Rev.

PROGRAM TO STRENGTHEN AND MODERNIZE THE HEALTH SECTOR

(VE-0091)

EXECUTIVE SUMMARY

BORROWER AND GUARANTOR:	The Republic of Venezuela	
EXECUTING AGENCY:	The Ministry of Health and Social Welfare (MSAS) and — as coexecuting agencies — the governments of the participating states	
AMOUNT AND SOURCE:	IDB:	US$150 million (OC)
	Local counterpart funding:	US$150 million
	- MSAS	US$104.3 million
	- State governments	US$ 45.7 million
	Total:	US$300 million
FINANCIAL TERMS AND CONDITIONS:	Amortization period:	20 years
	Disbursement period:	5 years
	Interest rate:	variable
	Inspection and supervision:	1%
	Credit fee:	0.75%

OBJECTIVES: The operation's specific objectives are: (a) to make public health spending more efficient by (i) providing care for low-income groups and (ii) adopting a health care model with a preventive approach based on epidemiological profiles; (b) to strengthen the agencies responsible for designing and implementing sector policy; and (c) to provide support for the decentralization of health service delivery and strengthening of regional and local institutions.

DESCRIPTION: The program has two components: (i) technical assistance for restructuring, strengthening, and modernizing the MSAS as the policy-setting agency for the health sector (which will entail paying employee entitlements for staff affected by the restructuring exercise); and (ii) technical assistance in support of the decentralization of health care services and funding of investments to rehabilitate the primary network in the states.

1. Restructuring of the MSAS

a. Strengthening and modernizing the MSAS

This will be achieved through two subprojects: (i) restructuring of the MSAS and job retraining, and (ii) strengthening and modernization of the MSAS.

Restructuring of the MSAS and job retraining. This activity will consist of reorganizing the MSAS to reduce significantly the number of organizational units and the resources assigned to each, with emphasis on job retraining and streamlining.

Strengthening and modernization of the MSAS. In support of the restructuring process, specific actions will be carried out to strengthen and modernize the MSAS, with an eye to rightsizing and adjusting the existing organizational structure and enhancing its capacity, so as to produce a more efficient and effective organization. The following activities will also be carried out: (i) public-administration support systems (e.g., staff policies, strategic planning, management control, epidemiology, administration) will be designed and implemented; (ii) staff will be trained to ensure efficient performance in their new duties; and (iii) the MSAS will receive equipment in order to set up an internal network and link it up with the rest of the health care network, so as to create an organized, national information system.

b. Reorganization of agencies overseen by the MSAS

Institutional evaluation and proposal for reorganization. This activity will consist of conducting an organizational evaluation, reviewing and evaluating the spending structure, and drawing up and implementing plans to modernize the independent institutes and foundations that operate under the MSAS, bearing in mind such reorganization options and spending-enhancement proposals as decentralization, transfers, rightsizing, and possible joint undertakings with other agencies. The necessary legal changes, which will be carried out with support from the proposed operation, will be reviewed in keeping with, or incorporated into, the new legal framework for health-related issues.

The following independent institute will be studied: INN, which runs food and nutritional surveillance programs; INAGER, which oversees care for the

elderly; INH, which is in charge of reviewing and analyzing biologicals, as well as bacteriological, parasitological, and chemical testing, and the preparation of biologicals; HUC, which offers educational and care-related services from its location at the Luis Razetti Medical School; and IVIC, which oversees pure and applied scientific research. The FIMA and PAMI foundations will also be studied.

The public-sector companies that will be studied are QUIMBIOTEC, which produces and markets blood products and other high-tech chemical products, and SEFAR, an independent service that oversees production of generic drugs and pharmaceuticals. For these companies, the study will focus on the possibility of joint undertakings with other agencies.

Reorganization of the health products and services inspection system. As part of this effort, support will be provided for the analysis to be undertaken for reorganizing the INH and the health products and services inspection office of the MSAS. Once the reorganization has been carried out, support will be furnished in the form of technical assistance and training for the control and registration of products for human use, along with investments in equipment and facilities, to upgrade quality control laboratories so they can perform post-registration control of products for human use.

c. Formulation of sector policy

This component will help to strengthen the MSAS's capacity to formulate policies to assign and monitor human, institutional, and budgetary resources in the sector, in accordance with rational criteria (i.e., epidemiological, technical, ethical, management, and cost-effectiveness) that reflect sector issues and the sector's sociopolitical and economic context. For this purpose, studies and actions will be carried out in the following areas:

Prevention and promotion program. The development and implementation of the disease prevention and health information and promotion program (PEPIS) will contribute to nationwide distribution of information aimed at: (i) preventing common diseases; (ii) promoting healthier lifestyles; and (iii) promoting appropriate use of health care services. Support will also be provided for specific campaigns aimed at common problems in the region — as defined by the epidemiological profile — and direct contact with

community groups and health service users, including indigenous communities.

Human resource training and administration policies. In this area, actions will be devised for the short, medium, and long terms with a view to remedying critical problems in health manpower supply and skills. These actions will be included in the national manpower training and administration policy that is to be implemented. As part of these activities, guidelines will be drawn up for the number and type of professionals and technical staff to be trained in the various health care areas and incorporated into the health care system, updating of school curricula in keeping with the occupational profiles required by the country's epidemiological needs and the new health care model, and proposals for improving working conditions and human resources administration in the sector.

d. Sector financing

This component will fund studies to draw up guidelines for the new financing model for the sector at the national and state levels, covering both the public and private sectors.

e. Legal framework for the sector

Funding will be provided for the technical assistance needed to update and define new health care legislation as part of the sector reform process.

2. Decentralization of health care services

a. Preinvestment

Support will be lent for preparing state health plans and prefeasibility and feasibility studies that will enable the states to prepare the projects identified in their plans.

b. Institutional strengthening of the state health systems

Organization of state health systems. Under this component, support will be provided for transferring areas of responsibility to the states. Activities will center on: (i) devising organizational structures for service management; (ii) drafting an organization manual; (iii) retraining key management personnel; and (iv) designing strategies for coordination with other service-provider agencies.

Technical assistance and training for state health systems (US$13.9 million). States will receive technical assistance, training, and equipment with a view to enhancing system implementation and operation. Technical assistance will focus on: (i) strategic planning, (ii) health products inspection, (iii) health surveillance and epidemiological control systems, (iv) management control at the state level, (v) policies and systems for human resources management, (vi) financial management systems, (vii) statistics and management information systems, (viii) supply systems, and (ix) solid waste management systems and maintenance systems. The program also includes financing for specific technical assistance and training proposals, which are to be submitted by each state.

c. Rehabilitation and outfitting of state health services

Although this activity will center on investments aimed at revamping the primary network in the states, funding may also be provided for investments in improvements (rehabilitation or replacement) and infrastructure for secondary and tertiary services at hospitals and outpatient clinics.

ENVIRONMENTAL CLASSIFICATION: The Environment Committee, at its meeting of March 16, 1993, classified this as a Category II operation.

BENEFITS: The main benefits of the program will be the improvement in health service quality resulting from more efficient use of sector resources and the new health care model. These benefits would accrue mostly to low-income groups, who are the principal users of the primary network in the states.

The benefits of decentralization will be the increased capacity to respond to the demands of each region with greater flexibility, efficiency, and quality, as well as the enhanced efficiency of spending as a result of the savings produced by the new health care model, which will bring about a drop in demand for curative treatment by focusing on preventive care.

RISKS: The program's main risk is associated with the planned institutional reforms, particularly the MSAS, and with the transfer of services to the states. This risk stems from current institutional weaknesses, at the regional and central levels, that limit the ability to take on the new functions. To

minimize this risk, the program stresses institutional considerations, including technical assistance, training, and outfitting of the MSAS and the participating states.

Furthermore, a structural reform of the depth of the one proposed here requires an appropriate level of consensus among the various social actors involved. Resistance to change could cause delays in the implementation of some reforms. With this in mind, the authorities have sought – through an ongoing process of consultation – to achieve consensus on the reform, since this will be a crucial factor for the reform's success. The various initiatives undertaken so far have included the National Health Council (a part of the MSAS), which advises the President on the major issues and policies of the health sector. Similarly, the Regional Health Council (made up of the MSAS and the governors of participating states) has as one of its objectives the promotion of consultations aimed at securing consensus among the various social agents and coordinating future actions of the different levels involved, in pursuit of sector policy.

Similarly, the current fiscal crisis may affect the timely availability of local funding, and this could delay program execution. The analysis of the financial projections indicates, however, that there would be adequate capacity for financing the sector reform as proposed in the program.

THE BANK'S COUNTRY AND SECTOR STRATEGY: The Bank's strategy in Venezuela is geared toward: (i) shoring up structural reforms through projects that specifically support administrative and regional decentralization of public services; (ii) reducing poverty levels and regional inequalities through support for policy reforms and institutional change, as well as funding for projects aimed at providing low-income groups with broader access to public services and better working conditions; and (iii) consolidation of macroeconomic reforms in order to pave the way for economic recovery.

IMPACT ON LOW-INCOME GROUPS: The percentage of program beneficiaries classified as low-income exceeds the overall national percentage, which means the program fulfills the second criterion of the Eighth Replenishment.

EXCEPTIONS TO BANK POLICY: The only exception to Bank policy would be the direct contracting of the UNDP to assist the MSAS in hiring technical assistance services and procuring equipment

abroad (see chapter III, section B.3 for details on this proposal).

In order to streamline program execution and facilitate supervision by the Country Office, it is proposed that the procedures for reviewing the process of selection and hiring of consulting services be modified to allow for an ex post sample-based review of individual consultant contracts for amounts less than US$20.000 (see paragraph 3.26).

PROCUREMENT BY COMPETITIVE BIDDING:

The cut-off levels over which program procurements will be through international competitive bidding are US$350,000 for goods and US$3 million for works contracts.

SPECIAL CONTRACTUAL CONDITIONS:

The following conditions must be met prior to first disbursement:

a. Presentation of the agreement to transfer loan proceeds to the MSAS, on a nonreimbursable basis, as well as the local counterpart (see paragraph 3.1).

b. Presentation by the MSAS of the outline and schedule for the decentralization plan and evidence of appointment of the technical team that will work on a full-time basis to support the decentralization process (see paragraph 3.9).

c. Presentation of the program operating regulations for approval (see paragraph 3.10).

d. Presentation of evidence of the establishment of a trust fund to channel program resources (see paragraph 3.14).

e. Presentation of the administration agreement with the UNDP for assisting the Program Coordinating Unit in hiring technical assistance, and procuring equipment abroad (see paragraph 3.16).

As conditions precedent to first disbursement under the component that will upgrade policy design capacity and restructure the MSAS, the executing agency is to:

f. Present the terms of reference for the study that will devise the national manpower training and administration policy (see paragraph 2.14).

g. Present the terms of reference for the study that will define the sector's financial policy (see paragraph 2.15).

h. Present the terms of reference for the institutional-strengthening studies in support of the MSAS restructuring process (see paragraph 2.6).

i. Present the MSAS restructuring and job retraining plans as agreed on with the Bank, including the transition structure of the MSAS and evidence of the establishment of the technical team that will work on the actions outlined in the plans (see paragraph 3.20).

Other conditions

j. For purposes of program supervision, the Bank and the executing agency will meet each year, beginning 12 months after program startup. These meetings will be held by February 28th of each year and will study the topics listed in paragraph 3.27, among others.

k. If, at these meetings, program progress is found to be unsatisfactory, the borrower – through the executing agency – will have 60 days from the date on which the comments are made to present the remedial measures that are to be taken and a schedule for carrying them out. If these measures are not satisfactory, the Bank may take such action as it deems appropriate under the provisions of the loan contract (see paragraph 3.30).

l. Expenses incurred up to the amount of US$3.5 million may be recognized against the loan proceeds and up to US$2.2 million against the local counterpart (see paragraph 3.34). Special consideration will be given to analyzing the continuation of disbursements of uncommitted funds and the execution of each component, if the targets are reasonably met each year.

I. FRAME OF REFERENCE

A. Introduction

1.1 The proposed operation is a key component of the government's reform strategy for the health sector, which seeks to enhance service delivery by means of: (i) more efficient use of sector resources; (ii) better organization of sector operations with an eye to preventing duplication of functions and creating a climate for greater productivity and equity in service delivery; and (iii) more modern institutions, especially the Ministry of Health, which would be in charge of defining sector policy and coordination.

B. Economic situation and public-sector reform

1.2 Amidst an economic crisis, the administration of President Pérez embarked on a stabilization program *cum* structural reform directed at obtaining a modern, open, and competitive non-oil sector. Amongst the structural reform measures were: foreign trade liberalization, reduction of price and interest controls, privatization of public enterprises, and decentralization. The big bang approach, combined with improving terms of trade, led quickly to declining inflation and high growth rates but was accompanied by a worsening of poverty. By 1992 the thrust of stabilization and structural reform dissipated partly due to a sharp deterioration in the sociopolitical matrix, which – combined with the fall in terms of trade – led to the reemergence of economic instability.

1.3 President Caldera's administration took power in February 1994, amidst a deteriorating economy compounded by severe adjustment fatigue and the country's worst financial crisis ever. Assistance to banks, approximately 12% of GDP, by the Insurance Fund (FOGADE) was essentially financed by credit from the central bank. The ensuing increase in liquidity led to a loss of monetary control and a large quasi-fiscal deficit, thus accentuating the macroeconomic disequilibrium. In July 1994, the government revoked constitutional rights, and imposed price and exchange controls. However, the deteriorating economic situation was not contained. In September 1994, the government announced a stabilization plan: the Stabilization and Economic Recovery Program (PERE). The plan involved short-term stabilization measures (including issue of dollar-indexed bonds, increase in domestic fuel prices, fiscal-monetary constraint) and structural reform measures (including the opening up of mining and the oil sector to foreign investment and privatization of public enterprises).

1.4 However, actual policy measures, including the budget for 1995, continue to give mixed signals regarding both the direction of policy and the speed of implementation. Prospects for the country

suggest continuation of macroeconomic difficulties over the medium term, unless a substantial economic program is implemented.

1.5 In addition to resolving the financial sector crisis and enacting stabilization measures, the central task facing the country is structural-institutional reform directed to modernize the non-oil economy. This adjustment will involve changing the dimension, efficiency, efficacy, and financing of the public sector; new clear "rules of the game" for the private sector; reform of the social security system, including severance payments.

1.6 The current administration has decided that decentralization of services (e.g., education, health, transportation) to the states should be the main mechanism for improving performance in their delivery, since it would be out of the control of the dysfunctional, ineffective central government. Under this scheme, the responsibility of providing basic services would be transferred to the states, together with some of the workers employed by line ministries. The transfer of workers would create the need to fund severance liabilities of approximately US$10 billion, of which the proposed reforms of the overall health sector would represent about 10 percent.

C. The health sector

1.7 Venezuela's health sector comprises a variety of institutions from the public sector and nonprofit and for-profit private institutions. In the public sector, the Ministry of Health and other government agencies oversee more than 50 services, which combine to form an intricate network of health care facilities at the national, state, and municipal levels. 1/ The private sector, too, is very active, with some 300 establishments, a number of clinics, and a handful of nonprofit private foundations, which — together — serve between 10 and 15 percent of the population.

1.8 The country's main service provider is the Ministry of Health, which runs 175 hospitals (for a total of 26,000 beds) and 3,700 rural and urban outpatient clinics with differing levels of complexity. The Venezuelan Social Security Institute [Instituto Venezolano de los Seguros Sociales] (IVSS) is the second largest service provider and offers curative care at 31 hospitals (total of 5,750 beds) and 76 outpatient clinics and other smaller services. Public-sector beds account for 75% of all hospital beds in Venezuela.

1.9 There are also some other public-sector agencies that provide social services through contracts with private-sector centers.

1/ Annex I-1 presents an analysis of the Ministry of Health's organizational structure.

This area has experienced considerable growth in recent years, albeit in an unorganized and unsupervised fashion.

1.10 An analysis of the sector has shown that the main shortcomings in terms of addressing the country's epidemiologic profile are to be found in the following areas:

1. Organization of the Ministry of Health

1.11 Declining efficiency and productivity in the Ministry of Health (MSAS) have crippled the sector's response capacity in recent years. This situation is due, in part, to the lack of planning that was evident during the ministry's expansion. Indeed, even as the MSAS was getting bigger, functions were being further centralized. Currently, the MSAS oversees the following agencies:

Venezuela's Ministry of Health		
13 sector divisions	14 institutes	5 independent specialized institutes:
66 line departments	7 national centers	National Hygiene Institute (INH)
36 special offices	4 commissions	National Gerontology Institute (INAGER)
27 programs	4 foundations	National Nutrition Institute (INN)
9 subregional units	1 school	Caracas University Hospital (HUC)
23 health bureaus		Venezuelan Scientific Research Institute (IVIC)
130 health districts		Foundation for Infrastructure Maintenance (FIMA)
		Expanded Maternal and Child Care Program (PAMI)

1.12 At the same time, the labor-related commitments that the MSAS has had to assume under collective bargaining agreements have produced a bloated work force that operates at marginal productivity owing

to the high number of *reposeros*, *suplentes*, and *prejubilados*. 2/ Consequently, the MSAS's maintenance and investment capacity has been weakened, as have its policy-setting and regulatory functions, contributing toward a gradual breakdown of its management capacity.

1.13 Such a situation points up the need to rethink the sector's institutional structure with a view to establishing clear lines of command, decentralizing managerial functions, promoting meaningful participation at the various levels, and reorganizing the administration of the myriad of sector agencies.

2. Imbalances in the structure and distribution of human resources

1.14 Human resources management is one of the biggest problems the health sector faces at present. With current staff levels exceeding the 100,000 mark, 75% of the MSAS's annual budget (US$420 million) goes to covering this category, thereby limiting possibilities for spending in other areas. There are also serious imbalances in terms of geographic distribution, level of training, and areas of specialization. Caracas, for instance, enjoys the country's highest concentration of physicians, dentists, registered nurses, and nurse's aides, while other areas of the country suffer from shortages of these resources. Also, recent years have seen a widening gap between the number of physicians and technical support staff, with the ratio currently standing at two registered nurses for every three physicians.

1.15 Furthermore, working conditions in the health sector reflect the situation created by low salaries, run down facilities, lack of incentives and motivation, and limited professional development, all of which have led to high levels of absenteeism and moonlighting and, as a result, inferior levels of service quality and productivity.

1.16 These observations all point toward the need for: (i) a training plan that covers all levels; (ii) a major overhaul of health manpower training; and (iii) consolidation and updating of current human resources policies.

3. Inappropriate health care model and faulty health products and services inspection

1.17 The health care model currently in place suffers from serious problems that prevent it from responding to the country's mixed epidemiological profile, which combines diseases that are typically

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2/ *Reposeros* are employees who are on extended medical leave. The people hired to cover their absences are called *suplentes*. *Prejubilados* are those staffers who are eligible for retirement but who remain on the payroll because the government lacks the necessary funds to pay for their benefits.

found in lesser-developed countries (preventable perinatal and infectious diseases) with other illnesses that are normally associated with more advanced levels of development. Although at the national level aggregate indicators are comparable with those of other countries at a similar level of development, the disparities registered at the local level, both geographically and by population group, are cause for considerable concern: preventable perinatal and infectious diseases continue to account for 20% of all deaths; tropical endemic diseases are on the rise (e.g., malaria, dengue fever, Chagas' disease, river blindness); and there have been registered outbreaks of tuberculosis, leprosy, and other infectious, contagious diseases. These are all indicators of the deterioration in the standard of living, especially among the urban and rural poor. Similarly, degenerative diseases and injuries associated with higher levels of development and industrialization (e.g., cardiovascular disease, cancer, accidents, violence), account for 30% of deaths and are a major stumbling block on the country's path to higher productivity (see Annex I-1).

1.18 Structurally, the country's health sector is poorly suited to respond to changes in epidemiological, demographic, and socioeconomic profiles. The current structure suffers from critical organizational and operational weaknesses at all care levels, for instance: (i) lack of coordination between the primary level and reference levels; (ii) limited flow of information between levels; (iii) bias toward curative treatment, at the expense of preventive care; (iv) low response capacity at public hospitals and clinics; and (v) poor human resources administration.

1.19 There is, then, an urgent need to overhaul the country's health care model in order to ensure proper epidemiological surveillance and response and the allocation of resources according to rational criteria weight the priorities to be given to curative and preventive health care.

1.20 Another imperative step is to reinforce the MSAS's capacity to ensure quality control of health care services, establishments, and staff, as well as of deliverables for human use. Given the increasing difficulty of guaranteeing the supply and quality of essential drugs, blood products, and biologicals, the role of the health control system needs to be redefined in order to enable it to regain its ability to monitor and supervise production in these areas.

4. Insufficient funding for the sector

1.21 The health sector is funded basically through: (i) allocations (totaling over US$1.3 billion) that are earmarked for the MSAS from the consolidated public sector; (ii) funds from the Venezuelan Social Security Institute that are channeled through the Health Fund, made up of contributions from employers, employees, and the government; and (iii) allocations from state and municipal

governments, which earmark on average 10 percent of their budgets for the health sector. 3/

1.22 However, the current system of budgeting and payment to service providers does not promote good distribution of resources or efficient service delivery. Hospitals and clinics receive budget allocations based on the previous year's spending levels, rather than service volumes or quality, or their impact on the population's health situation. Such procedures as fixed, yearly per-patient fees for outpatient care, fees for in-hospital care, or budgeting based on each hospital's functioning have not yet been implemented in Venezuela.

1.23 Worth noting is the fact that government-run health services normally do not charge for care provided to patients of the IVSS or private insurance companies. This is due mainly to the fact that the MSAS has been unable to devise a schedule of cost-based fees and to bill insurance companies for care provided.

1.24 The mounting problems with financial management in the sector, coupled with the sector's strong dependence on the central government, make it imperative that better structured and more efficient use be made of available resources and that alternative sources of additional funding be explored. As part of this exercise, consideration should be given to independent, self-managing, and self-financing services, looking at their implications, so that priorities can be determined with regard to actions that will have a greater impact on low-income users.

5. Poor service quality

1.25 The quality of health care delivery has not been immune from the general deterioration of the sector's infrastructure. Most public health care centers suffer from faulty infrastructure maintenance, outdated equipment, improper waste disposal, generalized shortcomings in management control and supervision, problems with information systems, and overcentralization of procurement procedures.

1.26 At the same time, capacity at public hospitals is underutilized, especially at level I facilities (i.e., those that provide in-hospital care and primary and secondary outpatient care) and level II facilities (i.e., those that provide basic medical services and various specialties). This is attributable both to the hospitals' low response capacity and to the public's preference to seek care at specialized, more prestigious public hospitals. Even at the primary care level, the long waits for care and the lack of confidence in service quality leads many patients to skip

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3/ Details on health sector spending can be found in chapter IV, section A.

outpatient clinics and go directly to a public hospital. As a result, public hospitals are not utilized to the best of their capacity and basic health care ends up being more costly.

1.27 Similarly, the practice of programming facilities, staff, and other resources on the basis of standardized allocations per population unit, without taking actual demand into account, has generated yawning gaps between the supply and demand for basic services.

D. Health sector reform

1.28 Although public health services are stratified by level of care (see Annex I-1), limitations still exist in terms of accessibility, response capacity, and efficiency. To remedy this situation, action needs to be taken with an eye to: (i) minimize geographic inequities with respect to outpatient clinics, beds, equipment, and skilled staff; (ii) step up infrastructure and equipment maintenance activities; (iii) implement systems to ensure the supply of critical inputs; (iv) reorganize the care and reference network; (v) enhance staff productivity; and (vi) promote preventive and primary health care.

1.29 The strategy of decentralizing health care delivery to the states will make it possible to: (i) encourage systematic planning of investments in programs and infrastructure in order to correct imbalances in the supply of services; (ii) spell out guidelines for coordination between the MSAS and the states (based on management performance commitments) that would link federal subsidies and other funding to the achievement of specific efficiency and efficacy targets; and (iii) devise efficient preventive maintenance systems and policies for health service equipment and infrastructure.

1.30 As part of this effort, the government intends to increase private-sector participation in health service delivery by means of a variety of formats that have been successfully tested in Venezuela and elsewhere. These formats include self-managed health care facilities, using private foundations, contracting of high-complexity services at public hospitals, and the creation of microenterprises for auxiliary services.

1.31 The Venezuelan authorities view the gradual decentralization of public services as one of the basic tools for achieving greater efficiency in service management. The idea is to have line ministries assume a policy-setting and regulatory role, while delegating greater authority and responsibility to state and municipal governments for actual service delivery. The legal framework covering health-related issues would be revised along these lines as part of the proposed operation (see section A in chapter III).

1.32 Under the decentralization process, agreements have been approved for the states of Anzoátegui, Aragua, Bolívar, Carabobo, Falcón, Mérida, and Zulia. Of these, Carabobo, Anzoátegui, Bolívar, and Mérida are expected to take part in the proposed program. The decentralization agreements with the remaining states that may participate in the program (up to a maximum of three) are at different stages of negotiation and are expected to be signed during the first half of 1995. The other 13 states are expected to sign decentralization agreements over the next three years.

E. Complementarity with World Bank action

1.33 The program agreed on by the IDB and the World Bank represents a first step in support for the health sector. The program's operating guidelines would be embodied in actions of national and regional scope. At the national level, the program will pave the way for government initiatives in the sector, beginning with the reorganization of the MSAS and a clearer definition of sector policy. At the regional level, eligible states will have more freedom to explore ways of implementing the proposed sector reforms. The IDB program would center mainly on the design and execution of these activities.

1.34 The World Bank operation would complement the IDB's action and would focus on supporting the decentralization of services by building up institutional capacity in four states (Aragua, Falcón, Trujillo, and Zulia) to allow them to plan and administer their health care systems. It also includes a component geared toward enhancing service delivery in those states by upgrading or replacing physical facilities, including basic outfitting of hospitals and outpatient clinics.

1. Other operations

1.35 The following actions are currently being carried out by the MSAS with external funding: (i) a nutrition and social development project, financed by the World Bank and UNICEF and targeting: (a) food distribution – through the Expanded Maternal and Child Program – and better primary health care, education, and public information – through the Food Subsidy Program; (b) broader coverage of the national home survey; and (c) a stronger management information system; (ii) an endemic disease control program, also financed by the World Bank, aimed at: (a) strengthening MSAS units in charge of endemic disease control; and (b) reducing the incidence and impact of such diseases as malaria, leprosy, dengue fever, and Chagas' disease; and (iii) the local health systems (SILOS) pilot project, launched by the Pan American Health Organization in the states of Táchira and Lara, which represents a step forward in the decentralization process.

F. IDB strategy in Venezuela

1.36 The Bank's strategy in Venezuela is geared toward: (i) shoring up structural reforms through projects that specifically support administrative and regional decentralization of public services; (ii) reducing poverty levels and regional inequities through support for policy reform and institutional change, as well as funding for projects aimed at providing low-income groups with broader access to public services and better working conditions; and (iii) consolidating macroeconomic reforms in order to pave the way for economic recovery.

1.37 The program to strengthen and modernize the health sector proposed herein is in keeping both with the Bank's strategy for Venezuela and with the actions outlined in the social agenda for the country, to the extent that it lends support for the implementation of institutional reforms aimed at decentralizing public services and, consequently, more efficient delivery and better quality of services. The program will also help to flatten regional inequities in health care access, especially among low-income groups.

G. Bank experience in the health sector

1.38 To date, Bank action in Venezuela's health sector has been limited to the social investment program that was approved in 1991 (PROINSOL, loan 658/OC-VE). The PROINSOL program was designed to provide funding and support for the social investment programs of the regional and local governments. One of the components funds investments in primary health care services, focusing on maternal and child care for low-income groups. It was under the PROINSOL program that the Bank began to provide support for setting up disciplined financing procedures for local governments' health investments, an activity that would be strengthened through the proposed program.

1.39 The PROINSOL program is currently under way and its project pipeline includes some 209 investment operations in various social-sector areas. Of these operations, 46 are in the health sector and have to do with the rehabilitation or construction of outpatient clinics for primary health care, mainly in rural areas. These investments will be part of the state investment programs that are to be drawn up under the program proposed herein.

II. THE PROGRAM

A. Objectives

2.1 The main objective of the program to strengthen and modernize the health sector is more efficient delivery of sector services. The operation's specific objectives are: (a) to make public health spending more efficient by (i) providing care for low-income groups and (ii) adopting a health care model with a preventive approach based on epidemiological profiles; (b) to strengthen the agencies responsible for designing and implementing sector policy; and (c) to provide support for the decentralization of health service delivery and strengthening of regional and local institutions.

B. Program description

2.2 The program has two components: (i) technical assistance for restructuring, strengthening, and modernizing the MSAS as the policy-setting agency for the health sector (which will entail paying employee entitlements for staff affected by the restructuring exercise); and (ii) technical assistance in support of the decentralization of health care services and funding of investments to rehabilitate the primary network in the states.

1. Restructuring the MSAS

a. Strengthening and modernizing the MSAS (US$56.9 million)

2.3 This will be achieved through two subprojects: (i) restructuring of the MSAS and job retraining, and (ii) strengthening and modernization of the MSAS.

2.4 Restructuring of the MSAS and job retraining (US$50 million). This activity will consist of reorganizing the MSAS to significantly reduce the number of organizational units and the resources assigned to each. The component includes, as well, the benefits to be paid to staff affected by the restructuring. 4/

2.5 In order to meet the needs of the restructured MSAS and absorb the impact of the restructuring exercise, a job retraining plan has been drawn up, which will provide: (i) refresher training; (ii) new skills training; (ii) technical assistance and job training for the self-employed or small-business operators; (iv) funds to cover payment during probationary periods at a company; and (v) compensation for workers not covered under any of the foregoing options. The program will lend assistance to the office overseeing this process.

4/ These benefits are not related to the IVSS social security contributions.

2.6 Strengthening and modernization of the MSAS (US$6.9 million). In support of the restructuring process, specific actions will be carried out to strengthen and modernize the MSAS with an eye to rightsizing and adjusting its organizational structure. Presentation of the terms of reference for studies on these actions will be a condition precedent to first disbursement. In addition, the following activities will also be carried out: (i) management systems (e.g. staff policies) will be designed and implemented; (ii) staff will receive training to ensure efficient performance in their new duties; and (iii) the MSAS will receive equipment to allow it to set up an internal network and link it up with the rest of the health care network, so as to create an organized, national information system.

b. Reorganization of agencies overseen by the MSAS (US$9.6 million)

2.7 Institutional evaluation and proposal for reorganization. This activity will consist of conducting an organizational assessment, reviewing the spending structure, and drawing up and implementing plans to modernize the independent institutes and foundations that operate under the MSAS, bearing in mind such reorganization options as decentralization, transfers, rightsizing, and possible joint undertakings with public- and private-sector agencies. The new legal framework for the sector will reflect the necessary changes, which will be carried out with support from the proposed operation.

2.8 The following independent institutes will be studied: INN, which runs food and nutrition surveillance programs; INAGER, which oversees care for the elderly; INH, which is in charge of reviewing and analyzing biologicals, as well as bacteriology, parasitology, and chemical testing, and the preparation of biologicals; HUC, which offers educational and care-related services from its location at the Luis Razetti Medical School; and IVIC, which oversees scientific research and its application.

2.9 The public-sector companies that will be studied are QUIMBIOTEC, which produces and markets blood products and other high-tech chemical products, and SEFAR, an independent service that oversees the production of generic drugs and pharmaceuticals. For these companies, the study will focus on the possibility of joint undertakings with other public- or private-sector agencies.

2.10 The foundations that will be studied include FIMA, which designs, formulates, implements, and evaluates infrastructure and maintenance programs for MSAS health care centers, and PAMI, which is in charge of the maternal and child food program and will be looked at with an eye to reorganization.

2.11 Reorganization of the health products and services inspection system. Support will be provided for the analysis to be undertaken for reorganizing the INH and the health products and services

inspection office of the MSAS. Once the reorganization has been carried out, these offices will receive technical assistance and training support for the inspection and registration of products for human use as well as investments in equipment and facilities (US$8.6 million) to upgrade quality control laboratories so they can perform post-registration control of products for human use.

c. Formulation of sector policy

2.12 This component will help to strengthen the MSAS's capacity to formulate policies to assign and monitor human, institutional, and budgetary resources in the sector in accordance with rational criteria (i.e., epidemiological, technical, ethical, management, and cost-efficiency) that reflect areas of concern to the sector and its sociopolitical and economic context. For this purpose, studies and actions will be carried out in the following areas:

2.13 Prevention and promotion program (US$13.6 million). The development and implementation of the disease prevention and health promotion and information program (PEPIS) will contribute to nationwide distribution of information aimed at: (i) preventing common diseases; (ii) promoting healthier lifestyles; and (iii) promoting appropriate use of health care services. Support will also be provided for specific campaigns targeting common problems in the region — as defined by the epidemiological profile — and direct contact with community groups and health service users, including indigenous communities.

2.14 Human resource training and administration policies (US$500,000). In this area, actions will be devised for the short, medium, and long terms with a view to remedying critical problems in health manpower supply and skills. These actions will be included in the national manpower training and administration policy that is to be implemented. As part of these activities, guidelines will be drawn up for the number and type of professionals to be trained in the various health care areas, school curricula will be updated to take account of the occupational profiles needed to respond to the country's epidemiological needs and the new health care model, and proposals for improving working conditions and human resources administration in the sector. Presentation of the terms of reference for this study will be a condition precedent for first disbursement under this component.

d. Sector financing (US$900,000)

2.15 This component will fund studies to draw up guidelines for the new financing model for the sector at the national and state levels, covering both the public and private sectors. Studies are scheduled to be carried out on: (i) a breakdown of health spending by source of funding, so as to establish how it dovetails with the controls and resource-allocation procedures to be implemented by the MSAS; (ii) funding projections at the central, state, and local

levels, in order to identify alternatives that will optimize funding levels and identify potential sources under the new financing structure; and (iii) updating the IVSS's actuarial tables, making projections based on the cost of the risks that will be defined according to which services are to be funded by the government.

2.16 Legal framework for the sector. Funding will be provided for the technical assistance needed to update and design new health care legislation as part of the sector reform process.

2. Decentralization of health care services (US$154.8 million)

2.17 This component will support the decentralization process, whereby MSAS health care services and resources will be transferred to the states in an efficient and orderly fashion and the states' institutional capacity will be strengthened in order to take on these services and resources and operate them efficiently. Actions in support of the decentralization process and the related investments will be administered through trust funds, which will be managed in accordance with operating regulations that define eligibility criteria and procedures to be followed by the states; the trust funds will receive counterpart funding from the state budgets and the MSAS. The resources to be made available will be used to finance institutional strengthening, preinvestment, and service modernization in support of decentralization in up to seven states.

a. Preinvestment (US$10.3 million)

2.18 States in which decentralization is under way (US$7.9 million). Support will be lent for preparing state health plans and prefeasibility and feasibility studies that will enable the states to prepare the projects identified in their plans.

2.19 Special support for less developed regions (US$2.4 million). This component will focus on the states of Apure, Cojedes, Amacuro, and Amazonas, which have relatively lower levels of development and require special support for institutional strengthening in order to prepare their state plans and preinvestment studies. These states would take part in investment funding during a possible second stage of the program.

b. Institutional strengthening of state health systems (US$24.4 million)

2.20 Organization of state health systems (US$5.3 million). Under this component, support will be provided for transferring areas of responsibility to the states. Activities will center on: (i) devising organizational structures for service management; (ii) drafting an organization manual; (iii) retraining key management personnel; and (iv) designing strategies for coordination with the IVSS and other agencies.

2.21 Technical assistance and training for state health systems (US$13.9 million). States will receive technical assistance, management training, and equipment with a view to enhancing system implementation and operation. Technical assistance will focus on: (i) strategic planning, (ii) health products and services inspection, (iii) health surveillance and epidemiological control systems, (iv) management control systems at the state level, (v) policies and systems for human resources administration, (vi) financial management systems, (vii) statistics and management information systems, (viii) supply systems, (ix) maintenance systems, and (x) solid waste management systems.

c. Modernization of state health services (US$120.1 million)

2.22 Although this activity will center on investments aimed at revamping the primary network in the states, funding may also be provided for investments in improvements (rehabilitation or replacement) and infrastructure for secondary and tertiary services at hospitals and outpatient clinics. This component includes financing for the necessary final designs and the supervision of investments.

C. Program size

2.23 The program's size reflects the government's ceiling for external borrowing, the expected availability of local counterpart during program execution, and the execution capacity of the MSAS and the states.

2.24 The MSAS restructuring, strengthening, and modernization activities have been sized according to estimates based on: the MSAS's restructuring proposal; the review, rightsizing, and regulation of positions and staff, with support from program consultancies; program-funded external job retraining for MSAS staff (identifying possible candidates, their profiles, and their options for finding work elsewhere); and an analysis of the human resources and their training needs.

2.25 The sizing of the decentralization component was based on an analysis of the investment needs of four states that account for 20% of Venezuela's population, selected for their demographic, socioeconomic, epidemiological, and administrative features, as well as the organization of their health services (either entirely public-sector or mixed public- and private-sector).

D. Total program cost

2.26 The total amount to be financed by the Bank is estimated at US$300 million equivalent, broken down by investment category and funding source as follows: 5/

COSTS AND FINANCING (in US$ millions)					
COST CATEGORY	SOURCE OF FINANCING				
	IDB	MSAS	STATE	TOTAL	%
1. ADMINISTRATION AND SUPERVISION	**0**	**10.21**	**7.44**	**17.65**	**5.88**
1.1.1 Staff and administration	0	3.88	4.92	8.80	2.93
1.1.2 External consultancies	0	1.48	2.52	4.00	1.33
1.3 Supervision and support	0	4.85	0	4.85	1.62
2. DIRECT COSTS	**107.06**	**91.01**	**38.22**	**236.30**	**78.77**
2.1 Upgrading policy design and execution capacity and MSAS restructuring	61.27	19.40	0.83	81.50	27.17
2.2 Decentralization of services	45.79	71.61	37.39	154.68	51.60
3. UNALLOCATED	**15.77**	**0**	**0**	**15.77**	**5.26**
4. FINANCING COSTS	**27.16**	**3.12**	**0**	**30.28**	**10.09**
4.1 Interest	25.66	0	0	25.66	8.55
4.2 Credit fee	0	3.12	0	3.12	1.04
4.3 Inspection and supervision	1.50	0	0	1.50	0.50
TOTAL	**150.00**	**104.34**	**45.66**	**300.00**	**100.00**

1. Administration and supervision (US$17.65 million)

2.27 This category, which accounts for 5.98% of the program's cost, would cover: (i) program overhead for the coordinating unit and the state units (US$8.8 million); (ii) specific consultancies to support the MSAS and the states (US$4 million); and (iii) program supervision and costs of program support intermediaries (US$4.85 million). Supervision of maintenance activities is not included as a cost; it would be performed by the coexecuting agencies through the state health service units.

2. Direct costs (US$236.3 million)

2.28 This category represents 78.77% of the total program cost and covers the direct costs associated with the projected investments and allocations for carrying out activities under the two compo-

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5/ A detailed breakdown of direct costs by component can be found in Annex II-1.

nents: (i) upgrading policy design and execution capacity and restructuring the MSAS (US$81.5 million), including benefits in the amount of approximately US$47 million in connection with staff affected by restructuring at the central level of the MSAS. Disbursements under this category will be paid each year out of the loan proceeds, based on the annual targets presented in Annex III-3, section 3; and (ii) decentralization, through a trust fund for US$154.68 million. In addition to the total direct cost of investments, an allowance was made of 20% to cover escalation of contingencies during program execution and possible variations in the employee entitlements that are to be paid out.

E. Program financing

2.29 The Bank would contribute US$150 million equivalent toward program execution (equivalent to 50% of the total program cost), to be disbursed in foreign exchange from the Bank's ordinary capital.

2.30 The Bank loan would be granted under the following terms and conditions: (i) amortization period: 20 years; (ii) interest rate: variable, following the Bank's interest rate policy; (iii) disbursement period: 5 years; (iv) commitment period: 4 years; (v) credit fee: 0.25% on undisbursed amounts; and (vi) inspection and supervision: 1% of the loan amount.

2.31 The local counterpart contribution of US$150 million equivalent, i.e., 50% of the program cost, would be covered through central government budget allocations to the MSAS totaling US$104.34 million and state budget allocations for around US$45.66 million. In addition to contributing to the funding of program administration and supervision, each state government would cover 25% of the investment costs of the program in its state.

III. PROGRAM EXECUTION

A. Institutional framework

3.1 The borrower would be the Republic of Venezuela, which would transfer the loan proceeds – on a nonreimbursable basis – and the local counterpart contribution (except for the states' contributions) to the executing agency under an agreement that is to be submitted as a condition precedent to first disbursement.

3.2 Program execution will be the responsibility of the Ministry of Health and Social Welfare (MSAS), through a program coordinating unit. The MSAS will be in charge of program development and implementation and will act as policy-setting agency and promoter vis-à-vis the state governments, which will act as coexecuting agencies for their individual projects through state executing units.

1. Legal framework

3.3 The health sector lacks the proper legal framework for operations under a restructured organization. Accordingly, the legislation governing the sector will need to be revised and updated. This revision will need to cover the National Health Care Act, the National Health System Act, and the Decentralization, Delimitation, and Transfer of Powers Act. Since the National Health System Act currently in force will expire in 1997, the MSAS will need to submit draft legislation during the second year of the program embodying the objectives set out in the Health Project and those set out in the Decentralization Act, specifying the minimum obligations of states to which responsibilities have been transferred, as well as the functions of the MSAS as policy-setting and regulatory agency of the decentralized services.

3.4 The transfer of health services to the states falls under the scope of the Decentralization, Delimitation and Transfer of Powers Act, which stipulates that funds be transferred from the MSAS's budget to the states through specific line entries. These transfers are not capped, so a state's annual budget will increase by the same percent increase in the national budget.

2. Program Coordinating Unit

3.5 The Program Coordinating Unit (PCU) was legally organized in January 1993 and reports to the Minister of Health, who appoints the PCU's general coordinator. The PCU will have the following functions: (i) supervise and monitor program execution; (ii) administer the trust fund for investment of program resources during program execution; (iii) assist the MSAS's divisions in carrying out projects under the program; (iv) review and recommend approval of state health plans according to criteria set out in the

program's operating regulations; (v) lend technical support to the coexecuting agencies; (vi) prepare and process the program's budget, making sure funds are available as needed; and (vii) present annual progress reports to the Bank, including those done by outside auditors.

3.6 During the program analysis stage, it was agreed that there would be only one PCU, which would jointly administer the IDB and the World Bank programs. The PCU will have two areas of responsibility (general technical management and general program management) and five support units (institutional relations, legal advice, information and documentation, management control, and administration). In addition to its scheduled staff of 43 (32 professionals, 6 technical support, and 5 administrative assistants), the PCU will also receive support from outside consultants in the areas of strategic planning, legal advice, support for preparation of state projects and plans, image management, and special advice on information systems. Once the projects are completed, the PCU staff could join the MSAS's full-time staff in positions related to the activities they performed during program execution.

3. Coexecuting agencies

3.7 Each state participating in the proposed operation will set up a Program Executing Unit (PEU). The PEUs will have a staff of between four and six professionals, depending on the size and complexity of the state's health system. They will report to the state's regional health director.

3.8 The PEUs will have the following functions: (i) assist the Regional Health Office in preparing, coordinating, and supervising execution of the state health plan agreed on with the PCU; (ii) engage consultants and sign contracts for projects to be financed out of the trust fund; (iii) administer program resources in the state; (iv) draw up the program budget, making sure the state's contribution is available when needed; and (v) present progress reports to the PCU as agreed in the operating regulations. As with the PCU, once the state's program comes to an end, the PEUs will be disbanded and their staff could be incorporated into the states' health departments.

B. Means of execution

1. Decentralization plan

3.9 The MSAS, with support from a technical team, will be in charge of carrying out a plan aimed at: (i) gradual decentralization of the health systems; (ii) redefinition of the administrative and financial responsibilities of the MSAS and the states, including design of the management control system whereby the MSAS will allocate federal funds; and (iii) development of a training plan based on the institutional strengthening projects. The documents

of the prospective financing are to include the commitment that, prior to first disbursement, the MSAS is to present the plan agreed on with the Bank and show that the technical team that will work full-time to support decentralization has been set up.

2. Operating regulations

3.10 The operating regulations will establish the terms and conditions that will govern access to program resources, including eligibility criteria, project analysis, financing conditions, means of execution, procedures for contracting works, procurement of goods and services, and operating and maintenance requirements. The regulations are also to include guidelines for the preparation of state plans and operating standards for program execution. A draft version of the operating regulations is available in the Bank's technical files. Presentation, approval by the Bank, and implementation of the operating regulations by the MSAS will be a condition precedent to first disbursement.

3.11 Each state is to draw up a state plan and present it to the MSAS, including: (i) a proposal for sector organization and funding, containing measures for ensuring efficient use of the resources to be transferred. When determining their investment requirements, states should bear in mind the decentralization of the IVSS, which will help to enhance the efficiency of the states' administration of services. Similarly, account should be taken of private-sector participation when establishing the size of the overall supply of health care services; (ii) institutional strengthening activities for the proposed new structure, including the design and implementation of management systems and the training of managers at the state level and at hospitals and outpatient clinics; (iii) a plan setting out investment priorities that respond to identified repair, replacement, and expansion needs (including outfitting), aimed at achieving optimum use and development of a functional network of services in the state; and (iv) a proposal for the organization of the Program Executing Unit. Details on the structure of the state health plans, including targets for measuring their impact on major health indicators, can be found in Annex III-1.

a. Criteria governing the use of program resources

3.12 To be eligible to receive financing under the program, projects must meet certain criteria. State plans must include specific investment projects ranked in order of priority on the basis of the criteria and indicators contained in the guidelines for the preparation of state plans. In addition, they are to focus on low-income groups and need to show that: (i) they broaden low-income groups' access to health services; (ii) they enhance the operating efficiency of the service network; (iii) their size and costs reflect true demand; and (iv) they have appropriate funding levels to cover their operation and maintenance.

3.13 Furthermore: (i) the states will finance up to 25% of the total cost of the projects, including the cost of studies, final designs, and engineering and overhead costs during program execution; (ii) land purchases as well as any financial costs incurred during execution may not be included as project costs; and (iii) allocations to any single coexecuting agency may not exceed 30% of the total program resources during the first three years. This ceiling may be raised thereafter, depending on the degree of preparation and execution of the investment projects.

3. Operational considerations

3.14 Program resources will be administered through a trust fund that is to be set up as a condition precedent to first disbursement.

3.15 The United Nations Development Programme (UNDP) will assist the MSAS in securing technical assistance services, consultancies, and equipment from abroad. Administration of the management training and job retraining subcomponents will be let under calls for bids issued by the MSAS. Administration of the restructuring subcomponent associated with the more efficient use of resources will be carried out through the Venezuelan Investment Fund, which will also lend support to the MSAS for execution of the subcomponent.

3.16 The Venezuelan government has asked that the UNDP be contracted directly, under an administration agreement that is to be submitted as a condition precedent to first disbursement. The request for UNDP cooperation in the program reflects the government's interest in streamlining the procurement and contracting processes, ensuring transparency in operations, facilitating the handling of program resources in foreign exchange, and benefitting from successful UNDP participation in other multilaterally funded programs in Venezuela.

3.17 The project team recommends that the UNDP be involved as of the initial stages of program execution, since – in addition to the foregoing reasons – the MSAS is unable to provide the services that will be requested of the UNDP and, moreover, it would not be productive to have the PCU mobilize an entire team and structure for a temporary activity.

3.18 The MSAS will open a special account with Venezuela's Central Bank to handle the proceeds of the loan and will issue requests for funds to be transferred to the trust fund, to the UNDP, or to the Venezuelan Investment Fund, as applicable. Similar procedures will be followed by the Finance Ministry for the local counterpart contribution. Both the PCU and the PEUs are to maintain records in keeping with generally accepted accounting standards and applicable legislation. The PCU and the PEUs are also to keep records by project cost category, which will be subject to auditing by the PCU and an outside firm.

C. Implementation of MSAS restructuring and job retraining

3.19 As a result of the changes that will take place in the MSAS through: (i) the delegation and transfer of service delivery; (ii) adjustments to be made pursuant to the recommendations contained in the reorganization studies; and (iii) the transfer of responsibilities to the states under the decentralization process, it will be necessary to devise plans for job retraining and restructuring of the MSAS. Accordingly, a condition will be included whereby the borrower, through the MSAS, is to present — prior to the first disbursement under this component — the MSAS restructuring and job retraining plans as agreed upon with the Bank, including the transition structure of the MSAS and its dependent agencies, and evidence that the technical team that will work full-time to support the actions indicated in said plans has been appointed. These plans are to be implemented during program execution and their progress will be monitored at annual supervisory meetings.

3.20 The MSAS restructuring will take place in two stages: the first year of execution will be a transition stage that will lead into the second year, by which time the new structure will be in place and will be shored up during program execution. The first stage is already under way, with the transition structure officially approved for implementation in 1995. The program also includes financing to support the streamlining of the MSAS's structure (benefits associated with the reduction in staff), to be released after achievement of specific targets that will be established in the restructuring plan (see Annex III-3).

3.21 Streamlining the MSAS's structure will create the need for a job retraining plan for staff leaving the ministry, including outplacement and financial assistance. Disbursements under this component will be pegged to progress in program implementation, as verified at the annual supervisory meetings.

D. Execution of investment projects

3.22 Standard Bank procurement procedures will be followed for works contracts and the procurement of goods in connection with project activities. Given that most of the works contracts will run between US$50,000 and US$2 million, the project team feels there is no need for prequalification of construction firms, except for the more complex projects (category III and IV hospitals), that cost over US$3 million. Most of the scheduled works are simple, of low complexity, and do not require sophisticated equipment or technology. To the extent possible, bids on engineering works for projects located in a given state will be grouped into packages in order to obtain better contract prices.

3.23 Once declared eligible, projects may be started with funding from the coexecuting agencies. Costs may be recognized as contributions

to the program, provided the procedures set forth in the operating regulations have been followed. Projects approved under state plans for amounts of less than US$50,000 need not be submitted to the PCU for consideration and evaluation. The PCU will evaluate these projects on an annual basis, using a randomly selected representative sample.

3.24 Technical supervision and quality control of program works will be performed by the MSAS and the respective states, working through consultants or their own technical staff, depending on the size of the project. To ensure efficient supervision, the PEUs will hire technical services and/or consulting firms to inspect and monitor the progress of work.

3.25 The goods and services needed for works contracts are to be procured pursuant to the procedures stipulated in Annex B to the loan contract. International competitive bidding will be required for goods and services valued at over US$350,000 and for works contracts valued at over US$3 million. These cut-off levels are justified by past experience, which has shown that foreign companies only bid on contracts above these levels. For operations below these levels, bidding will follow national legislation, which requires public calls for bids for works contracts valued at over US$500,000 and goods valued at over US$150,000, and restricted bidding for lesser amounts. 6/

3.26 In order to streamline the process of hiring individual consultants and given the program's need to hire advisers for institutional strengthening of the coexecuting agencies in each state, it was recommended that the Bank's prerequisites for the hiring of individual consultants be simplified when amounts under US$20,000 are involved. It is recommended that these contracts be signed without the normal prerequisites (e.g., prior presentation of terms of reference, names and resumés of consultants, model contracts). Instead, the Bank will conduct an ex post review of the procedures used in each case to verify whether consultants were selected and hired according to agreed on procedures; contracts not observing these procedures will not be accepted. It should be pointed out that this procedure does not constitute an exception to current Bank policy in this area.

E. Program supervision

3.27 Program supervision will be performed by the Country Office, with support from the project team. As part of this activity, the MSAS and the Bank will conduct joint annual revisions beginning 12 months after program start-up. These meetings, which are to be held before February 28 of each year, will study the status of

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6/ The procurement schedule can be found in Annex III-2.

program execution, including: (i) progress in implementing the MSAS restructuring and job retraining plans; (ii) progress in implementing the MSAS rightsizing plan; (iii) progress in implementing the recommendations contained in the studies on MSAS strengthening and modernization; (iv) progress in reorganizing and modernizing the agencies overseen by the MSAS; (v) progress in implementing the plan to upgrade sector policy design and execution and in drafting a new National Health Act; and (vi) evaluation of the implementation of state health plans and compliance with performance targets.

3.28 For purposes of monitoring program progress at the yearly meetings, a set of indicators has been devised for the various components, setting annual targets that are to be met (see Annex III-3). Funds will be committed and work carried out under each component only if the targets are reasonably met each year.

3.29 At least 15 days prior to the annual supervisory meeting, the MSAS is to submit to the Bank the respective reports on the aforementioned topics.

3.30 The Bank will closely monitor compliance in these areas. If, at one of the annual supervisory meetings, progress should be found to be unsatisfactory, the borrower — through the executing agency — will have 60 days as of the date on which the Bank makes its observations to present the remedial steps that are to be implemented and a schedule for carrying them out. If these remedial measures are not satisfactory, the Bank may take such action as it deems appropriate under the provisions of the loan contract.

F. Execution and investment schedule

3.31 The term for execution and disbursements under the program is estimated at five years, beginning on the date of entry into force of the loan contract. This period includes the time necessary for fulfilling the conditions precedent to first disbursement, issuing calls for bids, contracting, performing work, and making final settlement of contracts. The investment schedule was drawn up on the basis of a suitable sequence of studies and investments.

3.32 Most of the scheduled investments are small- to medium-scale works to be carried out in less than 12 months, the only exception being the more complex, category III and IV hospitals, which are to be contracted for by the end of the third year of the loan contract.

Investment Schedule
(in US$ millions equivalent)

Spending category	Year 1			Year 2			Year 3			Year 4			Year 5		
	IDB	States	MSAS	IDB	States	MSAS	IDB	States	MSAS	IDB	States	MSAS	IDB	States	MSAS
Adminis-tration and supervision	0	1.5	2.0	0	1.5	2.0	0	1.5	2.0	0	1.5	2.0	0	1.5	2.0
Direct costs	14.7	1.1	5.3	16.3	1.1	4.5	23.5	12.0	28.0	23.1	12.0	26.6	24.2	12.0	26.6
Unallocated	2.5	0	0	3.8	0	0	4.7	0	0	4.7	0	0	5.3	0	0
Financing costs	1.5	0	1.0	3.0	0	0.8	5.2	0	0.6	7.5	0	0.4	10.0	0	0.4
TOTAL	18.7	2.6	8.3	23.1	2.6	7.3	33.4	13.5	30.6	35.3	13.5	29.0	39.5	13.5	29.0

3.33 The disbursement schedule reflects the fact that activities during the first two years will focus on restructuring the MSAS, to be financed mainly out of the loan proceeds. The program also assumes that during the first two years the states will use decentralization funding mainly for preinvestment, organization of their state health systems, training, technical assistance, and purchase of equipment for management. Most of the investments per se will be made starting in the third year of execution.

G. Recognition of costs

3.34 In response to a request from the Government of Venezuela that the Bank recognize costs incurred totaling US$5.7 million, an estimated US$3.5 million equivalent for costs incurred during the 12 months prior to the approval date will be recognized against the Bank's loan proceeds, and up to US$2.2 million in costs incurred during the 18 months prior to that date will be recognized against the local contribution. It is recommended that the Bank recognize these amounts, subject to verification of compliance with requirements substantially similar to those set forth in the loan contract.

H. Advances

3.35 Considering the program's features, its broad geographical coverage and scope, the large number of coexecuting agencies, and the diverse nature of the projects scheduled to receive financing, it is recommended that an advance of up to 10 percent of the loan amount be made available so that funding requirements can be met on a timely basis.

I. Maintenance of works and equipment

3.36 Works and equipment covered under the state plans and financed out of program resources are to have a service maintenance and operation plan as of their transfer or start-up. These plans should spell out operations and maintenance activities and assign institutional and financial responsibility for execution of the

plan, as well as the amounts allocated starting in the year in which the plan is implemented.

3.37 The operating and maintenance costs of public health care services (including staff costs) are to be defrayed in full by the coexecuting agencies as of the effective date of the agreements governing their participation in the program. Upon conclusion of the program, the borrower will assume the commitment to maintain the health services and associated facilities in keeping with accepted technical standards. An evaluation of the maintenance status of said systems is to be submitted for the Bank's consideration.

J. Land and rights-of-way

3.38 According to the operating regulations, all sites and rights-of-way where project works are to be carried out must be free of any legal encumbrance and have clear title. For the works scheduled, no problems are foreseen concerning ownership of land where construction work is to take place.

K. Outside audit of the program

3.39 Beginning with the first year and continuing throughout the execution period, the MSAS is to submit to the Bank the program's financial statements, audited by an independent accounting firm.

L. Environmental impact

3.40 This program was classified as a Category II operation by the Environment Committee at its March 16, 1992, meeting. The program will have a beneficial impact on the environment, including the area of solid waste management. The operating regulations will include an annex on environmental impact, outlining methods for identifying, assessing, and proposing mitigative measures for the most common types of impact. The terms of reference for preparing the final engineering designs for the proposed infrastructure improvements call for re-examining environmental conditions at existing facilities; the final plans will include specific actions aimed at complying with existing and proposed standards. It has been recommended that the program include pollution control measures to remedy current problems stemming from the improper operation of hospitals and clinics. Environmental assessments will also be required for all new construction work, outlining the environmental impact and proposed measures to reduce or eliminate any negative impact, as defined by internationally accepted levels and those set by the Ministry of Natural Resources and Environmental Affairs.

M. Natural disasters

3.41 From time to time, Venezuela has seen occasional seismic activity, torrential rains, and flooding. The program proposed here includes

repair or replacement of buildings whose original design and construction included reasonable specifications for avoiding or controlling collapses and minimizing damage from flooding or other natural disasters that could seriously compromise building stability.

N. Ex post evaluation

3.42 Ex post evaluation will be geared toward assessing the program's success in: (i) making the health care system more equitable; and (ii) enhancing service quality and efficiency as a means of improving the target population's health situation. The borrower has agreed to obtain the specific data needed to carry out the ex post evaluation, since monitoring of the program and compliance with its objectives will be done on an ongoing basis. The MSAS will be responsible for systematic evaluation of the program and for drawing up the respective reports for consideration at the monitoring and supervisory meetings.

3.43 Evaluation will focus on the degree to which the following targets are achieved: (i) target indicators for coverage, accessibility, equity, and the population's health status; (ii) economic and financial targets based on indicators for growth, relative share of allocations to the various service categories, efficient use of allocations, service productivity, health care costs, and service financing; and (iii) institutional targets based on service organization and the implementation of new management and financing systems, with special emphasis on the impact of institutional strengthening activities.

3.44 The executing agency will compile data to be used in an ex post evaluation of program results, in accordance with the data compilation methodology and systems agreed upon with the Bank within the first 12 months of the contract. These data will be delivered at the annual evaluations as of the second year of the program and each year until program completion. The final evaluation report is to be drawn up two years after the date of the last disbursement and will be funded by the Bank.

IV. PROGRAM FEASIBILITY, BENEFITS, AND RISKS

A. Institutional and financial feasibility

1. Financial analysis of the program

a. Sector expenditures and financing

4.1 Consolidated public spending on health fell sharply in the 1980s, dropping from an annual US$102 per capita in 1985 to US$55 in 1988. During the period from 1989 to 1994, the trend reversed and spending rose to an average level of US$75.70 per person, equivalent to 2.5% of GDP, which was down from the maximum of 2.8% in 1991 but better than the 1990 low of 2.2%. In real terms, spending rose 6.8% between 1989 and 1994, although spending per capita and as a percentage of GDP were below 1989 levels. The following table presents a breakdown of health spending trends since 1989:.

Consolidated public spending on health (estimated)
(in millions of 1993 US dollars)

Agency	1989	1990	1991	1992	1993	1994 (est)
MSAS (net spending) 1/	541	471	630	678	585	571
Agencies overseen by the MSAS	299	258	393	399	404	299
Total spending allocated by the MSAS	840	729	1,023	1,077	989	870
Independent institutes	359	351	387	333	289	429
Other ministries	27	22	40	60	53	40
State governments	188	250	264	198	178	171
Total real consolidated public sector spending on health (CPSSH)	1,413	1,351	1,714	1,668	1,508	1,509
CPSSH as a percentage of GDP	2.5%	2.2%	2.8%	2.6%	2.5%	2.3%
Per capita spending (US$)	73	70	86	82	72	71

1/ Amount spent directly by the MSAS.

4.2 As can be seen from the table, public spending on health in 1993 broke down as follows: 39% from the MSAS, 27% from public agencies that receive funding from the MSAS, 19% from independent institutes (IVSS and IPASME), 3% from other ministries, and 12% from the state governments.

4.3 Between 1989 and 1994, MSAS spending (including the agencies it oversees) accounted for an average 6.6% of the government's overall budget, an average of 1.53% of GDP, and 60.3% of consolidated public-sector spending on health. Of the MSAS's operating costs, 78% went for salaries, 17.8% for supplies, repairs, and related costs, and 4.2% for investments.

b. Health spending by state governments

4.4 Between 1989 and 1993, state governments spent on average 9.84% of their overall budgets on health (US$11.50 per person per year). State government outlays accounted for an average of 10% of public-sector spending on health, ranging from a maximum of 13.1% in 1990 to a minimum of 7.9% in 1992.

4.5 Under the current arrangement, states provide part of the funding for the health care services located within their territory by covering immediate needs and those services that are not funded by the central government. In some cases, state governments have set up primary care services directly under the state or municipal government.

c. Health-sector employee entitlements 7/

4.6 The program will support the transfer of responsibility for service delivery to the states, which will entail transferring staff as well. Under Venezuelan labor legislation, this will mean that central government resources will have to be transferred to the states to cover the employee entitlements of transferred staff. To this end, the government has already opened a separate trust fund for each employee. In addition, the MSAS restructuring exercise will also involve staff downsizing and the corresponding payment of benefits.

4.7 Employee entitlements consist of one month's pay (at the employee's pay level on the date of transfer) for each year of service or fraction thereof greater than six months, plus interest on cumulative balances of basic benefits and interest accrued through the period immediately preceding the year of calculation. Blue-collar employees began earning interest on contributions in 1975, while white-collar employees began in 1991. Interest represents roughly 64% of the total employee entitlements.

4.8 Benefits were calculated jointly with the MSAS both during and after program analysis, and a study was done on the different funding sources that could be tapped to support the transfer process.

4.9 The figures examined with the MSAS indicated that the employee benefits associated with total decentralization of the sector would come to around US$915 million. Of this amount, the entitlements for the 34,043 employees to be transferred as part of the decentralization process in seven states were about US$279 million. The employee entitlements associated with the restructuring of the MSAS were estimated at US$47 million.

7/ See Annex IV-1 for a description of the benefits system.

2. Financial feasibility

4.10 The financial feasibility of the program was analyzed in terms of: (i) the central government's ability to service the debt, to make the local counterpart available, to finance staff cuts at the MSAS's central level, and to capitalize the cumulative employee entitlements of staff transferred to the states; and (ii) the states' ability to cover their contributions to the program, to cover the operating costs of transferred services, and to allocate additional funding under the state budget.

4.11 The program analysis stage examined both historical spending figures and fiscal projections for the coming years. Account was taken of the impact of currency devaluation, fluctuations in oil prices, revenue from privatization and budget adjustments, tax reform, an expanded tax base, and other steps taken by the new government to address the economic and financial crisis. Fiscal projections for 1995 through 1999 indicate the program would be sustainable in the medium and long terms, and that the local contributions would be available on a timely basis.

4.12 Restructuring the MSAS's central level will produce payroll savings of over US$30 million during program execution, and net savings of about US$7 million per year as of the sixth year.

4.13 Pursuant to the program's operating regulations, the state plans are to include estimates and funding sources for recurrent costs. The financial projections of the states' revenue (including transfers from the MSAS), coupled with the governors' stated intent to earmark a greater portion of the budget for the health sector, indicate that it will be possible to cover the incremental costs of the states' projects. No significant recurrent costs are foreseen at the central ministry level.

4.14 For staff transferred to the states, the central government will have to capitalize employee entitlements over a four-year period to each participating state. Staff transfers to seven states will involve the capitalization of employee entitlements totaling an estimated US$279 million. These entitlements will be capitalized by means of four annual payments, the first for this amount and the last three for 20% each. The studies on possible funding sources show that these amounts can feasibly be covered in the medium term. The funding sources identified are: the Intergovernment Decentralization Fund (FIDES); 8/ savings from the budgets of the MSAS and the agencies it oversees; "umbrella law" [*leyes paraguas*] funds that are being allocated for the decentralization

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8/ The FIDES would receive between 15% and 30% of the amount collected for the IGV. Up to 20% of the fund could be used for paying employee entitlements to states participating in the decentralization process.

of services to states and municipalities; and revenue generated by the privatization of public-sector companies.

4.15 The local contribution of each state to the program averages out to US$7.2 million, at a rate of US$2.5 million per year. Based on the historical budgets of the states studied and the projections made, it will be possible for them to fund these amounts.

4.16 The public-sector spending on health that is expected as a result of these reforms has been calculated at US$1,889 million for the fifth year of the program, which is equivalent to US$80 per person in the target population (as compared to US$71 in 1994). This represents a real increase of roughly 32% over 1994. This spending would be financed 80% by the central government and 20% by the states, compared with 89% and 11% in 1994.

4.17 The higher level of state spending is consistent with the recent changes in the tax system, which significantly raised the amount of constitutionally-mandated transfers (under Venezuela's revenue-sharing arrangement).

4.18 For the period under study, it is estimated that private-sector health spending will increase in real terms by 42.7%, with consolidated per capita spending going from US$81 in 1994 to US$92 in 1999.

3. Technical and institutional feasibility

4.19 The program's technical and institutional feasibility was analyzed on the basis of: (i) the means of execution as designed; (ii) the new functional structure of the MSAS and the proposed institutional organization of the states; and (iii) the political consensus and intent to implement the necessary changes in order to attain the program's objectives.

4.20 The scope, content, and conditions of the national-level actions display a good level of technical quality and are realistic in terms of the technical, physical, and financial resources available. The same conclusion was reached with regard to the proposed actions for reorganization, institutional strengthening, and training at the state level.

4.21 The following means of execution are considered to be suitable: (i) establishment of the PCU under the Office of the Minister; (ii) establishment of PEUs under the state health offices in participating states; (iii) participation of the UNDP and bank trust funds in handling program resources; (iv) use of bidding to contract out the administration of job training and retraining components; and (v) operating regulations that set forth the conditions, guidelines, and procedures for approval of the annual investment plans under the state health plans.

4.22 The program analysis stage examined and defined operational and technical responsibilities for each level of program execution, the organization of the PCU and the PEUs, the participation of the management agency, the conditions of the respective agreement, and the overall financial administration of program funds. The PCU's ability to carry out the Bank program has been strengthened through the experience gained in preparing other projects for the IDB and the World Bank and will benefit from consultancies scheduled under the program. Although to a lesser degree, a similar situation exists with the technical teams of the states.

4.23 The studies of the operating, technical, institutional, and administrative capacity of four of the states helped to identify institutional strengthening and operational needs in various areas and to plan the necessary steps for setting up the new state structure. The proposals for institutional strengthening and organization are consistent with the guiding principles of the decentralization process, as well as with the criteria decided on for technical assistance and related training. The transfer of responsibility for operation and maintenance to the states will be carried out in accordance with conditions that are to be spelled out in the decentralization agreements and that will be part of the state health plans.

4.24 The proposed restructuring of the MSAS is in keeping with its new policy-setting role, a more streamlined and efficient structure, and the transfer of functions to the states.

4.25 These elements, which together provide the institutional and policy framework for the program, all point toward the feasibility of program execution.

B. Socioeconomic evaluation

4.26 Socioeconomic evaluation seeks to gauge the program's impact in terms of: (i) improved quality of health among the target population, (ii) more efficient service delivery; and (iii) higher levels of equity, as shown by broader coverage of low-income groups.

1. Improved quality of health

4.27 The benefit to health conditions will be measured in terms of the improvement in a series of indicators that will be monitored, especially in the coexecuting states, even if a positive impact is expected in other related indicators. The indicators to be monitored are: (a) those associated with infant mortality, targeting mainly the eradication of measles, neonatal tetanus, and diphtheria, specifically: (i) maintaining polio vaccination coverage at 90%; (ii) raising measles vaccination coverage to 90%; (iii) raising full triple vaccination coverage to 80%; (iv) raising well-child checkup coverage to 20%; (v) raising oral rehydration

salt therapy for diarrhea treatment to 75%; and (vi) raising attended birth coverage (at a health care service) to 10%; (b) those associated with better rates of maternal mortality, especially by: (i) raising prenatal care levels by 15% and (ii) raising attended birth coverage (at a health care service) by 10%; and (c) better public health habits vis-à-vis such problems as diarrhea, malnutrition, high blood pressure, accidents, vaccinations, prenatal care, and breastfeeding; in some of the aforementioned cases, the indicator could be measured by an average increase of 10% in the national level for doctor's visits. These indicators and targets may be updated or expanded during monitoring at the time of the annual meetings of they may be replaced with other, more effective indicators, if the information system studies so warrant.

4.28 Improvements in the quality of health in each state will be secured through the targets, objectives, and actions outlined in the state health plans. Each of these plans includes: a health care action plan, a manpower training plan, institutional reform and strengthening, and an investment plan. In all cases, these four components were prepared on the basis of an analysis of demand, overall supply available to cover unmet demand, and alternatives for determining the least-cost solution in each case. Included as well is an analysis of the current and projected production costs of the state health care system, taking into account the impact of the proposed reforms.

2. More efficient service delivery

4.29 A further benefit of the program will be the savings generated by greater efficiency in: (i) service delivery, as shown by a comparison of the with- and without-program scenarios in selected states; and (ii) lower costs, as a result of the restructuring of the MSAS. The savings produced by more efficient service delivery, as measured by the savings in total costs under the with-program scenario, have been estimated at around 10% compared to the without-program scenario.

4.30 The social benefit of the proposal to restructure the MSAS lies in the expected savings (cost of the new structure compared to the cost of the current one) that the community will enjoy as a whole as a result of the MSAS's lower administrative overhead in performing its regulatory and policy-setting functions. The lower costs would allow net savings of 7.4%, approximately. In fact, this is a very conservative estimate since it only considers savings in terms of wages and does not include other factors such as office space and operating costs.

3. Impact on low-income groups

4.31 Some 44.4% of the population (7,952,000 people) lives below the Bank's low-income threshold. An estimated 52% of the people in

that group use public-sector health services. Since roughly 55% of the country's low-income population would benefit from this program, it fulfills the second criterion of the Eighth Replenishment concerning poverty alleviation, which states that the percentage of a program's target population that qualifies as low-income must be greater than the percentage of low-income groups in the national population.

4.32 Even so, this methodology underestimates the program's full impact, in that it does not take into account budget reallocations at the national and regional levels to target programs that have a major impact on low-income groups; factoring this in would push the low-income percentage up even higher. This element will be monitored throughout program execution in order to measure the improvement in coverage upon completion of the program.

C. Impact on women

4.33 Women's health is a crucial element in this program, which sets very clear guidelines for assigning priority to resources for maternal care, especially low-income mothers. The scheduled strengthening of the epidemiological surveillance system at the state level, together with the state and national planning activities, will make it possible to monitor women's health status on a continuous basis and plan actions in a timely fashion (e.g., family planning, prenatal care, attended deliveries, postnatal care, detection and control of cervical, uterine, and breast cancer, etc.). Worth highlighting is the fact that the PEPIS's design – which allows for rapid and flexible responses to epidemiological profiles that are not only different from one state to the next but also changing over time – contains an important critical mass targeted to women's health issues and elements linked to women's role as the principal health agent in the home.

D. Program risks

4.34 The program's main risk is associated with the planned institutional reforms, particularly in the MSAS, with the transfer of services to the states. This risk stems from current institutional weaknesses, at the central and regional levels, that limit their ability to take on the new functions. In order to minimize the risk, the program stresses institutional considerations, including technical assistance, training, and outfitting of the MSAS and the participating states.

4.35 Furthermore, a structural reform of the depth of the one proposed here requires an appropriate level of consensus among the various social actors involved. Resistance to change could cause delays in the implementation of some reforms. With this in mind, the authorities have sought to achieve consensus on the reform through an ongoing process of consultation that has included the National Health Council, which advises the President on the broad policy

lines of the sector. Also, a steering committee is being empaneled, to be made up of senior managers and professionals, and consultations are being held with the rest of the private and public sector. This generalized consensus – especially in the states that have signed decentralization agreements – among the population and many political, management, and business leaders with regard to the need for far-reaching changes in the health sector constitutes an important stimulus for carrying out these reforms.

4.36 Similarly, the current fiscal crisis may affect the timely availability of local funding, and this could delay program execution. The analysis of the financial projections indicates, however, that there would be adequate capacity for financing the sector reform as proposed in the program.

BACKGROUND ON THE MINISTRY OF HEALTH AND THE HEALTH SECTOR

I. STRUCTURE OF THE MINISTRY OF HEALTH

1.1 The Ministry of Health (MSAS) has an oversized central organization, as was described in part in the body of the loan proposal. Its full structure is described below:

Venezuela's Ministry of Health		
13 sector divisions	14 institutes	5 independent specialized institutes:
66 line departments	7 national centers	National Hygiene Institute (INM)
36 special offices	4 commissions	National Gerontology Institute (INAGER)
27 programs	4 foundations	National Nutrition Institute (INN)
9 subregional units	1 school	Caracas University Hospital (HUC)
23 health bureaus		Venezuelan Scientific Research Institute (IVIC)
130 health districts		Foundation for Infrastructure Maintenance (FIMA)
		Expanded Maternal and Child Care Program (PAMI)

1.2 The five independent institutes that the MSAS oversees have the following functions:

INSTITUTE	FUNCTIONS
National Health Institute	Participate in epidemiological surveillance and studies of infectious, contagious, and toxic diseases, by processing samples in its capacity as national reference laboratory. Quality control of products for human use, and vaccine production.
National Geriatrics and Gerontology Institute	Comprehensive policy on care for the elderly. Operation and subsidy of social support programs.
Caracas University Hospital	Located at the Central University's Faculty of Medicine, the hospital provides professional and specialized training in 36 areas.
National Nutrition Institute	Implements policies aimed at protecting low-income families through various nutrition programs.
Venezuelan Scientific Research Institute	Scientific and technological biomedical research and training programs.

II. SUPPLY AND DEMAND FOR SERVICES

2.1 The extensive public and private (coverage of 10% to 15%) service network has been expanding without the benefit of planning, with the result that there are high levels of duplication and inefficiency (see table below):

Public and Private Supply			
Resource	MSAS	IVSS	Private
Hospitals	175	31	311
Beds	26,000	5,750	11,000
Outpatient services	3,700	76	(not available)

2.2 Public-sector health services are organized by level of care, as outlined below. 1/ Theoretically, the first care level (class I and II rural and class I urban outpatient services) should be able to treat up to 85% of morbidity presented, with 10% being referred to the second level (class II and III urban outpatient services) and 5% to the third level (hospitals).

1. First level

2.3 Rural outpatient clinics provide comprehensive general and family medical care at the primary level (except for hospitalization) in towns of up to 10,000 inhabitants. Clinics are divided into two categories: class I facilities are located in areas with scattered populations and are staffed with a "simplified medicine" health auxiliary, who works under medical and nursing supervision, and a physician who makes weekly visits; class II facilities are located in areas with scattered or concentrated populations and are staffed by general practitioners. These facilities may have beds for patient observation and dental services. This category also includes class I urban outpatient facilities, which are distinguished from class II rural facilities in that they do not have beds and their services may include psychosocial care.

2. Second level

2.4 Urban outpatient clinics do not provide hospitalization. In addition to the class I facilities described above, there are two other categories. Class II facilities have greater response capacity in that they are staffed by a general practitioner, who can also perform educational functions, and they may have basic facilities for full-time obstetric, pediatric, laboratory, radiology, and emergency care, in addition to the standard services offered by class I facilities. Class III urban outpatient facilities represent the next higher level of complexity and provide comprehensive medical care at the primary and/or secondary levels; they are staffed by a physician with some clinical training, and are designed to provide general medical care, internal medicine, general surgery, gynecology-obstetrics, pediatrics, dermatology, venereology, cardiology, and emergency care.

1/ According to the Guidelines for the Classification of Public-Sector Health Care Establishments, issued by the Executive Branch on January 21, 1983 and published in issue 32,650 of the Official Gazette.

3. Third level

2.5 Hospitals provide comprehensive care at the primary, secondary, and tertiary levels, depending on their category. They are divided into four categories. Class I hospitals provide care to hospitalized patients, in addition to primary and secondary ambulatory, medical, and dental care, and serve as reference centers for outpatient facilities. Class I hospitals have a laboratory, X-ray equipment, pharmacy, anesthesia facilities, hemotherapy, and emergency equipment. Class II hospitals are those that can provide undergraduate and graduate-level training, as well as paramedic training, and research. In addition to basic clinical services, they offer services in cardiology, psychiatry, dermatology, venereology, pneumology, traumatology, otorhinolaryngology, and ophthalmology as well as nursing, social work, dietetics, and physical therapy. Class III hospitals offer medical care at the three clinical levels and are organized into departments and services: medicine (nephrology, rheumatology, neurology, gastroenterology, physical medicine, and rehabilitation), surgery (urology, otorhinolaryngology, ophthalmology, and traumatology), gynecology-obstetrics, and pediatrics. They have a core staff of nutritionists and registered nurses and perform teaching functions at the undergraduate level (medicine) as well as providing technical training. They serve as sites for graduate residencies in the basic specializations and carry out research functions. Class IV hospitals have the highest level of sophistication and, accordingly, their catchment area is much larger. These hospitals may have units for long-term care and resident wards.

2.6 The smaller hospitals (classes I and II) are underutilized, while the capacity of the more complex, larger ones is used inappropriately. The level of met demand for hospitalization in the public sector was on the order of 31.8 patient-days and 5.7 discharges per 100 population, which is equivalent to one hospitalization for every 17 doctor's visits and an average hospital stay of 5.6 days – even though available data indicate reasonable levels of utilization of doctor's office capacity. This notwithstanding, Venezuela presents one of the highest person-to-bed ratios in Latin America.

2.7 Data from the MSAS's outpatient services show that most activity is in the area of curative treatment, to the detriment of preventive care: 0.4 preventive visits were made for every curative visit; 0.2 dental visits were registered per person per year. In addition, 3.3 million "simplified medicine" visits were made at class I rural facilities, which – for an assigned notional population of 1,000 to be treated at this level – would represent 1.3 visits per person per year (which is somewhat high when compared with other countries).

2.8 There are some important discrepancies in the structure of public hospital facilities. For instance, there are only three class II hospitals for every two class III hospitals, with a similar proportion recorded for class III versus class IV facilities. In other words, the more complex hospitals are not being fully tapped as reference centers, and this means that their specialized resources are not being used efficiently.

III. HUMAN RESOURCES

3.1 The distribution of health manpower is marked by considerable variations in geographic terms (see following table), with a high concentration in and around Caracas and the central region. Similarly, there are broad gaps in distribution by profession (e.g., two nurses for every three physicians, a situation that is not offset by the presence of nurses's aides).

Variation in availability of health manpower by state (per 1,000 inhabitants)

Category	Minimum	Maximum
Physicians	0.7	2.2
Nurses	0.1	1.7
Nurse's aides	0.6	4.4
Dentists	0.1	1.1

3.2 Despite collective bargaining agreements that are renegotiated annually with the major unions in the sector, working conditions continue to be poor, with serious problems in pay levels (US$140 to US$250 per professional-month of labor cost), professional mobility, motivation and physical working conditions, reflected in high levels of absenteeism, moonlighting, and low quality and productivity of services.

3.3 The MSAS has a bloated payroll of permanent staff totaling some 107,000 employees April 1993), of whom 55,000 (51%) are blue collar workers and 5,200 work at the MSAS's central offices. This huge work force came about through payroll expansion over the last decade, but – lacking the corresponding increase in services – the result has been lower productivity. These figures include some 3,500 *reposeros* (people on long-term medical leave for over one

year) and a large group of nonpermanent skilled workers (*suplentes de reposeros* and *suplentes sin dependencia*) who are concentrated mainly in the blue collar staff. The MSAS's annual payroll expenses are roughly US$420 million, representing 73% of its net budget.

BREAKDOWN OF DIRECT COSTS	
(in US$ millions) Total	236.3
1. Upgrading the policy design and execution capacity and restructuring of the MSAS	81.5
1.1 Rightsizing and retraining of MSAS staff	50.0
1.2 Prevention and promotion program	13.6
1.3 Training and computer equipment at MSAS main offices	3.5
1.4 Modernization of MSAS main offices	3.4
1.5 Activities and studies for streamlining agencies overseen by the MSAS	9.6
1.6 Activities and studies on health manpower training, sector financing, and the legal framework for health-related issues	1.4
2. Service decentralization	154.8
2.1 Support for preparation of state health plans, systems organization, and job retraining	7.9
2.2 Management strengthening in outlying areas	2.4
2.3 Organization of state health systems	5.3
2.4 Technical assistance and specific training	7.6
2.5 General training courses	1.2
2.6 Equipment and software for seven states	5.1
2.7 Physical rehabilitation and outfitting of state health facilities	120.1
2.8 Other institutional strengthening	5.2

STATE HEALTH PLANS

I. BACKGROUND AND GENERAL APPROACH

1.1 The introduction of state health plans represents a major milestone on the path toward the decentralization of services, since they will help to organize and promote the efficient use of state resources for the sector, with a view to optimizing equity, effectiveness, quality, and efficiency in the improvement of public health levels. They make it possible to channel resources toward high-priority problems that have been identified through fine-tuned diagnostic processes which produce a continuous flow of rational solutions to the demographic, socioeconomic, epidemiological, institutional, and financial problems identified.

1.2 Accordingly, the planning processes that are formalized around these plans at the institutional level become strategic tools of the decentralization process, by virtue of their specific proposals for: (i) policies and budgets that provide a solid basis for state health systems (decentralization) and their administrative and technical organization; (ii) institutional strengthening to ensure the technical and management capacity and accountability of the state system and its human resources vis-à-vis the population and the Executive Branch; and (iii) high-priority physical investments that contribute to making the service network more efficient by optimizing available supply.

1.3 With this in mind, and in keeping with the diagnostic and decision-making processes proposed, the state health plans will have three key components:

a. a decentralized organization plan, 1/
b. an institutional strengthening plan, and
c. an investment plan.

1.4 These organizational tools, which reflect a decentralized program-based management approach, are based on: (i) policies and agreements (reached by the federal government and the state governments)

1/ The decentralized organization plan reflects the organization proposal presented by each state in its Health Services Transfer Project, which is to be submitted to the National Senate for approval. In the context of the state plan, this organization proposal could be evaluated and further developed in order to establish the actions necessary for its implementation.

that set each state's health goals, assign areas of responsibility, and set performance targets; (ii) specific programs geared toward special risk groups; (iii) rational criteria for allocating resources to programs and states; (iv) the individual stages foreseen for the decentralization process; and (v) flexible and responsive evaluation processes. The use of such tools is fully in line with the strategic and operating functions assumed by the state governments under the decentralization process and specific agreements (see Appendix III-2-A) for the planning, organization, administration, operation, and evaluation of health services and programs according to national policies and standards.

1.5 This new operating format for national, state, and local government agencies requires that the state executive branches take a more proactive role in: (i) identifying priorities and goals that pursue health policy and respond to the state's health situation; (ii) mobilizing and allocating resources toward achieving these goals; (iii) coordinating the action of the public and private health providers that operate in the state as well as other sectors that have an impact on health, bearing in mind the key role played by municipalities; (iv) effectively and efficiently administering available human, physical, and financial resources; (v) building, outfitting, and maintaining health sector infrastructure; and (vi) promoting community involvement in managing the public health services network. This activity will translate into the formulation of the yearly operating plans.

1.6 The expected impact of this process over a multiyear horizon would be: (i) a service structure whose accessibility, availability, and quality are able to meet the community's needs; (ii) effective and efficient organization of service delivery; (iii) appropriate financing levels for the health system's new goals and structure; and (iv) formalized planning processes in participating states.

II. GUIDELINES FOR PRESENTATION OF THE STATE HEALTH PLANS

2.1 In support of the states' planning processes, the Program Coordinating Unit (PCU) has drawn up a set of methodological planning guidelines to be used by participating states for: (i) preparation of a health situation and sector analysis in each participating state; (ii) strategic analysis; (iii) definition of strategies, objectives, and goals; and (iv) formulation of plans and programs for service organization and delivery, institutional strengthening, and investments.

2.2 The purpose of these guidelines is to provide general orientation, not to dictate rules. Although they follow generally accepted planning methodologies, they have not been submitted to the

competent MSAS departments for review. They are intended to serve as a technical reference for state planning processes which, in turn, provide the framework for health project planning in the states.

A. State health and sector situation analysis

2.3 Generally speaking, this analytical exercise will focus on studying strengths, weaknesses, opportunities, and risks in the areas of: (i) the sector's sphere of action, based on national policies and guidelines and the mission of services and facilities operated by the state executive branch; (ii) the physical setting; (iii) socio-economic aspects; (iv) the demographic, epidemiological, social, and cultural features of the state; (v) the health services network, including the demand for and supply of services, reference and cross-reference systems and their flows, and the capacity and status of the network of public and private providers and facilities; (vi) institutional aspects of the various public and private state agencies (e.g., state government, regional health offices, city hall, district management, clinics, private hospitals), including the availability and management of human, financial, and physical resources in the state's health sector; community involvement in health sector activities and their management; and (vii) financial considerations, geared toward gaining full familiarity with sector funding and its sources (e.g., central government, state and municipal taxes, IVSS, etc.).

B. Strategic analysis and assignment of priorities

2.4 The diagnostic input on the sector is consolidated in a process of strategic analysis and synthesis aimed basically at assigning priority to problems, possible solutions, and coverage in terms of geographical scope (e.g., districts), technical level (e.g., promotion, prevention), and institutional level of application, based on criteria that are consistent with national and state policies in the social area and the sector (e.g., equity and marginality, rationality and efficiency, preventive versus curative care, outpatient care versus hospitalization).

2.5 Thus, the state plans will assign the public funding available to the states (regardless of origin) to finance state services in accordance with the following strategic priorities: (i) expand service coverage and ensure primary health care for the state's low-income population; (ii) guarantee operation of key clinical services in the state; and (iii) optimize operation of hospital services, by making more efficient use of existing capacity and reducing care costs to levels that are consistent with an efficient state service structure. As a minimum, they are to cover the public-sector health services existing in the state, including those of the IVSS, provided the IVSS and the state government have

an agreement on the transfer or coordination of these services, under the direction of the state government.

C. Definition and fine-tuning of strategies, objectives, and goals

2.6 The translation of these priorities into specific strategies, objectives, and goals – and their periodic updating – as guiding, operative, and evaluative elements is expected to bring about specific, quantifiable improvements in: (i) the health levels of target population groups in the state; (ii) coverage and scope of public- and private-sector production in meeting demand in terms of precise parameters for equity, efficiency, and effectiveness; and (iii) emphasis, negotiation, and allocation of resources for the future.

D. Formulation and fine-tuning of plans and programs

2.7 These objectives are embodied in specific plans and programs that define the scope, content, terms, costs, and funding sources for the activity of the state executive branch in the sector. These plans and programs will specify priority aspects of service organization, delivery, and management and the priority requirements for institutional strengthening and investments.

2.8 Each state's organization plan for the administration and delivery of health services will be based on proposals for management and operating capacity and structure, i.e., regional health offices, districts, primary and secondary services and facilities, and vertical services (e.g., environmental sanitation, vector control, etc.). The plan should show how the new organization of the state health system will contribute to improving health service effectiveness and efficiency; and it should outline the strategy for the transition between the current and the target structure. The proposal should be consistent with applicable regulations and the conditions for its approval by the Legislative Assembly.

2.9 The state institutional strengthening (or development) plan should allow for technical inputs and studies to design and implement key management and operating systems, including the necessary technical and management training for staff at the various levels of the state system, in addition to any preinvestment studies that might be necessary.

2.10 Lastly, the state infrastructure and equipment investment plan should address the problems identified in the situation analysis and observe the policies and guidelines of the state plan, based on efficiency-ensuring criteria that will tap existing installed capacity in terms of met and unmet demand, and the requirements of the care model.

2.11 For purposes of the program to strengthen and modernize the health sector, investment schedules should be drawn up for each state, based on the profiles of projects that are to be financed under the respective state health plans (which are to be prepared in advance). These investment plans are to contain actions for institutional strengthening and development as well as investments in infrastructure rehabilitation and outfitting, and should be formulated in keeping with the general guidelines provided for such purpose by the PCU. The investments plans will be implemented through the annual action plans during each year of project execution. Actions so defined should be included in the states' yearly operating plans.

2.12 Accordingly, criteria have been drawn up governing eligibility, assignment of priority, and evaluation of infrastructure and outfitting activities under state investment projects. These criteria will be applied to an identified universe of projects for repair, rehabilitation, expansion, replacement, construction, and outfitting of outpatient facilities and hospitals in each participating state. Modern spatial and medical-functional programming methods will also be used to ensure efficient physical microplanning.

2.13 The eligibility criteria include: (i) the facility must be part of the MSAS network that is to be transferred to the state; (ii) funding must be available to cover the recurrent costs (operation and maintenance) associated with the projects during program execution; (iii) the budget reserves needed in order to cover the local counterpart for the period must be available; and (iv) improvements must focus on areas that will have an impact on the health and safety of patients and staff, with emphasis on facility operations and basic outfitting of services. When high-complexity equipment is involved, there must be due justification based on an analysis of supply and demand. Projects that expand the current supply of services will not be considered eligible. Also, financing may not be used for materials or supplies, since these are part of the operating costs and are to be covered at the regional level.

2.14 In order to receive funding under the program, states must have formulated their investment plans (under the respective state health plans) and submitted them for evaluation and approval by the PCU, in accordance with the established criteria.

2.15 These actions will be implemented through multiyear action plans (short, medium, and long terms) having realistic deadlines and supported by annual operating plans.

III. STATE PLANS

3.1 The states have progressed at different rates in the preparation of their state plans and, accordingly, of their respective investment plans, completion of which – according to the guidelines – is a prerequisite for disbursement and physical startup of work in each state. The coexecuting states are working to complete their plans in keeping with the established guidelines and with assistance from the PCU. The preparation and execution cycle of the state plans goes through a two-step process during which states are primed for the next stage of decentralization. During the first phase, state governments are given access to preinvestment financing for the preparation of their state health plans; the second phase prepares them to gain access to funding for institutional strengthening and modernization of their systems and infrastructure, as scheduled for the execution of the various components of their state health plans.

3.2 In order to gain access to second-phase resources, a state's health plan must be approved by the MSAS through the PCU. For this, it must contain the elements described above (e.g., health program, proposal for organization, financing, operation and maintenance of services in the state, organization of state offices responsible for program oversight and monitoring) and meet the criteria spelled out in the guidelines for the presentation of proposals for state health plans as agreed upon with the Bank (e.g., general eligibility, as well as technical, economic, financial, institutional, and environmental criteria).

3.3 The most advanced state plan is Carabobo's, which complies with the main policy elements, and is pending review of the initial assignment of priority to its investment plan. The other three states are at different stages in compiling the basic elements of their plans and components (organization, institutional strengthening, investment) and work is still under way to complete those plans, in keeping with the guidelines set and the instructions received from the PCU.

HEALTH-SECTOR RESPONSIBILITIES OF THE STATES	
Area	**Responsibility**
I. Policy-setting	Formulation of state plans and programs
II. Technical and policy supervision	Supervision, monitoring, and inspection of: a. Preparation, distribution, and sale of foodstuffs b. Startup, operation, and transfer of pharmaceutical establishments c. Application of legal and administrative measures in cases of infraction of national legislation governing health, pharmaceuticals, psychotropic substances, production of cosmetics, natural products, drugs, foodstuffs d. Environmental sanitation activities
III. Health service network	e. Establishment of mechanisms for modernization of health services management, promoting independent administration of health care centers and development of local health systems (SILOS) f. Registration, inspection, and surveillance of health care centers g. Care administered prior to and after hospitalization h. Administration and control of network child care centers i. Construction and maintenance of infrastructure, facilities, and equipment at state health system units j. Procurement, administration, and allocation of equipment and supplies for services under its management k. Mobilization and allocation of funds for operation of health services
IV. Human resources	l. Comprehensive human resources management within the state health system m. Implementation of staff training and policies, in accordance with regional requirements
V. Community involvement	n. Grassroots promotion, with emphasis on health education and community involvement at all levels and stages o. Creation of formats and spaces for community involvement

MSAS-IDB PROGRAM
SUMMARY OF STATE HEALTH PLAN COMPONENTS AND MAJOR ACCOMPLISHMENTS

Component	Status of progress in Carabobo State
Demographic and socioeconomic analysis	1.7 million persons in 10 municipalities (area of 4,650 square kilometers) Industrial park 94% literacy rate 3.5% growth rate of young population EVN: 73 F 68 M Poverty increased to over 60% of population (4 of the 10 municipalities) reflected in malnutrition levels
Health situation analysis	4.2 mortality rate Infant mortality of 22 per 1,000 live births Role of degenerative diseases (cancer, heart, high blood pressure, diabetes), accidents, infectious diseases (diarrheal, respiratory, endemic parasitic diseases), and perinatal diseases Maternal mortality of 6 per 10,000 live births Teen pregnancy rate of 18%
Health sector situation analysis	850 facilities located in 5 health districts (42 hospitals with 3,400 beds, 811 outpatient facilities and clinics) (MSAS/IVSS/state: 11 hospitals, with 2,500 beds, 111 outpatient services) Excess demand for emergency services (70%) Low demand for preventive care Strong curative bias in supply of and demand for primary care at private urban facilities 75% of births attended High-complexity hospitals are overcrowded, while simpler ones are underutilized Efficient, new "immediate care" (ambulance) service Real budget cutbacks, curative bias at expense of prevention and promotion Deterioration of infrastructure (50%) and lack of investment
Strategic analysis and assignment of priorities	Internal strengths of the sector: experience gained through the immediate care program, existing service network; decentralization; improvements in health indicators between 1990 and 1993 Health sector planning process Positive external contributing factors: upgraded social framework; reorganized MSAS; devolution of responsibilities to municipalities; community involvement and political reform; geographic and economic distribution in the state; economic and educational infrastructure Obstacles: Constraints on health system owing to population growth, low-income groups; deterioration of information and control systems; lack of motivation; low morale and discipline; deterioration of health indicators and resurgence of endemic diseases that were once under control; limited budget funds, inflation, and fraud; resistance to change; fiscal deficit; no spirit of coordination, cultural distancing between health system and community served, distorted incentive system, which rewards bad habits and penalizes good examples.

MSAS-IDB PROGRAM
SUMMARY OF STATE HEALTH PLAN COMPONENTS AND MAJOR ACCOMPLISHMENTS

Component	Status of progress in Carabobo State
Definition of strategies, objectives, and goals	Political priority of the health sector. Policies and plans to assign priority to health through actions geared toward specific determinants, and health rights and responsibilities of the community and the state. Target image: Make the healthy healthier! Mission: provide means, issue guidelines, implement programs, and monitor results, favoring health determinants and access thereto through health education, environmental sanitation, promotion, protection, and rehabilitation. Emphasis on operation and modernization of the system, quality, and productivity Primary health care and vulnerable groups (mothers and children) Formalize community involvement at the institutional level General objectives: longer life expectancy, lower birth and mortality rates, no unwanted teen pregnancies, fewer traffic accidents, lower impact on productive capacity, lower demand for emergency services and hospitalization, greater supply of preventive and promotion services.
Goals	a. Increase life expectancy by three years b. Reduce infant mortality by at least one third c. Expand coverage of the Expanded Immunization Program to 95% of the eligible population d. Increase productivity of resources, service quality, and acceptance by users. Progressive transfer of responsibilities to the municipalities Strategies: Strengthen management capacity and structure, preventive and curative capacity, promotion of healthy lifestyles, improvement and preservation of environment
Formulation of plans and programs	Four strategic programs for planned management structure, with detailed financial projections
Organization plan	Decentralization, re-engineering, and operational excellence of the health service (DEREX): Projects for modernization, financial support, and re-engineering of operating systems. Beta project: streamline and reorganize the Central Hospital in Valencia and the outpatient service network in its primary catchment area; incorporate new formats for financing, administration, and operation (e.g., the Valencia Hospital Foundation)
Institutional development plan	DEREX: Projects for modernization, improvement, promotion of operating systems, human resources development, changes in health programs, and adoption of relevant local health system (SILOS) methodologies Promotion and Education for Health (PROESA): long-term effort to have an impact on health culture and lifestyles through marketing (social), bringing in other institutions and grassroots organizations. Two phases, covering a total of 11 years at a cost of US$66 million
Investment plan	Infrastructure, Physical Outfitting, and Expansion of the Network (DINEFAR) Top priority assigned to physical refurbishing of existing primary centers, complemented by new ones as justified, at 76 high-priority establishments, at an estimated cost of US$93 million (see attached table) Environmental Sanitation and Preservation of Ecological Balance (SAMEC) Actions to upgrade the environment by reducing the impact of pollutants at a cost of US$8.4 million between 1994 and 1998, and US$58 million in 1999-2005.

GOALS OF THE CARABOBO STATE HEALTH PLAN

Goals	1996	1998	2005
coverage of the Immunization	From 60% to 80%	95%	Maintain current leve
overage of family services		From 8% to 15% (among women of childbearing age)	
care	80% of pregnant mothers		
ncidence of dental		From 90% to 50%	To 10%
tation of strategic	Develop and implement strategic programs described below. Complete process of devolution of responsibility for health services to municipalities.	Conclude infrastructure and equipment program	Conclude implementati overall
quality and vity of resources	Reduce idle human-resource capacity by 60% Reduce faulty equipment and facilities by 60%	90% productivity of human and physical resources	Attain levels compara reference countries
acceptance of ervices	5% over current level (from 75% to 80%)	90%	
lization program	Reach 100%	Consolidate re-engineering of operating systems and devolution of responsibility to municipalities	

PROCUREMENT PLAN

MAJOR PROCUREMENT ITEMS	Financing (US$000)		METHOD	PREQUAL.	PUBLICATION OF NOTICE
	IDB	LOCAL			
Consultancies Development of management systems for the MSAS	2,400		international bidding	YES	03/96
Development of management systems for the states	7,500		international bidding	YES	09/96
Model study for sector financing	450		international bidding	YES	11/95
Design of promotion campaign for PEPIS program	1,000		international bidding		03/96
Execution of promotion campaign for PEPIS program		8,000	local bidding		03/97
Study on reorganization of MSAS and dependent agencies		1,650	local bidding		09/95
Management training		4,450	local bidding		03/96
Study on reorganization of state health systems		5,300	local bidding		06/96
Subtotal	11,350	19,400			
Investment projects 4 calls for bids for 4 hospitals		3,200 4,200 4,000 3,900 4,600 6,900 8,100 3,400	local bidding	NO NO 	06/98 06/98 04/99 04/99 03/96 06/97 06/98 06/99
Subtotal		38,300			
Equipment Computers	 2,500 3,900		 ICB*	 NO	 03/97 03/98
Computers	300		restricted bidding	NO	02/96
Hospital equipment	6,710 19,000 13,750		ICB* ICB ICB	YES YES YES	06/97 06/98 06/99
		5,500 6,500 6,500 2,500	LCB** LCB LCB restricted bidding	YES YES YES NO	03/97 03/98 03/99 03/96
Subtotal	39,010	21,000			
Total	57,060	78,700			

* International competitive bidding
** Local competitive bidding

PROGRESS MONITORING					
nt	Year 1	Year 2	Year 3	Year 4	Year 5
ruc- an	Implementation of transitional organizational and functional structure Performance of technical studies on design of new MSAS structure Approval of new MSAS structure Startup of implementation of new structure	Satisfactory progress in implementation of new structure	Satisfactory progress in implementation of new structure	Completion of implementation of new structure	
g plan	Hiring of consultants Hiring of agency or trustee to administer the job retraining program Startup of job retraining program	Implementation of job retraining program, with evidence of number and type of staff retrained according to the job retraining plan	Evidence of progress in the retraining program, indicating number and type of staff retrained under the retraining plan	Completion of the job retraining plan	
r more use ces at	Hiring of consultants Implementation of the staff rightsizing plan at the central level, with evidence of reduction in staff through mandatory retirements, disability terminations, and the retraining program	Evidence of reduction in staff under the rightsizing plan	Evidence of reduction in staff under the rightsizing plan	Completion of the rightsizing plan	
ening rniza- the	Hiring of consultants and startup of technical assistance to support restructuring Approval of criteria for annual evaluation of the subcomponent	Hiring of consultants and startup of activities associated with training and institutional development Satisfactory progress in the evaluation criteria	Award of equipment procurement contracts Satisfactory progress in evaluation criteria Completion of staff training in epidemiological, management, and technical information systems	Satisfactory progress in annual evaluation criteria	Completion of t and institution strengthening p

PROGRESS MONITORING					
nt	Year 1	Year 2	Year 3	Year 4	Year 5
zation rn- of by the IC, , FIMA, H, EC)	Contracting of studies on various reorganization options	Presentation of plan for various reorganization options	Presentation of a legislative package recommending restructuring, reassignment, and/or termination of dependent agencies Satisfactory progress in the reorganization of dependent agencies	Satisfactory progress in the reorganization of dependent agencies	Satisfactory pro the reorganizati dependent agenci
olicies					
motion pre- tion gram	Review and final drafting of the program Presentation of the plan for startup of campaigns	Completion of three national PEPIS campaigns	Completion of six national PEPIS campaigns	Completion of additional PEPIS campaigns	Presentation of of activities co and results obta based on: - behavior chang vis-à-vis diseas targeted under t program - expanded cover preventive care services
icies human ources inis- tion ining	Hiring of consultants to do the necessary studies	Completion of the studies, which should include: (i) quantitative needs; (ii) occupational profiles; (iii) curriculum adjustments; and (iv) necessary adjustments in working conditions Dissemination of results at the central and state levels Consultations with unions, universities, legislators, and grassroots organizations	Process of consensus-building and consultation for devising policies	Presentation of final policy guidelines drawn up with participation of main agents Startup of implementation of programs, projects, and agreements	Implementation operating plan short-term actio human resource administration training policie Presentation of of the signature agreements with agencies involve

PROGRESS INDICATORS					
nt	Year 1	Year 2	Year 3	Year 4	Year 5
or ncing	Hiring of consultants to do studies Presentation of findings of financing study, by source, at the national and state levels	Startup of other studies	Process of consensus-building and consultation for definition of financing policy	Progress in implementation of financing model based on indicators agreed on	Full implementat the financing mo
1 ework		Presentation of the action plan and implementation schedule for review of the Health Act Establishment of the MSAS-Congressional committees	Presentation of the draft legislation to Congress	Evidence of steps taken by the MSAS to facilitate implementation, in the event of approval	
ntral- ion of th ices	Approval of state health plans of two states Administrative transfer of staff and startup of training plan in those two states	Approval of state health plans in two additional states Administrative transfer of staff and startup of training plan in two additional states Presentation of the design of the performance control system	Approval of state health plans in the three remaining states Administrative transfer of staff and startup of training plan in the three remaining states Presentation of evidence of the implementation in two states of the performance control system	Presentation of evidence of the implementation in the remaining states of the performance control system	

DECENTRALIZATION OF HEALTH SERVICES AND SEVERANCE PAYMENTS

I. SEVERANCE PAYMENTS

1.1 Severance payments, are tax exempt, and are paid upon voluntary termination of employment and -with double value in case of- unfair dismissal. Just cause, however, is very narrowly defined and does not include economic or technological reasons.

1.2 Employers are mandated to create reserves equal to the current basic wage times the number of years tenure without limit. Funds increase retroactively with salary increases. Since 1990s, due to Labour Code reform in 1989, accrued severance obligations are subject to an interest rate, where interest earned should be paid out annually. However, the central government and many small to medium firms capitalize interest payment due. The difference between severance liabilities under interest capitalization and annual interest clearance grow exponentially with increasing wages and interest rates. Further, public sector severance liabilities are unfunded.

1.3 The actual system carries out essentially four functions. First, supplementary pensions when severance is used to buy an annuity, given that the formal pension system, IVSS, is inadequate. Second, as a form of unemployment insurance, given the formal system, also managed by IVSS, is ineffective. Third, a source of or collateral for financing housing or improvements. Fourth, as a mechanism of unemployment deterrence. Thus any reform of the severance payment system has to be embedded in a comprehensive reform of the country's social security system.

1.4 The health sector reform, supported by the proposed operation, involves the creation of a mechanism that will not set a limiting precedent for such a global reform, but which eases the decentralization of health services.

1.5 The health sector reform implies a reduction of personnel in MSAS as well as transfer of personnel to the local authorities. The reduction of persons in the ministry, over four years, implies severance payments of approximately US$47 million. The transfer of personnel involves approximately 34 thousand employees, with unfunded liabilities of about US$279 million, to 7 states. The program envisages decentralization to two states in the first year, followed by another two and three states in the following two years. The central government will fund over four years, from the date of decentralization to a given state the severance payment liabilities of transferred personnel. Funding will be 40% of outstanding liabilities in the first year, followed by equal 20% in

the following three years. These resources will be deposited in individual accounts in a state trust fund to be used at the moment of separation.

1.6 The Transfer Agreement reached between the central government and local authorities is that any increase in the stock of severance liabilities, prior to transfer of the employee, resulting from wage increase mandated by the central government will be funded by the central government. If wage increases are authorized by the local authority it has to fund the associated liabilities.

Box 1: Details of Severance System

Based on:	Last months salary (base salary, plus vacation, housing and profit sharing bonuses)
Amount	employees of seniority greater than 6 months entitled to one month plus additional month salary for each year or fraction (greater than six months worked). Not subject to tax.
Employer	Accrued benefits increase retroactively with salary increases. Employers register accrued benefits in company books, payment takes preference over any other claim except mortgage guarantees. Employers must extent loans or guarantee loans up to amount of accrued benefits for housing, paying mortgage, tuition. Tax deductible from business taxes
Interest	Accrued liabilities started bearing interest since 1990. Where interest rate is the average deposit rate of six largest commercial banks. Interest on accrued severance obligations must be paid out annually.

PROPOSED RESOLUTION

VENEZUELA. LOAN /OC-VE TO THE REPUBLIC OF VENEZUELA
(Modernization and Strengthening of Health Sector Program)

The Board of Executive Directors

RESOLVES:

That the President of the Bank, or such representative as he shall designate, is authorized, in the name and on behalf of the Bank, to enter into such contract or contracts as may be necessary with the Republic of Venezuela, as Borrower, for the purpose of granting it a loan to cooperate in the financing of Modernization and Strengthening of Health Sector Program. This financing will be for the sum of up to US$150,000,000 or its equivalent in other currencies, except that of the Republic of Venezuela, which are part of the ordinary capital resources of the Bank, and shall be subject to the "Special Contractual Conditions" and the "Terms and Financial Conditions" set forth in the Executive Summary of the Loan Proposal.