.438	3.733	9.980	39.151	19.5	50.4	17.0	20.0	10.2
Salta	52.361	5.191	24.206	81.758	19.0	29.3	26.3	21.2	12.3
San Juan	28.965	5.407	15.721	50.093	19.6	38.6	72.1	27.2	10.1
San Luis	15.255	810	5.515	21.580	19.9	18.0	31.2	21.8	10.1
Santa Cruz	5.549	1.752	300	7.601	9.9	17.3	3.0	10.0	6.6
Santa Fe	158.836	23.535	131.588	313.959	22.6	36.7	21.8	22.9	12.7
Santiago del Estero	40.875	1.231	8.284	50.390	18.5	14.3	15.3	17.7	6.9
Tucumán	57.669	8.621	38.270	104.560	19.8	24.3	31.7	23.4	10.7
Tierra del Fuego, Antártida e Islas del Atlántico Sud	2.156	-	220	2.376	10.9	-	18.3	11.3	8.7

FUENTE: (1) Estadísticas vitales para Sector Oficial (excento Córdoba y Río Negro),  
(2) Catastro de Recursos (1979)

DISTRIBUCION SECTORIAL DE CAMAS GPM (1) EN LAS PROVINCIAS DEL PROGRAMA - 1985

PROVINCIA	CAMAS						POBLACION (EN MILES)						CAMAS POR 1000 HABITANTES		
	PUBLICO		OTROS 2)		TOTAL		N.B.I.		OTROS		TOTAL		3)		
	NUMERO	%	NUMERO	%	NUMERO	%	NUMERO	%	NUMERO	%	NUMERO	%	PUBLICO	OTROS	TOTAL
BOGOTA	1854	57.33	1380	42.67	3234	100.00	399	51.30	378	48.70	777	100.00	2.39	1.78	4.17
BAJA	645	74.05	226	25.95	871	100.00	249	32.30	523	67.70	772	100.00	0.84	0.29	1.13
BOGOTA	849	68.86	384	31.14	1233	100.00	178	53.80	153	46.20	331	100.00	2.56	1.16	3.72
BOGOTA	2416	57.79	1765	42.21	4181	100.00	317	24.00	1005	76.00	1322	100.00	1.83	1.34	3.17
BOGOTA	1323	57.03	997	42.97	2320	100.00	301	44.70	372	55.30	673	100.00	1.97	1.48	3.45
BOGOTA	808	59.76	544	40.24	1352	100.00	115	38.30	186	61.70	301	100.00	2.68	1.81	4.49
BOGOTA*	1174	62.45	706	37.55	1880	100.00	175	38.00	285	62.00	460	100.00	2.55	1.53	4.08
BOGOTA	2615	67.26	1273	32.74	3888	100.00	346	46.10	405	53.90	751	100.00	3.48	1.70	5.18
BOGOTA	1224	72.68	460	27.32	1684	100.00	157	30.60	355	69.40	512	100.00	2.39	0.90	3.29
BOGOTA	7584	50.40	7463	49.60	15047	100.00	654	24.70	1993	75.30	2647	100.00	2.87	2.82	5.69
BOGOTA	2527	58.73	1776	41.27	4303	100.00	456	41.80	634	58.20	1090	100.00	2.32	1.63	3.95
TOTAL	23019	57.56	16974	42.44	39993	100.00	3347	34.73	6289	65.27	9636	100.00	2.39	1.76	4.15

1) Incluye las camas de O.S. en CAMAS OTROS por falta de dato.

GPM = camas generales + pediátricas + maternas.

2) Incluye la suma de subsectores privado y obras sociales.

3) Incluye el sector público y otro sector respectivamente x 1000 habitantes de la población total.

4) Incluye todas las cifras son de camas pediátricas y población de menores de 15 años.

5) Fuente: Ministerio de Salud y Acción Social.

DISTRIBUCION SECTORIAL DE CAMAS GPM (1) EN LOS AGLOMERADOS DEL PROGRAMA - 1985

	CAMAS						POBLACION (EN MILES)						CAMAS POR 1000 HABITANTE		
	PUBLICO		OTROS 2)		TOTAL		N.B.I.		OTROS		TOTAL		3)		
	NUMERO	%	NUMERO	%	NUMERO	%	NUMERO	%	NUMERO	%	NUMERO	%	PUBLICO	OTROS	TOTAL
...	529	39.48	811	60.52	1340	100.00	90	34.42	172	65.58	262	100.00	2.02	3.10	5.12
A 4)	305	68.08	143	31.92	448	100.00	92	28.56	231	71.44	323	100.00	0.94	0.44	1.38
A	287	60.17	190	39.83	477	100.00	44	39.66	67	60.34	111	100.00	2.59	1.71	4.30
A 5)	1263	49.74	1276	50.26	2539	100.00	108	15.95	570	84.05	678	100.00	1.86	1.88	3.74
S	324	41.59	455	58.41	779	100.00	55	32.00	116	68.00	171	100.00	1.89	2.66	4.55
I	272	50.37	268	49.63	540	100.00	36	30.00	85	70.00	121	100.00	2.25	2.21	4.46
RO	54	39.13	84	60.87	138	100.00	17	33.57	34	66.43	51	100.00	1.06	1.65	2.71
	1244	62.61	743	37.39	1987	100.00	82	26.46	227	73.54	309	100.00	4.03	2.40	6.43
N	976	68.93	440	31.07	1416	100.00	74	22.61	254	77.39	328	100.00	2.98	1.34	4.32
E	1263	50.97	1215	49.03	2478	100.00	70	21.99	248	78.01	318	100.00	3.97	3.82	7.79
I	1271	48.57	1346	51.43	2617	100.00	178	30.98	396	69.02	574	100.00	2.21	2.34	4.55
ES	7788	52.77	6971	47.23	14759	100.00	846	26.08	2400	73.92	3246	100.00	2.40	2.15	4.55

GPM = camas generales + pediátricas + maternas.

es la suma de subsectores privado y obras sociales.

del sector público y otro sector respectivamente x 1000 habitantes de la población total.

oba las cifras son de camas pediátricas y población de menores de 15 años.

AS OTROS el número de camas del subsector privado (1024) es dato de 1984.

Ministerio de Salud y Acción Social.



NUMERO DE CAMAS GPM (1) DEL SUBSECTOR PUBLICO SIN Y CON EL PROGRAMA  
( En los aglomerados )

PROVINCIA	AGLOMERADO	SIN PROYECTO ( AÑO 1985 )						CON PROYECTO ( AÑO 1995 )			DIFEREN.
		HOSPITALES POR REEMPLAZAR		OTROS HOSPITALES		TOTAL AGLOMERADO		HOSPITALES POR REEMPLAZAR		TOTAL AGOLMER.	HOSPIT.O AGLOMER.
		NUMERO	%	NUMERO	%	NUMERO	%	NUMERO	%	NUMERO	NUMERO
CHACO	GRAN RESISTENCIA	529	100.00	0	0.00	529	100.00	338	100.00	338	-191
CORDOBA	GRAN CORDOBA	208	68.20	97	31.80	305	100.00	293	75.13	390	85
FORMOSA	FORMOSA	287	100.00	0	0.00	287	100.00	304	100.00	304	17
MENDOZA	GRAN MENDOSA *	0	0.00	1263	100.00	1263	100.00	220	14.83	1483	220
MISIONES	POSADAS	324	100.00	0	0.00	324	100.00	322	100.00	322	-2
NEUQUEN	NEUQUEN *	0	0.00	272	100.00	272	100.00	120	30.61	392	120
RIO NEGRO	CIPOLLETI	54	100.00	0	0.00	54	100.00	120	100.00	120	66
SALTA	SALTA	560	45.02	684	54.98	1244	100.00	322	32.01	1006	-238
SAN JUAN	GRAN SAN JUAN	606	62.09	370	37.91	976	100.00	338	47.74	708	-268
SANTA FE	SANTA FE	499	58.50	354	41.50	853	100.00	288	44.86	642	-211
TUCUMAN	GRAN TUCUMAN	453	35.64	818	64.36	1271	100.00	312	27.61	1130	-141
TOTALES		3520	47.71	3858	52.29	7378	100.00	2977	43.56	6835	-543

\* Nuevos hospitales.

1) Camas GPM = camas generales + pediátricas + maternas.

Fuente: Ministerio de Salud y Acción Social.

INDICADORES DE SALUD EN PROVINCIAS PARTICIPANTES

	<u>Chaco</u>	<u>Formosa</u>	<u>Misiones</u>	<u>Tucumán</u>	<u>Salta</u>	<u>Cordoba</u>	<u>Sta.Fe</u>	<u>Mendoza</u>	<u>San Juan</u>	<u>Neuquen</u>
esperanza de vida al nacer (años)	65,0	65,9	65,0	67,0	64,1	70,8	70,0	70,0	67,0	67,0
mortalidad general (por mil)	8,3	6,5	7,8	8,1	7,9	8,0	9,3	7,3	7,2	5,3
mortalidad infantil (por miles de vivos)	54,2	38,1	51,9	42,0	52,1	24,2	34,3	31,8	30,1	31,7
mortalidad (1 a 4 años) (por mil)	4,1	3,2	4,0	2,2	3,8	0,9	1,0	1,5	1,3	1,6
mortalidad materna (por mil)	1,0	1,2	1,0	1,0	1,6	0,5	0,8	0,5	0,8	0,8
principales causas de muerte										
enfermedades del corazón %	19,3	19,8	20,7	27,1	16,7	37,6	31,1	26,6	25,7	16,5
tumores malignos %	10,9	10,3	9,8	11,9	7,8	18,9	19,3	15,4	13,8	13,7
perinatales %	8,6	8,3	10,3	6,7	7,8	3,2	-	6,3	6,1	7,3
neumonía e influenza %	5,8	-	-	4,9	-	-	-	-	-	-
cerebro-vasculares %	7,4	8,3	6,9	9,3	4,9	9,6	12,1	9,8	10,7	6,1
infectivos %	-	5,9	6,6	-	9,3	4,6	5,7	6,3	5,8	11,5
accidentes (por mil habitantes)	7,6	7,9	6,8	5,9	10,0	2,6	5,9	5,9	6,9	11,8
hospitalizaciones por habitante	1,9	1,0	1,2	1,3	1,8	1,6	1,3	1,4	1,8	2,2

DATOS BASICOS DE LAS PROVINCIAS DEL PROGRAMA

	<u>Chaco</u>	<u>Formosa</u>	<u>Misiones</u>	<u>Tucumán</u>	<u>Salta</u>	<u>Cordoba</u>	<u>Sta.Fe</u>	<u>Mendoza</u>	<u>San Juan</u>	<u>Neuquén</u>
lación (1980) miles hab.	701,0	296,0	589,0	973,0	663,0	2408,0	2466,0	1196,0	466,0	244,0
lación Urbana %	60,9	56,0	51,4	70,1	71,8	79,7	82,0	68,9	72,0	76,0
sidad demográf.hab/km2	7,0	4,0	19,8	43,2	4,3	14,3	18,5	8,0	5,2	2,0
lación menor 15 años	39,4	41,0	40,5	35,5	39,6	29,2	28,2	32,0	35,1	39,0
labetismo %	16,5	12,3	11,9	8,4	11,1	5,2	5,8	7,3	7,1	9,0
a potable de red %	47,0	40,0	31,0	60,0	70,0	54,0	48,0	60,0	80,0	70,0
antarillado %	10,0	10,0	3,0	18,0	52,0	11,0	26,0	30,0	12,0	20,0
. con necesidades básicas atisfechas (NBI)%	44,8	45,8	39,2	19,0	42,4	19,4	8,1	20,4	26,0	33,0
. afiliada a obras sociales	90,6	52,5	61,8	88,1	75,0	71,0	75,1	66,0	49,3	86,0

PROGRAMA MEDICO

Guía de Contenido

A. Marco de Referencia - Síntesis de la Provincia

1. Situación geográfica y política.
2. Estructura y dinámica demográfica.
3. Estructura económica.
4. Situación de educación.
5. Situación de vivienda y saneamiento básico.
6. Otros aspectos de interés.

B. Situación de Salud de la Provincia

1. El estado de salud: morbi-mortalidad; hábitos de salud; estructura epidemiológica; indicadores de salud.
2. El sector salud: estructura, composición.
3. Los recursos de salud en la provincia: físicos, humanos, financieros.
4. La organización de los recursos, la red de servicios y sus niveles: primario, secundario, terciario.
5. La producción de los recursos.
6. Grado de utilización de los servicios.
7. Otros aspectos de interés: existencia de planes provinciales de salud, etc.

C. Programa médico propiamente dicho

1. Justificación: descripción del hospital (actual) a ser reemplazado.
  - (a) Planta física: servicios, camas, grados de obsolescencia, etc.
  - (b) Equipamiento, grado de obsolescencia.
  - (c) Personal: listado por categorías.
  - (d) Organización.
  - (e) Nivel de complejidad.
  - (f) Nivel de demanda; la población beneficiaria.
  - (g) Producción: consultas, egresos, partos, operaciones, etc.
  - (h) Presupuesto operativo.

2. Objetivos, bases del nuevo hospital.
  3. Localización del nuevo hospital, necesidades de la comunidad.
  4. Descripción del nuevo hospital.
    - (a) Funciones y actividades: niveles de organización.
    - (b) Programas de salud a desarrollar: preventivos; asistenciales; docentes.
    - (c) Características y dimensionamiento.
    - (d) Articulación con la red de servicios.
    - (e) Nivel de complejidad teórica.
    - (f) Demanda potencial.
    - (g) Servicios o unidades hospitalarias.
      - (i) Dirección y administración
      - (ii) Consulta externa, ambulatorio, servicio social médico
      - (iii) Emergencia
      - (iv) Registros médicos y estadísticas
      - (v) Unidades de internamiento; cuidado intensivo
      - (vi) Servicios auxiliares de diagnóstico y tratamiento: laboratorio; imágenes; diálisis, etc.
      - (vii) Centro quirúrgico, centro obstétrico, centro de recuperación; centro de esterilización de equipos, etc.
      - (viii) Servicios generales: lavandería, nutrición, talleres de mantenimiento, etc.
- En cada servicio o unidad se describirán sus componentes (tantos consultorios médicos, quirúrgicos, pediátricos, etc.) y sus características (áreas en m<sup>2</sup>).
- (h) Equipo: distribución por categorías (fijo, mobiliario, clínico, quirúrgico, etc.); porcentajes y listados básicos, con estimación preliminar de costos. Deberá analizarse el equipo existente y recuperable y el que se adquirirá.
  - (i) Personal: describir la plantilla total del hospital y distribuir el personal por categorías (médicos, enfermeras, odontólogos, etc.) y por área de trabajo en los diferentes servicios (internación, centro quirúrgico, registros médicos, etc.). Analizar la plantilla existente y si serán necesarios nuevos recursos.

- (j) La producción esperada con el nuevo hospital: consultas externas, atenciones de emergencia, egresos hospitalarios, intervenciones quirúrgicas, etc.
- (k) Perfil arquitectónico:
  - o características del terreno
  - o sistema arquitectónico (pabellones, monobloques, etc.)
  - o área construida
  - o expansión prevista
- (l) Gastos de funcionamiento que va a generar el nuevo hospital: total por año y desglose por partidas (servicios personales; servicios no personales; materiales y suministros, etc.). Proyección para los tres primeros años de funcionamiento; fuentes de financiamiento.
- (m) Costo de la inversión:
  - o terreno
  - o construcción
  - o equipamiento

(datos estimados)
- (n) Estado actual del programa de cada provincia.

ANEXOInformación sobre Localización y Servicios de los Terrenos

## 1. CHACO

El terreno se encuentra en el Area Metropolitana de Gran Resistencia, anexo al actual Hospital "Perrado". Posee la siguiente infraestructura de servicios:

- a) accesibilidad de transporte, ya que está servido por la mayoría de líneas de colectivos urbanos.
- b) Existe una red externa de agua potable, además de la utilización de la red interna del hospital Perrando.
- c) Cuenta con servicio de electricidad con una capacidad total de 2.000 KVa.
- d) Hay red de desagues cloacales.
- e) Hay red de servicios telefónicos.

## 2. FORMOSA

Localizado en el área urbana de Formosa:

- a) La accesibilidad es buena, abastecida por 6 líneas de transporte urbano.
- b) Existe servicio de red externa de agua.
- c) Existe servicio de red eléctrica pública.
- d) Existe servicio de red externa de desagues cloacales.
- e) No cuenta con servicio telefónico.

## 3. MISIONES

Terreno localizado en el área urbana adyacente al predio del actual hospital.

- a) La accesibilidad de medios de transporte es buena.
- b) El abastecimiento de agua es por medio de un tanque que abastece al actual hospital.
- c) Cuenta con servicio eléctrico de la red pública.
- d) No hay red de desague cloacal, los desagues son lanzados al mismo destino del actual hospital (quebrada seca a 800 metros).

e) Cuenta con servicios telefónicos.

4. CORDOBA

Terreno ubicado en el área urbana de la ciudad.

- a) Cuenta con buena accesibilidad (a 600 metros está la terminal de buses de corta y media distancia).
- b) Cuenta con servicios público de abastecimiento de agua.
- c) Existe red eléctrica de servicio público.
- d) Existe con servicio de desagüe cloacal.
- e) Cuenta con disponibilidad de servicio telefónico.

5. MENDOZA

El terreno es el mismo donde existió el hospital destruido por el terremoto, cuenta con todos los servicios infraestructura pública.

6. NEUQUEN

El terreno está localizado dentro del área urbana de la ciudad.

- a) Los medios de accesibilidad son buenos.
- b) Cuenta con servicio público de abastecimiento de agua a 180 metros
- c) Hay condiciones de suministrar servicios de energía eléctrica.
- d) Hay condiciones de disponibilidad de red telefónica.

7. RIO NEGRO

El terreno está ubicado dentro del área urbana de Cippolletti.

- a) Cuenta con adecuados servicios de transporte.
- b) Cuenta con red domiciliaria de agua
- c) Cuenta con red pública de energía eléctrica
- d) Tiene red de desagües cloacales
- e) Se cuenta con servicios telefónicos disponibles.

8. SALTA

El terreno es el mismo que actualmente ocupa el actual hospital. Cuenta con los servicios de infraestructura pública.



9. SAN JUAN

El terreno es el mismo que ocupa el actual hospital. Cuenta con la infraestructura adecuada de servicios públicos.

10. SANTA FE

Terreno ubicado en el área urbana de la ciudad

- a) Cuenta con buena accesibilidad de medios de transporte
- b) Cuenta con servicio público de abastecimiento de agua.
- c) Se puede disponer de la energía eléctrica requerida.
- d) No cuenta con servicio de desague cloacal, pero se puede conectar a una colectora próxima (800 Mts.).
- e) No posee servicios telefónicos.

11. TUCUMAN

Terreno ubicado en el área urbana de la ciudad

- a) Cuenta con servicio de transporte
- b) Cuenta con servicio público de agua
- c) Existe servicio de red de energía eléctrica
- d) Existe servicio de desague cloacal
- e) No existe servicio telefónico; pero hay disponibilidad

PROYECTO DE DESARROLLO DEL SISTEMA NACIONAL DE SALUD - SS-BID

ANUEPROYECTO DE EQUIPAMIENTO

ESTABLECIMIENTOS	SECTORES	MISIONES	FORMOSA	CHACO	TUCUMAN	SAN JUAN	SALTA	NEUQUEN	RIO NEGRO	MENDOZA	SANTA FE	CORDOBA	TOTAL
Direc. - Administ. - Estadíst. Serv. Social		467.655	467.655	467.655	467.655	467.655	467.655	303.975	303.975	467.655	467.655	467.655	
Internación		393.827	393.827	393.827	334.624	393.827	334.624	153.488	153.488	295.392	334.624	364.896	
Cuidados Intensivos adultos		218.354	218.354	218.354	218.354	218.354	97.037	60.649	60.649	194.075	97.037	-	
Cuidados Intensivos pediátricos		-	175.056	175.056	175.056	175.056	175.056	-	-	-	175.056	196.938	
Neonatología		88.513	88.513	88.513	88.513	88.513	136.160	27.232	27.232	88.513	88.513	-	
Centro Quirúrgico		467.521	467.521	467.521	467.521	467.521	467.521	233.760	233.760	311.680	467.521	430.521	
Centro Obstétrico		164.234	164.234	164.234	164.234	164.234	164.234	123.174	123.174	164.234	164.234	-	
Consulta Ambulatoria		184.888	110.928	184.888	184.888	184.888	184.888	101.684	101.684	147.904	110.928	226.478	
Emergencia		70.991	70.991	70.991	70.991	70.991	141.982	35.496	35.496	70.991	70.991	86.960	
Hospital de día		-	7.770	-	7.770	7.770	-	-	-	-	7.770	12.300	
Anatomía Patológica		88.021	88.021	88.021	88.021	88.021	88.021	45.000	45.000	88.021	88.021	88.021	
Hemoterapia		44.836	44.836	44.836	44.836	44.836	44.836	22.418	22.418	44.836	44.836	49.036	
Hemodinamia		-	-	496.200	496.200	496.200	-	-	-	-	-	496.200	
Rehabilitación		-	8.211	10.948	10.948	10.948	8.211	-	-	-	-	8.211	
Dialisis		80.742	80.742	80.742	80.742	80.742	-	-	-	-	-	80.742	
Medicina Nuclear		393.127	-	-	393.127	393.127	-	-	-	-	-	393.127	
Rayos X - Mamografía - Ecografía		416.362	416.362	416.362	416.362	416.362	416.362	208.181	208.181	416.362	416.362	402.680	
Tomografía		-	-	643.089	643.089	643.089	-	-	-	-	-	-	
Laboratorio		543.611	543.611	543.611	543.611	543.611	543.611	230.725	230.725	380.528	543.611	550.000	
Docencia e Investigación		-	-	8.432	8.432	8.432	-	-	-	-	-	8.432	
Quemados		-	80.619	-	134.619	-	80.619	-	-	-	-	94.234	
Abastecim. - Procesamiento		422.051	422.051	422.051	422.051	422.051	422.051	179.131	179.131	295.436	422.051	422.051	
Servicios Complementarios		19.589	19.589	19.589	19.589	19.589	19.589	8.314	8.314	13.952	19.589	19.589	
Hospedaje		21.333	21.333	21.333	21.333	21.333	21.333	12.802	12.802	17.079	21.333	-	
Medios de Transporte		73.009	73.009	73.009	73.009	73.009	73.009	37.000	37.000	73.009	73.009	73.000	
Talleres Mantenimiento		82.658	82.658	82.658	82.658	82.658	82.658	46.500	46.500	62.000	82.658	82.658	
Equipamiento General (Sub-Tot.)		4.241.322	4.045.549	5.191.920	5.553.233	5.582.817	3.969.457	1.829.529	1.829.529	3.131.658	3.695.799	4.553.729	43.749.884
Acces. Compl. - Repuest. ; U. de Reempl. ; otros (10%)		424.132	386.855	518.192	555.023	555.282	396.946	102.953	102.953	313.166	369.580	455.373	4.354.255
Instrumental		351.395	320.511	429.323	468.787	452.539	323.872	151.360	151.360	259.459	306.200	377.278	3.597.086
TOTAL EQUIPAMIENTO		5.016.849	4.753.253	6.129.437	6.692.843	6.593.638	4.695.275	2.163.842	2.163.842	3.704.283	4.371.579	5.385.380	51.651.225

# DIMENSIONAMIENTO DE LOS HOSPITALES

## PROGRAMAS MEDICO- FUNCIONALES

### MODELOS

AREAS Y SECTORES	CHACO	CORDOBA	FORROSA	MENDOZA	MISIONES	NEQUEN	RIO NEGRO	SALTA	SANTA FE	SAN JUAN	TUCUMAN	REFERENCIAS
<b>Emergencias</b>	B	5	B	B	B	C	C	A	B	B	B	A : 8 consultorios B : 4 consultorios C : 2 consultorios
<b>Consultorios Externos</b>	A	49	C	B	A	C	C	A	C	A	A	A : 40/48 ambientes B : 32 ambientes C : 22/24 ambientes
<b>Hospital de Día</b>	X	Si	X	X	X	X	X	X	X	X	X	X : Modelo único
<b>TOTAL DE CAMAS</b>												
<b>Cuidados generales indiferenciados</b>	A	252	A	C	A	D	D	B	B	A	B	A : 272 camas B : 238 camas C : 204 camas D : 106 camas
<b>Neonatología</b>	B	-	B	C	B	D	D	A	B	B	B	A : 40 unidades B : 26 unidades C : 16 unidades D : 8 unidades
<b>Cuidados intensivos adultos</b>	A	-	A	A	A	B	B	B	B	A	A	A : 16/18 unidades B : 5/8 unidades
<b>Cuidados intensivos pediátricos</b>	A	18	B	B	B	-	-	A	A	A	A	A : 16 camas B : 10 camas
<b>Unidad de Quemados</b>	-	7	-	-	-	-	-	B	-	-	A	A : 10 camas B : 6 camas
<b>Docencia e Investigación</b>	X	Si	X	X	X	-	-	X	X	X	X	X : Modelo único

AREAS Y SECTORES	CHCO	CORDOBA *	FORMOSA	MENDOZA	MISIONES	NEUQUEN	RIO NEGRO	SALTA	SANTA FE	SAN JUAN	TUCUMAN	REFERENCIAS
Centro Quirúrgico	A	A	A	B	A	B	B	A	A	A	A	A : 6 quirófanos B : 3/4 quirófanos
	A	-	A	A	A	B	B	A	A	A	A	A : 4 salas expulsivas B : 3 salas expulsivas
Laboratorio	A	8	A	B	A	C	C	A	A	A	A	A : 4 boxes B : 3 boxes c/parasit. C : 3 boxes sin parasit. bacteriol.
	A	5	A	A	A	B	B	A	A	A	A	A : 4 boxes B : 2 boxes
	A	6	A	A	A	B	B	A	A	A	A	A : 6 salas B : 3 salas
Tomografía Computada	X	-	-	-	-	-	-	-	-	X	X	X : Modelo único
	X	SI	-	-	-	-	-	-	X	X	X	X : Modelo único
Hemodinamia												
		SI	-	-	X	-	-	-	-	X	X	X : Modelo único
Medicina Nuclear												
Diálisis												
	X	SI	X	-	X	-	-	-	-	X	X	X : Modelo único
Anatomía Patológica												
	A	A	A	A	A	B	B	A	A	A	A	A : con salas Autopsia y Laboratorio B : con morgue
Rehabilitación												
	A	3	B	-	-	-	-	B	-	A	A	A : 8 ambientes B : 6 ambientes
Servicios Técnicos												
	A	21	A	A	A	B	B	A	A	A	A	A : 31 ambientes B : 21 ambientes

DIAGNOSTICO Y TRATAMIENTO

AREAS Y SECTORES	CHUB	CORONA	FORMOSA	MENDOZA	MISIONES	NEOQUEN	RIO NEGRO	SALTA	SANTA FE	SAN JUAN	TUCUMAN	REFERENCIAS
Dirección y Administración	A	B	A	A	A	B	B	A	A	A	A	A : 25 oficinas B : 20 oficinas
	A	B	A	B	A	C	C	A	A	A	A	A : 402 m <sup>2</sup> 400-450 m <sup>2</sup> B : 325 m <sup>2</sup> 300-350 C : m <sup>2</sup> 200-250
	A	A	A	B	A	C	C	A	A	A	A	A : m <sup>2</sup> 1000-1200 m <sup>2</sup> B : m <sup>2</sup> 600-800 C : m <sup>2</sup> 300-500
Servicios Complementarios	A	A	A	C	A	B	B	A	A	A	A	A : m <sup>2</sup> 1400-1600 m <sup>2</sup> B : m <sup>2</sup> 1000-1200 C : m <sup>2</sup> 600-800
	A	A	A	C	A	B	B	A	A	A	A	
	A	A	A	C	A	B	B	A	A	A	A	
Central de Abastecimiento y Procesamiento	A	A	A	C	A	B	B	A	A	A	A	

FORTALECIMIENTO INSTITUCIONAL  
NIVEL 11 PROVINCIAS

RECURSOS AREAS	CONSULTORIAS NACIONALES	CONSULTORIAS INTERNACION.	SEMINARIOS PROVINCIALES	BECAS EXTER- NAS "CORTAS"	BECAS INTERNAS	TOTAL	%
1. MANTENIMIENTO	165.0	154.0	312.4	132.0	198.0	961,4	21.5
2. ORGANIZACION SER- VICIOS DE SALUD	247.5	77.0	412.5	176.0	495.0	1.408,0	31.5
2.1 Apertura Hosp.							
2.2 Cons. Externa							
2.3 Emergencias							
2.4 Internación							
2.5 Centro Quirúrg.							
2.6 Laboratorio							
2.7 Radiodiagnóst.							
2.8 Centro Obstetr.							
2.9 Enfermería							
2.10 Nutrición							
2.11 Archivo Médico							
2.12 Lavandería							
2.13 Serv. Generales							
2.14 Docencia							
2.15 S. Especiales							
3. ADMINISTRACION HOSPITALARIA	--	--	--	--	759.0	759.0	17.0
4. SISTEMAS INFORMACION Y ESTADISTICAS DE SALUD	99.0	--	82.5	--	99.0	280.5	6.3
5. INVESTIGACION EN TECNOLOGIAS DE OPERACION DE SERV.	165,0	77,0	192,5	--	--	434,5	9.7
5.1 Red de Servi- cios. Referen- cias							
5.2 Calidad de la Atenc. Médica							
5.3 1er Nivel de Atención							
5.4 Utilizacion Servicios							
5.5 Descentraliza- ción Servicios							
5.6 Participación de los usuarios							
6. SISTEMA CONTABLE FINANCIERO Y COSTOS	99,0	--	57.75	66.0	99.0	321.75	7.2
7. CAPACITACION MEDICA	--	--	158.4	--	148.5	306.9	6.8
7.1 Clínica Médica							
7.2 Cirugía							
7.3 Pediatría							
7.4 Tocoginecolog.							
7.5 S. Diagnóstico							
7.6 Enfermería							
TOTAL	775.5 17.3%	308.0 6.9%	1216.05 27.2%	374.0 8.4%	1798.5 40.2%	4472.050	100



*Ministerio de Salud y Acción Social*  
SECRETARIA DE SALUD

FORTALECIMIENTO INSTITUCIONAL

NIVEL CENTRAL

AREAS	RECURSOS	CONSULTORIAS NACIONALES	CONSULT. INTERNAC.	SEMINARIOS TALLERES	BECAS EXTER NAS "CORTAS"	BECAS INTERNAS	TOTAL	%
1.	SISTEMA CONTABLE, FINAN- CIERO Y COSTOS	54.0	12.0	33.3	18.0	14.4 <del>13.5</del>	131.7 <del>130.8</del>	24.8
2.	SISTEMA GERENCIAL	4.5	36.0	41.7	24.0	90.0	196.2	37.2
2.1	Administración Hospi- talaria							
2.2	Sistemas de Informa- ción							
3.	SISTEMA DE SERVICIOS DE SALUD	54.0	18.0	45.5	--	82.5	200.0	38.0
3.1	Proceso de Apertura Hospitalaria							
3.2	Investigación en Tec- nologías de Operación							
TOTAL		112.5 21.3%	66.0 12.5%	120.5 22.9%	42.0 8.0%	186.9 35.3%	527.9 =	100.0



*Ministerio de Salud y Acción Social*

SECRETARIA DE SALUD

RESUMEN

I. NIVEL PROVINCIAS

<u>Areas</u>	<u>U\$S Monto</u>	<u>%</u>
1. Mantenimiento	961.400,00	21.5
2. Organización de Servicios	1.408.000,00	31.5
3. Administración Hospitalares	759.000,00	17.0
4. Sistema Información y Estadísticas de Salud	280.500,00	6.3
5. Investigación Operativa de Servicios	434.500,00	9.7
6. Sistema Contable Financiero-Costos	321.750,00	7.2
7. Area Médica-Paramédica	306.900,00	6.8
	<u>4.472.050,00</u>	
<u>Recursos</u>		
1. Consultorías Nacionales	775.500,00	17.3
2. Consultorías Internacionales	308.000,00	6.9
3. Seminarios Provinciales	1.216.050,00	27.2
4. Becas "Externas"	374.000,00	8.4
5. Becas "Internas"	1.798.500,00	40.2
	<u>4.472.050,00</u>	100.0%

II. NIVEL CENTRAL

<u>Areas</u>	<u>U\$S Monto</u>	<u>%</u>
1. Sistema contable, financiero y Costos	130.800,00	24.8
2. Sistema Gerencial	196.200,00	37.2
3. Sistema de Servicios de Salud	200.000,00	38.0
	<u>527.000,00</u>	100.0
<u>Recursos</u>		
1. Consultorías Nacionales	112.500,00	21.3
2. Consultorías Internacionales	66.000,00	12.5
3. Seminarios-Talleres Nacionales	120.500,00	22.9
4. Becas "Externas"	42.000,00	8.0
5. Becas "Internas"	186.000,00	35.3
	<u>527.000,00</u>	100.0





COMPONENTE: FORTALECIMIENTO INSTITUCIONAL

NIVEL: PROVINCIAS

1. AREA MANTENIMIENTO: U\$S 961.400

1.1 Consultorías Nacionales:

- a) 10 meses consultor por Provincia: Total = 110 meses
- b) Costo mes consultor: U\$S 1.500
- c) Costo Total : U\$S 165.000

1.2 Consultorías Internacionales:

- a) 2 meses consultor por Provincia: Total = 22 meses
- b) Costo mes consultor: U\$S 7.000
- c) Costo Total: U\$S154.000

1.3 Seminarios Provinciales:

- a) 8 seminarios por Provincia: Total = 88 meses
- b) 10 participantes por seminario: Total = 880
- c) Duración Seminario: 15 días
- d) Costo Seminario: U\$S 3.550
- e) Costo 88 seminarios: U\$S312.400

1.4 Becas Externas

- a) Duración: 2 meses
- b) Costo beca: U\$S 6.000
- c) Becarios: 2 por provincia = 22
- d) Costo Total: U\$S132.000

1.5 Becas Internas:

- a) Duración: 4 meses (4)
- b) Costo beca: U\$S3.000
- c) Becarios: 6 por provincia = 66
- d) Costo Total: U\$S198.000

2. ORGANIZACION DE SERVICIOS DE SALUD: U\$S 1.408.000

2.1 Consultorías Nacionales

- a) 15 meses consultor por provincia
- b) Total: 165 meses consultor
- c) Costo mes consultor: U\$S 1.500
- d) Costo Total: U\$S147.500

2.2 Consultorías Internacionales

- a) 1 mes consultor por provincia
- b) Total: 11 meses
- c) Costo mes consultor: U\$S 7.000
- d) Costo Total: U\$S77.000



### 2.3 Seminarios Provinciales

- a) 15 seminarios por provincia
- b) Total: 165 (duración: 10 días)
- c) Costo Seminario U\$S 2.500
- d) Costo Total: U\$S412.500

### 2.4 Becas Externas (Tipo Visitas Observación)

- a) Duración: 3 semanas
- b) Costo becas: U\$S 2.000
- c) Becarios: 88 (8 por provincia)
- d) Costo Total: U\$S176.000

### 2.5 Becas Internas

- a) Duración: 4 meses
- b) Costo: U\$S 3.000
- c) Becarios: 165 (15 por provincia)
- d) Costo Total: U\$S495.000

## 3. ADMINISTRACION HOSPITALARIA: U\$S 759.000

Capacitación propuesta utilizando la infraestructura existente y funcionando en Argentina. Escuelas de Salud Pública y similares.

### 3.1 Becas Internas

#### 3.1.1 Corta Duración: 4 meses

- a) Becarios: 165 (15 por provincia)
- b) Costo beca: U\$S 3.000
- c) Costo Total: U\$S495.000

#### 3.1.2 Regulares = 8 meses

- a) Becarios: 44 (4 por provincia)
- b) Costo beca: U\$S 6.000
- c) Costo Total: U\$S264.000

## 4. SISTEMA INFORMACION Y ESTADISTICAS DE SALUD: U\$S 280.500

### 4.1 Consultorías nacionales

- a) 6 meses consultor por provincia
- b) Total: 66 meses consultor
- c) Costo mes consultor: U\$S 1.500
- d) Costo Total: U\$S99.000

### 4.2 Seminarios Provinciales

- a) 2 por provincia. Total: 22
- b) 10 participantes por seminario. Total: 220
- c) Costo por seminario: U\$S 3.750
- d) Duración: 15 días
- e) Costo Total: U\$S82.500

### 4.3 Becas Internas

- a) Duración: 3 meses
- b) Becarios: 44 (4 por provincia)
- c) Costo beca: U\$S 2.250
- d) Costo Total: U\$S99.000



5. INVESTIGACION OPERATIVA DE SERVICIOS DE SALUD: U\$S 434.500

5.1 Consultorías Nacionales

- a) 10 meses consultor por Provincia
- b) Total: 110 meses consultor
- c) Costo mes consultor: U\$S 1.500
- d) Costo Total: U\$S165.000

5.2 Consultorías Internacionales

- a) 1 mes consultor por Provincia
- b) Total: 11 meses consultor
- c) Costo mes consultor: U\$S 7.000
- d) Costo Total: U\$S77.000

5.3 Seminarios Provinciales

- a) 55 seminarios (5 por Provincia)
- b) 10 participantes por seminario
- c) Duración: 10 días
- d) Costo Seminario: U\$S 3.500
- e) Costo Total: U\$S192.500

6. SISTEMA CONTABLE FINANCIEROS COSTOS: U\$S 321.750

6.1 Consultorías Nacionales

- a) 66 meses consultor (6 meses por Provincia)
- b) Costo mes consultor: U\$S 1.500
- c) Costo Total: U\$S99.000

6.2 Seminarios Provinciales

- a) 11 (uno por Provincia)
- b) Duración: 15 días
- c) Participantes: 110 (10 por provincia)
- d) Costo Seminario: U\$S 5.250
- e) Costo Total: U\$S57.750

6.3 Becas Externas (tipo visita observación)

- a) 22 (2 por Provincia)
- b) Duración: un mes
- c) Costo beca: U\$S 3.000
- d) Costo Total: U\$S66.000

6.4 Becas Internas

- a) 66 (6 por Provincia)
- b) Duración: 2 meses
- c) Costo beca: U\$S 1.500
- d) Costo Total: U\$S99.000



7. AREA MEDICA Y PARAMEDICA: U\$S 306.900

7.1 Seminarios Provinciales

- a) 198 (18 por Provincia)
- b) 3.960 participantes (20 por seminario)
- c) Duración: 5 días
- d) Costo Seminario: U\$S 800
- e) Costo Total: U\$S158.400

7.2 Becas Internas

- a) 198 becas (18 por Provincia)
- b) Duración: un mes
- c) Costo beca: U\$S 750
- d) Costo Total: U\$S148.500



COMPONENTE: FORTALECIMIENTO INSTITUCIONAL

NIVEL: CENTRAL

1. AREA SISTEMA CONTABLE Y FINANCIERO Y COSTOS

1.1 Consultoría Nacionales

- a) 18 meses consultor: 6 consultores (2 por c/area)
- b) Costo mes consultor: US\$ 1.500
- c) Costo Total: US\$54.000

1.2 Consultorías Internacionales

- a) 2 meses consultor: (area de costos)
- b) Costo mes consultor: US\$ 6.000
- c) Costo Total: US\$12.000

1.3 Seminarios-Talleres

- a) 3 seminarios-Talleres nacionales (1 por c/area)
- b) Duración: 5 días c/uno
- c) Participantes: 31 (2 por c/Provincia y 9 del Nivel Central)
- d) Costo por seminario: US\$ 11.100
- e) Costo Total: US\$ 33.300

1.4 Becas Externas

- a) Duración: 2 meses
- b) Costo Beca por mes: US\$ 3.000
- c) Becarios: 3 (uno por c/área)
- d) Costo Total: US\$ 18.000

1.5 Becas Internas

- a) 9 becarios (3 por c/área)
- b) Duración: 1 mes
- c) Costo beca por mes: US\$ 1.500
- d) Costo Total: US\$ ~~13.500~~ 10.500

2. AREA SISTEMA GERENCIAL

2.1 Consultorias Nacionales

- a) 3 meses consultor: (2 consultores, 1 por c/área)
- b) Costo mes consultor: US\$ 1.500
- c) Costo Total: US\$ 4.500

2.2 Consultorias Internacionales

- a) 6 meses consultor: (2 consultores)
- b) Costo mes consultor: US\$ 6.000
- c) Costo Total: US\$ 36.000



### 2.3 Seminarios-Talleres

- a) 2 seminarios talleres nacionales
- b) Duración: 15 días
- c) Participantes: 30 (2 por c/Provincia y 8 del Nivel Central)
- d) Costo por Seminario: U\$S 20.850
- e) Costo Total: U\$S 41.700

### 2.4 Becas externas

- a) Duración: 2 meses
- b) Costo beca por mes: U\$S 3.000
- c) Becarios: 4
- d) Costo Total: U\$S 24.000

### 2.5 Becas Internas

- a) 10 becarios
- b) Duración: 6 meses
- c) Costo beca mensual: U\$S 1.500
- d) Costo Total: U\$S 90.000

## 3. AREA SISTEMA DE SERVICIOS DE SALUD

### 3.1 Consultorias Nacionales

- a) 36 meses consultor: 6 consultores
- b) Costo mes consultor: U\$S 1.500
- c) Costo Total: U\$S 54.000

### 3.2 Consultorias Internacionales

- a) 3 meses consultor: 2 consultores
- b) Costo mes consultor: U\$S 6.000
- c) Costo Total: u4s 18.000

### 3.3 Seminarios-Talleres

- a) 4 seminarios talleres nacionales
- b) Duración: 15 días
- c) Participantes: 20 (3 por c/Provincia y 8 del Nivel Central)
- d) Costo por Seminario: U\$S 11.375
- e) Costo Total: U\$S 45.500

### 3.4 Becas Externas

### 3.5 Becas Internas

- a) 11 becarios
- b) Duración: 5 meses
- c) Costo beca mensual: U\$S 1.500
- d) Costo Total: U\$S 82.500

TERMINOS DE REFERENCIA

1. EXPERTO EN MANTENIMIENTO

1.1 Requisitos:

- (a) Deberá ser un ingeniero civil con experiencia en el diseño y operación de sistemas de mantenimiento de edificios y de equipos de naturaleza hospitalaria.
- (b) Se requiere dominio del castellano.
- (c) Ser originario de país miembro del Banco.

1.2 Funciones:

- (a) Revisar los programas de mantenimiento del país y de las provincias, desarrollar el diseño de un sistema propio para el hospital respectivo, que comprenda normas y procedimientos de operación.
- (b) Cooperar en la capacitación del personal responsable de las actividades, a través de los cursos y seminarios.

2. EXPERTO EN ORGANIZACION DE SERVICIOS DE SALUD

2.1 Requisitos:

- (a) Deberá ser un profesional en el campo de la salud, preferiblemente médico con experiencia en planificación y administración de hospitales.
- (b) Dominio del idioma castellano.
- (c) Originario del país miembro del Banco.

2.2 Funciones:

- (a) Cooperar en el diseño de un programa que comprenda la apertura del hospital y la adecuada organización de los diferentes servicios hospitalarios.
- (b) Colaborar en el programa de adiestramiento del personal a través del cursos y seminarios provinciales.

3. EXPERTO EN ESTADISTICA Y SISTEMAS DE INFORMACION DE SALUD

3.1 Requisitos:

- (a) Deberá ser un profesional especializado en estadísticas de salud y hospitalarios, con experiencia en diseños de sistemas de información de salud.
- (b) Se requiere el dominio del idioma castellano.
- (c) Deberá ser originario de país miembro del Banco.

3.2 Funciones:

- (a) Cooperar en el diseño de un sistema de información de salud aplicable al hospital del programa.
- (b) Colaborar en el proceso de capacitación del personal responsable del desarrollo de las actividades de estadísticas e información de salud.

4. EXPERTO EN INVESTIGACIONES OPERATIVAS DE LOS SERVICIOS DE SALUD

4.1 Requisitos:

- (a) Deberá ser un profesional de salud, preferentemente médico con experiencia en planificación de salud y administración hospitalaria y haber desarrollado estudios de investigación operativa de los servicios.
- (b) Deberá tener dominio del idioma castellano y ser originario de un país miembro del Banco.

4.2 Funciones:

- (a) Cooperar en el diseño de una metodología de investigación que analice la situación actual y proponga recomendaciones factibles para mejorar el funcionamiento de la red de servicios del área de influencia del hospital del programa.
- (b) Cooperar en el diseño y ejecución de estudios sobre realización de los servicios del hospital y otros establecimientos del área de influencia.
- (c) Cooperar en el diseño y ejecución de estudios sobre grado de satisfacción de los usuarios del hospital.
- (d) Cooperar en la capacitación del personal.



5. EXPERTO EN SISTEMA CONTABLE FINANCIERO

5.1 Requisitos:

- (a) Deberá ser un contador público con experiencia en análisis financieros de servicios de salud.
- (b) Se requiere dominio del idioma castellano, y que sea originario de un país miembro del Banco.

5.2 Funciones:

- (a) Cooperar en el desarrollo de un diseño de una sistema financiero contable hospitalario.
- (b) Cooperar en el diseño de un sistema operativo de costos hospitalarios.
- (c) Colaborar en el diseño de un sistema de presupuesto por programa aplicable al hospital.
- (d) Cooperar en el adiestramiento del personal.

NIVELES DE COMPLEJIDADClasificación de Establecimientos

Los establecimientos de salud del país se clasifican en 9 niveles de complejidad según el grado de desarrollo de sus actividades. Los niveles identificados como I-II-V- y VII corresponden a servicios sin internación (ya sea de atención, o sólo de diagnóstico); y III-IV-VI-VII y IX corresponden a los servicios de salud con internación de pacientes para diagnóstico y tratamiento.

Un centro de salud rural que sólo proporcione consulta médica general, obstetricia y Pediatría le corresponderá una complejidad I.

Un centro de salud que proporcione además consulta ginecológica, de cirugía general, odontológica, y que posea laboratorio clínico tendría complejidad II.

Un centro de salud con consulta de medicina y especialidades médicas; pediatría; obstetricia; ginecología; cirugía; odontología; laboratorio clínico y radio-diagnóstico, será de Nivel V.

Un establecimiento que además de los servicios del Nivel V cuente con consulta quirúrgica especializada y con otros servicios de diagnóstico (tomografía, ecografía, etc.) será a nivel máximo de complejidad (VII) en atención médica externa.

Con respecto a los establecimientos con internación (hospitales) de Nivel Secundario o Terciario de atención, pueden asimismo tener distintas complejidades. Así un hospital "rural" corresponde a un nivel de complejidad III para atención médica y de materno-infancia de internación; laboratorio clínico, Rayos X y quirófano. Un hospital con Nivel IV de complejidad tiene atención de internación en medicina, cirugía, pediatría, obstetricia, ginecología y además cuenta con laboratorio clínico, radiodiagnóstico y centro quirúrgico diferenciado.

Un hospital con Nivel VI de complejidad cuenta con los servicios de Nivel IV, más internación de algunas especialidades médico-quirúrgicas (cardiología, endocrinología, gastroenterología, ortopedia, oftalmología, otorrinolaringología, etc.). Además cuenta con servicios especiales: cuidados intensivos indiferenciados, neonatología.

Un hospital de Nivel VIII cuenta con los mismos servicios del Nivel VI, pero además proporciona atención más especializada (neurocirugía, cirugía torácica) y cuenta con servicios especiales: diagnóstico por imágenes (tomografía, ecografía), diálisis, cuidado intensivo diferenciado (unidad coronaria, cuidado intensivo); centro quirúrgico, centro obstétrico, neonatología.

Un hospital de Nivel IX es el establecimiento más especializado de toda la red de servicios de salud. Generalmente los hospitales provinciales están comprendidos dentro del Nivel IV y VI de complejidad.

## AREA: SERVICIOS DE SALUD - PUESTA EN MARCHA

ANEXO III-6  
Pág. 2 de 3

Valores en Dolares de Sept./86

ACTIVIDAD	CONSULTOR NACIONAL		VIAJES DE/A PCIAS.			OTROS	TOTAL
	Meses/Hombre	Costo	Viajes	Dias	Costo	GASTOS	
Análisis, selección de metodologías y criterios organizativos	60,0	150.000	11	7	5.500		155.500
Diseño de sistemas, Métodos y Procedimientos	84,0	210.000			0		210.000
Elaboración de Manuales de Normas y Procedimientos	18,0	45.000	11	10	7.150		52.150
Grafica de Manuales						4.950	4.950
Programas para computadoras	12,0	30.000				225.000	255.000
Seminarios y Talleres de discusión y Capacitación	22,0	55.000	11	60	34.650		89.650
Asistencia durante la Apertura	13,2	33.000	11	36	21.450		54.450
TOTAL SERVICIOS DE SALUD	209,2	523.000	44	113	68.750	229.950	821.700

## AREA: SISTEMAS DE INFORMACION - ESTADISTICA

Valores en Dolares de Sept./86

ACTIVIDAD	CONSULTOR NACIONAL		VIAJES DE/A PCIAS.			OTROS	TOTAL
	Meses/Hombre	Costo	Viajes	Dias	Costo	GASTOS	
Análisis, selección de metodologías y criterios organizativos	24,0	60.000	11	4	3.850		63.850
Diseño de sistemas, Métodos y Procedimientos	12,0	30.000			0		30.000
Elaboración de Manuales de Normas y Procedimientos	12,0	30.000			0		30.000
Grafica de Manuales						1.320	1.320
Programas para computadoras	12,0	30.000	22	60	69.300	120.000	219.300
Seminarios y Talleres de discusión y Capacitación	11,0	27.500	11	30	18.150		45.650
Asistencia durante la Apertura	12,1	30.250	11	33	19.800		50.050
TOTAL SIST. INF. Y ESTADISTICA	83,1	207.750	55	127	111.100	121.320	440.170

## AREA: SISTEMAS ADMINISTR.-GERENCIAL Y ECONOMICO-FINANCIERO

Valores en Dolares de Sept./86

ACTIVIDAD	CONSULTOR NACIONAL		VIAJES DE/A PCIAS.			OTROS	TOTAL
	Meses/Hombre	Costo	Viajes	Dias	Costo	GASTOS	
Análisis, selección de metodologías y criterios organizativos	96,0	240.000	22	4	7.700		247.700
Diseño de sistemas, Métodos y Procedimientos	66,0	165.000			0		165.000
Elaboración de Manuales de Normas y Procedimientos	18,0	45.000	11	10	7.150		52.150
Grafica de Manuales						2.640	2.640
Programas para computadoras	12,0	30.000			0	225.000	255.000
Seminarios y Talleres de discusión y Capacitación	33,0	82.500	22	45	52.800		135.300
Asistencia durante la Apertura	7,7	19.250	11	21	13.200		32.450
TOTAL SIST. ADM.-ECON.-FINANC.	232,7	581.750	66	80	80.850	227.640	890.240

## AREA: CONSOLIDADO 3 AREAS PARA APERTURA HOSPITALES

Valores en Dolares de Sept./86

ACTIVIDAD	CONSULTOR NACIONAL		VIAJES DE/A PCIAS.			OTROS	TOTAL
	Meses/Hombre	Costo	Viajes	Dias	Costo	GASTOS	
Análisis, selección de metodologías y criterios organizativos	180,0	450.000	44,0	15,0	17.050		467.050
Diseño de sistemas, Métodos y Procedimientos	162,0	405.000	0,0	0,0	0		405.000
Elaboración de Manuales de Normas y Procedimientos	48,0	120.000	22,0	20,0	14.300		134.300
Grafica de Manuales			0,0	0,0	0	8.910	8.910
Programas para computadoras	36,0	90.000	22,0	60,0	69.300	570.000	729.300
Seminarios y Talleres de discusión y Capacitación	66,0	165.000	44,0	135,0	105.600		270.600
Asistencia durante la Apertura	33,0	82.500	33,0	90,0	54.450		136.950
TOTAL CONSOLIDADO	525,0	1.312.500	143	320	260.700	578.910	2.152.110

PRESUPUESTO DETALLADO DE LA

UNIDAD EJECUTORA CENTRAL

(En el equivalente de miles de US\$)

AÑO	1	2	3	4	5	TOTAL
PERSONAL	671	671	671	671	670	3354,0
VIATICOS Y MOBILIDAD	130	145	175	170	120	740,0
CONSULTORIA Y LOCACION OBRAS	250	250	250	150	100	1000,0
EQUIPAMIENTO	80	-	-	-	-	80,0
MUEBLES	60	-	-	-	-	60,0
ALQUILERES Y SERVICIOS	50	50	50	50	50	250,0
GASTOS DE FUNCIONAMIENTO	<u>200</u>	<u>200</u>	<u>200</u>	<u>200</u>	<u>200</u>	<u>1000,0</u>
	1441	1316	1346	124,1	1140	6484,0
	=====	=====	=====	=====	=====	=====

PRESUPUESTO DETALLADO DE UNA  
UNIDAD EJECUTORA PROVINCIAL TIPICA  
(En equivalente de miles de US\$)

AÑO <u>a/</u>	1	2	3	<u>TOTAL</u>
PERSONAL <u>b/</u>	51	51	51	153
VIATICOS Y MOBILIDAD	12	20	12	44
CONSULTORIA	12	12	12	36
MUEBLES	20	-	-	20
ALQUILERES Y SERVICIOS	15	15	15	45
GASTOS DE FUNCIONAMIENTO <u>c/</u>	<u>36</u>	<u>36</u>	<u>36</u>	<u>118</u>
T O T A L	<u>146</u> ===	<u>134</u> ===	<u>126</u> ===	<u>406</u> ===

a/ El año 1 corresponde al primer año de la UEP y no al año 1 del Programa, el calendario de desembolsos para todas las UEP del Programa se presenta en la página siguiente.

b/ Corresponde al nuevo personal contratado e incluye un pago incremental al personal actual que se dedicaría en forma exclusiva a la UEP.

COSTO UNIDADES EJECUTORAS - CONSOLIDADO SEGUN P.E.P.

Planilla "5"

Dolares de Setiembre/86

CONSTRUCCION:		TRIMESTRE																			
DURAC.	INICIO:	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20
11	3	26.94	26.94	26.94	26.94	29.44	29.44	29.44	29.44	30.55	30.55	30.55	30.55	39.98	39.98						
10	3	27.22	27.22	27.22	27.22	29.44	29.44	29.44	29.44	30.69	30.69	30.69	30.69	56.98							
10	3	27.22	27.22	27.22	27.22	29.44	29.44	29.44	29.44	30.69	30.69	30.69	30.69	56.98							
10	4		27.22	27.22	27.22	27.22	29.44	29.44	29.44	30.69	30.69	30.69	30.69	56.98							
10	4		27.22	27.22	27.22	27.22	29.44	29.44	29.44	30.69	30.69	30.69	30.69	56.98							
10	5			27.22	27.22	27.22	27.22	29.44	29.44	29.44	30.69	30.69	30.69	56.98							
10	7				27.22	27.22	27.22	27.22	29.44	29.44	29.44	30.69	30.69	56.98							
10	9						27.22	27.22	27.22	27.22	29.44	29.44	29.44	30.69	30.69	30.69	30.69	56.98			
10	9							27.22	27.22	27.22	27.22	29.44	29.44	29.44	30.69	30.69	30.69	30.69	56.98		
8	11									28.53	28.53	28.53	28.53	31.94	31.94	31.94	31.94	33.54	33.54	33.54	
8	11									28.53	28.53	28.53	28.53	31.94	31.94	31.94	31.94	33.54	33.54	33.54	
PCIAS. - Trimes.		0.0	81.4	135.8	163.0	163.0	197.2	201.6	258.3	258.3	321.2	323.7	329.3	329.3	399.4	338.1	212.9	155.9	185.4	128.5	181.0
PCIAS. - Anual		380.2				820.1				1232.4				1279.8				650.9			
L - Anual		1440.8				1315.8				1345.8				1240.8				1140.8			
RAS - Anual		1821.0				2135.9				2578.2				2520.6				1791.7			

SITUACION DE LOS HOSPITALES A REEMPLAZARSE1. CHACO

El hospital "Perrando", ubicado en Resistencia es el establecimiento de mayor complejidad de la provincia. Construido en 1910 con un sistema de pabellones separados entre sí con circulaciones de vehículos, personas y pacientes descubiertas y expuestas a las condiciones climatológicas. Cada pabellón es una sala común para 30 pacientes y dos conjuntos de baños.

En 1958 por falta de espacio, el Servicio de Pediatría se trasladó a un edificio adaptado y que funciona actualmente como hospital pediátrico; ambos hospitales son obsoletos física y funcionalmente. La dotación actual de camas es de 523 y su distribución es la siguiente: cirugía: 118; medicina: 140; obstetricia ginecología: 118; pediatría: 77; y crónicos: 70 (40 para tuberculosis y 30 para psiquiatría). Estas 523 camas significan el 16,6% del total de camas de la provincia incluyendo las privadas y el 44% de la ciudad Resistencia.

La producción de los 2 hospitales para 1984 se presenta a continuación:

<u>Hospital</u>	<u>Egresos</u> <u>a/</u>	<u>Obitos</u>	<u>Tasa de</u> <u>Mortalidad</u> <u>b/</u>	<u>Ocupa-</u> <u>ción</u> <u>%</u>	<u>Promedio</u> <u>Perman.</u> <u>(días)</u>	<u>Giro</u> <u>Camas</u>	<u>Consultas</u> <u>c/</u>
Perrando	9.815	431	4,4	82,5	12,2	22	110.694
Pediátrico	2.149	293	13,6	78,8	10,2	28	77.675
Total	11.964	724	6,0				188.369

Observaciones

a/ Los egresos significan el 22,2% del total de egresos públicos de la provincia.

b/ Mortalidad intrahospitalaria elevada (muy elevada en el Pediátrico)

c/ Las consultas representan el 14,1% del subsector público de la Provincia.

Con respecto a la utilización futura, sólo un pabellón sería utilizado habilitando 40 camas para pacientes geriátricos y psiquiátricos en la modalidad de "hospital-día". Estas 40 camas tendrían el siguiente gasto de funcionamiento anual: gastos de personal: US\$97.500; no personal: US\$10.000; medicinas: US\$19.890; alimentos: US\$43.800; mantenimiento: US\$5.360. Con un total de US\$176.550, cuya responsabilidad sería del Ministerio y de la Sociedad de Beneficiencia Provincia.



## 2. FORMOSA

El Hospital "Central" ubicado en la capital fue construido en 1924 con un sistema pabellonar propio de su época, con salas comunes para 30 pacientes. Posteriormente (1971) se construyeron con material semi-industrializado los servicios de obstetricia y pediatria que en 1983 tuvieron que acomodarse en otro hospital que había sido construido en 1970 para neuropsiquiatria, que ahora funciona como Hospital "Madre y Niño". Ambos edificios son obsoletos en su funcionamiento.

La dotación de camas de los dos hospitales es la siguiente: cirugía: 68; medicina: 50; pediatria 77; obstetricia-ginecología 60; y crónicos: 28 (tuberculosis). Con un total de 283 camas las cuales significan el 28,3% de todas las camas de la provincia (incluidas las privadas) y el 58,3% de todas las camas de la capital.

La producción para 1984 es la siguiente:

<u>Hospital</u>	<u>Egresos</u> <u>a/</u>	<u>Obitos</u>	<u>Tasa de</u> <u>Mortalidad</u> <u>b/</u>	<u>Ocupa-</u> <u>ción</u> <u>%</u>	<u>Promedio</u> <u>Perman.</u> <u>Días</u>	<u>Giro</u> <u>Camas</u>	<u>Consultas</u> <u>c/</u>
Central	2.635	215	8,2	83,0	17	18	69.948
Madre-Niño	5.198	109	2,1	62,0	6	38	69.726
Total	<u>7.833</u>	<u>324</u>	<u>4,1</u>				<u>139.674</u>

### Observaciones

- a/ Los egresos significan el 31,6% del total de egresos del sector público de la provincia.
- b/ Elevada mortalidad hospitalaria en el Hospital Central.
- c/ Las consultas representan el 32,4% del total del Sector Público de la Provincia.

Con respecto a la utilización futura de ambos hospitales, ninguno de ellos será utilizado para atención médica hospitalaria. El Madre y Niño será utilizado para oficinas técnico-administrativas del Ministerio que ahora se encuentran alquilando locales.

## 3. MISIONES

El Hospital "Madariaga" ubicado en Posadas, construido en 1916 con un sistema de pabellones separados entre sí, con circulaciones abiertas y expuestos a condiciones climatológicas, con salas comunes para 30 pacientes. En 1955 se construyó el pabellón para obstetricia, siendo éste el más "nuevo". Su obsolescencia es tanto física como funcional. Cuenta con 310 camas que representan el 13,4% del total de camas del Sector Salud a nivel provincial y el 27,8 de total de camas de la ciudad, con la siguiente distribución: cirugía 101; medicina: 52;

obstetricia-ginecología: 40; pediatría: 103; y crónicos 14 (tuberculosis).

El actual hospital no será utilizado en el futuro para la atención médico-hospitalaria. La producción del hospital para 1984 fue la siguiente:

<u>Hospital</u>	<u>Egresos</u> <u>a/</u>	<u>Obitos</u>	<u>%</u> <u>Mortalidad</u> <u>b/</u>	<u>Ocupa-</u> <u>ción</u> <u>%</u>	<u>Tasa de</u> <u>Perman.</u> <u>Días</u>	<u>Giro</u> <u>Cama</u>	<u>Consultas</u> <u>c/</u>
Madariaga	10.455	568	5,4	77,3	8,4	34	248.437

#### Observaciones

- a/ Los egresos significan el 25,8% del total de egresos del sector público de la provincia.  
b/ Mortalidad hospitalaria elevada.  
c/ Las consultas representan el 35,2% de las consultas del sector público de la provincia.

Con respecto a la utilización futura, las instalaciones no serán utilizadas para atención médico hospitalaria. Un pabellón será acondicionado para ocupar oficinas técnico-administrativas del Ministerio de Salud. En el mismo predio se construirá el nuevo hospital.

#### 4. TUCUMAN

El hospital "Padilla" de la ciudad capital, fue construido en 1880 con un sistema pabellonar de salas comunes para 30 pacientes. Los dos últimos pabellones fueron construidos en 1950. Su obsolescencia es marcada, tanto física como funcional. La dotación de camas es de 453 con la siguiente distribución: cirugía: 268; medicina: 178; y crónicos: 7 (lepra). Los pacientes de Pediatría y Obstetricia se encuentran en otros edificios adaptados (hospital de Madre y Niño).

2.80 La producción para 1984 es la siguiente:

<u>Egresos</u> <u>a/</u>	<u>Obitos</u>	<u>Tasa</u> <u>Mortalidad</u> <u>b/</u>	<u>%</u> <u>Ocupa-</u> <u>ción</u>	<u>Perma-</u> <u>nencia</u> <u>(días)</u>	<u>Giro</u> <u>Cama</u>	<u>Consultas</u> <u>c/</u>
7.111	582	8,2	77,0	17,4	15	92.944

#### Observaciones

- a/ Los egresos significan el 15,0% de los egresos públicos de la provincia.  
b/ Mortalidad hospitalaria muy elevada.  
c/ Las consultas representan el 7,0% del total del sector público de la provincia.

Las instalaciones no serían realizadas para atención médico-hospitalaria.

5. SALTA

El Hospital "Del Milagro" de la ciudad capital fue construido en 1884 básicamente para la atención de tuberculosis y lepra; con las características de la época: pabellones, con salas comunes para 30-40 pacientes. En 1913 se construyó al lado, el hospital materno-infantil. Física y funcionalmente están completamente obsoletos. La dotación de camas es de 576 y su distribución es la siguiente: cirugía: 110; medicina: 82; obstetricia y ginecología: 108; pediatría: 226; y crónicos: 50 (30 para tuberculosis y 20 para convalecientes).

La producción de los 2 hospitales es la siguiente:

<u>Hospital</u>	<u>Egresos</u> <u>a/</u>	<u>Permanencia</u> <u>(días)</u>	<u>Giro</u> <u>Camas</u>	<u>Consultas</u> <u>b/</u>
Milagro	2.070	27	9	122.996
Madre y Niño	14.696	6	45	187.170
Total	16.766			310.166

Observaciones

a/ Los egresos significan el 25,2% del total de la Provincia (públicos).

b/ Las consultas representaron el 18,2 del total de la Provincia.

El Hospital "Del Milagro" será demolido y allí mismo se construirá el nuevo hospital, el hospital Madre y Niño será parcialmente utilizado por oficinas técnicas del Ministerio de Salud Provincial.

6. SANTA FE

El Hospital "Cullen" de la Ciudad Capital fue construido en 1904 y pertenece a la Sociedad de Beneficencia de la Provincia. Esta configurado por dos patios centrales alrededor de los cuales se encuentran los pabellones con salas comunes para 30-40 pacientes. En 1940 se construyó un bloque de 3 plantas para los servicios de obstetricia y ginecología; y hace 5 años se tuvo que clausurar dos pabellones (neonatología y pediatría) por hundimiento y derrumbe. Su grado de obsolescencia es marcada física y funcionalmente.

Su dotación es de 418 camas con la siguiente distribución: cirugía 201; medicina: 120; obstetricia y ginecología: 77; y pediatría: 20.

La producción del hospital es la siguiente:

<u>Egresos</u>	<u>Obitos</u>	<u>% Mortalidad</u>	<u>Ocupa- ción</u>	<u>Perma- nencia</u>	<u>Giro Cama</u>	<u>Consultas</u>
<u>a/</u>		<u>b/</u>	<u>%</u>	<u>(días)</u>		<u>c/</u>
9.526	558	5,9	71,1	11,4	22,8	132.547

Observaciones

- a/ Los egresos significan el 12,0% del total de los egresos públicos de la Provincia.  
 b/ Tasa de mortalidad hospitalaria elevada.  
 c/ Las consultas representan el 6,4% del total de los públicos de la provincia.

En cuanto a la utilización futura, el edificio será entregado a la Sociedad de Beneficencia de la Provincia. Parece ser que sería utilizado parcialmente para residencia de ancianos (El bloque "nuevo"). Los gastos recurrentes para 30 camas sería de US\$128.325 al año, se describinan así: Serv. personales: 78.000; Servicios no personales y mantenimiento: 12.000; medicamentos: 10.850; y alimentos: 27.375.

7. CORDOBA

El Hospital "Santísima Trinidad" de la ciudad capital fue construido en 1894 por la Sociedad de Beneficencia de Córdoba para la atención pediátrica. Constituye un mosaico de edificios de 3 épocas (1894 - 1930 y 1950) con circulaciones abiertas y cerradas. Su dotación es de 208 camas pediátricas en salas de 16-20 pacientes cada una. El actual edificio no será utilizado para la atención médico-hospitalaria.

La producción del hospital en 1984 fue:

<u>Egresos</u>	<u>Obitos</u>	<u>% Mortalidad</u>	<u>Ocupa- ción</u>	<u>Perma- nencia</u>	<u>Giro Cama</u>	<u>Consultas</u>
		<u>a/</u>	<u>%</u>	<u>(días)</u>		
4.525	183	4,0	82,8	11,8	24,3	172.732

Observaciones

- a/ Tasa de mortalidad hospitalaria en el límite superior.

8. MENDOZA

El hospital "El Carmen" de la ciudad capital construido en 1896 tenía una dotación de 200 camas, fue demolido en 1985 a causa de los daños sufridos por el sismo ocurrido ese año, pertenecía a la obra social de empleados públicos de la Provincia.

Durante 1984 (último año de funcionamiento) el hospital tuvo la siguiente producción:

<u>Egresos</u> <u>a/</u>	<u>Obitos</u>	<u>%</u> <u>Mortalidad</u> <u>b/</u>	<u>Ocupa-</u> <u>ción</u> <u>%</u>	<u>Perma-</u> <u>nencia</u> <u>días</u>	<u>Giro</u> <u>Cama</u>	<u>Consultas</u> <u>c/</u>
3.694	282	7,6	83,3	13,0	20,3	79.032

Observaciones

- a/ Los egresos significan el 4,6% del total del sector público de la Provincia.  
b/ Tasa de mortalidad hospitalaria elevada.  
c/ Las consultas representan el 4,7% del total del sector público de la Provincia.

9. SAN JUAN

El Hospital "Rawson", construido en 1920 con la estructura pabellonar. De los 19 pabellones que lo constituyen, 7 fueron construidos después del terremoto de 1944; y todos presentan actualmente una degradación de su estructura física que representa un serio riesgo dada las condiciones sísmicas de la provincia. El hospital tiene 536 camas con la siguiente distribución: cirugía: 151; medicina: 93; obstetricia y ginecología: 148; pediatría: 134; y crónicos: 10 (psiquiatría).

La producción en 1984 fue la siguiente:

<u>Egresos</u> <u>a/</u>	<u>Obitos</u>	<u>%</u> <u>Mortalidad</u> <u>b/</u>	<u>Ocupa-</u> <u>ción</u> <u>%</u>	<u>Perma-</u> <u>nencia</u> <u>(días)</u>	<u>Giro</u> <u>Cama</u>	<u>Consultas</u> <u>c/</u>
16.824	608	3,6	66,6	7,7	31,3	219.559

Observaciones

- a/ Los egresos significan el 53,.0% del total de la Provincia. (Públicos)  
b/ Tasa de mortalidad hospitalaria dentro de límites normales.  
c/ Las consultas representaron el 43% del total de la Provincia. (Públicos)

Las condiciones de la planta física no permite su utilización futura.

10. RIO NEGRO

El Hospital de "Cipolletti" fue construido en 1901 y hace 2 años sufrió graves daños en su estructura que tuvo que evacuarse los pacientes y acomodarse en 4 edificios separados e inadecuados para la atención médica. En el edificio del hospital sólo funciona la consulta externa;

las urgencias de adulto; el servicio social y las dependencias administrativas. Esta planta física se está actualmente reparando. En una casa adaptada funciona el programa de salud mental; el consultorio de oftalmología, la atención médica primaria y la cocina y lavadero. En una clínica privada se ha alquilado una planta para 36 camas para obstetricia, ginecología y pediatría. En un cuarto local ubicado en un barrio periférico funciona la internación de medicina y cirugía. La ambulancia hace el transporte de pacientes, ropa, comida, medicamentos, etc. entre uno y otro local. Cuenta con 77 camas distribuidas así: cirugía: 16; medicina: 25; tocoginecología: 12; pediatría: 24.

La producción del hospital en 1984 fue:

<u>Egresos</u> <u>a/</u>	<u>Obitos</u>	<u>%</u> <u>Mortalidad</u> <u>b/</u>	<u>Ocupa-</u> <u>ción</u> <u>%</u>	<u>Perma-</u> <u>nencia</u> <u>(días)</u>	<u>Giro</u> <u>Cama</u>	<u>Consultas</u>
1.876	68	3,6	63,5	9,0	24,6	7.267

#### Observaciones

a/ La mayoría de pacientes graves son atendidos en Neuquen.

b/ Tasa de mortalidad hospitalaria está dentro de límites normales.

El edificio que está siendo reparado será utilizado para la atención de pacientes crónicos, adaptándose a 30 camas, con un gasto anual de US\$128.325 que se distribuyen: personal: 78.000; mantenimiento y no personal: 12.000; medicamentos: 10.950; y alimentos: 27.375.

#### 11. NEUQUEN

En esta provincia no hay hospital de reemplazo, ya que es el único establecimiento nuevo del programa.

A R G E N T I N A

AR-0045

CONVENIO DE PARTICIPACION

-----Entre el Ministerio de Salud y Acción Social de la Nación, en adelante el, "MINISTERIO", representado en este acto por el señor \_\_\_\_\_ y el Gobierno de la Provincia de \_\_\_\_\_, en adelante "LA PROVINCIA", representada en este acto por el señor \_\_\_\_\_, se celebra el presente convenio relacionado con la ejecución de un "Programa de Rehabilitación de la Infraestructura de Salud" del que forma parte esta Provincia, enmarcado en el Contrato de Préstamo B.I.D. \_\_\_\_\_, que consta de las siguientes cláusulas:

PRIMERA: "LA PROVINCIA" se obliga a entregar en comodato, hasta la entrega definitiva del hospital proyectado a la Provincia, al "MINISTERIO" un terreno de su propiedad cuyos datos son: \_\_\_\_\_ en el cual éste a través de la UNIDAD EJECUTORA CENTRAL DEL PROGRAMA construirá y equipará un hospital, siguiendo las especificaciones técnicas que la propia UEC aportará. Asimismo "LA PROVINCIA" se compromete a no sustituir el terreno antes individualizado por ningún motivo y suministrará un certificado de dominio actualizado de dicho inmueble. Debiendo el mismo disponer de suficiente agua potable, servicio telefónico, gas, electricidad, servicios cloacales, etc. Asimismo "LA PROVINCIA" propiciará el dictado del acto administrativo o legal que según su propia legislación resulte necesario para cumplir con el comodato establecido.

SEGUNDA: "LA PROVINCIA" por intermedio de su Ministerio de Salud o Secretaría de Salud, según corresponda, designará para participar en la ejecución de las obras a realizar en el marco del presente convenio, un organismo denominado en adelante "UNIDAD EJECUTORA PROVINCIAL - UEP", la que deberá llevar a cabo las tareas que delegue la UEC. La UEP deberá adaptar su funcionamiento y operaciones al reglamento que sobre el particular fije la UEC para el programa. Asimismo, "LA PROVINCIA" deberá: (a) designar oportunamente y de acuerdo al requerimiento que le formule la UEC el personal profesional, técnico, administrativo y de apoyo, para que la UEP pueda cumplir con sus funciones; (b) asignar los locales, muebles y la movilidad dentro del radio de ubicación del hospital a construirse que sean necesarios; y (c) designar un representante para que participe en los actos licitatorios, que serán llevados a cabo por la UEC.

TERCERA: "LA PROVINCIA" se obliga, a requerimiento del "MINISTERIO", a nombrar el personal que integrará la dotación de su nuevo hospital dentro del plazo de sesenta días desde que se formule el requerimiento, dándole a dicho personal las facilidades para que pueda recibir la capacitación necesaria para el manejo del hospital proyectado y prestar todo el apoyo necesario que le sea solicitado por la UEC.

1/ Se adaptará la redacción al caso concreto según el nivel de disponibilidad que el terreno posea de los servicios requeridos, de acuerdo a lo previsto en el Apéndice III A-2-c y d.

CUARTA: La UEC será la responsable de la ejecución del programa. El mismo comprende: (a) la realización de todos los actos necesarios para la contratación y ejecución de las obras y la compra e instalación del equipamiento del futuro hospital; (b) el diseño de los sistemas, métodos y procedimientos de operación y mantenimiento del nuevo hospital; y (c) la formulación y puesta en práctica de un programa de capacitación para el personal del hospital proyectado.

QUINTA: "LA PROVINCIA" deberá arbitrar todo lo necesario para constituir el nuevo hospital en un "efector" de las Obras Sociales Provinciales que actúen en ella, de manera tal que parte del costo de funcionamiento del nuevo establecimiento pueda ser solventado con los recursos provenientes de la facturación de los servicios que, a dichas Obras Sociales se les pueda brindar de acuerdo al nomenclador que se establezca. A los efectos de lograr más acabadamente el objetivo previsto, "LA PROVINCIA" deberá desarrollar formas de participación de la comunidad en la gestión de su nuevo hospital.

SEXTA: "LA PROVINCIA" deberá: (a) presentar y poner en práctica durante un período de 10 años un plan anual de mantenimiento del hospital de acuerdo a las normas elaboradas por la UEC, debiendo presentarse el primero de ellos durante el proceso de apertura del hospital; (b) poner en práctica el plan de operación y mantenimiento, los sistemas, métodos y procedimientos del hospital, incluyendo el presupuesto descentralizado que será elaborado mediante el Sub-programa de Fortalecimiento Institucional, que incluirá los procedimientos para identificar a los afiliados de las obras sociales para cumplir con fines estadísticos, así como para proceder a la facturación a aquellas obras sociales con las que se hayan firmado convenio; y (c) proporcionar toda la información necesaria para la evaluación a posteriori, de acuerdo a las normas de procedimiento elaboradas por la UEC.

SEPTIMA: "LA PROVINCIA" queda obligada por el término de cinco años a presentar a partir de la puesta en marcha de su nuevo hospital, un informe anual sobre su estadística médica y de costos, de acuerdo al modelo que establezca la UEC.

OCTAVA: El Ministerio de Salud y Acción Social a través de la UEC, colaborará en forma conjunta con la Provincia, de acuerdo a los términos de contrato de préstamo BID \_\_\_\_\_, en la elaboración de: (a) un plan de crecimiento futuro del nuevo hospital; (b) el programa de utilización y destino de las instalaciones actuales a sustituir por el nuevo hospital, que no podrá incluir su uso para atenciones médico-hospitalarias, excepto para pacientes crónicos cuando así se justifique; (c) la puesta en marcha y correcto funcionamiento del nuevo establecimiento; y (d) una evaluación del nivel de cumplimiento de los objetivos del programa.

NOVENA: Una vez finalizada la puesta en funcionamiento del hospital proyectado, el "MINISTERIO" transferirá en propiedad a "LA PROVINCIA" el mismo, y ésta se obliga a recibirlo y a cumplir con todo lo estipulado en el presente convenio y a proveer lo necesario para solventar sus gastos de mantenimiento y funcionamiento. En caso de incumplimiento de las obligaciones previstas, se propiciará el dictado de la norma legal que posibilite reasignar el crédito que se le asigne a la Provincia en el presupuesto de la Nación (fondos PAS o la partida que lo sustituyere) en la medida que resulte necesario para asegurar el plan de mantenimiento y funcionamiento del hospital.

DECIMA: "LA PROVINCIA", a través de su Ministerio de Salud o Secretaría de Salud según corresponda, se compromete a presentar semestralmente al



Ministerio de Salud y Acción Social, a partir de la puesta en servicio del hospital y hasta un año después del último desembolso, un informe sobre la labor que se ha realizado con Obras Sociales para prestar servicios a sus asociados a través del hospital del Programa. Este informe presentará el número de facturaciones, el monto facturado y el monto pagado por cada Obra Social en el semestre anterior. Este requerimiento responde a las obligaciones asumidas por la Nación en el convenio de préstamo BID\_\_\_\_\_.

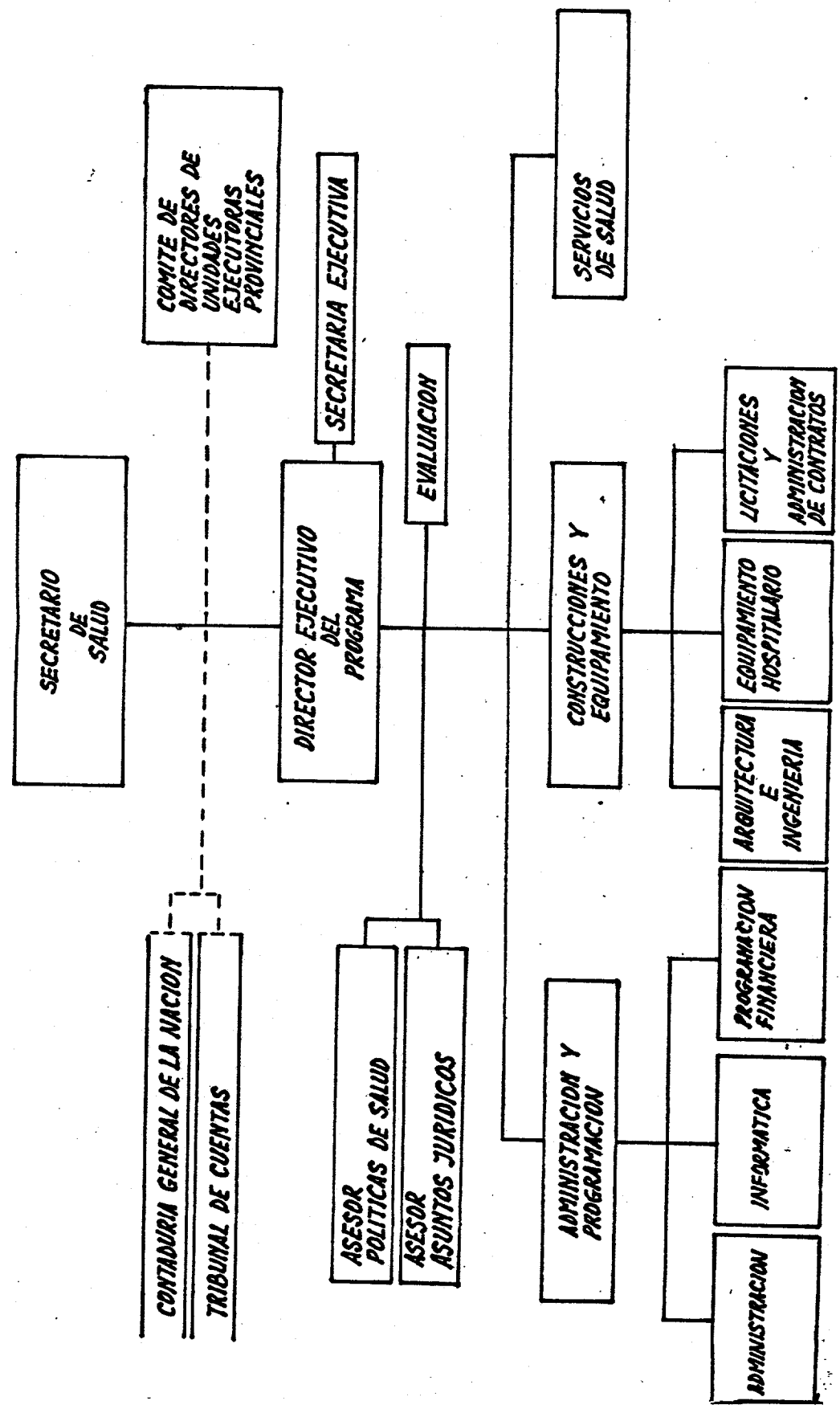
UNDECIMA: Durante los ejercicios presupuestarios correspondientes a los años 1987-1991 los fondos correspondientes a la Partida principal 3220 "Aportes a Provincias y Territorio Nacional" correspondientes al programa 036-Apoyo a Provincias para Programas de Salud, Jurisdicción 81 - Secretaría de Salud, conformarán los fondos de contrapartida nacional del Programa de Rehabilitación de la Infraestructura Hospitalaria de "LA PROVINCIA". En caso que la total ejecución del programa lo demande, el período antes mencionado podrá ser ampliado, quedando "LA PROVINCIA" debidamente notificada y aceptándolo.

DUODECIMA: La falta de cumplimiento de las cláusulas del presente convenio por una de las partes, dará a la otra el derecho a exigir su cumplimiento o su denuncia, sin perjuicio de otras consecuencias jurídicas que el ordenamiento legal contemple, comenzando a regir el mismo a partir del día siguiente al de su firma. Las partes establecen los siguientes domicilios especiales en los cuales será válida toda comunicación y notificación que recíprocamente se cursen a saber, "EL MINISTERIO, en la \_\_\_\_\_ - \_\_\_\_\_ de la Ciudad de Buenos Aires, y LA PROVINCIA en la calle \_\_\_\_\_ de la Ciudad de \_\_\_\_\_.

CONVENIO (AR0045)

**ORGANIGRAMA DE UNIDAD EJECUTORA CENTRAL**

PROGRAMA SS/BID



## ORGANIZACION EJECUTIVA DEL PROGRAMA

### 1. MARCO GENERAL

El Ejecutor del Programa sera el Ministerio de Salud y Accion Social, a traves de la Secretaria de Salud. La Direccion Nacional del Programa sera ejercida por el Secretario de Salud, de quien dependera directamente una Unidad Ejecutora Central, de aqui en adelante denominada UEC, la cual sera la encargada de ejecutar el Programa.

La UEC debera atender al desenvolvimiento de dos sub-programas, como responsable del cumplimiento de los objetivos previstos para cada uno de ellos, dentro del plazo estipulado.

#### a) Construcciones y Equipamiento:

Construccion y Equipamiento de los 11 Hospitales, listos para su entrada en operacion, dentro de las normas y criterios preestablecidos.

#### b) Fortalecimiento Institucional:

Desarrollo de un programa destinado a la proveer al personal de los Hospitales de un sistema organizativo y de un nivel de capacitacion que permitan colocar la calidad de las prestaciones a un nivel en consonancia con el de la infraestructura prevista, manteniendo un nivel de costos adecuado y contribuyendo a los sistemas sanitarios provinciales.

La UEC dispondra de un periodo de 5 anos a partir de la firma del contrato de prestamo con el BID, para ejecutar el Programa, con los fondos a ser desembolsados por los recursos locales y del BID que se asignan al Programa, por un monto total equivalente a 285 millones de dolares.

Para el mejor cumplimiento de su mision, la UEC contara con la colaboracion, en cada Provincia integrante del Programa, de una Unidad Ejecutora Provincial, en adelante denominada UEP, en la cual delegara algunas de sus funciones. La UEP sera creada en el marco del Ministerio o Secretaria de Salud provincial, segun corresponda, de acuerdo a lo que se establece en el convenio a ser firmado entre el Ministerio de Salud y Accion Social de la Nacion y cada una de las Provincias.

La UEC se integrara con un equipo de personal de la maxima calificacion profesional posible, el cual sera contratado como locacion de servicios por el periodo necesario, que en la mayoria de los casos sera el de la duracion del programa, pero nunca superior al mismo.

Debido a las características del programa es previsible la existencia de picos de trabajo en ciertos periodos, que seran suplidos mediante la contratacion de profesionales para la ejecucion de actividades especificas con duracion prefijada, como locacion de obra. En los casos en que resulte necesario, la UEC podra contratar servicios de consultoria y/o asesoramiento por periodos y en temas preestablecidos, ya sea a traves de expertos individuales o de firmas consultoras o de servicios. La UEC podra contar tambien con el apoyo de consultores de organismos internacionales (OPS y FNUD), si bien que, en principio, dichas consultorias, al igual que la mayor parte de las contrataciones de obras o servicios especificos que se efectuen, se destinaran al Sub-Programa de Fortalecimiento Institucional y no al funcionamiento de la UEC.

Las UEP se constituirán dentro de lo posible con personal de planta de la Administración Pública Provincial, a los cuales se les reconocerá un adicional salarial por su participación en la UEP. En aquellos casos en los que no se disponga de personal para cumplir algunas de las funciones previstas, se efectuarán contrataciones con un régimen similar, en lo posible, al de la UEC. Para algunas de las actividades puntuales se prevé la contratación de consultores especializados.

La administración del Programa será efectuada por la UEC con la intervención de la Dirección de Administración de la Secretaría de Salud, la auditoría de la Contaduría General de la Nación y la intervención del Tribunal de Cuentas.

Los gastos que demande el funcionamiento de la UEC así como los gastos incrementales de las UEP serán financiados por el propio Programa, con fondos de contrapartida nacional.

Como órgano consultivo en relación a la marcha de la ejecución del Programa, será creado un Comité de Directores de Unidades Ejecutoras Provinciales, presidido por el Secretario de Salud en su carácter de Director Nacional del Programa e integrado por los Directores de cada una de las UEP y al Director Ejecutivo de la UEC.

## **2. FUNCIONES**

Las funciones a ser cumplidas por la UEC y por las UEP pueden ser agrupadas en tres grandes áreas.

### **2.1. Ejecución de los 11 Hospitales**

Corresponde a la puesta en práctica de todos los actos necesarios para la contratación y ejecución de las obras y la compra e instalación del equipamiento para los 11 Hospitales, comprendiendo:

- a) Diseño arquitectónico y de ingeniería, a nivel de proyecto final para licitación y elaboración de los pliegos completos para las obras, para todos los hospitales que en la fase de formulación fueron aprobados a nivel de ante-proyecto;
- b) Actos licitatorios para las 11 obras: precalificaciones, licitaciones, adjudicaciones y negociaciones;
- c) Inspección y supervisión de las obras, programación y seguimiento y administración de los contratos;
- d) Evaluación de proveedores de equipamientos y de posibles fuentes de financiamiento comercial;
- e) Actos licitatorios referidos al equipamiento hospitalario: precalificaciones, licitaciones, adjudicaciones y negociaciones;
- f) Recepción, instalación y aprobación de los equipamientos y administración de los contratos.

Las UEP intervendrán en los ítems "a" y "e", siendo sus funciones:

- a) Inspección de obras, recepción de certificados, aprobación de las mediciones. La UEC efectuará la supervisión y auditoría, dando apoyo a las UEP en lo que sea necesario;

b) Recepcion, instalacion y aprobacion de los equipamientos, bajo la supervision de la UEP.

## **2.2. Fortalecimiento Institucional**

Corresponde a la ejecucion de todos los actos necesarios para el cumplimiento del sub-programa, que comprende:

a) Programa de formacion basica complementaria en el area administrativo-gerencial para el futuro personal directivo de los Hospitales y de sus principales sectores;

b) Analisis y diseno de sistemas, metodos y procedimientos medicos y gerenciales con sus correspondientes manuales, para un adecuado funcionamiento de los Hospitales, incluyendo los sistemas de computacion, configuracion y software para los sectores de los hospitales a ser informatizados;

c) Diseno del programa de apertura del hospital;

d) Programa de entrenamiento para el personal de cada sector, incluyendo asistencia durante el proceso de prueba en vacio y apertura del Hospital.

Para ello, debera elaborar programas de accion y terminos de referencia detallados, seleccionar contratar y recibir los productos de firmas consultoras, expertos y consultores individuales y docentes, organizar las diversas actividades, seleccionar participantes y becarios, solicitar, recibir y atender consultores de organismos internacionales.

Las UEP tendran la funcion de actuar como enlace con el personal que estara a cargo del futuro Hospital, organizando la infraestructura para las actividades en la provincia asi como los viajes necesarios.

## **2.3. Programa Global**

Corresponde a la ejecucion de todos los actos necesarios para que puedan ser ejecutadas eficazmente las actividades de las otras areas y para un adecuado funcionamiento del programa en su totalidad, en sus aspectos gerenciales, institucionales y financieros, asi como el seguimiento permanente de su marcha para control y posterior evaluacion. Comprende:

a) Apoyo administrativo interno;

b) Apoyo en Informatica y Modelos matematicos, incluyendo desarrollo previo y procesamiento del software necesario para las operaciones de los contratos y del Programa;

c) Programacion y Control Financiero, incluyendo la autorizacion de compromisos, aprobacion de libramientos y solicitud de desembolsos;

d) Administracion de la Cuenta Especial, incluyendo Servicio Administrativo del Programa;

e) Relaciones institucionales: BID, Organismos Internacionales, Reparticiones y Organismos de la Administracion Publica;

f) Seguimiento y control de la marcha del programa;

g) Preparacion de la evaluacion ex-post.

### 3. ORGANIZACION DE LA UEC

La UEC estara dirigida por un Director Ejecutivo del Programa, que dependera directamente del Secretario de Salud, el que ejercera las funciones de Director Nacional del Programa.

Internamente, la UEC se organizara en tres grandes areas (ver Organigrama) que en lineas generales se corresponden con las 3 areas en las que fueron agrupadas las funciones en el item "2".

#### 3.1. Construcciones y Equipamiento

Es el area responsable por las funciones indicadas en "2.1.", para lo cual se subdivide a su vez en 3 sectores:

- \* Arquitectura e Ingenieria
- \* Equipamiento Hospitalario
- \* Licitaciones y Administracion de Contratos

Los 2 primeros sectores abarcan las funciones especificamente tecnicas, siendo responsabilidad del tercero las funciones administrativas, comerciales y financieras relativas a las precalificaciones, licitaciones y contratos.

#### 3.2. Servicios de Salud

Funcionando como un equipo unico, sera responsable de todas las funciones relativas al sub-programa de Fortalecimiento Institucional, segun se indica en "2.2."

#### 3.3. Administracion y Programacion

Es el area responsable por la ejecucion de las actividades destinadas a cumplir con las funciones agrupadas en el item "2.3.", con excepcion de los asuntos juridicos y la evaluacion. Para ello se subdivide en tres sectores:

- \* Administracion
- \* Informatica
- \* Programacion Financiera

El primer sector esta a cargo del servicio administrativo interno y de brindar apoyo de infraestructura administrativa a todos los sectores de la UEC.

Informatica, cumplira las funciones de elaboracion y procesamiento propias del area referidas al Programa (administracion, programacion y control, estadisticas) y tambien de los contratos, dando ademas apoyo a las otras areas.

Programacion Financiera debera programar y controlar la marcha financiera del Programa y de la Cuenta Especial, desembolsos del BID y de contraparte, preparando tambien los informes periodicos.

### 3.4. Otros Sectores

En dependencia directa del Director Ejecutivo, se localiza el sector:

- \* Evaluacion

que tendra a su cargo las funciones de control de la marcha del programa y preparacion de la evaluacion ex-post.

Tambien dependeran del Director Ejecutivo los asesores especiales en:

- \* Politicas de Salud

- \* Asuntos Juridicos

### 4. ESQUEMA ADMINISTRATIVO

Todo el manejo administrativo del Programa, Cuenta Especial, Contratos y gastos propios de la UEC sera procesado por la UEC a traves de su area ADMINISTRACION Y PROGRAMACION, con la intervencion de las otras areas en lo que se refiere al analisis y eventual negociacion sobre certificados o sobre servicios, con el apoyo del sector de Informatica para el proceso de los mismos y con la intervencion de Programacion Financiera si hubiera alteracion en compromisos futuros. Una vez aprobado por el area correspondiente, toda la documentacion sera entregada al sector Administracion, que abra el expediente correspondiente preparando el libramiento, autorizando el desembolso y contabilizando en la Cuenta Especial y en la cuenta corriente bancaria propia del Programa. La intervencion de la Direccion de Administracion de la Secretaria de Salud se dara a pedido de la UEC, que girara el expediente para la firma del libramiento y el correspondiente pago por la Tesoreria de la Secretaria, girando sobre la Cuenta Corriente del Programa.

### 5. ORGANIZACION DE LAS UEP

La UEP de cada Provincia, debera comenzar a funcionar tres meses antes del inicio de las obras, o sea coincidiendo con la fase de preadjudicacion, finalizando su cometido con la puesta en funcionamiento del Hospital, prevista para los seis meses siguientes a la finalizacion de las obras. Por lo tanto operara durante un periodo nueve meses mayor que la duracion de la construccion.

Teniendo en cuenta las funciones atribuidas a la UEP, su organizacion es relativamente sencilla. Su maxima autoridad sera el Director Ejecutivo, que respondera al Ministro o Secretario de Salud Provincial y del cual dependeran directamente cuatro sectores.

- \* Construcciones

Cumplira las funciones de Inspeccion de Obra y control de avance fisico y mediciones, aprobando u observando los certificados del contratista. Funcionara durante todo el periodo con personal variable de acuerdo a los cronogramas previstos de obra. Contara con el refuerzo de consultores para especialidades de Ingenieria muy especificos y con requerimiento en fases puntuales, que no justifican la contratacion de personal al efecto.

**\* Equipamiento Hospitalario**

Debera cumplir las funciones de preparar la recepcion, recibir, controlar la instalacion y la prueba del equipamiento, verificando el cumplimiento de las especificaciones tecnica. Comenzara a funcionar seis meses antes de la finalizacion de la obra.

**\* Servicios de Salud**

Debera cumplir las funciones indicadas para las UEP en el sub-programa de Fortalecimiento Institucional (item "2.2."). Funcionara durante todo el periodo.

**\* Administracion y Contratos**

Sera responsable de la administracion de la UEP, del apoyo de infraestructura a la misma, de la recepcion y verificacion formal de los certificados y su envio a la UEC.

**6. MODALIDAD DE CONTRATACION**

Actualmente el Gobierno Nacional se encuentra realizando el maximo esfuerzo posible, en orden a lograr una reduccion del numero de empleados publicos, sin que ello de lugar a un problema de tipo social. La reduccion se esta logrando por un decrecimiento vegetativo y no por despidos u otras formas posibles de desplazamiento del empleado publico.

En atencion a lo expuesto en el parrafo precedente, es que se arbitrara una modalidad de contratacion para el personal que desempeñe funciones de UNIDAD EJECUTORA Central del Programa, que no signifique un incremento innecesario en la dotacion permanente de empleados publicos.

Tambien debe ser considerado y como de fundamental importancia, el hecho de que el referido personal debe contar con el maximo nivel de idoneidad profesional que resulta indispensable para la correcta ejecucion del Programa.

En consideracion a lo mencionado en los parrafos precedentes, la mejor modalidad de contratacion para el personal que dependa o cumpla funciones en la Unidad Ejecutora Central del Programa es la "Locacion de Servicios" y la "Locacion de Obra".

Estas dos opciones obedecen a distintas necesidades operativas que la propia U.E.C. podra requerir para su desenvolvimiento. En el primer caso, la "locacion de servicios" se empleara para el personal cuyas tareas resulten necesarias durante toda la ejecucion del proyecto. El supuesto de "locacion de obra" es para la contratacion de profesionales, a los cuales se le encargara la realizacion de un trabajo perfectamente delimitado en cuanto a su extension.

En ambos supuestos, la retribucion que perciba el personal contratado, lo sera en concepto de honorarios y los mismos no se encuentran sujetos a descuentos ni aportes al sistema provisional.



Con relacion a la prohibicion de efectuar contrataciones, establecida en los Decretos 983/85 y 2256/85, cabe destacar que, habiendo sido establecida la prohibicion por Decretos, la misma puede ser exceptuada mediante otro Decreto. Dado que la UEC debiera ser creada por Decreto del Poder Ejecutivo Nacional, en el mismo se estableciera expresamente la excepcion a las contrataciones del personal de la misma, de lo dispuesto en los ya mencionados Decretos.

## 7. PERSONAL Y COSTOS

### 7.1. Gastos de Ejecucion

En la Planilla "1", se presenta el personal que cumplira las diversas funciones en la UEC durante los 5 anos del periodo de ejecucion del Programa, con sus remuneraciones, sub-totales por sector y total de las mismas, ano por ano. Debe notarse que la misma esta anualizada a partir del mes 1 del ano 1 del programa, independientemente de las fechas reales que resulten de la fecha de firma del contrato.

En la misma planilla se incluyen los demas gastos necesarios para el funcionamiento de la UEC. Los montos correspondientes a "Viaticos y Movilidad" se estimaron a partir del cronograma indicado en el PEP del Programa. Los "Equipamientos" corresponden a copiadoras de planos, fotocopidora, micro-computadoras, maquinas de calcular y de escribir. Los gastos de "Alquileres y Servicios" y "Gastos de Funcionamiento" resultan de la cantidad de personal y de la carga de trabajo en funcion del PEP. El rubro "Consultoria y Locacion de Obra" se destina a atender picos transitorios en la carga de trabajo, mediante el regimen de locacion de obra indicado en el item "6".

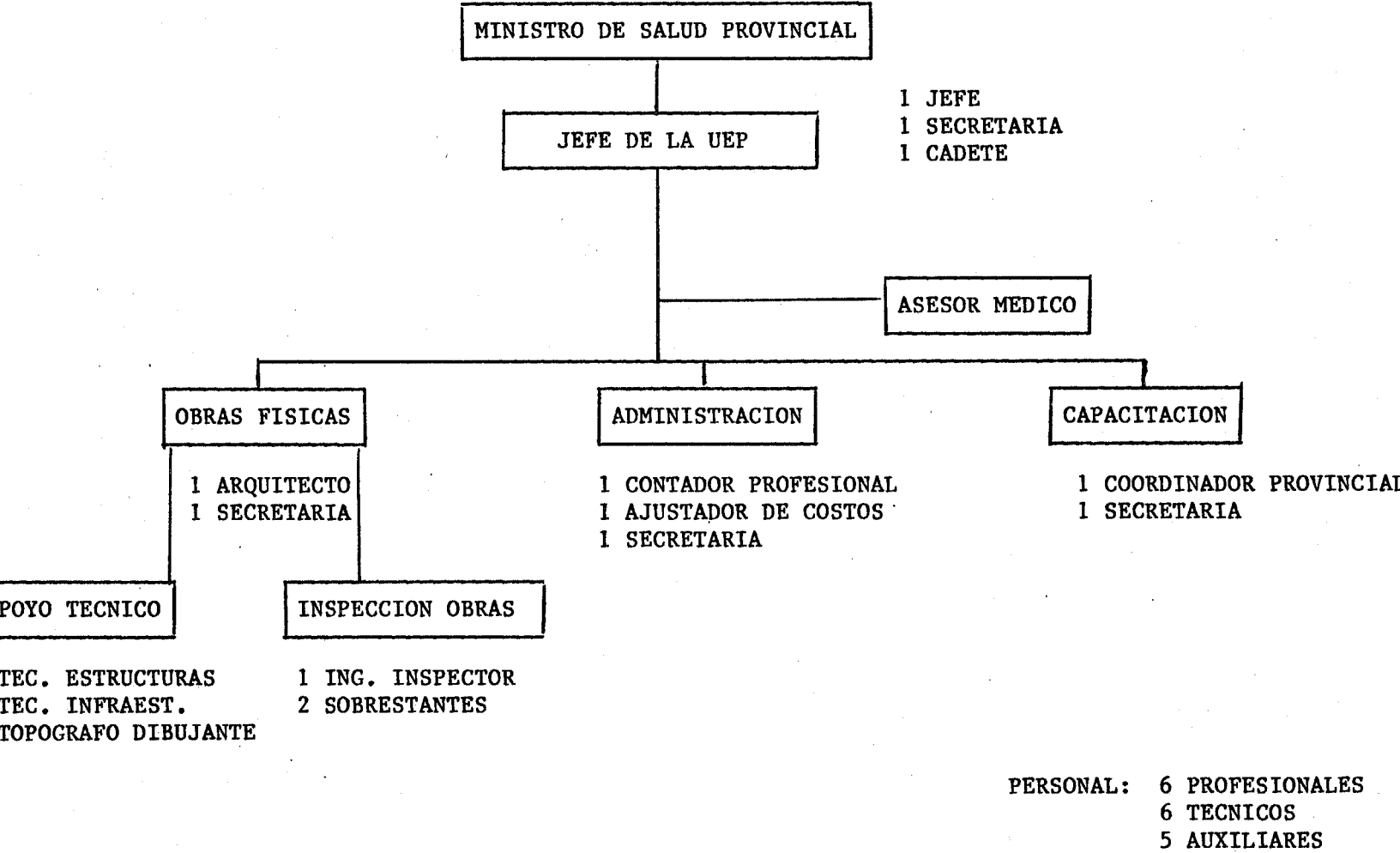
En las planillas "2A", "3A" y "4A", similares a la "1", se presenta la lista de personal, con sus costos y demas gastos para las UEP, en 3 modelos, segun la duracion de la obra, de la cual resulta el periodo de funcionamiento de la UEP y la distribucion de la carga de personal y gastos. Las correspondientes planillas "B", presentan un resumen de los gastos, separados en incrementales y no incrementales. El criterio es considerar gastos incrementales a:

- \* 40% de los gastos con personal
- \* 100% de los gastos de viaticos y movilidad y de la consultoria
- \* 50% de los gastos en muebles e instalaciones
- \* 0% de los gastos de alquileres y servicios
- \* 30% de los gastos de funcionamiento

Todas las planillas parten del mes 1 del ano 1, correspondiente a tres meses antes del inicio de la obra, prevista para el mes 3 del ano 1. Para la consolidacion de los gastos de las 11 provincias debe tomarse en cuenta la fecha de inicio prevista para cada obra en el PEP. Esta consolidacion se encuentra en la planilla "3".

La totalidad de los gastos de la UEC asi como el total de los gastos incrementales de las UEP se imputan a la categoria de inversion: "Ingenieria y Administracion" del Programa, siendo asumidos con fondos de contrapartida nacional.

ORGANIGRAMA Y PERSONAL DE LAS UNIDADES EJECUTORAS PROVINCIALES (UEP)



PROGRAMA SS/BID

P.E.P. - PROGRAMA DE EJECUCION PRELIMINAR - PROYECCION TRIMESTRAL ESTIMADA

[illegible]

PROGRAMA 55/BID

P.E.P. - PROGRAMA DE EJECUCION PRELIMINAR - PROYECCION TRIMESTRAL ESTIMADA

DESCRIPCION	DURAC.	INICID:	TRIMESTRES																				
			0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20
HOSPITAL MENDOZA	10	4																					
Diseno y Pliegos			+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+
Proceso Licitat.					+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+
Construccion							+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+
Recepcion Obra																	+	+	+	+	+	+	+
Proceso Licitat.											+	+	+	+	+	+	+	+	+	+	+	+	+
Equipamiento												+	+	+	+	+	+	+	+	+	+	+	+
Recepcion Equip.																	+	+	+	+	+	+	+
Capacitacion																	+	+	+	+	+	+	+
Apertura Hosp.																	+	+	+	+	+	+	+
HOSPITAL SAN JUAN	10	5																					
Diseno y Pliegos			+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+
Proceso Licitat.					+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+
Construccion							+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+
Recepcion Obra																	+	+	+	+	+	+	+
Proceso Licitat.											+	+	+	+	+	+	+	+	+	+	+	+	+
Equipamiento												+	+	+	+	+	+	+	+	+	+	+	+
Recepcion Equip.																	+	+	+	+	+	+	+
Capacitacion																	+	+	+	+	+	+	+
Apertura Hosp.																	+	+	+	+	+	+	+
HOSPITAL 7	10	7																					
Diseno y Pliegos				+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+
Proceso Licitat.					+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+
Construccion							+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+
Recepcion Obra																		+	+	+	+	+	+
Proceso Licitat.												+	+	+	+	+	+	+	+	+	+	+	+
Equipamiento													+	+	+	+	+	+	+	+	+	+	+
Recepcion Equip.																		+	+	+	+	+	+
Capacitacion																		+	+	+	+	+	+
Apertura Hosp.																		+	+	+	+	+	+
HOSPITAL 8	10	9																					
Diseno y Pliegos				+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+
Proceso Licitat.					+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+
Construccion							+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+
Recepcion Obra																		+	+	+	+	+	+
Proceso Licitat.													+	+	+	+	+	+	+	+	+	+	+
Equipamiento														+	+	+	+	+	+	+	+	+	+
Recepcion Equip.																		+	+	+	+	+	+
Capacitacion																		+	+	+	+	+	+
Apertura Hosp.																		+	+	+	+	+	+
HOSPITAL 9	10	9																					
Diseno y Pliegos				+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+
Proceso Licitat.					+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+
Construccion							+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+
Recepcion Obra																		+	+	+	+	+	+
Proceso Licitat.													+	+	+	+	+	+	+	+	+	+	+
Equipamiento														+	+	+	+	+	+	+	+	+	+
Recepcion Equip.																		+	+	+	+	+	+
Capacitacion																		+	+	+	+	+	+
Apertura Hosp.																		+	+	+	+	+	+
HOSPITAL 10 Y 11	8	11																					
Diseno y Pliegos				+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+
Proceso Licitat.					+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+
Construccion							+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+
Recepcion Obra																		+	+	+	+	+	+
Proceso Licitat.													+	+	+	+	+	+	+	+	+	+	+
Equipamiento														+	+	+	+	+	+	+	+	+	+
Recepcion Equip.																		+	+	+	+	+	+
Capacitacion																		+	+	+	+	+	+
Apertura Hosp.																		+	+	+	+	+	+

SIST SEGUIMIENTO PROYECTOS-PMS\*

CALENDARIO DE ACTIVIDADES

RED DEL PROYECTO ARGE (AR-0045) PROGRAMA DE SALUD

INICIO PROYECTO 10 DIC 86 FECHA ACTUA: 10 DIC 86  
TERM. PROYECTO 1 ABR 92 PROX. ACTUALIZ. 30 SET 87

CALENDARIO DE ACTIVIDADES POR ACTIVIDAD

POR COD. DE ORGANIZACION

RANGO MINIMO 10 DIC 86 FECHA PROC. 10 OCT 86  
RANGO MAXIMO 1 ABR 92 SEC. PROCESO 0  
PAG. 1.

COD.DE ACTIVIDAD	DESCRIPCION DE ACTIVIDAD	DUR. REMAN	% CUM	INICIO TEMP.	INICIO TARDIO	DEMORA MAX	TERM. TEMP.	TERM. TARDIO	DEMORA DISPON.	CAL
1000	APROBACION DIRECTORIO	0.	0	10DIC86	10DIC86	NADA	10DIC86	10DIC86	NADA	71990
1010	SUSCRIBIR Y LEGALIZAR CONTRATO	112.0	0	10DIC86	10DIC86	NADA	31MAR87	31MAR87	NADA	71 00
1111	PREPARAR INFORME JURIDICO	25.0	0	1ABR87	31DIC87	274.	25ABR87	24ENE88	NADA	71 00
1112	APROBAR BID INFORME JURIDICO	15.0	0	26ABR87	25ENE88	274.	10MAY87	8FEB88	140.	71 00
1121	NOMBRAR REPRESENTANTES LEGALES	30.0	0	1ABR87	10ENE88	284.	30ABR87	8FEB88	150.	71 00
1500	ELEGIBILIDAD PARA DESEMBOLSOS	4.0	0	28SET87	9FEB88	134.	10OCT87	12FEB88	NADA	71 00
1700	VIGENCIA DEL CONTRATO	0.	0	31MAR87	12AGO87	134.	31MAR87	12AGO87	NADA	71990
2001	TRAMITIR Y RECIBIR I DESEMBOLSO	20.0	0	20OCT87	13FEB88	134.	21OCT87	3MAR88	134.	71 00
2011	DEMONSTRAR DISPONIBIL. RECURSOS AND 1	20.0	0	1ABR87	20ENE88	294.	20ABR87	8FEB88	160.	71 00
2021	INSTRUMENTAR CONTROL GESTION	30.0	0	1ABR87	10ENE88	284.	30ABR87	8FEB88	150.	71 00
2031	PREPARAR PLAN DE CUENTAS	20.	0	1ABR87	10ENE88	284.	20ABR87	29ENE88	NADA	71 00
2032	APROBAR BID PLAN DE CUENTAS	10.0	0	21ABR87	30ENE88	284.	30ABR87	8FEB88	150.	71 00
2999	TRAMITIR Y RECIBIR ULTIMO DESEMBOLSO	90.0	0	3ENE92	3ENE92	NADA	1ABR92	1A2R92	NADA	71 00
3011	APROBAR PAQUETE LEGAL INTERNACIONAL	180.0	0	10DIC86	6JUL87	208.	7JUN87	1ENE88	NADA	71 00
3012	INCORPORAR R.H.V.E.P.	30.0	0	8JUN87	2ENE88	208.	7JUL87	31ENE88	NADA	71 00
3013	PONER EN MARCHA V.E.P.	8.0	0	8JUL87	1FEB88	208.	15JUL87	8FEB88	74.	71 00
3021	PREPARAR PEP INICIAL	30.0	0	1ABR87	26DIC87	269.	30ABR87	24ENE88	NADA	71 00
3022	APROBAR BID PEP INICIAL	15.0	0	1MAY87	25ENE88	269.	15MAY87	8FEB88	135.	71 00
3100	CUMPLIR OTRAS CONDICIONES PREVIAS	180.0	0	1ABR87	13AGO87	134.	27SET87	8FEB88	NADA	71 00
3800	FIN DEL PROYECTO	0.	0	1ABR92	1ABR92	NADA	1ABR92	1ABR92	NADA	71990
4010	OBRAS 1: PRECALIF. FIRMAS CONSTRUCTORA	92.0	0	1ABR87	1ABR87	NADA	1JUL87	1JUL87	NADA	71 00
4020	OBRAS 2: PRECALIF. FIRMAS CONSTRUCTORA	92.0	0	2JUL87	30DIC87	121.	10OCT87	30MAR88	NADA	71 00
4030	OBRAS 3: PRECALIF. FIRMAS CONSTRUCTORA	92.0	0	20OCT87	1JUL88	273.	1ENE88	30SET88	273.	71 00
4100	OBRAS 1: ELABORAR BASES Y PLIEGOS	120.0	0	10DIC86	4MAR87	84.	8ABR87	1JUL87	NADA	71 00
4110	OBRAS 2: ELABORAR BASES Y PLIEGOS	120.0	0	9ABR87	2DIC87	237.	6AGO87	30MAR88	NADA	71 00
4120	OBRAS 3: ELABORAR BASES Y PLIEGOS	120.0	0	7AGO87	3JUN88	301.	4DIC87	30SET88	301.	71 00
5000	OBRAS 1: LICITAR GRUPO 1	90.0	0	2JUL87	2JUL87	NADA	29SET87	29SET87	NADA	71 00
5010	OBRAS 1: CONTRATAR GRUPO 1	90.0	0	30SET87	16OCT87	16.	28DIC87	13ENE88	NADA	71 00
5020	OBRAS 1: INICIO OBRAS GRUPO 1	20.0	0	28DIC87	14ENE88	16.	17ENE88	2FEB88	NADA	71 00
5030	OBRAS 1: EJECUTAR OBRAS GRUPO 1	800.0	0	18ENE88	3FEB88	16.	27MAR90	12ABR90	NADA	71 00
5040	EQUIPOS 1 PRECALIFICAR PROVEEDORES	180.0	0	16JUL88	20SET88	66.	11ENE89	18MAR89	NADA	71 00
5050	EQUIPOS 1: LICITAR GRUPO 1	90.0	0	12ENE89	19MAR89	66.	11ABR89	16JUN89	NADA	71 00
5060	EQUIPOS 1: NEGOCIAR CONTRATAR GRUPO 1	270.0	0	12ABR89	17JUN89	66.	6ENE90	13MAR90	50.	71 00
5070	EQUIPOS 1: RECIBIR GRUPO 1	90.0	0	28DIC89	13ENE90	16.	27MAR90	12ABR90	NADA	71 00
5080	OBRAS 1: PRUEBA HOSPITAL EN VACIO	60.0	0	27ENE90	12FEB90	16.	27MAR90	12ABR90	9.	71 00
5090	OBRAS 1: CAPACITAR PERSONAL	1099.0	0	30SET87	7OCT87	7.	20OCT90	9OCT90	NADA	71 06

UNIDAD DE TIEMPO DEL INFORME = DIAS

( ) REALIZADA HOLGURA ( ) REALIZADA HOLGURA  
TOTAL DISPON.

SIST SEGUIMIENTO PROYECTOS-PMS\*

CALENDARIO DE ACTIVIDADES

RED DEL PROYECTO ARGE (AR-0045) PROGRAMA DE SALUD

CALENDARIO DE ACTIVIDADES POR ACTIVIDAD

INICIO PROYECTO 10 DIC 86 FECHA ACTUA: 10 DIC 86  
TERM. PROYECTO 1 ABR 92 PROX. ACTUALIZ. 30 SET 97

POR COD. DE ORGANIZACION

RANGO MINIMO 10 DIC 86 FECHA PROC. 10 OCT 86  
RANGO MAXIMO 1 ABR 92 SEC. PROCESO 0  
PAG. 2

COD.DE ACTIVIDAD	DESCRIPCION DE ACTIVIDAD	DUR. REMAN	% CUM	INICIO TEMP.	INICIO TARDIO	DEMORA MAX	TERM. TEMP.	TERM. TARDIO	DEMORA DISPON.	CAL
5099	OBRAS 1: ENTREGA GRUPO 1	180.0	0	6ABR90	13ABR90	7.	20CT90	90CT90	6.	71 00
5300	OBRAS 2: LICITAR GRUPO 2	90.0	0	31MAR89	31MAR89	NADA	28JUN89	28JUN89	NADA	71 00
5310	OBRAS 2: CONTRATAR GRUPO 2	90.0	0	29JUN89	12JUL89	13.	26SET89	90CT89	NADA	71 00
5320	OBRAS 2: INICIO OBRAS GRUPO 2	20.0	0	27SET89	100CT89	13.	160CT89	290CT89	NADA	71 00
5330	OBRAS 2: EJECUTAR GRUPO 2	800.0	0	170CT89	300CT89	13.	25DIC90	7ENE91	NADA	71 00
5350	EQUIPOS 2: LICITAR GRUPO 2	90.0	0	29JUN89	150CT89	108.	26SET89	12ENE90	NADA	71 00
5360	EQUIPOS 2: NEGOCIAR CONTRATAR GRUPO 2	270.0	0	27SET89	13ENE90	108.	23JUN90	90CT90	95.	71 00
5370	EQUIPOS 2: RECIBIR GRUPO 2	90.0	0	27SET90	100CT90	13.	25DIC90	7ENE91	NADA	71 00
5380	OBRAS 2: PRUEBAS HOSPITAL EN VACIO	60.0	0	270CT90	9NOV90	13.	25DIC90	7ENE91	9.	71 00
5390	OBRAS 2: CAPACITAR PERSONAL GRUPO 2	1099.0	0	29JUN89	3JUL89	4.	2JUL91	6JUL91	NADA	71 06
5399	OBRAS 2: ENTREGA GRUPO GRUPO 2	180.0	0	4ENE91	8ENE91	4.	2JUL91	6JUL91	3.	71 00
5500	OBRAS 3: LICITAR GRUPO 3	90.0	0	10CT89	10CT89	NADA	29DIC89	29DIC89	NADA	71 00
5510	OBRAS 3: CONTRATAR GRUPO 3	90.0	0	30DIC89	8ENE89	9.	29MAR89	7ABR89	NADA	71 00
5520	OBRAS 3: INICIO OBRAS GRUPOS	20.0	0	30MAR89	8ABR89	9.	18ABR89	27ABR89	NADA	71 00
5530	OBRAS 3: EJECUTAR GRUPO 3	800.0	0	19ABR89	28ABR89	9.	27JUN91	6JUL91	NADA	71 00
5550	EQUIPOS 3: LICITA GRUPO 3	90.0	0	30DIC89	13ABR90	104.	29MAR90	11JUL90	NADA	71 00
5560	EQUIPOS 3: NEGOCIAR, CONTRATAR GRUPO 3	270.0	0	30MAR90	12JUL90	104.	24DIC90	7ABR91	95.	71 00
5570	EQUIPOS 3: RECIBIR, GRUPO 3	90.0	0	30MAR91	8ABR91	9.	27JUN91	6JUL91	NADA	71 00
5580	OBRAS 3: PRUEBAS HOSP. EN VACIO GRUPO 3	60.0	0	29ABR91	8MAY91	9.	27JUN91	6JUL91	9.	71 00
5590	OBRAS 3: CAPACITAR PERSONAL GRUPO 3	1099.0	0	30DIC89	30DIC89	NADA	2ENE92	2ENE92	NADA	71 06
5599	OBRAS 3: ENTREGA GRUPO 3	180.0	0	7JUL91	7JUL91	NADA	2ENE92	2ENE92	NADA	71 00
9999	FIN DE LAS OBRAS	0.	0	2ENE92	2ENE92	NADA	2ENE92	2ENE92	NADA	71990

UNIDAD DE TIEMPO DEL INFORME = DIAS

( ) REALIZADA HOLGURA ( ) REALIZADA HOLGURA  
TOTAL DISPON.

FIN DEL INFORME

DURACION DEL PROYECTO = 1940.0 DIAS

WPC/AR0093-3  
AR-0045

ANEXO B

PROCEDIMIENTO DE LICITACIONES

Artículo 1o. Aplicación: Deberá utilizarse el sistema de licitación pública para la adquisición de bienes y/o la contratación de obras o servicios, en todos los casos en que el valor de las adquisiciones o de las contrataciones excedan del equivalente de doscientos mil dólares de los Estados Unidos de América (US\$200.000).

Artículo 2o. Ambito de licitaciones: Las licitaciones se limitarán a los países miembros del Banco.

Artículo 3o. Modalidad de licitaciones: Cuando para financiar total o parcialmente las contrataciones indicadas en el Artículo 1o. deban utilizarse dólares o moneda de otros países distintos a la Argentina y siempre que el valor de las contrataciones supere el monto determinado en el Artículo 1o. el procedimiento de licitación deberá tener carácter internacional. Cuando se utilicen exclusivamente recursos de contrapartida local, las licitaciones podrán restringirse al ámbito nacional de Argentina.

Artículo 4o. Otras modalidades: En las contrataciones y adquisiciones que se realicen por debajo del monto fijado en el Artículo 1o., el Organismo Ejecutor aplicará procedimientos que aseguren la debida atención a los aspectos de economía y eficiencia en la utilización de los recursos destinados al Programa.

Artículo 5o. Libertad de concurrencia: Cuando los bienes o servicios que se adquieran o contraten se financien total o parcialmente con las divisas del Financiamiento, los procedimientos y las bases específicas de las licitaciones u otra forma de compra o contratación deberán permitir la libre concurrencia de bienes y servicios, incluyendo aquellos relativos a cualquier modo de transporte, originarios de países miembros del Banco. Consecuentemente, en los citados procedimientos y bases específicas, no se impondrán condiciones que limiten o restrinjan la oferta de bienes o la participación de contratistas originarios de esos países.

Artículo 6o. Adquisiciones financiadas con otros recursos. Cuando se utilicen otras fuentes de financiamiento que no sean los recursos del préstamo ni el aporte local, el Prestatario podrá acordar con dichas fuentes el procedimiento a seguir en materia de adquisiciones y contratación de obras. Sin embargo, a solicitud del Banco, el Prestatario deberá demostrar la razonabilidad tanto del precio pactado o pagado para la compra de bienes, como de las condiciones financieras establecidas en cuanto a los créditos, inclusive que la calidad de los bienes guarde conformidad con los requisitos técnicos del Programa.

Artículo 7o. Precalificación: El Organismo Ejecutor podrá convocar a precalificación una vez que haya sido notificado por el Banco de la aprobación del Financiamiento, ajustándose a los procedimientos de este Reglamento. En los casos de ejecución de obras que formen parte del Programa, financiadas con recursos del Banco, se efectuará la precalificación de las firmas proponentes con referencia a su experiencia e idoneidad técnica y financiera. En los casos de licitaciones para adquisiciones de bienes el Organismo Ejecutor podrá prescindir del requisito de precalificación. Los llamados a la precalificación se publicarán en la forma indicada en los Artículos 9o. y 10o. y contendrán la información indicada en el Artículo 8o. en lo que corresponda. Los interesados dispondrán de un plazo mínimo de 30 días contado a partir de la última publicación para presentar al Organismo Ejecutor sus antecedentes. Los formularios y las bases para la precalificación serán acordados entre el Organismo Ejecutor y el Banco previamente a la publicación del llamado a precalificación. Con los datos proporcionados por los interesados, el Organismo Ejecutor verificará, estudiará y analizará el informe de cada uno de ellos y determinará como elegibles solamente a aquellos que sean capacitados técnica, financiera, legal y administrativamente para ejecutar las obras de acuerdo con las especificaciones requeridas y en el plazo fijado. Copia de los análisis hechos y de las listas de las firmas se presentará a la consideración del Banco, a través del Organismo Ejecutor, junto con los criterios generales que se utilizaron para la selección de los posibles contratistas. En estos casos, la licitación de las obras se efectuará únicamente entre las firmas precalificadas y la adjudicación se hará a la oferta de precios y condiciones más convenientes, prescindiendo de los factores de experiencia e idoneidad técnica y financiera ya evaluados en la precalificación, salvo para considerar hechos sobrevinientes con posterioridad a la presentación de los datos de la respectiva precalificación. Para el llamado a licitación se hará una notificación fehaciente a las firmas que hayan sido calificadas, la cual se cumplirá el mismo día. El Organismo Ejecutor deberá exigir a las firmas notificadas un acuse de recibo por escrito y enviará copia de todo lo actuado al Banco.

Artículo 8o. Convocatoria a licitación: La convocatoria a licitación deberá indicar como mínimo el ámbito de la licitación, la prestación que motiva el llamado, el lugar, hora y fecha en que pueden obtenerse las bases de licitación, la oficina, lugar, hora y fecha en que deban presentarse las ofertas, el importe de la garantía, la fuente de financiamiento y las restricciones sobre los países de origen de las ofertas. En los casos de ejecución de obras debe indicarse además el lugar de emplazamiento de las obras. Dicho llamado deberá ser aprobado por el Organismo Ejecutor y el Banco antes de que se publique, a menos que la licitación vaya a ser financiada con recursos de contrapartida exclusivamente.

Artículo 9o. Publicidad: Las convocatorias a licitación se publicarán, como mínimo, en dos diarios de los de mayor circulación en la Capital Federal, así como en un diario de la provincia en donde se ejecutarán las obras respectivas, debiendo mediar, cuando menos, un intervalo de tres días entre cada publicación del correspondiente aviso de licitación, en el que se indicará como plazo para el recibo de las ofertas, un mínimo de 45 días corridos, contados a partir de la fecha de la última publicación. Cuando la licitación sea nacional bastará que la publicación se efectúe en sólo dos diarios de la Capital Federal.



Artículo 10o. Avisos a Embajadas y Consulados: Simultáneamente con la publicación de las convocatorias a precalificación y a licitación pública internacional, se cursarán invitaciones a cada una de las Embajadas, o en su defecto a los Consulados de los países miembros del Banco, que tuvieran representación acreditada ante el Gobierno de la Nación Argentina. Las invitaciones deberán contener copia de la convocatoria.

Artículo 11o. Pliego de condiciones: El pliego de condiciones, que incluye los planos y especificaciones de la licitación, será redactado por el Organismo Ejecutor y se venderá a los postores elegibles, una vez que el pliego haya sido aprobado entre el Organismo Ejecutor y el Banco antes de cada licitación. Las modificaciones y adiciones a dicho pliego que sean sustanciales, serán acordadas en la misma forma que el pliego original y automáticamente se prorrogará el plazo de presentación de ofertas por la mitad, por lo menos, del plazo original. Las consultas que evacúe el Organismo Ejecutor serán puestas en conocimiento de todos los posibles oferentes y del Banco, y no producirán efecto suspensivo sobre el plazo de presentación de oferta.

Artículo 12o. Apertura de las ofertas: Las ofertas serán recibidas en el lugar, día y hora establecidos en la convocatoria a licitación, momento en que se abrirán en acto público anunciándose en tal oportunidad únicamente los nombre de los oferentes y los precios totales de cada oferta. Finalizada la apertura de ofertas, se levantará un acta en la que constarán los nombres de los oferentes y los precios de sus ofertas y que será suscrita por autoridades del Organismo Ejecutor y los oferentes presentes que desearan hacerlo. A partir de la hora indicada para la apertura de las ofertas, los proponentes no podrán alterar ni retirar las mismas. El Organismo Ejecutor podrá, con posterioridad a la apertura, solicitar a los proponentes aclaración de cualquier aspecto de las ofertas y los proponentes podrán formular las aclaraciones pertinentes siempre que no modifiquen las condiciones de la licitación o de la oferta.

Artículo 13o. Análisis de las ofertas y preselección: Presentadas las ofertas, el Organismo Ejecutor procederá a elaborar el cuadro comparativo de las mismas con los dictámenes correspondientes, los que serán enviados al Banco para su conformidad, antes de que sea comunicado el resultado a la firma así preseleccionada, junto con la indicación de la oferta que ha evaluado como la de valor más bajo y las razones que tiene para llegar a dicha conclusión. Este requisito no rige cuando las licitaciones se financien exclusivamente con recursos de contrapartida adicionales a los financiamientos del Banco.

Artículo 14o. Modificación de la selección: Si se decidiera adjudicar la licitación a un oferente diferente al recomendado y respecto del cual el Banco hubiera dado su conformidad, o se introdujeran otros cambios sustanciales en el informe, se enviarán nuevamente al Banco los documentos pertinentes para su conformidad, debiéndose proceder de acuerdo a lo establecido en el artículo anterior.

Artículo 15o. Adjudicación: Obtenido el acuerdo del Banco, el Organismo Ejecutor adjudicará la licitación comunicándolo a quien correspondiera según lo previsto en los pliegos de licitación. El Organismo Ejecutor enviará al

Banco copia de la notificación de adjudicación, y además le enviará para su aprobación, copia del proyecto de contrato que firmará con el adjudicatario.

Artículo 16o. Licitación desierta: El Organismo Ejecutor podrá declarar desierta la licitación en los casos en que no pueda adjudicar el contrato por falta de oferentes. Asimismo, se podrá declarar desierta la licitación en los casos en que no se presente oferta alguna con precio aceptable o ajustada a las condiciones del pliego o si la adjudicación no conviniera a sus intereses. Este deberá reservarse expresamente estos derechos en los pliegos de licitación. En las situaciones antedichas, el Organismo Ejecutor deberá oír al Banco antes de pronunciarse al respecto, salvo que la licitación se prevea financiar con recursos distintos a los del financiamiento del Banco. En todo caso en que se declare desierta una licitación a ser financiada con recursos del financiamiento del Banco se efectuará una segunda, salvo que el Organismo Ejecutor y el Banco convengan en otra forma de proceder para la selección del adjudicatario.

Artículo 17o. Rescisiones: Cuando un contrato haya sido rescindido por falta de cumplimiento del contratista, ya sea que se trate de la calidad de la obra o del plazo de la ejecución, o de la calidad o plazo de entrega del a maquinaria, equipo y otros bienes y otras causales establecidas en el respectivo contrato, el Organismo Ejecutor y el Banco deberán acordar el curso a tomar frente a esta situación.

Artículo 18o. Márgenes de preferencia: En la evaluación y adjudicación de las ofertas que se reciban como consecuencia de una licitación internacional para la adquisición de bienes (maquinaria, equipo, materiales, etc.), se podrá reconocer a los bienes de origen argentino u originarios de países pertenecientes a la Asociación Latinoamericana de Integración (ALADI), un margen de preferencia conforme con las siguientes normas:

(a) Margen de preferencia nacional

- (i) Se considerará que un bien es originario de Argentina cuando el costo de los materiales, mano de obra y servicios argentinos empleados en su fabricación represente por lo menos un 40% del costo total del bien.
- (ii) A los efectos de la comparación de ofertas, se tendrá como precio de la oferta de productos de origen argentino, el precio de entrega del producto puesto al pie de la obra, una vez deducido lo siguiente: (1) los derechos de importación pagados sobre materias primas principales o sobre componentes manufacturados; y (2) los impuestos nacionales sobre ventas al consumo y al valor agregado, incorporados al costo del artículo ofertado.

El oferente deberá proporcionar la prueba documentada de las cantidades que de conformidad con los subincisos (1) y (2) anteriores, deben deducirse, con el solo objeto de facilitar el cotejo de ofertas.

- (iii) También a los efectos de esa comparación, se tendrá como precio de la oferta de productos de origen extranjero, el precio CIF del mismo producto (excluidos derechos de importación, consulares y portuarios), al cual deberá sumarse el importe de los gastos siguientes: (1) los de manipuleo en puerto; y (2) los de transporte local, desde el puerto o lugar fronterizo de entrada hasta el pie de la obra.
- (iv) Para efectuar el cotejo de precios entre ofertas de origen nacional y extranjero se estará a lo siguiente:
  - (1) los costos expresados en moneda extranjera se convertirán a su equivalente en australes, para lo cual se utilizará el tipo de cambio acordado por el Banco, a la fecha de comparación; y
  - (2) al precio de las ofertas de productos extranjeros, calculado conforme se estipula en el inciso (iii), y expresado en el equivalente en australes, se sumará un margen de preferencia del 15% o el derecho aduanero real, según cual sea menor.

(a) Margen de preferencia regional

- (i) Se considerará que un bien es de origen regional cuando: (1) se lo produzca en un país miembro de la ALADI y cumpla con los requisitos establecidos en los instrumentos jurídicos que gobiernan esa asociación en cuanto a origen y otras materias vinculadas con los programas de liberalización el comercio regional; y (2) el costo de los materiales, mano de obra y servicios, empleados en su fabricación en el país originario, sea por lo menos el 40% del costo total del bien.
- (ii) Se sumarán al costo CIF del producto ofertado los costos locales referidos en (iii)(1) y (2) del párrafo (a) (margen de preferencia nacional) de este artículo.
- (iii) Para efectuar el cotejo de precios entre ofertas de bienes originarios de países de la ALADI y las de bienes originarios de otros países extranjeros elegibles, se estará a lo siguiente:
  - (1) también se convertirá a su equivalente en australes los precios expresados en moneda extranjera, sobre la misma base de cálculo establecida en el inciso (a)(iv)(1) anterior; y
  - (2) se sumará a las ofertas de bienes originarios de países que no sean parte de la ALADI, y expresadas en el equivalente en australes un margen del 15%, o bien la diferencia entre los derechos de importación aplicables a bienes originarios de países que integran esa asociación y los derechos aplicables a bienes originarios de países extranjeros elegibles que no sean parte de la ALADI, según cual sea menor.

Artículo 19o. Pronunciamiento oportuno del Banco: El Banco deberá pronunciarse sobre los documentos que se someten a su consideración en forma oportuna, para que no sufra perjuicio la marcha normal del Programa y se respeten los calendarios de ejecución oportunamente programados.

Artículo 20o. Origen de los bienes: El origen de los materiales y/o equipos a adquirirse, es el país en el cual el material y/o equipo ha sido extraído, cultivado o producido ya sea por manufactura, procesamiento o ensamble. El origen del artículo "producido", necesariamente es el país en el cual, como resultado de dicho procedimiento, manufactura o ensamble, resulta en otro artículo, comercialmente reconocido, que difiere sustancialmente en sus características básicas, en su propósito o finalidad de cualquiera de sus componentes importados. La nacionalidad de la firma que produce o vende los bienes o el equipo es irrelevante para determinar el origen de tales bienes y equipos.

Artículo 21o. Nacionalidad de firmas: Para determinar la nacionalidad de una firma constructora y su elegibilidad para participar en licitaciones de contratos financiados con recursos del Banco, se aplicarán las siguientes normas:

- (a) que esté constituida u organizada de otra manera, en un país elegible;
- (b) que tenga la sede principal de sus negocios en un país elegible;
- (c) (i) que más del 50% de su capital sea propiedad de una empresa o empresas en uno o más países elegibles (dicha empresa o empresas también deberán calificar en cuanto a su nacionalidad) y/o de ciudadanos o residentes "bona-fide" de esos países elegibles, y (ii) que constituya una parte integral de la economía del país elegible en que está domiciliada;
- (d) que no exista arreglo alguno en virtud del cual una parte sustancial de las utilidades netas o de otros beneficios tangibles de las empresas sean acreditados o pagados a personas que no sean ciudadanos o residentes "bona-fide" de los países elegibles; y
- (e) que por lo menos el 80% de todas las personas que presenten servicios conforme al contrato de construcción en el país donde ésta se lleva a cabo ya estén empleadas directamente por el contratista o por un subcontratista, sean ciudadanos de un país elegible. Para los efectos de este cómputo, y respecto de una firma proveniente de un país que no sea el de la localidad de la construcción, no se tendrán en cuenta ciudadanos o residentes permanentes del país donde se lleve a cabo la construcción.

Las normas anteriores se aplicarán a cada uno de los miembros de un "joint venture" o consorcio (asociación de dos o más empresas) y a cada empresa que se proponga para subcontratar parte del trabajo.

Artículo 22o. Criterios básicos: La aplicación de los anteriores procedimientos se basará en los principios de competencia, publicidad e igualdad entre oferentes.

WPC/AR0092  
AR-0045

ANEXO C

SELECCION Y CONTRATACION DE FIRMAS CONSULTORAS  
Y/O EXPERTOS INDIVIDUALES

En la selección y la contratación de firmas consultoras, instituciones especializadas y/o expertos individuales (en adelante denominados indistintamente los "Consultores") necesarios para la ejecución del Programa se estará a lo siguiente:

I. DEFINICIONES

Se establecen las siguientes definiciones:

- 1.01 Experto individual es todo profesional o técnico en alguna ciencia, arte u oficio.
- 1.02 Firma consultora es toda asociación legalmente constituida, integrada principalmente por personal profesional, para ofrecer servicios de consulta, asesoría, dictámenes de expertos y servicios profesionales de diversa índole.
- 1.03 Para los propósitos de este Anexo, organizaciones sin fines de lucro tales como universidades, fundaciones, organismos autónomos o semiautónomos u organizaciones internacionales que ofrezcan servicios de consulta, se considerarán como firmas consultoras.

II. INCOMPATIBILIDADES

- 2.01 No podrán utilizarse recursos del Banco para contratar Consultores del país del Prestatario si ellos pertenecen al personal permanente o temporal del Estado o de la institución que reciba el Financiamiento o que es beneficiario de los servicios de los expertos, o si han pertenecido a cualquiera de ellos dentro de los seis meses previos a una de las siguientes fechas: (a) la de la presentación de la solicitud; o (b) la de la selección del experto individual, a menos que el Banco acuerde reducir ese plazo.
- 2.02 Una firma consultora plenamente calificada que sea filial o subsidiaria de un contratista de construcciones, de un proveedor de equipos o de una sociedad de cartera ("holding company"), generalmente se considerará aceptable sólo si conviene, por escrito, en limitar sus funciones a los servicios de consulta profesional y acepta en el contrato que suscriba que la firma y sus asociados no podrán participar en la construcción del proyecto, en el suministro de materiales y equipos para el mismo o en carácter financiero.

III. ELEGIBILIDAD Y REQUISITOS SOBRE NACIONALIDAD

- 3.01 El Prestatario no podrá introducir en la aplicación de los procedimientos establecidos en este Anexo, disposiciones o condiciones que restrijan o impidan la participación de Consultores originarios de países miembros del Banco.
- 3.02 Sólo podrán contratarse Consultores que sean nacionales de países miembros del Banco. Para determinar la nacionalidad de una firma consultora se considerarán los siguientes criterios:
- (a) El país en el cual la firma consultora esté debidamente constituida o legalmente organizada.
  - (b) El país en el cual la firma consultora tenga establecido el asiento principal de sus negocios.
  - (c) La nacionalidad de las firmas o la ciudadanía o residencia bona fide de los individuos que tengan en la firma consultora la propiedad, con derecho a participar en las utilidades de dicha firma en exceso del cincuenta por ciento (50%), conforme con lo establecido mediante certificación extendida por un funcionario de la firma consultora, debidamente autorizado.
  - (d) La existencia de arreglos en virtud de los cuales una parte sustancial de las utilidades o beneficios tangibles de la firma se destina a firmas o personas de una determinada nacionalidad.
  - (e) La determinación por parte del Banco de que la firma consultora constituye una parte integral de la economía de un país, comprobado por la residencia bona fide en el país de una parte sustancial del personal ejecutivo, técnico y profesional de la firma, y que la firma consultora cuenta en el país con el equipo operativo u otros elementos necesarios para llevar a cabo los servicios por contratar.
- 3.03 Los requisitos de nacionalidad exigidos por el Banco serán también aplicables a las firmas propuestas para prestar una parte de los servicios requeridos, en virtud de asociación conjunta o de un subcontrato con una firma consultora calificada que satisfaga los requisitos de nacionalidad.
- 3.04 Para establecer la nacionalidad de un experto individual se estará a la que se determine en su pasaporte u otro documento oficial de identidad. El Banco, sin embargo, podrá admitir excepciones a esta regla en aquellos casos en que el experto individual, no siendo elegible por razón de nacionalidad: (i) tenga domicilio establecido en un país elegible, esté en situación legal de poder trabajar en él (fuera del status de funcionario internacional) y que haya declarado que no tiene intenciones de regresar a su país de origen en un futuro inmediato; o bien (ii) haya fijado su domicilio permanente en un país elegible y haya residido en él por 5 años como mínimo.

#### IV. CALIFICACIONES PROFESIONALES

- 4.01 El análisis de las calificaciones profesionales de una firma consultora tendrá en cuenta la experiencia de la firma y de su personal directivo en la prestación de servicios de consultoría satisfactorios en proyectos o programas de dimensión, complejidad y especialidad técnica comparables a los de los trabajos respectivos; el número asignado de personal profesionalmente calificado; la experiencia previa en la región y en zonas extranjeras; el conocimiento del idioma; la capacidad financiera; la carga actual de trabajo; la capacidad para organizar a un número suficiente de personal para realizar los trabajos dentro del plazo previsto; la buena reputación ética y profesional; y la desvinculación absoluta de todo posible conflicto de intereses.

#### V. PROCEDIMIENTOS DE SELECCION Y CONTRATACION

##### A. Selección y contratación de firmas consultoras

- 5.01 En el caso de selección y contratación de una firma consultora:
- (a) Antes de efectuarse la selección de la firma consultora, el Prestatario deberá someter a la aprobación del Banco lo que sigue:
    - (i) el procedimiento que se utilizará en la selección y contratación de la firma consultora. Si se estima que el costo de los servicios no excederá de cien mil dólares de los Estados Unidos de América (US\$100.000) o su equivalente, calculado de acuerdo con lo dispuesto en el Artículo 3.05(a) de las Normas Generales, bastará que se efectúe un concurso privado de servicios de consultoría, o que se aplique otro método similar. Si se prevé, en cambio, que el costo excederá esa suma, la selección y contratación deberá anunciarse en la prensa nacional y, si así procediere por la complejidad y grado de especialización del asesoramiento solicitado, en publicaciones extranjeras especializadas. Además, deberá informarse al Banco sobre esos anuncios y enviársele recortes de los mismos, con especificación de fecha y nombre de la publicación en que hayan aparecido;
    - (ii) los términos de referencia que describan los trabajos que realizará la firma consultora, junto con una estimación del costo; y
    - (iii) una lista de por lo menos tres y no más de seis firmas consultoras a las cuales se proyecta cursar invitación para que presenten propuestas de trabajo.
  - (b) Una vez que el Banco haya aprobado los requisitos anteriores, se solicitará a todas las firmas consultoras aprobadas la

presentación de propuestas, conforme con los procedimientos y términos de referencia aprobados.

(c) En las invitaciones a presentar propuestas deberá establecerse el uso de una de las modalidades siguientes, según sea pertinente:

- (i) En el primer caso, se presentará un solo sobre cerrado que contendrá la propuesta técnica, sin cotización de precios. El Prestatario analizará las propuestas recibidas y establecerá el orden de mérito de éstas. Si la complejidad del caso así lo requiera, el Prestatario podrá recurrir por su propia cuenta a un grupo de consultores para que examine las propuestas y proporcione asesoramiento técnico y especializado en la clasificación por mérito.

Una vez establecido este orden de mérito de las firmas consultoras, se invitará a negociar un contrato a la firma consultora clasificada en primer lugar. En estas negociaciones se examinarán en forma completa los detalles de los términos de referencia a fin de que exista un pleno y recíproco entendimiento con la firma consultora, se examinarán los requisitos contractuales y legales del acuerdo y, por último, se elaborarán costos detallados. Si no pudiese llegarse a un acuerdo con esta firma consultora respecto de las condiciones contractuales, se le notificará por escrito que se ha rechazado su propuesta y se iniciarán negociaciones con la segunda firma, y así sucesivamente, hasta que se llegue a un acuerdo satisfactorio.

- (ii) En el segundo caso deberán presentarse dos sobres cerrados, el primero de los cuales contendrá la propuesta técnica, sin indicación de costos, y el segundo contendrá el costo propuesto por los servicios.

El Prestatario analizará las propuestas técnicas y establecerá el orden de mérito de éstas. La negociación contractual comenzará con la firma consultora que ofrezca la mejor propuesta técnica. El segundo sobre presentado por esta firma consultora se abrirá en presencia de uno o más representantes de la misma, y se lo utilizará en la negociación contractual. Todos los segundos sobres presentados por las otras firmas continuarán cerrados y, de llegarse a un acuerdo con la primera firma, serán devueltos a las firmas respectivas. De no llegarse a un acuerdo con la primera firma respecto de las condiciones contractuales se le notificará por escrito ese desacuerdo y se iniciará la negociación con la segunda firma, y así sucesivamente, hasta llegar a un acuerdo satisfactorio.

El no poder llegar a un acuerdo respecto de los costos detallados o de la remuneración de los servicios, o el que el Prestatario considere que dichos costos o remuneración



son inapropiados o excesivos, será causa suficiente para notificar el rechazo de la propuesta e iniciar negociaciones con la firma que le siga en orden de mérito. Cuando se haya rechazado a una firma, no se la volverá a llamar para ulteriores negociaciones correspondientes a ese contrato.

- (d) El texto del proyecto de contrato negociado con la firma consultora deberá ser sometido a la aprobación del Banco, antes de su firma y de la iniciación de los servicios. Copia fiel del texto firmado deberá enviarse prontamente al Banco.

**B. Selección y contratación de expertos individuales**

**5.02 En el caso de selección y contratación de expertos individuales:**

- (a) Antes de efectuarse la selección de los expertos, el Prestatario deberá someter a la aprobación del Banco lo que sigue:
  - (i) el procedimiento de selección;
  - (ii) los términos de referencia (especificaciones) y el calendario referentes a los servicios a ser proporcionados;
  - (iii) los nombres de los expertos tentativamente seleccionados, señalando detalladamente su nacionalidad y domicilio, antecedentes, experiencia profesional y conocimiento de idiomas; y
  - (iv) el formulario del contrato que se utilizará para contratar a los expertos.
- (b) Una vez que el Prestatario y el Banco hayan aprobado los requisitos anteriores, el Prestatario procederá a contratar los expertos. El contrato que haya de suscribirse con cada uno de ellos deberá ajustarse al modelo de contrato que el Banco y el Prestatario hayan acordado. Copia fiel del texto firmado de cada contrato deberá enviarse prontamente al Banco.

5.03 No obstante lo establecido en los párrafos 5.01 y 5.02 anteriores, y a solicitud del Prestatario, el Banco podrá colaborar en la selección de los Consultores, lo mismo que en la elaboración de los contratos respectivos. Es entendido, sin embargo, que la negociación final de los contratos y su suscripción, en términos y condiciones aceptables al Banco, corresponderán exclusivamente al Prestatario, sin que el Banco asuma responsabilidad alguna al respecto.

**VI. MONEDAS DE PAGO A LOS CONSULTORES**

6.01 Se establecen las siguientes modalidades en cuanto a las monedas con que se pagará a los Consultores:

(a) Pagos a firmas consultoras: Los contratos que se suscriban con las firmas consultoras deberán reflejar una de las siguientes modalidades, según sea el caso:

- (i) Si la firma consultora está domiciliada en el país donde debe rendir los servicios, su remuneración se pagará exclusivamente en la moneda de ese país, con excepción de gastos incurridos en divisas para pago de pasajes externos o viáticos en el exterior, los que se reembolsarán en dólares o su equivalente en otras monedas que formen parte del Financiamiento, excepto la del país del estudio.
- (ii) Si la firma consultora no está domiciliada en el país donde deba rendir los servicios, el máximo porcentaje posible de su remuneración se pagará en la moneda de ese país, y el resto en dólares, o su equivalente en otras monedas que formen parte del Financiamiento, excepto la de ese país, en el entendido que la partida correspondiente a viáticos deberá pagarse en la moneda del país o países en los cuales los respectivos servicios han de ser rendidos. En caso de que el porcentaje que vaya a pagarse en la moneda del país en que se va a rendir el servicio, sea inferior al 30% (treinta por ciento) del total de la remuneración de la firma consultora, una justificación completa y detallada se someterá, según corresponda, al Banco para su examen y comentarios.
- (iii) Si se trata de un consorcio integrado por firmas domiciliadas en el país donde prestarán sus servicios y firmas no domiciliadas en el mismo, la parte de la remuneración que corresponda a cada uno de los integrantes del consorcio se pagará de acuerdo con las reglas señaladas en los párrafos (i) y (ii) anteriores.
- (iv) Se aplicará lo dispuesto en el Artículo 3.05(a) de las Normas Generales respecto al tipo de cambio.

(b) Pagos a expertos individuales. Deben seguirse las mismas reglas del inciso (a) anterior.

## VII. RECOMENDACIONES DE LOS CONSULTORES

7.01 Queda establecido que las opiniones y recomendaciones de los Consultores no comprometen ni al Prestatario, ni a los beneficiarios, ni al Banco, los que se reservan el derecho de formular al respecto las observaciones o salvedades que consideren apropiadas.

## VIII. ALCANCE DEL COMPROMISO DEL BANCO

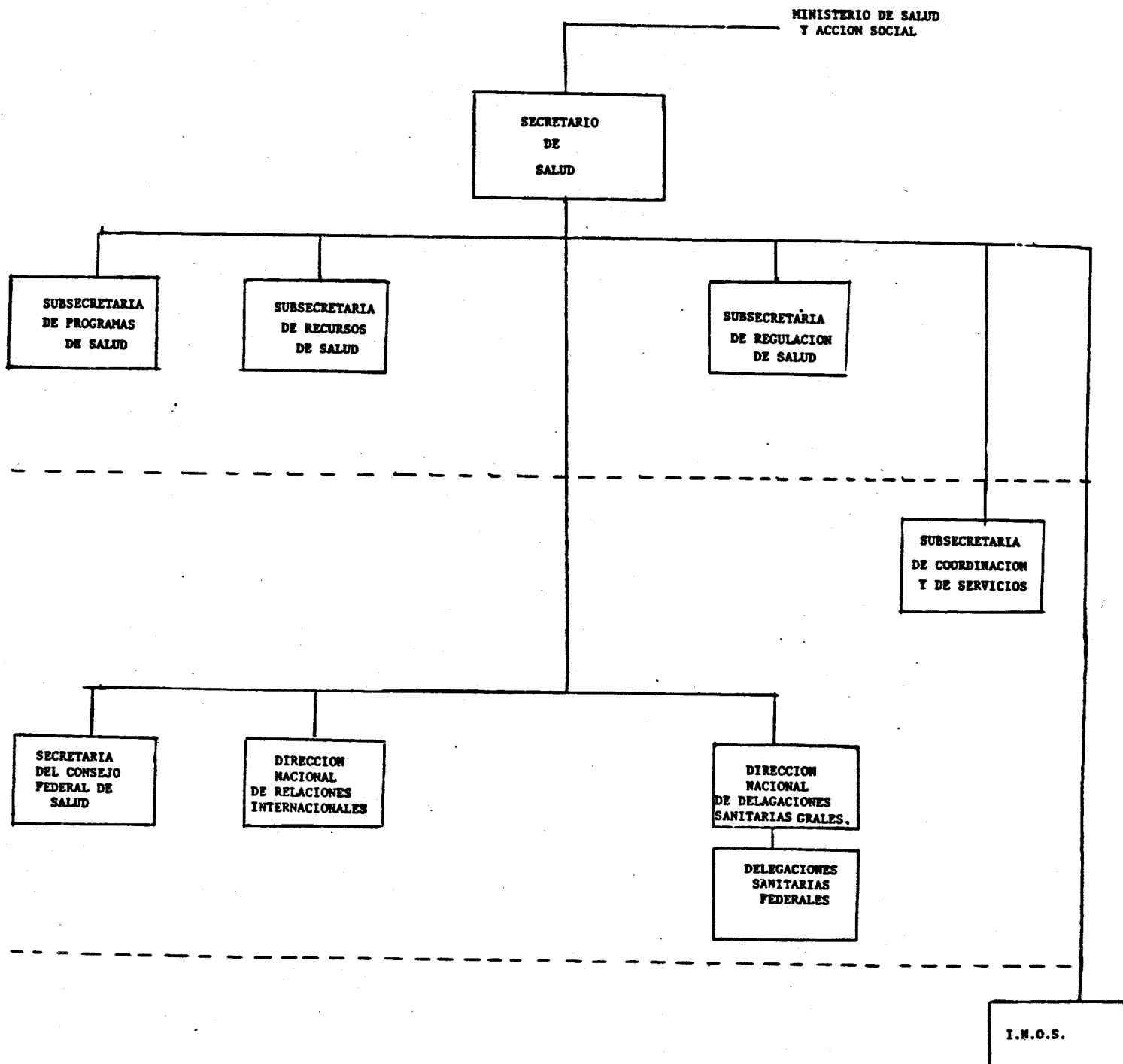
8.01 Queda establecido que el Banco no asume compromiso alguno de financiar total o parcialmente ningún programa o proyecto que, directa o indirectamente, pudiera resultar de los servicios rendidos por los

Consultores o de las recomendaciones formuladas por ellos o las alternativas a que se refiere la Sección 7.01 de este Anexo.

**IX. CONDICIONES ESPECIALES**

- 9.01 En los contratos que suscriba el Prestatario con los Consultores deberá estipularse que:
- (a) Los Consultores deberán desempeñar sus trabajos en forma integrada con el personal profesional local que, conforme a lo estipulado en el Contrato, se asigne o contrate para participar en la realización del Programa, a fin de alcanzar a la terminación de los trabajos un adiestramiento técnico y operativo de dicho personal.
  - (b) El último pago acordado en el contrato estará sujeto a la aceptación del informe final de los Consultores por el Prestatario y el Banco. Dicho pago final constituirá por lo menos un 10% del monto total de la suma que por concepto de honorarios se convenga en el contrato.

ORGANIGRAMA DE LA SECRETARIA DE SALUD



COSTOS DE OPERACION Y MANTENIMIENTO  
HOSPITALES DE REEMPLAZO  
(en miles de US\$)

	Históricos	%	Nuevo	%	Aumento (Disminución)
<u>Misiones</u>					
Personal	1,443.	65	2,068.	50	525.
No Personal	86.	4	496.	12	410.
Medic.y Mat.	328.	15	1,144.	28	816.
Alimentos	287.	13	231.	6	(56).
Mantenimiento	72.	3	172.	4	100.
	<u>2,216.</u>	<u>100</u>	<u>4,111</u>	<u>100</u>	<u>1,895</u>
<u>CHACO</u>					
Personal	4,333.	73	3,034.	57	(1.299).
No Personal	145.	3	503.	9	358.
Medic.y Mat.	1,047.	18	1,377.	25	270.
Alimentos	239.	4	243.	5	4
Mantenimiento	143.	2	212.	4	69.
	<u>5,907</u>	<u>100</u>	<u>5,309</u>	<u>100</u>	<u>(598)</u>
<u>Córdoba</u>					
Personal	1,743.	70	2,567.	60	824.
No Personal	118.	5	313.	7	195.
Medic.y Mat.	424.	17	1,064.	25	640.
Alimentos	157.	6	208.	5	51.
Mantenimiento	44.	2	160.	3	116.
	<u>2,486</u>	<u>100</u>	<u>4,312</u>	<u>100</u>	<u>1,826</u>
<u>Formosa</u>					
Personal	5,614.	81	2.837.	59	(2.777).
No Personal	78.	1	496.	10	418.
Medic.y Mat.	884.	13	979.	20	95.
Alimentos	370.	5	224.	5	(146).
Mantenimiento	17.	-	267.	6	250.
	<u>6,936</u>	<u>100</u>	<u>4.803</u>	<u>100</u>	<u>(2.160)</u>
<u>Río Negro</u>					
Personal	1,510.	78	1,444.	64	(66).
No Personal	28.	1	155.	7	127.
Medic.y Mat.	363.	19	467.	24	104.
Alimentos	32.	2	84.	4	52.
Mantenimiento	13.	0	88.	4	75.
	<u>1,946</u>	<u>100</u>	<u>2,238</u>	<u>100</u>	<u>292</u>
<u>Salta</u>					
Personal	4,292.	74	2.489.	55	(1.803).
No Personal	131.	2	391.	9	260.
Medic.y Mat.	734.	13	1,158.	26	424.
Alimentos	506.	9	231.	5	(275).
Mantenimiento	121.	2	224.	5	103.
	<u>5,784</u>	<u>100</u>	<u>4.493</u>	<u>100</u>	<u>(1.291)</u>

	Viejo	%	Nuevo	%	Aumento (Disminución)
<u>Mendoza</u>					
Personal	3,603.	69	1.746.	59	(1,857).
No Personal	131.	3	259.	9	128.
Medic.y Mat.	790.	15	678.	23	(112).
Alimentos	471.	9	158.	5	(313).
Mantenimiento	228.	4	124.	4	(104).
	<u>5,223</u>	<u>100</u>	<u>2.965</u>	<u>100</u>	<u>(2.258)</u>
<u>San Juan</u>					
Personal	4,309.	81	2,171.	52	(2.138).
No Personal	85.	2	303.	7	218.
Medic.y Mat.	713.	13	1,317.	31	604.
Alimentos	154.	3	243.	6	89.
Mantenimiento	76.	1	172.	4	96.
	<u>5,337</u>	<u>100</u>	<u>4.206</u>	<u>100</u>	<u>(1.131)</u>
<u>Santa Fé</u>					
Personal	3,041.	80	2,402.	61	(639) .
No Personal	65.	2	309.	8	244.
Medic.y Mat.	626.	16	864.	22	238.
Alimentos	72.	2	208.	5	136.
Mantenimiento	11.	-	176.	4	165.
	<u>3,815</u>	<u>100</u>	<u>3.959</u>	<u>100</u>	<u>144</u>
<u>Tucuman</u>					
Personal	2,373.	81	1.988.	49	(385).
No Personal	35.	2	317.	8	244.
Medic.y Mat.	361.	12	1,339.	33	978.
Alimentos	128.	4	225.	6	97.
Mantenimiento	19.	1	172.	4	153.
	<u>2,916</u>	<u>100</u>	<u>4.041</u>	<u>100</u>	<u>1.125</u>
<u>Neuquén *</u>					
Personal	NA	NA	1.444	64	1.444
No Personal	NA	NA	155	7	155
Medic.y Mat.	NA	NA	467	21	467
Alimentos	NA	NA	84	4	84
Mantenimiento	NA	NA	88	4	88
	<u>NA</u>	<u>NA</u>	<u>2.238</u>	<u>100</u>	<u>2.238</u>

\* No reemplaza hospital.

Factores de Recuperación  
Obras Sociales Públicos Provincias

<u>Provincia</u>	<u>Porcentaje de</u> <u>Población Afilia-</u> <u>do a Obra Soc.Pub.</u>	<u>Consulta</u>		<u>Internación</u>	
		<u>60% de</u> <u>Población</u>	<u>70%</u> <u>Recuperab.</u>	<u>40%</u> <u>Población</u>	<u>70%</u> <u>Recuperab.</u>
Chaco	12,1	7,3	5,1	4,8	3,4
Formosa	18,9	11,3	7,9	7,6	5,3
Misiones	8,4	5,0	3,5	3,4	2,4
Córdoba	8,9	5,3	3,7	3,6	2,5
Mendoza	16,6	10,0	7,0	6,6	4,6
Neuquén	20,4	12,2	8,5	8,2	5,7
Otras *	14,2	8,5	6,0	5,7	4,0

\* Otras provincias se proyectaron en un promedio del resto de las provincias.

Derivación del Déficit de Servicios Hospitalarios  
(Internación y Consultas Ambulatorias)  
en las Areas de Influencia del Programa

a) Metodología

El método empleado para calcular el dimensionamiento del proyecto, páginas 3 a 6 define para dos períodos (1995 y 2000) el déficit ('demanda' potencial del Programa) de servicios de internación (egresos) y consultas ambulatorias en función de i) la tasa actual (1985) de servicios (públicos) por habitante año; ii) crecimiento de la población y, iii) egresos (o consultas) de otros hospitales públicos en funcionamiento o de otros proyectos paralelos (estos últimos se suponen con valor zero) dentro del área geográfica de influencia del proyecto, el aglomerado.

En los períodos correspondientes ( $i = 1995$  ó  $i = 2000$ ), la tasa del sector público  $T_i (= E_i/P_i)$  es el número de sus egresos ( $E_i$ ) dividido entre la población total del aglomerado ( $P_i$ ). La "demanda" potencial del subsector público  $D_i (= T_{85} \times P_i)$  se estima para ambos períodos manteniendo constante la tasa actual<sup>1</sup> ( $T_{85}$ ) y multiplicando por las proyecciones de población  $P_i$  del período correspondiente. La oferta (egresos) potencial de otros hospitales,  $O_i (= C_i \times G_i)$  es el número de camas (disponibles) de otros hospitales públicos<sup>1</sup> (que actualmente funcionan en el aglomerado) multiplicado por el giro 4/ potencial de las mismas.

El déficit (demanda potencial del proyecto),  $D_i (= D_i - O_i)$  es el residuo de la demanda ( $D_i$ ) no cubierta por la oferta<sup>1</sup> ( $O_i$ ) de otros hospitales. El número de camas (consultorios) requeridos para cubrir el

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4/ Este parámetro fue determinado por el técnico médico del Banco. El promedio (potencial) de egresos por cama,  $G (= O/C)$  y la oferta (potencial) de egresos,  $O [= C(365 \times p) / Y]$  dependen de i) el número de camas disponibles en el año, ( $C$ ); ii) el porcentaje de ocupación de las mismas, ( $p$ ); y iii) el promedio de días de estadía de los pacientes, ( $Y$ ). Si  $P = 80\%$  y  $Y = 10$ , el giro de una cama se calcula en el ejemplo siguiente:

C	p	días cama por año	Y	G
1	80%	292.0	10	29.2
1	70%	255.5	8	31.9



déficit,  $C_i (= D_i/G')$  se estima dividiendo el déficit ( $D_i$ ) entre el giro cama que el proyecto asume como meta ( $G'$ ) 5/. Finalmente, comparando (en las dos últimas columnas de los cuadros correspondientes) el valor de  $C_i$  con el número de camas (consultorios) del proyecto se determina si el dimensionamiento del Programa excede (-) o no (+) la demanda.

b) Limitaciones

Las limitaciones principales de este análisis son las siguientes: En primer lugar, la metodología condiciona el dimensionamiento del Programa a la tasa de participación ('demanda') actual 6/ del sector público. Sin embargo en la medida que el Programa contempla no solamente mejorar la calidad de los servicios tradicionales, sino además ofrecer servicios nuevos de mayor complejidad, la demanda actual no es el mejor indicador de la demanda futura ya que los servicios correspondientes no son homogéneos. De esta manera estimado el déficit, la demanda del proyecto (medida como déficit residual no cubierto por otros hospitales públicos) debe tomarse como un indicador de demanda mínima.

En segundo lugar, la metodología no incluye en forma explícita y cuantitativa el subsector privado. A falta de información sobre magnitud y características de la demanda y oferta del subsector privado, el análisis del déficit se reduce a un ejercicio parcial cuyas conclusiones deberán juzgarse en virtud de la validez de supuestos implícitos sobre el comportamiento del subsector privado. Los principales supuestos son: a) cualquiera que fuera la tasa de participación actual del subsector privado (de servicios por habitante año) este subsector crecerá a futuro lo necesario para mantener su cobertura; b) la distribución actual de la demanda global entre ambos subsectores está determinada en parte por el tipo y calidad de los servicios y por la capacidad de pago de los pacientes. De manera que manteniendo la misma distribución de ingreso a futuro, la proporción de la población de bajos ingresos que tiene que atenderse en el subsector público por falta de acceso al efector privado no variaría. En lo que respecta a esta población los subsectores no son competitivos.

Sin embargo para el resto de la población el Proyecto, dependiendo de la relación (complementaria o sustitutiva) de los servicios de los subsectores podría causar una redistribución (ignorada en el análisis) de la demanda global a favor del subsector público. En ambos casos aquí considerados si los supuestos (a y b) fallan por que el subsector privado crece menos de lo esperado o por que parte de su demanda tradicional (i.e. obras sociales) se reduce como efecto del proyecto, el análisis efectuado subestima el déficit y por lo tanto la demanda del Programa.

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5/ Este parámetro fue determinado por el técnico médico del Banco.

6/ Aceptando implícitamente que la actual cobertura del subsector público es adecuado.

SUBSECTOR PUBLICO - EGRESOS GPM, TASA DE UTILIZACION DE INFRAESTRUCTURA  
Y TASA DE EGRESO POR HABITANTE DEL AGLOMERADO - 1985

		EGRESOS G.P.M. Y UTILIZACION DE INFRAESTRUCTURA DEL SUBSECTOR PUBLICO								
PROVINCIA	AGLOMERADO	TOTAL	HOSPITALES A REEMPLAZAR		OTROS HOSPITALES			TOTAL	EGRESOS POR HABITANTE	
		AGLOMER.		%	%		%	%		
		EGRESOS	EGRESOS	EGRESOS	OCUPACION	EGRESOS	EGRESOS	OCUPACION		En miles
CHACO	GRAN RESISTENCIA	11758	11758	100.00	82.50	0	0.00	0.00	262.0	0.0449
CORDOBA	GRAN CORDOBA 1)	8127	5371	66.09	79.60	2756	33.91	65.00	323.0	0.0252
FORMOSA	FORMOSA	8090	8090	100.00	74.00	0	0.00	0.00	111.0	0.0729
MENDOZA	GRAN MENDOSA *	37452	0	0.00	0.00	37452	100.00	80.00	678.0	0.0552
MISIONES	POSADAS	10448	10448	100.00	70.00	0	0.00	0.00	171.0	0.0611
NEUQUEN	NEUQUEN *	9713	0	0.00	0.00	9713	100.00	85.00	121.0	0.0803
RIO NEGRO	CIPOLLETI	1727	1727	100.00	64.90	0	0.00	0.00	51.0	0.0339
SALTA	SALTA	26932	16930	62.86	63.30	10002	37.14	78.00	309.0	0.0872
SAN JUAN	GRAN SAN JUAN	22952	17323	75.47	66.60	5629	24.53	NA	328.0	0.0700
SANTA FE	SANTA FE	20245	9324	46.06	71.10	10921	53.94	65.00	318.0	0.0637
TUCUMAN	GRAN TUCUMAN	29540	6807	23.04	77.00	22733	76.96	69.00	574.0	0.0515
TOTALES		186984	87778	46.94	71.23	99206	53.06	NA	3246.0	0.0576

\* Nuevos hospitales.

1) Las cifras son de egresos pediatricos y poblacion de menores de 15 anos.

Fuente: Ministerio de Salud y Accion Social.

OS 1995 Y 2000 ) DE LOS HOSPITALES Y OFERTA DE EGRESOS DEL PROGRAMA

O 1)	TASA ACTUAL 2)	POBLACION DEL AGLOMERADO ( En miles )		DEMANDA POTENCIAL 3) ( Egresos )		OFERTA POTENCIAL DE OTROS HOSPITA- LES 4)	EGRESOS DE PROYECTOS PARALELOS 5)	DEFICIT ( Egresos )		EGRESOS DEL PROYECTO	CAMAS REQUERIDAS PARA CUBRIR DEFICIT 6)		CAMAS DEL PROYECTO	SU SOBR DIMENS 1995
	EGRESOS POR HAB./ANO	1995	2000	1995	2000			1995	2000		1995	2000		
STENCIA	0.0449	350	397	15707	17817	0	0	15707	17817	9870	538	610	338	200
OBA	0.0252	382	413	9617	10379	1940	0	7677	8439	8556	263	289	293	-30
	0.0729	150	171	10932	12463	0	0	10932	12463	8877	374	427	304	70
OSA *	0.0552	825	904	45572	49936	27786	0	17786	22150	6424	609	759	220	389
	0.0611	230	264	14053	16130	0	0	14053	16130	9402	481	552	322	159
*	0.0803	202	255	16215	20470	7942	0	8273	12527	3504	283	429	120	163
	0.0339	77	94	2607	3183	0	0	2607	3183	3504	89	109	120	-31
	0.0872	420	481	36607	41923	15048	0	21559	26875	9402	738	920	322	416
JUAN	0.0700	403	443	28200	30999	8140	0	20060	22859	9870	687	783	338	349
	0.0637	366	390	23301	24829	7788	0	15513	17041	8410	531	584	288	243
MAN	0.0515	735	822	37826	42303	17996	0	19830	24307	9110	679	832	312	367
	0.0576	4140	4634	240637	270431	86640	0	153997	183791	86928	5274	6294	2977	2297

ciudad capital mas localidades adyacentes dentro de zona de influencia del hospital.

numero de egresos del subsector publico en el aglomerado dividido entre la poblacion del aglomerado.

de egreso por habitante/año de 1985.

cial dado por el tecnico medico del BANCO.

cutaria ningun otro proyecto durante el periodo en consideracion.

l proyecto: tasa de ocupacion = 80%; promedio dias estada = 10; giro = 29.2.

alud y Accion Social.

SUBSECTOR PUBLICO-CONSULTAS Y TASA DE CONSULTAS POR HABITANTE DEL ALOMERADO-1985

PROVINCIA	AGLOMERADO	CONSULTAS DEL SUBSECTOR PUBLICO (En miles)					POBLACION TOTAL AGLOMERADO (EN MILES)	CONSULTAS POR HABITANTE
		TOTAL AGLOM.	HOSPITAL A REEMPLAZ	OTRAS CONSULTAS				
				%	%			
		CONSULTAS	CONSULTAS	CONSULTAS	CONSULTAS	CONSULTAS		
CHACO		520.800	189.969	36.48	331.831	63.72	262.0	1.9878
CORDOBA		392.821	179.904	45.80	212.917	54.20	323.0	1.2162
FORMOSA		241.559	137.236	56.81	104.323	43.19	111.0	2.1762
MENDOZA		1022.572	0.000	0.00	1022.572	100.00	678.0	1.5082
MISIONES		235.403	168.975	71.78	66.428	28.22	171.0	1.3766
NEUQUEN		278.163	0.000	0.00	278.163	100.00	121.0	2.2989
RIO NEGRO		124.629	91.144	73.13	33.485	26.87	51.0	2.4437
SALTA		923.148	339.610	36.79	583.538	63.21	309.0	2.9875
SAN JUAN		524.522	221.926	42.31	302.596	57.69	328.0	1.5992
SANTA FE		577.600	132.293	22.90	445.307	77.10	318.0	1.8164
TUCUMAN		649.335	114.544	17.64	534.791	82.36	574.0	1.1312
TOTALES		5490.552	1575.601	28.70	3915.951	71.32	3246.0	1.6915

(AÑOS 1995 Y 2000) DE LOS HOSPITALES Y OFERTA DE CONSULTAS DEL PROGRAMA

CASA ACTUAL ULTA POR /AÑO 2)	POBLACION DEL AGLOMERADO (En miles)		DEMANDA POTENCIAL 3) (Consultas)		OFERTA POTENCIAL DE OTROS 4)	CONSULTAS DE PROYECTOS PARALELOS 5)	DEFICIT (Consultas)		CONSULTAS DEL PROYECTO	CONSULTORIOS REQUERIDOS PARA CUBRIR DEFICIT 6)		CONSUL- TORIOS DEL PROYECTO	SUB (+) SOBRE (-) DIMENSION 1995
	1995	2000	1995	2000			1995	2000		1995	2000		
1.9878	350.0	397.0	695725	789151	331831	0	363894	457320	313600	89	101	40	49
1.2162	382.2	412.5	464818	501668	212917	0	251901	288751	282240	59	64	36	23
2.1762	150.0	171.0	326431	372131	104323	0	222108	267808	227360	42	47	29	13
1.5082	825.0	904.0	1244280	1363429	1022572	0	221708	340857	156800	159	174	20	139
1.3766	230.0	264.0	316624	363429	66428	0	250196	297001	282240	40	46	36	4
2.2989	202.0	255.0	464371	586211	278163	0	186208	308048	141120	59	75	18	41
2.4437	77.0	94.0	188165	229708	33485	0	154680	196223	141120	24	29	18	6
2.9875	420.0	481.0	1254764	1437004	583538	0	671226	853466	313600	160	183	40	120
1.5992	403.0	443.0	644458	708425	302596	0	341862	405829	313600	82	90	40	42
1.8164	366.0	390.0	664785	708377	445307	0	219478	263070	188160	85	90	24	61
1.1312	735.0	822.0	831466	929884	534791	0	296675	395093	337120	106	119	43	63
1.6915	4140	4633.5	7095888	7989418	3915951	0	3179937	4073467	2696960	905	1019	344	561

ende ciudad capital mas localidades adyacentes dentro del area de influencia del hospital.

5) - Numero de consultas del subsector publico en el aglomerado dividido entre poblacion del aglomerado.

6) - Casa de consulta por habitante/año de 1985.

7) - Se atendera el numero de otras consultas del subsector publico al nivel de 1985.

8) - Se ejecutaran otros proyectos paralelos.

9) - Se divide el total de consultas /año a ser atendidas por consultorio en el año ( = 7840).

Eficiencia de la utilización de los hospitales

Para determinar la eficiencia en la utilización de las instalaciones hospitalarias se analiza la tasa promedio de ocupación anual junto con el número de días en el cual se rechazan pacientes. En general altas tasas de ocupación se obtienen solamente a costo de mayor rechazo. La relación directa sucede por la alta estacionalidad de la demanda por algunos servicios hospitalarios, o por inflexibilidad físico-funcional de los establecimientos, o cuando el tamaño del hospital es muy chico.

En general tasas de ocupación promedio anual mayor de 90% señalan un alto rechazo de pacientes por falta de camas disponibles en meses de alta demanda. El análisis de ocupación de camas <sup>9/</sup> de una muestra de cuatro hospitales señala que mientras en algunos servicios se rechaza demanda cuando la ocupación es 100% o más, en otros existe una ocupación muy baja y por falta de flexibilidad de los establecimientos no es posible reducir el congestionamiento de una sala desviando la demanda hacia otras áreas de servicios subutilizados. (Anexo VI-4). Por ejemplo, en julio de 1985 (Anexo VI-4 Pag. 1), ginecología del Hospital Perrando en Chaco tiene todos los días del mes 90% o más de ocupación, mientras cirugía de mujeres no tiene ningún día del mes ocupación mayor de 79%. En el Hospital Central de Formosa (Anexo VI-4 Pag. 2) el promedio de ocupación anual de 1985 es 74%, sin embargo en cirugía de mujeres, a octubre de 1985, hay 20 días con más de 100% de ocupación. El standard en países desarrollados es un máximo de 6 días al año de rechazo.

Los hospitales del programa se han diseñado con flexibilidad físico funcional de manera que permitan promedios anuales de ocupación de 80% reduciendo los niveles actuales de rechazo. Del total de camas en cada hospital 80% son indiferenciadas de manera que puedan adaptarse, dependiendo de la demanda, para atender pacientes de diferentes servicios.

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<sup>9/</sup> Este análisis se hizo para una muestra de cuatro hospitales.

PORCENTAJE OCUPACION CAMAS POR SERVICIO Y NUMERO DE DIAS AL MES CON  
100% O MAS Y 90% O MAS Y 80% O MAS

<u>HOSPITALES PERRANDO</u> <u>Y PEDIATRICOS</u> <u>(CHACO)</u>		<u>DEPARTAMENTOS</u>										<u>Total</u>
		<u>Medicina</u> <u>Hombres</u>	<u>Medicina</u> <u>Mujeres</u>	<u>Cirugía</u> <u>Hombres</u>	<u>Cirugía</u> <u>Mujeres</u>	<u>Pediatría</u>	<u>Neonato-</u> <u>logía</u>	<u>Obstetricia</u>	<u>Ginecología</u>	<u>Trauma</u> <u>Ortopedia</u>	<u>Otros</u>	
Jul/85	Tasa % Ocupación	100	98.4	80	61.12	72.4	100	99.5	100	77.3	91.9	88.5
	Número de camas disponibles	24.2	19.9	26.0	26.0	47.5	22.5	62.2	19.8	41.8	151.6	440.8
	No. días mensuales con 100% o más disponibles	10	15	1	0	0	15	17	13	0	11	
	No. días mensuales con 90% ó más de ocupación	13	19	6	0	2	30	22	31	0	16	
	Número de días mensuales con 80% ó más de ocupación	30	22	18	0	8	31	29	31	10	28	
Oct. 1985	Tasa % Ocupación	72.3	74.9	87.1	86.5	72.5	82.5	74	71.1	90.1	89.2	81.3
	Número de Camas disponibles	42	30	26	26	53	24	90	28	41	155	515
	Número de días mensuales con 100% ó más de ocupación	1	0	0	0	0	0	0	0	0	0	
	Número de días mensuales con 90% ó más	4	2	13	21	0	7	1	6	21	9	
	Número de días mensuales con 80% ó más	10	16	31	28	6	25	13	12	31	31	

PORCENTAJE OCUPACIÓN CAMAS POR SERVICIO Y NÚMERO DE DÍAS AL MES SON 100% O MÁS, 90% O MÁS Y 80% O MÁS

Hospital: Central y Madre y Niño Potosí	DEPARTAMENTOS													Total	
	Medi- cina	Medicina Hombres	Medicina Mujeres	Ciru- gía	Cirugía Hombres	Cirugía Mujeres	Espec. Pediat.	Pediatría	Neonato- logía	Obste- tricia	Gineco- logía	Trauma Ortopedia	Otros		
<u>Jul. 1985</u>	Tasa % Ocupación	94	93	95	81	76	100	64	76	71	68	62	84	83	79
	No. de camas dis- ponibles	45	28	17	42	21	14	7	58	30	32	18	18	44	257
	No. días mensua- les con 100% o más de ocupación	5	8	16	5	1	17	7	1	0	2	1	14	0	
	No. de días men- suales con 90% más de ocupación	29	24	30	10	11	28	9	4	0	4	4	15	5	
	No. de días men- suales con 80% o más de ocupación	31	31	30	17	18	30	13	10	5	9	6	17	27	
<u>Oct. 1985</u>	Tasa de % Ocupación	92	88	99	84	73	100	78	68	47	63	73	74	69	72
	No. de camas dis- ponibles	46	28	18	44	21	17	6	58	30	34	18	18	44	292
	No. de días men- suales con 100% o más de ocupación	6	3	19	0	0	20	8	0	0	0	4	2	0	
	No. de días men- suales con 90% o más de ocupación	23	13	31	11	7	26	18	0	0	0	7	3	0	
	No. de días con 80% o más de ocu- pación	31	30	31	25	18	30	27	1	0	1	13	16	3	
<u>Ene. 1986</u>	Tasa % Ocupación	90	87	96	74	92	68	48	54	79	76	68	93	57	72
	No. de camas dis- ponibles	46	28	18	54	21	26	7	58	28	28	18	18	44	294
	No. de días men- suales con 100% o más de ocupación	5	6	13	0	10	2	4	0	1	2	1	15	0	
	No. de días men- suales con 90% o más de ocupación	21	15	28	9	24	6	7	0	5	8	4	21	0	
	No. de días men- suales con 80% o más de ocupación	30	24	30	12	29	14	11	0	19	13	8	30	0	



PORCENTAJE OCUPACION CAMAS POR SERVICIO Y NUMERO DE DIAS AL MES SON 100% O MAS, 90% O MAS Y 80% O MAS

Hospital: Central "Razón Maderalaga" (Misiones)	DEPARTAMENTOS										
	Medicina	Medicina	Cirugía	Cirugía	Espec.	Pediatría	Pediatría	Neonatología	Obstetricia	Ginecología	Trauma
	Hombres	Mujeres	Hombres	Mujeres	Pediatría	Pediatría	Neonatología	Obstetricia	Ginecología	Ortopedia	Otros Total
<u>Jul. 1985</u>	<u>Tasa % Ocupación</u>	96,33	86	89,6	99,6	94,09	47,4	32,8	61,9	64,3	89,2 81,7
	No. de camas disponibles	20,19	20,07	22,07	16,29	10,39	69,07	33	48	23	26,23 37,77
	No. días mensuales con 100% o más de ocupación	15	5	11	20	14	0	0	0	0	5 0
	No. de días mensuales con 90% más de ocupación	29	16	16	28	22	0	0	0	0	17 5
	No. de días mensuales con 80% o más de ocupación	31	24	25	31	26	0	0	1	6	26 21
<u>Oct. 1985</u>	<u>Tasa % Ocupación</u>	94,86	91,16	83,7	99,7	90,14	58,9	65,2	62,3	67,1	96,06 85,06
	No. de camas disponibles	20,10	20,06	22	11,61	8,83	70,48	33	48	23	29,52 32,42
	No. de días mensuales con 100% o más de ocupación	14	11	1	19	12	0	0	0	0	9 18
	No. de días mensuales con 90% o más de ocupación	26	21	9	30	16	0	2	0	0	24 25
	No. de días con 80% o más de ocupación	30	27	20	31	22	0	13	4	9	31 31
<u>Ene. 1986</u>	<u>Tasa % Ocupación</u>	96,16	86,22	88,12	95,7	74,38	57,5	43,59	80,96	50,4	83,86 89,6
	No. de camas disponibles	20,16	20,13	22,19	15,77	9,19	69,84	33	40	23	26,39 21,65
	No. de días mensuales con 100% o más de ocupación	17	7	12	21	3	0	0	1	0	3 29
	No. de días mensuales con 90% o más de ocupación	29	18	25	24	9	0	0	11	2	15 30
	No. de días mensuales con 80% o más de ocupación	30	25	29	26	15	0	0	18	3	23 31

PORCENTAJE OCUPACIÓN CAMAS POR SERVICIO Y NUMERO DE DIAS AL MES SON 100% O MAS, 90% O MAS Y 80% O MAS

Hospital: Provincial Dr. Eduardo Castro Rendón Rauquén		DEPARTAMENTOS								Total
		Medicina de Hombres y Mujeres	Cirugía de hombres, mujeres y de Espec. Pediatr.	Pediatría	Neon- tología	Obste- tricia	Gineco- logía	Trauma Ortope- dia	Otros	
<u>Jul. 1985</u>	Tasa % Ocupación	96,7	88,1	91,3	86,9	99,6	59,6	74,7	63,8	86,6
	No. de camas dis- ponibles	45	46	40	18	33	19	16	21	238
	No. días mensua- les con 100% o más de ocupación	16	5	9	8	17	1	0	0	
	No. de días men- suales con 90% más de ocupación	28	15	19	15	25	3	11	0	
	No. de días men- suales con 80% ó más de ocupación	31	27	28	19	31	5	13	0	
<u>Oct. 1985</u>	Tasa de % Ocupación	89,7	90,7	65,8	92,2	99,9	80,0	81,1	68,7	84,4
	No. de camas dis- ponibles	45	47	41	17	36	19	13	21	238
	No. de días men- suales con 100% ó más de ocupa- ción	1	3	0	16	15	3	4	0	
	No. de días men- suales con 90% ó más de ocupación	16	19	1	22	27	10	11	0	
	No. de días con 80% o más de ocu- pación	29	31	6	26	31	18	24	5	
<u>Ene. 1986</u>	Tasa % Ocupación	80,6	90,6	62,7	99,0	96,1	60,5	67,0	57,1	78,1
	No. de camas dis- ponibles	45	47	41	18	33	18	16	20	238
	No. de días men- suales con 100% o más de ocupa- ción	0	3	0	17	17	1	3	0	
	No. de días men- suales con 90% ó más de ocupación	4	22	0	30	22	3	3	0	
	No. de días men- suales con 80% ó más de ocupación	23	26	1	31	29	7	3	0	