

# HEALTH SECTOR DEVELOPMENT PROGRAM MATERNAL AND CHILD HEALTH CARE COVERAGE

(PE-0146)

## EXECUTIVE SUMMARY

<b>Borrower and guarantor:</b>	Government of Peru	
<b>Executing agency:</b>	Ministry of Health (MINSA)	
<b>Amount and source:</b>	<u>Phase One:</u>	
	IDB: (OC)	US\$ 87 million
	Local:	<u>US\$ 38 million</u>
	Total:	US\$125 million
	<u>Phase Two:</u>	
	IDB: (OC)	US\$50 million
<b>Financial terms and conditions:</b>	Local:	<u>US\$22 million</u>
	Total:	US\$72 million
	Amortization period:	25 years
	Disbursement period:	3 years
	Interest rate:	variable
	Inspection and supervision:	1%
<b>Objectives:</b>	Credit fee:	0.75%
	Currency:	U.S. dollars, under the Single Currency Facility
	<p>The general objective of the program is to support the gradual modernization and reform of the health care system in Peru, in order to improve the state of health of the population through expanded access to effective, efficient, and quality health care services. The program is oriented toward solving the population's main health problems: maternal and child morbidity and mortality.</p> <p>The specific objectives are:</p> <ol style="list-style-type: none"> <li>a. To lower maternal and child morbidity and mortality rates by eliminating economic, physical, and cultural obstacles that keep impoverished and vulnerable populations from using maternal and child health services.</li> </ol>	

- b. To reinforce public health efforts, mainly in the area of communicable disease and environmental health, as well as epidemiological surveillance.
- c. To support the development, initiation, and pursuit of sector policies that make it possible to target public spending to vulnerable groups and cost-effective interventions.
- d. To develop new models of organization, management, financing, and service delivery oriented toward increasing the productivity and efficiency of sector resources.
- e. To help MINSA to strengthen its leadership capabilities and guidance of the sector.

**Description:**

Health care reform is understood as a broad-based process that will be supported by the IDB, the World Bank, and other agencies. To foster this long-term process (which will require systematic and sustained support), the IDB will use the multiple-phase loan modality. Although the reform program has well-defined, long-term objectives, two kinds of actions will be undertaken in order to achieve them: specific, short-term actions whose implementation will be used to confirm policies, and design activities for long-term structural changes. The program proposed in this document will support phase one of the reform, which consists of launching a program of maternal and child health care coverage (SMI) to eliminate the economic and sociocultural barriers that impoverished populations encounter, and developing proposals and validating new institutional policies and structures. Once 75 percent of the loan's resources have been disbursed, and the targets agreed upon as triggers have been met (see Annex I-1), a second loan in the amount of US\$50 million will be processed. This second phase will focus on introducing and consolidating the new policies, and extending new forms of organization, financing, management, and service delivery. In order to maintain the integral character of the reform efforts, the program was prepared as a whole, and the banks' financing was divided among the departments of the country.

The three-year program to be supported by the loan proposed here aims at addressing needs that cannot be postponed with respect to fighting maternal and child morbidity and mortality, through the design and introduction of medium- and long-term strategies for modernizing and reforming the health sector. The program's strategy is based on using the improvement in maternal and child services as the driving force in the process of modernizing this sector. In this respect, most of the program's resources will support activities aimed at improving access to and the quality of basic services, by financing

the SMI and extending related care services. Nonetheless, in order for the effects of this improvement in basic health care to become lasting and effective, advances must be made in the process of modernizing the sector, by developing new financing policies, and through institutional and organizational change.

In accordance with this strategy, the program comprises three components:

**Improvement of personal and public health care services (US\$98.3 million).** The objective of this component is to improve the health conditions of the population. The following will be financed: (a) the SMI, an integral strategy for financing and providing health care services that seeks to eliminate the economic and sociocultural barriers to maternal and child health care services that prevent mothers and children of limited means from using those services, while at the same time promoting improvements in the quality of those services; (b) health care for widely dispersed populations, through adapting the SMI, in pilot projects, in areas where population density and physical access to services are extremely low; (c) strengthening public health efforts, including controlling communicable diseases and promoting environmental health, and (d) investments in infrastructure and equipment to ensure response capacity on the part of institutions upon introduction of the SMI and other priority interventions. During the second phase, coverage will be extended to 100% of the target population, by which time the government will have assumed all the operating costs of maternal and child health care coverage.

**Development of policy instruments (US\$2.6 million).** The objective of this component is to support the planning, introduction, evaluation, and pursuit of new policy instruments that make it possible to target public spending to maternal and child care and other priority interventions, and to the most impoverished and vulnerable populations. Technical assistance will be financed for: (a) development of a proposal for new mechanisms for mobilizing and allocating financial resources to ensure sustainability, efficiency, and equity public spending on interventions targeting the most impoverished groups; and (b) development of a proposal for strategies and mechanisms to increase the coverage of independent workers with the ability to pay through the system of social contributions, and the introduction of pilot programs. These proposals will be implemented during the second phase of the program. This component will also finance the planning and introduction of a proposal for public health efforts in the context of epidemiological transition, which will cover the entire population regardless of their ability to pay.

**Institutional modernization (US\$4.9 million).** The objective of this component is to start the process of modernizing organizations in the sector, in order to increase the productivity, efficiency, and quality of services, and adapt them to the priorities of the sector. The program will be finance: (a) the restructuring of MINSA, in order to reinforce its leadership and guidance; (b) strengthening of MINSA's epidemiological surveillance system, mainly in areas of maternal and perinatal mortality and communicable disease, and (c) the process of transforming public institutions into more flexible and productive organizations, by extending community involvement mechanisms in the management of those institutions. The restructuring of MINSA will occur during the second phase of the program, in parallel with the deepening of the process of transformation of public-sector health facilities.

**Program administration (US\$2.7 million).** The program's activities will be implemented through MINSA's line agencies, and coordinated and administered by a coordinating unit the function of which will be to ensure congruity and quality in implementing the activities described above.

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

The planned actions are consistent with the Bank's strategy for the country's social sectors, the objectives of which are to support government efforts to expand coverage and to set up efficient systems for providing and financing services (Peru country paper, GN-1992-1).

**Environmental and social review:**

The program will have a positive environmental impact. The civil engineering work contemplated in the program will be directed mainly toward rehabilitating existing infrastructure and, therefore, it is estimated that its impact on the environment will be minimal. Nonetheless, the standards for rehabilitating the health care institutions include instituting waste management systems. Additionally, the environmental health subcomponent will prepare communities for disinfecting water and food, and finance consulting and management training services for environmental health and risk management. The social impact of the program is described below.

**Benefits:**

**Health impact:** The main benefits of the program relate to reducing morbidity and mortality among mothers and children. Once the SMI is fully implemented at the national level (at the end of the fifth year), the increase in health care coverage for pregnant women will result in 900 fewer deaths each year and a reduction in maternal mortality from 265 to 128 per 100,000 live births. In turn, the increase in coverage for children under the age of four years will result in 23,400 fewer deaths annually, helping to reduce child mortality rates from 59 to 49 per 1,000 live births.

**Economic impact:** This is a program of highly cost-effective actions that will help increase the efficient use of resources in the sector, targeting spending to cost-effective interventions. In addition to directing this spending toward financing cost-effective services, the reform process will improve efficiency in allocating resources as well as the internal efficiency of the system.

**Social impact:** In addition to preventing the death of pregnant women, the program will also generate additional significant social and economic impacts. By eliminating economic, physical, and sociocultural barriers to health care services, the SMI will prevent losses of life, productivity, and capacity in the current generation of mothers, and in the future generation of children.

Through its economic and social impact and targeting strategies, this project will create the conditions for greater social equity both in the gradual distribution of the State subsidy and strategies for providing health care services.

**Risks:**

**Excessive demand for services.** The demand generated by the SMI may exceed the response capacity of the services in less developed areas. In order to mitigate this risk, the program includes a phase for creating the conditions needed for the delivery of quality services in each area. Additionally, the currently low productivity rate indicates the presence of idle capacity that can be trained to meet demand in the short term.

**Implementation capacity.** As in any program of this type, which requires the involvement of multiple and varied players, there is an implicit risk relating to the capacity for implementation and coordination. This risk is mitigated in various ways: by the gradual expansion of the SMI, which will give rise to the preparation and training interventions that must precede expansion; by support from the coordinating unit, which will build on experience obtained in implementing other projects with international financing; and by the commitment of the authorities.

**Sustainability in the short and medium term.** To achieve nationwide coverage of the SMI, which will be completed in the five years following program startup, means that as of 2005, the government will need to have increased spending on maternal and child services by approximately US\$74 million annually, corresponding to a manageable 7.6 percent increase over the current public health care budget. Moreover, the loan includes the development of a proposal for new resource mobilization and allocation mechanisms for ensuring the program's medium-term sustainability.

**Changes in the reform agenda.** Implementation of the program will begin in the last year of this administration, which implies the risk of not counting on similar political support in the medium term. This risk is minimal in regard to the SMI, which enjoys broad consensus and support from all international donors. With regard to the other reform activities, the annual project reviews will serve as an opportunity for discussion and maintaining the program's focus.

**Special contractual clauses:**

Prior to the first disbursement:

- a. Submission of the action plans for the seven departments covered in the first year of the program (see paragraph 2.11).
- b. Creation and introduction of the Maternal and Child Health Care Coverage Unit (see paragraph 3.8).
- c. Official establishment of the Program Investment Committee and entry into force of its operating regulations (see paragraph 3.10).
- d. Arrangements have been agreed on for transferring loan proceeds to MINSA through a special foreign-exchange account (see paragraph 3.24).

**Poverty-targeting and social sector classification:**

This operation qualifies as a social equity enhancing project, as described in the indicative targets mandated by the Bank's Eighth Replenishment (document AB-1704).

Furthermore, this operation qualifies automatically as a poverty-targeted investment through its support for primary health care (see paragraph 4.8). The borrower will be using the 10 percentage points in additional financing.

**Exceptions to Bank policy:**

None.

**Procurement:**

The procurement of goods, works, and consulting services will be handled in conformity with Bank policy. International competitive bidding will be used for the procurement of goods and related services for amounts greater than US\$250,000 and for construction work for amounts greater than US\$3 million. Below those thresholds, bidding will be conducted in conformity with local legislation. Consulting services will be contracted out in conformity with Bank procedures. A tentative procurement schedule is attached to this document.

## **I. FRAME OF REFERENCE**

### **A. Background**

- 1.1 In the late 1980s, the public health care system in Peru was on the verge of collapse as a consequence of the acute institutional and financial crisis that affected the public sector in general. Since 1991, the government has concentrated its efforts on restoring the financing levels and operational capacity of health care services. With the gradual recovery of the public sector and the growth of the private sector, the government has initiated a long-term process of modernization and reform in this sector. The conceptual design of this reform and its initial applications have been supported by the Bank, through the Program for Strengthening Health Care Services (PFSS); the World Bank, through the Health and Basic Nutrition Program (PSNB); the United States Agency for International Development (USAID), through Project 2000; and the United Kingdom Department for International Development (DFID), through the Capacity Creation project. Starting with these initial efforts, reform proposals oriented toward improving the health care situation of the population have been developed, principally through reducing maternal and child mortality.

### **B. The health care sector**

#### **1. The health framework of the country<sup>1</sup>**

- 1.2 Health conditions in Peru have improved substantially in recent decades as a result of successful immunization campaigns and other vertical programs. From 1985 to 1997, life expectancy at birth increased by 10 years, from 58 to 68 years on average. Infant mortality improved at the same rate, falling from 101 deaths per thousand live births in 1980 to 47.9 per thousand in 1996. The overall fertility rate dropped from 6.7 children per woman in 1985 to 3 in 1997. However, not all health indicators have improved substantially: maternal mortality even reached the high rate of 265 per hundred thousand live births, and the reduction in neonatal mortality (first month of life) was substantially lower than that in infant mortality.
- 1.3 Although the statistics cited above, with the exception of maternal mortality, correspond to the average in Latin America,<sup>2</sup> the mortality rates are far higher than those in countries with similar per capita income levels, such as Colombia and

---

<sup>1</sup> The health indicators used in this document come from the National Bureau of Statistics (Peru), MINSA, Pan American Health Organization, Latin American Demographic Center, and the World Bank.

<sup>2</sup> The averages for Latin America and the Caribbean in 1995 were: life expectancy, 68.7 years; infant mortality, 45.1 per thousand live births; and fertility rate, 3.1.

Costa Rica.<sup>3</sup> Peru continues to be one of the seven countries in Latin America with a mortality rate for children under the age of five years that exceeds 55 per thousand live births; five of these countries (Haiti, Bolivia, Guatemala, Nicaragua, and Honduras) have per capita incomes that are substantially lower than those of Peru. Additionally, despite the improvement in national averages, significant disparities are observed between geographic regions, socioeconomic strata, and ethnic groups. For example, while the infant mortality rate in the province of Lima is 26 per thousand, in Huancavelica the rate is 109 per thousand.

- 1.4 The mortality profile in the poorest strata of the population is still comprised mainly of community bold diseases and external causes. By contrast, the same profile for the richest strata is comprised of chronic and degenerative diseases, as in developed countries.

## **2. Organization and financing of the health sector**

- 1.5 The Peruvian health care sector is a segmented system comprising three main subsectors: a) the public subsector, comprising the Ministry of Health (MINSA) and the Regional Health Departments (DISA), which are responsible for providing services to the uninsured population; b) Social Security, through ESSALUD, previously known as the Peruvian Institute of Social Security (IPSS) which, until 1997, held the monopoly as the insurer and provider of direct services for workers in the formal sector, retirees and their families, approximately 6.5 million individuals; and c) the private subsector, financed by direct payments by consumers, health care reimbursements, and pre-paid health care, which generally serves the high and medium income population concentrated in Lima.
- 1.6 In 1996, total health care spending in Peru amounted to approximately 4 percent of GDP, equaling US\$103 per capita. Despite the recovery in recent years, which included a significant effort by the public sector through the establishment of the Basic Health Care for All Program (PSBPT) as part of the programs in the fight against poverty, the level achieved as a percentage of GDP continues to be lower than that recorded at the start of the previous decade. The main sources of financing for expenditures in 1995, the most recent year for which detailed information is available, were households (41 percent), followed by businesses (31 percent), and the government (27 percent). In light of the low level of financial mediation through private insurance, spending by households comprises essentially direct out-of-pocket payments to cover medications and fees, both in the public sector and the private sector.

---

<sup>3</sup> The rate of maternal mortality is 87 per hundred thousand live births in Colombia, and 29 per hundred thousand in Costa Rica. The infant mortality rate is 24 per thousand in Colombia and 12 per thousand in Costa Rica.



- 1.7 The organization and financing of the Peruvian health care sector are inadequate to meet the needs of the population. Since the population in general, whether insured or not, uses both public and private services, and since a significant group of those affiliated with Social Security also contribute to private plans, it is difficult to quantify the actual coverage of each subsector. However, it is estimated that approximately 25 percent of the population which theoretically is dependent upon MINSA does not have regular access to basic services owing to economic, physical, and cultural barriers. The economic barrier resulting from the collection of fees for office visits, hospitalizations, and medications is key: various surveys show that among the individuals who do not make a health care appointment when they believe that it is necessary (a figure that amounts to nearly 75 percent among those in the poorest quintile, 70 to 80 percent do not do so for lack of resources.

### **3. Main problems in the sector**

- 1.8 In summary, the following are among the most significant problems in the sector:

#### **a. Inadequate care during pregnancy and childbirth**

- 1.9 The maternal mortality rate is nearly 1.5 times higher than the average in Latin America, and 15 times higher than the average in developed countries, reflecting the inadequacy of health care during pregnancy, childbirth, and the puerperium period. Although 57 percent of expected mothers receive some prenatal care, only 32 percent receive sufficient care of the least four months prior to the birth. More than half of all births occur without the assistance of trained personnel, a rate that reaches 88 percent in rural areas. The neonatal mortality rate, which fell only 17 percent between 1990 and 1996, in comparison to a 35 percent reduction in post neonatal mortality, also reflects inadequate care during pregnancy and childbirth. However, health care institutions are not properly equipped to provide the required services.

#### **b. Financing characterized by insufficient resources and the inefficient use of those resources**

- 1.10 The country spends relatively little on health care: the total spending of 4 percent of GDP in 1996 is far below the average for Latin America and the Caribbean (6 percent). Additionally, scarce public resources are poorly distributed, and are utilized inefficiently. A large part of the public resources are spent on specialized institutions and national hospitals in Lima, to the detriment of basic care and public health activities. Additionally, deficiencies in managing these services results in low levels of productivity, and indiscriminate collection from consumers results in a low degree of utilization of existing services.

**c. Inequity characterized by inadequate targeting of public health care spending**

- 1.11 Public spending is allocated in a proportional manner among all income strata of the population, i.e., spending is not targeted to the poorest sector. Collections for services in the public sector, which should serve as a tool for targeting collection toward those with the ability to pay, result instead in greater inequity due to a lack of clear exemption mechanisms. Of all the visits that are fully exempted, 82 percent of individual benefiting from exemptions do not belong to the poorest quintile.
- 1.12 Spending in the public subsector is also characterized by significant geographical inequality. For example, spending per uninsured individual is 148 nuevo soles in Callao, but barely 25 nuevo soles in Cajamarca. MINSA's Basic Health Care for All Program does have a redistributive effect, but it is insufficient to offset regional budgets, which are highly regressive.

**d. Low quality of services and consumer dissatisfaction**

- 1.13 Public providers have few incentives for offering the patient quality care, given the budget allocation that is not linked to results, the lack of competence and incentives that reward performance, and the limited ability of consumer to exercise choice. The level of dissatisfaction with public services is expressed in the flow of patients to the private sector. Nonetheless, the private subsector is poorly regulated, and the level of quality of those services is unknown.

**e. Limited guidance capacity of MINSA in the sector**

- 1.14 Although, in recent years, MINSA has managed to improve its performance and response capacity, it maintains a centralized pyramid structure with numerous agencies acting in an uncoordinated manner, which favors duplication of activities and makes the flow of information difficult. Only a small percentage of its personnel performs normative functions such as planning, accreditation of service providers, and epidemiological surveillance. Additionally, MINSA's leadership capacity within the public subsector is limited, since much of the financing for services outside metropolitan Lima comes directly from the Ministry of the Presidency, through regional budgets.

**C. Health sector reform**

- 1.15 As an initial response to the problems in this sector, in 1997 the government approved the General Health Law and the Law on Modernizing Social Security in Health, and the regulations applying to it, which form the basis for the modernization and reform process. This new legal foundation provides an organizational framework for integrating the once fragmented system, thereby development the beginnings of a universal coverage system and greater equity in the distribution of benefits. This framework creates a health care system comprised

of a paying plan and a subsidized plan, based on the payment capacity of the population covered, which will allow for better targeting public spending toward the poorest groups.

- 1.16 The legal underpinnings of the **paying plan** are found in the changes introduced in the Law on the Modernization of Social Security and the Law Establishing the ESSALUD. The basic change is the practical elimination of ESSALUD's monopoly, opening up the possibility that less complex services may be provided by private enterprises, called health care providers (EPS), which will provide these services through their own infrastructure and third-party infrastructure. Employers may hire an EPS through the collective decision of its employees, and shall receive, in exchange, a credit of 25 percent on their contributions to ESSALUD. This will result in the partial elimination of double payment now made by various companies that, in addition to contributing to social security, buy private insurance for their employees.
- 1.17 Additionally, this change will create competence in providing services, through the participation of the private sector, and a greater ability among consumers to exercise choice. The new legislation also facilitates greater coverage through the development of mechanisms for incorporating independent, professional, and informal workers.
- 1.18 The **subsidized plan** is directed toward the population that lacks the means to join the paying plan, and will be financed mainly through the public treasury. Spending will be targeted to the benefit of the impoverished population, and will place priority on a guaranteed health care services plan that will include highly cost-effective preventive and curative individual health interventions. Through these actions, greater equity and efficiency will be achieved in allocating and utilizing public resources. The introduction of the guaranteed plan will start with maternal and child services, which constitute the bulk of care covered by the plan. The supply of services at the primary and secondary level under the subsidized plan will be organized into networks of establishments of differing levels of complexity. The objective of these networks is to guarantee integral services for the population for which they are responsible, through management agreements with MINSA that provide incentives for productivity, quality, and social monitoring. The reform also involves a reorganization of national hospitals of greater complexity, in the framework of regulated autonomy, in which financing will be based mainly on the sale of services to different purchasers.
- 1.19 In the medium term, the introduction of the reform will establish a system of universal access to health care services, through targeting public spending, greater efficiency in the utilization of resources, placing priority on cost-effective interventions, and paying providers based on results incorporated in management contracts and agreements. Table I-1 presents a schematic view of the new system.

<b>Table I-1</b> <b>Overview of the reformed health care system</b>			
Categories	Public health	Individual health	
		Subsidized plan	Paying plan
Coverage of population	Universal	Poor population	Population with the ability to pay (dependent and retired workers, independent, professional, and informal workers)
Schedule of benefits	Public health care interventions (public welfare, interventions with high levels of externality)	MINSA Guaranteed Health Care Services Plan (which will gradually come to be like the paying plan)	Paying plan defined in the regulations of the Law on Modernizing Social Security
Source of financing	Public treasury	Public treasury and independent income	Contributions from those affiliated with the plan
Providing services	Responsibility of the State, which may delegate implementation to other entities	Public and private establishments, organized into networks of services operating through contracting mechanisms (management contracts or agreements)	

#### D. Advances in reform

- 1.20 The introduction of the new **paying plan** began with establishing the Superintendency of Health Care Providers (SEPS) in 1998 as an autonomous organization that regulates and oversees the functioning of the EPS participating in the system. So far, four EPS have been authorized to operate, and two more are currently in the approval process. In 1998, the Multilateral Investment Fund approved an operation in support of the SEPS (ATN/MT-6155-PE). A standing committee was created (COMSSS) and was charged with monitoring the development of the paying plan through normative proposals.
- 1.21 The government has also sought progressively to solve the main problems facing the **subsidized plan**, mainly those relating to inadequate spending and the inadequate targeting of that spending, insufficient coverage, and low quality of services. The following are among the government's main initiatives:
- 1.22 **Basic Health Care for All Program (PSBPT).** The government has increased public spending through new, targeted programs. The most important of these, the Basic Health Care for All Program, began in 1994 as part of the Plan for Improving Basic Social Spending, which is an integral part of the Budget Law. The objective of the PSBPT was to make health centers and health posts in rural and low-income areas operate, mainly through supplementary payments to staff. The PSBPT contributed not only to an increase in public spending, but also to a reduction in the geographical inequality in the distribution of public spending. Thus, while eight of

the most impoverished departments receive only 16 percent of the regional budgets, they receive 37 percent of PSBPT spending.

- 1.23 **Local Health Care Administration Committees (CLAS):** In 1994, the government established the Shared Administration Program, which aimed at improving the quality of basic health care services, expanding the coverage of those services, and increasing productivity through community involvement in managing institutions at the primary level. Local Health Care Administration Committees were created, non-profit civil associations with legal capacity, which are made up of community representatives. Their task is to administer a health post or health center. The CLAS are a form of decentralized administration of primary care services, where the government, represented by MINSA, shares its efforts and resources with the community. Private administration of the institution introduces flexibility into budgetary and personnel management, and fosters a more efficient use of resources. By mid-1999, there were 529 CLAS covering approximately four million inhabitants.
- 1.24 The CLAS scheme was applied mainly to individual health centers or posts. Recently, MINSA has begun to develop integrated service networks, incorporating primary and secondary care, based on the CLAS experience. The integration of various institutions would make greater effectiveness and efficiency in the use of resources possible. Work is under way in five networks under management agreements with MINSA, where initial applications are managing to validate and develop new programming and management instruments, which will be implemented in consolidating and extending the CLAS model.
- 1.25 **Maternal and Child Health Care Coverage (SMI):** The government has also started programs intended to eliminate economic barriers to access to services on the part of vulnerable populations. The School Health Care Plan, established in 1997, provides free services to students in public primary and secondary schools. Additionally, the implementation of the Guaranteed Health Care Services Plan began with the introduction, as a pilot project, of the SMI, which is oriented toward solving the serious problem of maternal and child mortality and morbidity. The SMI is now in the pilot phase, and is being evaluated in two of the country's departments, Tacna and San Martín.
- 1.26 The government has decided to concentrate its reform efforts over the next three year on implementing the SMI at the national level, and has requested the support of the IDB and of the World Bank to that end. The SMI will function as a motivating element for the modernization and reform of the sector, since changes in the organization and financing of services will be introduced through it. Specifically, through its introduction at the national level, a significant extension of coverage will be achieved, based on targeting public spending on cost-effective interventions and vulnerable populations. Additionally, by eliminating economic and sociocultural barriers, the SMI will increase demand, and will subject the

service production system to demanding tests of its capacity to solve problems, operate, and organize. The modernization of management through management agreements and the expansion of the CLAS to the institutions involved will contribute to better utilization of financial and human resources, meeting the challenge to its capacities.

- 1.27 **Decentralization:** A preliminary draft law is currently under discussion regarding decentralization of public services in education and health. This law focuses on decentralizing the two primary levels of basic public health care, responsibility for which would be transferred to the municipalities over a four-year period. During that time, the municipalities must take over the presidency of the CLAS, which will be the entities that sign the transfer agreements with MINSA. The proposed law is compatible with the program's activities planned in this document, for which reason the establishment of the CLAS is a precondition for the transfer of services to the municipalities, which is what is desirable for managing the activities of the SMI.

**E. The Bank's experience and strategy**

- 1.28 The Bank began its activities in the health care sector in Peru with the PFSS, the objective of which was to regain the analytical capacity of the public services system following the crisis of the 1980s. A principal component of the program, with a total investment of US\$98 million, US\$68 million of which came from IDB loan 741/OC-PE, was to rehabilitate health care institutions, to develop operating system, and to supply basic equipment.
- 1.29 Additionally, the PFSS supported the design and initiated the process of reforming the health care sector through: (a) formulating and approving standards and regulations applicable to the sector, both in the subsidized plan and the paying plan; (b) formulating and placing into operation technical and administrative processes oriented toward modernizing the management of public hospitals and basic health care institutions, in the services network mode, and (c) developing the proposal for the Guaranteed Health Care Services Plan, oriented toward attaining significant reductions in disease rates, through highly cost-effective interventions. This proposal, in turn, served as the basis for formulating the SMI. A more detailed report on the achievements of the PFSS is found in the technical archives of the project. The PFSS is in its final months of implementation; nearly 99.5 percent of the resources have been disbursed, and the final disbursement is scheduled for December 1999.
- 1.30 The operation proposed here will maintain the continuity of the Bank's support for sector reform. The actions planned are consistent with the Bank's strategy for the social sectors of the country, the objectives of which are to support the government's efforts to increase coverage and to establish efficient systems for providing and financing services (Peru country paper, GN-1992-1).

- 1.31 The reform of the health care sector is conceived of as a broad-ranging process that will take several years. Given its duration and the complexity of the activities required, the process has been structured in two phases: an initial phase that consists of extending the SMI, developing proposals, and verifying new institutional policies and transformations; and a second phase that is characterized by the implementation and consolidation of these new policies, and extending new forms of organization, financing, management, and provision of services at the national level.
- 1.32 To foster this long-term process (which will require systematic and sustained support), the IDB will use a multiple-phase loan modality. Although the reform program has well-defined, long-term objectives, two kinds of actions will be undertaken in order to achieve them: specific, short-term actions whose implementation will be used to confirm policies, and design activities for long-term structural changes. Accordingly, the first phase will focus on extending basic service coverage and the design and testing of new policy instruments and institutional changes; the second phase will focus on implementing and consolidating these new policy instruments and institutional changes. This arrangement will allow for more active Bank participation in actions that require sustained support in order to solve problems inherent in this sector. The loan (US\$87 million) proposed in this document will support the first phase of reform, and will run for three years. A new loan in the amount of US\$50 million to support the second phase, which would run for three years, will be processed once 75 percent of the resources of the first loan have been disbursed and the agreed goals have been accomplished as triggers, as detailed in Annex I-1. This strategy will make possible the continuity of the Bank's support for the reform process during the period envisioned. In addition, this modality is compatible with the adjustable loan program that the World Bank is using for the same operation.

**F. Other financial agencies**

- 1.33 It has been estimated that supporting the introduction of the SMI and the other health care reform actions at the national level will require approximately US\$350 million over a six-year period. Of that amount, the Government of Peru will finance US\$137 million with IDB resources (US\$87 million for the first phase, and US\$50 million for the second); the remainder will be financed with resources from other international agencies, principally the World Bank, and with national counterpart resources.
- 1.34 The World Bank is supporting the health care sector reform process through two modalities. The social structural adjustment loan, currently in the process of negotiation, includes measures designed to stimulate reform, in its matrix of conditions. Among these measures are the creation of the SMI, the expansion of the CLAS, and the integration of MINSA's vertical maternal and child health care programs. The matrix also promises the government an increase of US\$20 million

over the 1998 primary care budget, including the SMI, enabling the government to increase its involvement in financing the incremental spending of the SMI. Additionally, a parallel loan similar to that of the IDB is in preparation. In order to maintain the integrality of the reform actions, the program has been prepared as a whole, independent of the source of financing, and distinct geographical areas have been earmarked for the financing from each bank. Project preparation has also been coordinated with USAID and DFID, which will maintain their support for the reform process.



## **II. THE PROGRAM**

### **A. Objectives**

- 2.1 The general objective of the program is to support the gradual process of modernization and reform of the health care system in Peru, in order to improve the state of health of the population by expanding access to effective, efficient, and quality health care services. The program is oriented toward solving the principal health care problems of the population: maternal and child morbidity and mortality.
- 2.2 The specific objectives are:
- a. To reduce maternal and child morbidity and mortality by eliminating economic, physical, and cultural barriers to the utilization of maternal and child services by the poor and vulnerable populations.
  - b. To strengthen public health actions, mainly in the field of communicable diseases and environmental health, and epidemiological surveillance.
  - c. To support the development, introduction, and pursuit of sector policies that allow for targeting public spending toward vulnerable groups and cost-effective strategies.
  - d. To develop new models of organization, management, financing, and providing services, oriented toward increasing the productivity and efficiency of the sector's resources.
  - e. To develop new capacities within MINSA in order to strengthen its leadership and guidance in the sector.

### **B. Program strategy**

- 2.3 The three-year program to be supported by the loan proposed in this document aims at addressing needs that cannot be postponed with respect to fighting maternal and child morbidity and mortality, through the design and introduction of medium- and long-term strategies for modernizing and reforming the health care sector. The program's strategy is based on using the improvement in maternal and child services as the driving force in the process of modernizing this sector. In this respect, most of the program's resources will support activities aimed at improving access to and the quality of basic services, by financing the SMI and extending related care services. Nonetheless, in order for the effects of this improvement in basic health care to become lasting and effective, advances must be made in the process of modernizing the sector, by developing new financing policies, and through institutional and organizational change. This loan represents the first phase

of that process; as mentioned in chapter I, these structural changes will be deepened through a second loan.

- 2.4 In keeping with this strategy, the program includes a set of coordinated actions comprised of technical assistance, studies, pilot programs, investments in expanding services, equipment, and infrastructure rehabilitation, groups into three components covering the key areas of the health care sector:
- a. **Health care services.** This component will finance improvement in basic health care services directed toward low-income and widely dispersed groups, placing priority on maternal and child care and controlling communicable diseases.
  - b. **Policies.** This component will support the development of specific policy instruments that facilitate the introduction of the contributing and subsidized plans; the objective is to target public spending toward maternal and child care, and other priority interventions, and toward the most vulnerable groups.
  - c. **Institutions.** This component will support the development and modernization of sector institutions; the objective is to increase the productivity, efficiency, and quality of maternal and child services, and to strengthen the guiding role of MINSA.
- 2.5 Table II-1 presents the links between the sector problems identified in chapter I and the program's components and activities. In their entirety, these activities will improve access to and the quality of basic services, particularly in the areas of maternal and child health and public health. These activities will also produce policy recommendations and will strengthen the institutional and analytical capacity for implementing and evaluating the changes in the sector that will be introduced and consolidated over the next six years. The expected results at the conclusion of the three-year program are detailed in Annex II-1, which contains the logical framework.

<b>Table II-1</b> <b>Correlation between health care sector problems and the strategies and activities of the program</b>		
<b>Analysis</b>	<b>Strategies</b>	<b>Components</b>
<b><u>Health conditions:</u></b> <ul style="list-style-type: none"> <li>• High rates of maternal and perinatal mortality and morbidity</li> <li>• Unacceptable levels of communicable diseases</li> <li>• Diseases caused by unhealthy environmental conditions</li> </ul>	<ul style="list-style-type: none"> <li>• Introduction of SMI</li> <li>• Introduction of strategies to control malaria, Chagas' disease, and yellow fever</li> <li>• Training the population to management water and food, and strengthening management capacities in environmental health</li> </ul>	<b>Component 1: Services</b> <i>(improving individual and public health care services)</i>
<b><u>Health care services:</u></b> <ul style="list-style-type: none"> <li>• Inefficient allocation and use of public resources</li> <li>• Economic, sociocultural, and geographic barriers to the use of services</li> <li>• Low productivity of services</li> <li>• Low quality of services, and consumer dissatisfaction</li> <li>• Few incentives that reward performance</li> <li>• Lack of key equipment for transport, laboratories, and communications in the areas of greatest need</li> <li>• Deteriorated physical infrastructure and obsolete equipment</li> </ul>	<ul style="list-style-type: none"> <li>• Introduction of SMI</li> <li>• Introduction of financial incentives that link payments to providers with their performance (quantity and quality) through management</li> <li>• Support for clinical and community training programs to improve the quality of maternal and child health care services and consumer satisfaction levels</li> <li>• Introduce modern administrative techniques in primary and secondary level public institutions</li> <li>• Provide key equipment for delivering SMI and rehabilitate physical infrastructure</li> </ul>	<b>Component 1: Services</b>  <b>Component 3: Institutions</b> <i>(Institutional modernization)</i>
<b><u>Sector policies:</u></b> <ul style="list-style-type: none"> <li>• Insufficient public resources and inefficient use of those resources</li> <li>• Low coverage within the social security system of populations with the ability to pay</li> <li>• Inequity characterized by inadequate targeting of public spending</li> <li>• Lack of a clear policy for recovering costs, resulting in arbitrary and untargeted fees</li> <li>• Lack of policies and actions to promote public health</li> </ul>	<ul style="list-style-type: none"> <li>• Provide incentives for populations with the ability to pay to join the social security system, freeing up resources for subsidizing poor populations</li> <li>• Introduce a system for targeting public spending on health care, based on providing a guaranteed plan of highly cost-effective services, starting with the SMI, for the population without the ability to pay</li> <li>• Rationalize fees of public institutions</li> <li>• Propose new mechanisms for mobilizing financial resources that make it possible to guarantee the sustainability, efficiency, and equity of public spending</li> <li>• Develop and implement public health care policies</li> </ul>	<b>Component 2: Policies</b> <i>(Development of policy instruments)</i>
<b><u>Institutional capacity:</u></b> <ul style="list-style-type: none"> <li>• Limited guidance capacity of MINSA in the sector</li> <li>• Lack of managerial capacity, community involvement, and continuity of care in public institutions at the local level</li> <li>• Little use and distribution of health, administrative, and financial information for decision-making</li> </ul>	<ul style="list-style-type: none"> <li>• Develop proposals so that MINSA can fulfill its functions of leading, formulating, and coordinating national health policy</li> <li>• Modernize management at the local level, and restructure local services based on the CLAS model so that they function as a network</li> </ul>	<b>Component 3: Institutions</b>

- 2.6 Given the complex and evolving nature of the reform process in the social sectors, and the need to adapt actions as a function of the problems identified and the results achieved, the program will finance activities sequentially, using the results of studies, pilot projects, and policy decisions during each year in order to define the operating plan for the subsequent years. The operating plan for each year of work will be defined in annual reviews, performed jointly by the government and the Bank.

**C. Scope of the project**

- 2.7 The proposals for sector reform and modernization introduced by the program will be applied at the national level by MINSA, while the actions aimed at improving health care services encompassed in the first component are concentrated in 15 of the 24 departments of the country, bringing them in gradually. These 15 departments are home to approximately 41 percent of the country's population. Table II-2 presents the main characteristics of these departments in relation to the country as a whole. The remaining departments will be covered by the parallel loan from the World Bank.

<b>Table II-2</b>					
<b>Geographic territory of the project</b>					
<b>Department IDB financing</b>	<b>Target population</b>		<b>% of poor households (1996)</b>	<b>% Hospital births (1998)</b>	<b>Infant mortality (per 1,000 live births (1996)</b>
	<b>Expectant mothers</b>	<b>Children (0-4 years)</b>			
<b><u>Year 1</u></b>					
Huancavelica	14,144	42,432	77.4	17.6	109
Huanuco	22,651	67,952	64.5	19.3	59
Junín	29,082	87,264	39.8	19.7	57
Amazonas	3,881	11,643	47.7	21.9	51
Ayacucho	14,651	43,952	69.0	36.4	69
San Martín (1)	14,784	44,352	45.8	42.7	47
Tacna (1)	4,621	13,864	26.8	68.4	26
<b><u>Year 2</u></b>					
Pasco	6,608	13,216	58.2	31.9	67
Loreto	26,055	52,110	57.6	33.5	50
Ucayali	11,357	22,714	43.8	38.6	64
Ancash	26,055	52,110	46.0	43.7	41
<b><u>Year 3</u></b>					
Lima and Callao (2)	46,425	92,850	27.9	50.6	26
Arequipa	15,732	31,464	33.7	52.0	50
Moquegua	2,324	4,648	37.7	52.8	52
Ica	12,795	25,590	38.7	63.0	39
<b>Total 15 Depts.</b>	<b>250,791</b>	<b>605,395</b>	<b>-</b>	<b>-</b>	<b>-</b>
<b>Peru</b>	<b>532,716</b>	<b>1,312,699</b>	<b>44.1</b>	<b>34.2</b>	<b>48</b>
(1) Departments with pilot programs begun in 1998.					
(2) IDB financing will cover Lima East, Lima City, and Callao, while World Bank financing will cover Lima South and Lima North.					

**D. Components and activities**

- 2.8 The organization of the components and subcomponents of the program are presented in Table II-3, below. A description of the activities follows:

<b>Table II-3</b>	
<b>Components and subcomponents of the program</b>	
<b>Component</b>	<b>Subcomponents</b>
1. Improving personal and public health care services	A. Maternal and child health care coverage B. Health care for widely dispersed populations C. Environmental health D. Investments in infrastructure and equipment
2. Developing policy instruments	A. Development of the subsidized plan B. Development of the paying plan C. Public health
3. Institutional modernization	A. Institutional development of MINSA B. Strengthening of the epidemiological surveillance system C. Modernization of health care institution management

**1. Component: Improving personal and public health care services (US\$98.3 million)**

- 2.9 The objective of this component is: (a) to eliminate financial, physical, and sociocultural barriers to access to basic services, starting with maternal and child health care, and (b) to strengthen public health actions, including the control of communicable diseases and the promotion of environmental health.

**a. Subcomponent: Maternal and child health care coverage (SMI)**

- 2.10 Maternal and child health care coverage (SMI) is an integral strategy for financing and providing health care services that seeks to eliminate the economic and sociocultural barriers to maternal and child health care that prevent low-income mothers and children from using these services, while simultaneously improving the quality of those services. The SMI covers a package of cost-effective services designed to reduce maternal and child morbidity and mortality. The economic barriers to using the services included in the package will be reduced by eliminating fees in rural areas, and replacing them with participant rate for members that is lower than current prices for those services in poor urban areas. The sociocultural barriers will be reduced by actions aiming at improving the quality of services, adapting them to community preferences. A brief description of the SMI, including its objectives, schedule of benefits, clinical, administrative, and financial support activities, and monitoring and oversight systems is presented in Annex II-2.

- 2.11 The program will finance the variable costs of the SMI benefits package, including personnel expenses estimated at US\$61.4 per expectant mother, and US\$33.6 per child, and complementary activities designed to increase the quality of services, adapt the supply to sociocultural preferences, and provide information for consumers. Based on the prior experiences of the PFSS, projects financed by USAID and the World Bank, and the National Maternal and Perinatal Program the following will be financed: (a) development of a management agreement with indicators suitable for monitoring and oversight; (b) training for professionals in women's and children's health, with particular emphasis on detecting and managing obstetric emergencies; (c) training midwives and other community agents in conducting normal births, and detecting warning and reference signs; (d) formulating logistic and clinical protocols for reference and counter-reference; (e) adapting clinical protocols to actual cultural practices in indigenous areas; (f) logistical coordination at the network level, including providing medications and other supplies; (g) preventive and promotional information, education, and communications activities (IEC), and (h) establishing community funds for financing transport in emergency cases. Each department will have an action plan that encompasses these activities in an integrated manner. **Submission of the action plans for the seven departments covered in the first year of the program is a condition precedent for the first disbursement.**
- 2.12 At the national level, the target population of the SMI is 532,716 expectant mothers per year, and 1,312,699 children, of whom 219,940 expectant mothers and 848,343 children live in departments financed by the Bank. The SMI is already in operation, in a pilot phase, in San Martín and Tacna, departments selected based on their operational capacity. In subsequent years, the SMI will be introduced gradually in the remaining departments based on the hospital birth rate (starting with the lowest), which bears a high correlation (68 percent) to the poverty rate. Projections for expansion are provided in the technical archives of the project. At the end of the first stage of the program (three years), 85 percent of the target population will be covered. For reasons of sustainability, it has been agreed with the government that the Bank's resources will finance 90 percent of the cost of introducing the SMI in the first year, dropping to 75 percent in the second year, and to 60 percent in the third. Decreasing financing by the Bank will continue in the second phase up to the fifth year, at which point the Government of Peru will cover 100 percent of the operating costs of the SMI.
- 2.13 In order to allow the medium-term impact of the SMI to be measured, the program will finance the design and implementation of maternal and perinatal morbidity and mortality modules and health care spending and utilization modules by the national demographic and health survey (ENDES).

**b. Subcomponent: Health care for widely dispersed populations**

- 2.14 In networks where the population density and physical access to services are extremely low, the SMI will be adapted to that reality. In the first year of the program, an organizational and operational proposal will be developed for field work, via traveling teams providing integral health care, with active community involvement, emphasizing cultural suitability. This proposal will be implemented in two pilot areas (Huanuco and Amazonas) which will be evaluated at the end of this year. Based on these pilot projects, this subcomponent will be implemented in additional areas to be defined.

**c. Subcomponent: Environmental health**

- 2.15 The objective of this subcomponent is to help prevent diseases and infections that are caused mainly by unhealthy conditions in the environmental, in complement to the activities of the SMI. In the first year of the loan, financing will be provided for the expansion of methodologies based on pilot projects financed by the previous loan (PFSS), specifically: (a) training in disinfecting water and food, through community work; (b) expanding waste management systems in institutions covered by the program, and (c) consulting, training, and workshop services for strengthening management capacities in environmental health and risk management, within networks and at the national level.
- 2.16 This subcomponent will also finance prevention and control activities concerning endemic communicable diseases not covered by other programs and that are a major cause of morbidity and mortality for poor populations. Financing will be provided for technical assistance, training, community workshops, and education campaigns for controlling Chagas' disease, yellow fever, and malaria. Follow-up will be done on the effectiveness of the strategies used for controlling communicable diseases through the epidemiological surveillance system (see paragraph 2.29).

**d. Subcomponent: Investments in infrastructure and equipment**

- 2.17 In order to ensure the response capacity of institutions to the introduction of the SMI and other priority interventions, the program will finance investments in expanding and adapting services. Management of these resources will be provided through an allocation mechanism (fund), which will operate as part of the Health Care Investment System, which will be placed into operation with the program. Details of this mechanism are described in paragraph 3.10. The lines of investment to be financed with the project are: (a) infrastructure, including the expansion, rehabilitation, and improvement of health care institutions in the context of networks and institutions of varying complexity up to the secondary level; (b) providing biomedical equipment, transportation, furnishings, and instruments for the institutions, in order to improve their analytical capacity and the quality of

the health care services they provide that are covered by the SMI, and (c) technical assistance for modernizing operating and information systems, and for developing computer and communications infrastructure to make them operational, including the necessary training. At the end of the three years of implementation, it is expected that investments in civil engineering projects and medical equipment will have affected approximately 524 institutions, 382 of which will be health case posts, 129 health care centers, 5 hospitals, and 8 rehabilitation hospitals.

## **2. Component: Developing policy instruments (US\$2.6 million)**

- 2.18 The objective of this component is to support the design, implementation, evaluation, and follow-up of new policy instruments that make it possible to target public spending on maternal and child health care and other priority interventions and on the most impoverished and vulnerable populations.

### **a. Subcomponent: Development of the subsidized plan**

- 2.19 The main objective of the reform is to guarantee access, on the part of the population without the ability to pay, to health care services through the subsidized plan. So far, the government has concentrated its efforts on lowering economic barriers to access, by implementing the School Health Care plan and the SMI. The program will finance: (a) an initial evaluation of the School Health Care plan, in operation since 1997, and the development of instruments for the ongoing monitoring of the program; and (b) a medium-term evaluation of the SMI. Both evaluations will analyze the impact of eliminating direct payments by users on the demand for and utilization of services, by income quintile, and the impact of the new payment mechanisms on the productivity and efficiency of the supply. The results of these evaluations will make it possible to make changes in the scheduled actions.
- 2.20 Additionally, the program will finance the development of a proposal for new mobilization and allocation mechanisms for financial resources that will make it possible to guarantee the sustainability, efficiency, and equity of public spending on priority interventions targeting the most impoverished groups. This proposal will include the following elements: (a) identifying potential efficiencies and savings within the public subsector, mainly at the hospital level, which will make it possible to reallocate resources for maternal and child health care, public health actions, and other priority interventions; (b) developing a fee policy along with effective mechanisms for exempting the most impoverished, for services not included in the SMI; (c) development of a methodology for the geographic allocation of resources at sub-national levels that favors the most impoverished departments and the populations with the greatest need, and (d) adapting the mechanisms for payments to providers and the performance indicators used in management agreements, developed based on the results of experiences now under way, which will make it possible to reward efficiency in public spending.



- 2.21 This global proposal for mobilizing and reallocating public resources will be translated into an action plan for gradual implementation. Additionally, it is expected that in the second phase of the program, the proposal can be adapted to the Guaranteed Health Care Services Plan, which will include a group of interventions that is broader than the SMI.

**b. Subcomponent: Development of the paying plan**

- 2.22 One of the main objective of reforming the sector is to insure the population that has the ability to pay, through the paying plan, freeing up resources that will make it possible to target public spending on the most impoverished groups.
- 2.23 The program will finance technical assistance for: (a) developing the system of indicators for monitoring the paying plan; and (b) developing a proposal of strategies and mechanisms for increasing coverage of independent workers who have the ability to pay, and for setting coverage goals for these groups. Based on this proposal, two pilot projects will be implemented for incorporating informal workers, which will be evaluated as the program advances.

**c. Subcomponent: Public health**

- 2.24 The subsidized and paying plans are oriented toward financing individual health care services. The Peruvian reform also plans to place increasing emphasis on public health actions directed toward the entire population, regardless of their ability to pay. This subcomponent will finance technical assistance for identifying the main risk factors in the context of the epidemiological transition, and the design and implementation of a proposal for promoting healthy practices among the population.

**3. Component: Institutional modernization (US\$4.9 million)**

- 2.25 The objective of this component is to start the process of modernizing organizations in the sector, in order to increase the productivity, efficiency, and quality of services and to adapt them to sector priorities. The program will finance the restructuring of MINSA, in order to strengthen its leadership and guidance, and the process of transforming public institutions into more flexible and productive organizations will be undertaken.

**a. Subcomponent: Institutional development of MINSA**

- 2.26 The program will begin the process of the institutional modernization of MINSA so that it can fulfill its guiding role in the sector, including conducting, formulating, and coordinating individual and public national health care policy, as well as evaluating and supervising that policy.

- 2.27 The initial restructuring of MINSA will be directed toward adapting its structure as a function of the SMI, through rationalizing and integrating vertical programs targeting the maternal and child population, which are now organized as a function of specific diseases and are managed in a parallel manner. Additionally, the program will finance the development of strategic guidelines for modernizing MINSA, oriented toward strengthening its guidance and strategic planning functions, reducing the number of offices and programs, consolidating functions that are now widely dispersed – making it possible to achieve economies of scale – and defining the roles and responsibilities at the central and sub-national levels in the context of the new decentralization proposal. Based on these guidelines, a preliminary draft of a law relating to organization and functions will be developed, and an action plan will be prepared for its gradual implementation.
- 2.28 Considering that a significant portion of the program's resources is oriented toward financing investment projects in the sector, the GOP has decided to take this opportunity to establish, for the health care sector, a permanent mechanism for allocating resources of this type.<sup>4</sup> Thus, the project will finance the technical assistance needed for organizing, establishing, and implementing, within MINSA, the Public Investment in Health Care System. Financing will be provided for consulting services required to formulate strategic plans at the central and local level, and for setting up and training work teams in local areas (DISA and networks of institutions).

**b. Subcomponent: Strengthening of the epidemiological surveillance system**

- 2.29 One of the key functions of MINSA, which has not been addressed so far, is the epidemiological analysis needed to define policies, determine health care priorities, and allocate resources. The objective of this subcomponent is to strengthen and adapt to be epidemiological surveillance system to the priority interventions in the area of maternal and child health care and public health. The program will finance: (a) the planning and implementation of subsystems for monitoring maternal and perinatal mortality and communicable diseases; (b) consulting and training services to support the system in terms of communications, information, and laboratories; (c) training in the analysis of epidemiological information at the national, DISA, and network level; and (d) improving the system of recording vital statistics.

---

<sup>4</sup> In this context, the Ministry of Economy and Finance (MEF), through the Office of Investments (ODI), is implementing the Program for Improving the Planning Mechanism for Public Investment, the general objective of which is to improve the allocation of investment resources by modernizing its resource allocation mechanism, helping to develop and implement an institutional scheme based on the ODI and the sector offices and institutions participating in the public investment process. The Health Care Investment System is the first step in this direction.

**c. Subcomponent: Modernization of health care institution management**

- 2.30 In order to guarantee the ability to respond to the new demands created as a function of the SMI and to provide incentives for increasing productivity and efficiency in the use of public resources, and as a social control on the use of those resources, the program will support the continuation of successful experiments in creating CLAS. As described in chapter I, the CLAS, in addition to providing community involvement in the management of health care services, allows for greater flexibility in managing human and budgetary resources in comparison to public institutions that are not organized in accordance with the CLAS model.
- 2.31 Initially, proposals will be financed for: (a) adapting the CLAS model to function in institutions belonging to service networks; and (b) systematizing experiences in management strengthening in the initial applications introduced under the PFSS, and programs financed by international agencies. Based on these studies, an action plan for developing CLAS and management strengthening will be prepared for the networks that join the SMI.
- 2.32 The action plan will include technical assistance, training, and workshops for carrying out the following activities: (a) definition of networks; (b) creating community involvement mechanisms based on the CLAS model; (c) developing and implementing the new management model; (d) rendering personnel contracts more flexible, and developing and operating a system of monitoring and oversight of personnel performance; (e) developing and operating administrative systems for logistics, human resources, accounting, and maintenance; (f) developing and operating a system of health planning and programming, and (g) developing mechanisms for buying and selling services of other providers, starting with the maternal and child services provided by ESSALUD in areas where this metallic day is cost-effective.

**4. Program administration (US\$2.7 million)**

- 2.33 MINSA's line agencies and decentralized institutions will be responsible for implementing the program's activities, and will be supported by a coordinating unit that will administer both the IDB loan and the World Bank loan. The project will finance the operation of this unit, which will include: an executive director of the program, who will coordinate with the various functional units of MINSA, and will supervise all the program's activities; an administrative unit, which will be responsible for financial and accounting follow-up, for the operational activities and support of the program, and a technical unit which will supply ongoing technical assistance, quality control, monitoring, and coordination of all activities directed toward defining policies, plans, and programs (see chapter III for further details). The program will also finance fees for consulting services that may be used to support the procurement process.

## E. Cost and financing of the program

### 1. Program cost

- 2.34 The total cost of the program is estimated at the equivalent of US\$125 million, including a loan with ordinary capital resources of US\$87 million. The breakdown and sources of financing are presented in Table II-4.

<b>Table II-4</b> <b>Health sector development program</b> <b>Maternal and child health care coverage (PE-0146)</b> <b>Total costs</b> <b>(US\$000 equivalent)</b>				
Specifying category	IDB	Local	Total	%
<b>1. Administration</b>	<b>1,126</b>	<b>1,540</b>	<b>2,666</b>	<b>2.2</b>
1.1 Coordination Unit	1,126	1,540	2,666	2.1
<b>2. Direct costs</b>	<b>81,006</b>	<b>24,798</b>	<b>105,804</b>	<b>84.6</b>
2.1 Improvement of health care services	75,343	22,925	98,268	78.6
- Introduction of the SMI	51,458	22,213	73,671	58.9
- Investments	23,885	712	24,597	19.7
2.2 Development of policy instruments	2,007	602	2,609	2.1
2.3 Institutional modernization	3,656	1,271	4,927	3.9
<b>3. Associated costs</b>	<b>1,576</b>	<b>1,540</b>	<b>3,116</b>	<b>2.5</b>
3.1 Support for the procurement process	1,576	0	1,576	1.3
3.2 Maintenance of new construction and equipment	0	1,540	1,540	1.2
<b>Subtotal</b>	<b>83,708</b>	<b>27,878</b>	<b>111,586</b>	<b>89.3</b>
<b>4. Contingencies</b>	<b>2,421</b>	<b>990</b>	<b>3,411</b>	<b>2.7</b>
<b>5. Financial costs</b>	<b>870</b>	<b>9,133</b>	<b>10,003</b>	<b>8.0</b>
5.1 Interest	0	8,123	8,123	6.5
5.2 Credit fee	0	1,010	1,010	0.8
5.3 Inspection and supervision	870	0	870	0.7
<b>Total</b>	<b>87,000</b>	<b>38,000</b>	<b>125,000</b>	<b>100.0</b>
<b>% by source</b>	<b>70</b>	<b>30</b>	<b>100</b>	<b>0.0</b>

### 2. Financing plan

- 2.35 The program requires that the borrower contribute US\$38 million in the three years of implementation, which will be done on an incremental basis, starting with US\$4 million in the first year, and amounting to US\$23 million in the final year. For the year 2000, the government has budgeted US\$10 million, an amount sufficient to cover the needs of the first year of implementation. Since the annual amounts required for the remaining years are manageable figures in relation to annual public spending on health care, no problems are anticipated with regard to

the borrower's capacity to cover the required amounts. Moreover, the Fund for International Development of OPEC has provided Peru with an US\$8 million loan to be used for financing the activities planned in this operation. These funds will be considered part of the local counterpart contribution.

- 2.36 The Bank's financing, in the amount of US\$87 million, will come from the Ordinary Capital, under the Single Currency Facility. These funds will cover some 70 percent of the program's needs. The 70%/30% financing matrix applies, since this program is directed toward primary health care. Table II-5 presents the conditions of the loan:

<b>Table II-5</b> <b>Conditions of the loan</b>	
Source of funds:	Ordinary Capital
Amount:	US\$87 million
Conditions:	
Amortization period	25 years
Commitment of funds	2.5 years
Disbursements	3 years
Interest rate	Variable
Credit fee:	0.75 percent per year on undisbursed amounts
Inspection and supervision:	1 percent of the amount of the loan
Currency:	U.S. dollars, under the Single Currency Facility

### **III. PROGRAM IMPLEMENTATION**

#### **A. Institutional framework**

##### **1. Borrower and executing agency**

- 3.1 The borrower will be the Republic of Peru, and the executing agency will be the Ministry of Health (MINSA), which will implement all the activities of the program through its areas lying agencies and decentralized agencies. For administration of the program, MINSA will draw on the support of the Program Coordinating Unit (UCP).
- 3.2 In order to support the high-level management of MINSA, the Coordination Unit for Modernizing the Public Health Subsector (UCM) was established by ministerial decree No. 052-98-SA, entrusting it with the conduct, oversight, and follow-up of activities for modernizing the public health care subsector. Therefore, it is appropriate for the UCM to maintain a direct link with the Minister and the Vice Minister of Health, in terms of: (a) formulating, the value grading, and adapting policies and general guidelines for implementation of the program in the context of developing the public subsector; and (b) ensuring consistency among the various projects being implemented in the subsector, as well as providing the necessary coordination in implementing the activities undertaking, both by the various agencies at the central level of MINSA and by the Regional Health Departments (DISA).

##### **2. Program implementation strategy**

- 3.3 Since the reform process requires continuous review and adjustment of the institutional and organizational structure, as well as the redesign of processes and mechanisms for the operation of programs and projects, the implementation strategy off the program is based on a flexible approach, and comprises a combination of the following elements: (a) the detailed definition of activities to be conducted during the first year, and the general definition of activities to be conducted in the following years, and (b) monitoring of key decisions and topics, which will be handled based on periodic reviews of action plans and the agreed indicators.
- 3.4 It is important to emphasize that program implementation will be the primary responsibility of the various line agencies and decentralized agencies of MINSA, with the support of temporary consulting services contracted through the program for specific topics concerning the process of implementing the reform, and if necessary, temporarily financing all or part of the payment for new staff positions at MINSA agencies that will be involved in implementing the program. This strategy will avoid the creation of a parallel structure for implementation of the program

and, fundamentally, will aim at utilizing the implementation of the program as a means for strengthening and/or creating new capacities in institutions in the sector, and for institutionalizing more modern, effective, and efficient structures and processes that will insure the full sustainability of sector reform.

**B. Organizational structure, responsibilities, and operational framework for program implementation**

- 3.5 For implementation, the activities of the program have been divided into three major categories, which are: (a) activities specifically involving the providing of maternal and child health care services; (b) activities involving physical investments (construction and equipment) which support providing maternal and child health care services; and (c) activities relating to consulting and other services in support of the other components of the program. In this context, the following implementation scheme has been prepared.

**1. Activities of the SMI**

- 3.6 The provision of services will be the responsibility of the health units that, operating as health care networks (health posts and centers linked to referring hospitals), will care for mothers and children covered under the plan, following the guidelines and protocols for care established to guarantee the standard quality of care.
- 3.7 Financing for operating costs will reach the health care units (networks) through the DISA, which are the health care authorities at the department level. The program will utilize the resources by channeling payments to the DISA, supported by requests for reimbursement that the SMI will review and approve based on the management agreements that are previously arranged. Expenses that will be acknowledged are: (a) expenses for signing up expectant mothers or children with the SMI; (b) expenses relating to prenatal exams and for healthy child exams; and (c) expenses for other services such as complications of pregnancy, child birth care, and obstetrics complications. The amounts to be reimbursed will be determined on the basis of a rate schedule, and as a function of meeting goals.
- 3.8 In order to implement and administer its operations, an SMI unit will be established that will be structured as a line agency of MINSA, reporting to high-level management, and that will be regulated by a set of Regulations on Organization and Functions (ROF). In order to achieve operational integrity, the SMI will be responsible both for supervising the providing services and for authorizing and making reimbursements. Additionally, it will be responsible for coordinating the execution of technical assistance activities related to the SMI. Initially, it has been provided that the SMI will have, at the central level, an Executive Office that will be supported by an Office of Operations, an Office of Control and Auditing, an Information Unit, and the Planning and Financing Unit. At the DISA level, the

SMI will have a Regional Executive Office that, in turn, will be supported by an Office of Oversight and Auditing and an Office of Marketing and Health Care Promotion. The proposed structure for the organization of the SMI is presented in the technical archives of the project. **The establishment and implementation of this SMI unit is a condition precedent for the first disbursement.**

## **2. Program investments**

- 3.9 The investment resources of the program will be implemented through a Program Investment Fund (FIP) that will be established and institutionalized within MINSA in the context of the Public Health Care Investment System. This system will develop progressively as it achieves the objectives of the Program for Improving the Planning Mechanism for Public Investment that the Ministry of Economy and Finance (MEF) is implementing through the Office of Investments (ODI).
- 3.10 Within MINSA, the system for investment in health care will function through an Investment Committee that will be responsible for ensuring that applications for financing of construction and procurement of equipment comply with the operating regulations in which the investment lines are established to which they may have access, as well as the evaluation and privatization criteria for selecting investment projects. These criteria were formulated as a function off the services covered under the SMI. These operating regulations will be complemented with methodological guidelines for formulating and evaluating the various types of health care projects. **The official establishment of the Investment Committee and the implementation of the operational regulations of the FIP are conditions precedent for the first disbursement.**
- 3.11 In order to link investments to the needs of the maternal and child health care program, the program will conduct a study to determine the scope of the investments required in each of the areas in which the SMI is being established. These studies will be prepared in accordance with the priorities set for the areas in which the SMI will be established. Health care institutions, which will identify their investment needs, will be actively involved in preparing these studies, and their requests for financing will be formulated based on the criteria of the fund's operating regulations. At the intermediate level, the DISA will be responsible for handling requests for project financing that complying with the objectives set in their health care plans. The operating scheme of the investments system is presented in the technical archives of the project.
- 3.12 During the preparation of this project, new exercises of this type were conducted that served as the basis for estimating the amount and type of investment needed in each service network.



### **3. Other activities and technical assistance services**

- 3.13 The other activities of the SMI designed to increase the quality of services, to adapt supply to sociocultural preferences, and to provide information to consumers will be implemented by contracting with consulting firms. Similarly, activities of technical assistance, procurement of goods, construction, and services corresponding to the subcomponents of health care for widely dispersed populations and environmental health, as well as the components relating to development of policy instruments and institutional modernization, will also be implemented through contracting their services of consulting firms and individual consultants. As stated above, if necessary, the program can finance all or part of the salaries of employees in new positions at MINSA agencies that will be involved in implementation of the program.
- 3.14 Since the activities that will be carried out in the policy and institutional development components are activities that fall under the day-to-day responsibility of the operational units of MINSA, these units will be responsible for preparing the terms of reference for consulting, and for supervising the consultants and analyzing the results. These line units will take on their respective responsibilities with the support and technical assistance of individual consultants and consulting firms hired by the program.

#### **C. Project administration**

- 3.15 In order to ensure the coordination and consistency of all activities of the project, the project will have a Program Coordinating Unit (UCP) that will perform the following basic functions: (a) planning and programming all activities of the program with respect to technical, financial, and administrative aspects, in coordination with the pertinent offices at MINSA; (b) providing technical assistance to line agencies of MINSA, and support for the appropriate implementation of the activities for which it is responsible, including support for the preparation and coordination of the procurement process for construction, goods, and services; (c) periodically monitoring the results and impact of the program, and presenting to the high-level management of MINSA its pertinent suggestions and recommendations to ensure suitable implementation, and (d) keeping the accounting books of the program, and preparing and submitting the necessary reports to the Bank.
- 3.16 The UCP will have a basic organization comprising the general coordinator and to support units, one technical and nature, the other administrative. Additionally, it will have a budget for contracting temporary support in any administrative or technical area, particularly for evaluating and auditing the project.
- 3.17 The Administrative Unit, under the charge of an administrative coordinator, will be responsible for records and financial and accounting controls, as well as logistical

support for the procurement of goods and services and contracting of construction. To the extent possible, the project will seek to choose consultants specializing in these processes.

- 3.18 The Technical Unit, under the charge of a technical coordinator, will be responsible primarily for supporting the functional units, at the central and local level, in defining the terms of reference, selecting and contracting technical assistance, methodological, and operational services in order to ensure the appropriate implementation of the program. It will conduct its operations through specific consulting arrangements that will act as support for the coordination, planning, and supervision of the three components of the program.
- 3.19 The general coordinator of the program, who will be appointed by the Minister of Health, will participate as necessary in the working groups and/or meetings of the Coordination Unit for the Modernization of the Public Health Care Subsector.

**D. Procedure for contracting and procuring goods, services, and construction**

- 3.20 Procurement of goods and services and contracting for construction work will be handled in conformity with the procedures stipulated in Annex B to the loan agreement. International competitive bidding will be mandatory for procurement with a value in excess of US\$250,000 for goods and services, and US\$3 million for construction work. These limits are justified based on experience in the country with similar projects, which indicates that bidding above these amounts favors international participation. Bidding below these limits will be done in conformity with national law. Procurements and contracting financed by the local counterpart contribution maybe restricted to the national territory, as well as procurements that, by their nature, are justified and accepted by the Bank. The preliminary schedule for the program's main procurements is presented in Annex III-1.
- 3.21 Selection and contracting of consulting services for the program will be conducted in conformity with the Bank's procedures, as set forth in Annex C to the loan agreement.
- 3.22 With regard to contracting for consulting services financed at the expense of the counterpart contribution, and in amounts less than the equivalent of US\$100,000, the Bank may review and notes and names, background, terms of reference, and honoraria of the consultants, after the fact. In all other cases, the Bank will review and approve consultants before they are hired. The amount set as the limits may be modified as necessary during implementation of the program, in accordance with the results of annual reviews.

**E. Schedule of disbursements**

- 3.23 In conformity with the implementation program, the tentative schedule for disbursement of the resources of the loan and the local counterpart contribution are presented below:

<b>Table III-1</b>					
<b>Disbursement schedule</b>					
<b>(US\$000 equivalent)</b>					
<b>Source</b>	<b>Year 1</b>	<b>Year 2</b>	<b>Year 3</b>	<b>Total</b>	<b>%</b>
IDB	21,526	31,167	34,307	87,000	70
Local	4,158	10,850	22,992	38,000	30
<b>Total</b>	<b>25,685</b>	<b>42,017</b>	<b>57,299</b>	<b>125,000</b>	<b>100</b>
%	21	34	45	100	

- 3.24 As a condition precedent to the first disbursement, the borrower must submit proof, to the satisfaction of the Bank, that it has established the mechanism for transferring financing resources to MINSA through a special bank account in foreign exchange in the name of the executing agency and of the program, at a bank of its choice, in which the resources of the financing will be deposited through the revolving fund arrangement.

**F. Revolving fund**

- 3.25 Given the type of activities to be conducted and the planned scheduled for implementation of this program during the first year, it is recommended that a revolving fund be established in an amount equivalent to five percent of the financing, or US\$4.35 million.
- 3.26 It is provided that up to the equivalent of US\$500,000 of the financing resources of the Bank will be used for reimburse in expenses for preparation of the program. Additionally, it is provided that up to US\$1 million, charged to the local counterpart contribution, will be acknowledged for expenses incurred by MINSA in initial actions for the program. These expenses will be acknowledged in accordance with the procedures of the Bank.

**G. Bank monitoring during program implementation**

- 3.27 Monitoring and evaluation will make it possible to identify problems and in a timely manner to make the changes necessary for the successful implementation of the program. The methodology for monitoring and evaluation will be based on the benchmarks of the program (Annex II-1), and the corresponding information will be compiled in accordance with the responsibilities and modalities agreed upon with the Bank. The Bank's Country Office in Peru will handle oversight of the

general progress of the program. In principle, monitoring and evaluation will be performed as follows:

**1. Initial implementation meeting**

- 3.28 In a period no greater than three months after the loan has been declared eligible for disbursements. The borrower, with the assistance of the Bank, will conduct an implementation seminar/workshop for the program. The event will be attended by personnel responsible for implementing the activities of the program, as well as other participants in its implementation. The content, duration, and other aspects will be agreed upon with the Bank prior to the first disbursement. The preliminary operating plan for the first year of the program is available in the technical archives.

**2. Annual monitoring meetings**

- 3.29 In the last week of February each year, MINSA will submit a report on progress made in implementation of the program, noting the status of accomplishment of the annual goals. This progress report will serve as basis for the annual monitoring meeting on the program, to be held during the third or fourth week of April each year. In this way, necessary adjustments can be made in the proposed MINSA budget for the following year, which must be submitted to the MEF in May or June of each year.
- 3.30 The following topics have been identified, tentatively, for discussion during the annual meetings:
- a. Review of program implementation during the prior year, including the activities performed, the expenses incurred, and the accomplishment of annual goals.
  - b. Evaluation of the implementation and coordination mechanisms of the program, with special emphasis on the operating plan for the year, and its conformity with the terms of reference of consulting firms hired to support implementation.
  - c. Technical review of the products, progress reports, and final reports of the various consulting firms and individual consultants hired.
  - d. Technical review and evaluation of the conclusions and recommendations generated, in order to adjust the implementation of the program to achieve the target goals.
  - e. Consideration of new policy and strategy proposals formulated by high-level management with the support of the functional offices involved in implementing the program.
  - f. Generating consensus and defining the operating plan for the following year, based on the considerations outlined above.

g. Adjusting goals and defining corrective measures to be taken, as a function of appropriate coordination, administration, and implementation of the program.

3.31 The annual follow-up meetings will be held by the Bank's Country Office in Peru with the support of the project team based at headquarters.

### **3. Evaluation of triggers**

3.32 Once 75 percent of the resources of the loan have been disbursed, the Government of Peru and the Bank will perform an evaluation of the results of teams by the program in relation to the oversight indicators agreed upon as triggers (Annex I-1), which will form the basis for processing the financing of the second phase of the operation.

### **4. Ex post evaluation**

3.33 The country has indicated that, for this first phase of the program, an ex post evaluation is unnecessary, particularly since specific oversight mechanisms have been established for the main health care issues that will be addressed by the program.

### **H. Outside auditing**

3.34 During the implementation period, the executing agency will submit the financial statements of the program annually, properly audited by an independent auditing firm acceptable to the Bank, and chosen by public bid through the Office of the Comptroller General of the Republic of Peru.

## **IV. BENEFITS AND RISKS**

### **A. Benefits of the program**

#### **1. Impact on health**

- 4.1 The main benefits of the program relate to a reduction in maternal and child morbidity and mortality. Improving maternal and child health care, as studies done into other countries of the region show, is an investment that generates significant health gains. These studies<sup>5</sup> show that improving access to and the quality of basic health care services in low-income areas can save around 10 percent of the average disease rate in years of life adjusted by disability. The case of Mexico suggests that improving maternal and child health care results in an average savings of 47 years of healthy life for every 100 beneficiaries/year.
- 4.2 Although there are no estimates for the disease rates in Peru that would make it possible to calculate health benefits in terms of the number of years of healthy life, available data does allow an estimate of the number of deaths avoided each year. Once the SMI is fully implemented at the national level (at the end of the fifth year), the increase in health care coverage for expectant mothers will result in 900 fewer deaths per year, and a reduction in maternal mortality from 265 to 128 per hundred thousand live births. In turn, the increase in coverage of children under the age of four years will result in 23,400 fewer deaths each year, helping to reduce childhood mortality from 59 to 49 per thousand live births.

#### **2. Economic impact**

- 4.3 This is a program of highly cost-effective actions, since, with an additional investment of US\$40 per potential beneficiary per year (women in their childbearing years and children between zero and four years of age), 24,300 deaths will be avoided. In this way, the project will help increase efficiency in the use of sector resources, targeting spending on cost-effective interventions.
- 4.4 In addition to targeting spending toward the financing of cost-effective services, the process of reform would increase efficiency and allocation of resources and the internal efficiency of the system through the following actions: (a) strengthening the normative, administrative, and planning capacity of MINSA at various levels; (b) improving the management of services and introducing incentives for efficiency and productivity through management agreements and new payments mechanisms,

---

<sup>5</sup> See: "Economy and Health", vol. 11 (México, D.F: FUNSALUD, 1994) and "Disease rates in Colombia" (Ministry of Health, Bogotá, 1994). See also IDB, Paraguay, Program of Primary Health Care Reforms (PR-2194).

and (c) improving the problem solving capacity of the institutions, by reducing the need to handle patients at more complex and expensive levels.

### **3. Social impact**

- 4.5 In addition to preventing the death of the expectant mother, the program will also have additional significant social and economic impacts. When a woman dies, families lose the woman's contribution toward managing the household and the care that she provides for the children and other members of the family; the economy loses the contribution of a woman in the workforce; and community is lose a vital number whose unpaid work is fundamental to community life. The salaries and work of women within a household – rich, it in turn, depend on the women remaining healthy – are continuing to gain in importance. Additionally, the number of women who are heads of households is increasing in Peru – nearly 20 percent of households are presided over by women and many of them include small children. In addition, the death of a mother threatens the health, well-being, and even survival of her children. Studies have shown that orphans children have fewer opportunities for obtaining higher education and health care as they grow older. Studies also show that women, more often than men, use their income to improve the well-being of their families through additional food, better health care, and providing school supplies for the children. By eliminating the economic, physical, and sociocultural barriers to services, the SMI will prevent these losses of life, productivity, and capacity among the current generation of mothers and the future generation of children.
- 4.6 The indigenous population of Peru is enormous, estimated to be at least 40 percent of the overall population based on linguistic criteria. The burden of maternal morbidity and mortality is heavy among indigenous communities. Half of the population is under the age of 14 years, and exhibits a fertility rate that is far higher than the rest of the country, between 7 to 11 children per woman, on average. The program will respond to these populations with specific strategies to eliminate sociocultural to barriers to health care services, as well as pilot project for providing services to remote and widely dispersed communities, the majority of which are indigenous communities.

### **4. Impact on equity and poverty**

- 4.7 **Social equity:** Through its economic and social impact, and its targeting strategies, this project will create the conditions for greater social equity both in terms of the progressive distribution of State subsidies and in terms of health care service strategies. With regard to the distribution of the public subsidies, the establishment of the contributing and subsidized plans will help expand the coverage of the social security system for populations with the ability to pay, thereby freeing up resources to subsidize extremely impoverished populations. Additionally, the establishment of the SMI amounts to a reallocation of resources toward vulnerable groups. The

services covered by the SMI will be provided through the health posts and health centers of MINSA, where care is provided mainly for the most impoverished quintiles of the population.

- 4.8 **Poverty-targeted investment (PTI):** This project automatically qualifies as a PTI owing to its support for primary health care. Maternal and child services are a key element of the primary health care strategy adopted by the member countries of the World Health Organization at Alma Ata in 1977.

## **5. Environmental impact**

- 4.9 The program will have a positive environmental impact. The construction work contemplated in the program will be directed mainly toward the rehabilitation of existing infrastructure, and therefore it is estimated that its impact on the environment will be minimal. Nonetheless, the standards for rehabilitation of the health care institutions include the installation of waste management systems. Additionally, the environmental health subcomponent will train communities in this infected water and food, and will finance consulting and management training services for environmental health and risk management. Activities directed toward the prevention of communicable diseases, such as malaria, Chagas' disease, and yellow fever will also help to improve the health conditions of the environment.

## **B. Risks**

### **1. Excess demand for services**

- 4.10 The pilot projects of the SMI in Tacna and Moyobamba have generated a rapid insignificant increase in the use of health services. This implies that in less developed areas, use may exceed the response capacity on the part of health care services. In order to mitigate this risk, the program includes a phase for the creation of the conditions necessary for providing quality services in each area. Additionally, low current productivity rate indicates that there is untapped capacity that, in the short term, can be trained to meet demand.

### **2. Implementation capacity**

- 4.11 As in any program of this type, which requires the involvement of multiple and varied players, there is an implicit risk relating to the capacity for implementation and coordination. From the organizational perspective, the program requires the some existing organic units must be consolidated into a single unit to form the SMI, and that new units will be established, such as the SMI itself, and the Health Care Investment System. Additionally, it will be necessary for decentralized unit to play an active role in a program that will be coordinated at the central level initially. This risk relating to implementation capacity is mitigated in various ways: on the one hand, by the gradual expansion of the SMI, which will give rise to the preparation and training interventions that must precede expansion; on the other hand, the



organic units of MINSA and the DISA that will participate in the implementation process will be supported by a coordination unit that will be founded on the experience obtained in implementing other projects with international financing; and finally, the sense of commitment by the authorities at all levels ensures the active participation in the plan for implementation of the program's activities. In light of the foregoing considerations, the project team does not anticipate any serious problems in carrying out all the planned activities.

### **3. Sustainability in the short and medium term**

- 4.12 The overall expansion of the SMI at the national level, which will be completed in the five years following the start of the program's activities, involves total annual spending on the order of US\$92 million by the government. Of that amount, it is estimated that 80 percent is for variable incremental spending, which means that starting in 2005, the government must have increased spending on maternal and child services by approximately US\$74 million annually. This figure is manageable when compared with overall public spending on health care, currently US\$970 million, an increase of only 7.6 percent. The country's commitment to supporting the increase in spending for primary health care is reflected in the agreement that the government is putting together with the World Bank, in the framework of the conditions for the structural adjustment loan, which states that spending on primary health care or the year 2000 will be increased by 20 percent. Moreover, the loan includes the development of a proposal for new resource mobilization and allocation mechanisms for ensuring the program's medium-term sustainability. Among the key activities of the proposal is identifying potential efficiencies and savings in national hospitals, which would make it possible to reallocate resources for primary care.

### **4. Changes in the reform agenda**

- 4.13 Implementation of the program will begin in the last year of this administration, which implies the risk of not counting on similar political support in the medium term. This risk is minimal in regard to the SMI, regarding which there is broad consensus and support from all international donors. With regard to the other reform activities, the annual project reviews will serve as an opportunity for discussion and maintaining the program's focus.



## TRIGGERS FOR PROCESSING THE HEALTH SECTOR DEVELOPMENT PROGRAM MATERNAL AND CHILD HEALTH CARE COVERAGE

The IDB will use the multi-phase loan modality to support reform of the health sector in Peru. The program proposed in this document will support the first phase of the health sector reform, and will run for three years. The second phase will be processed once 75 percent of the resources of the first loan are disbursed and the benchmarks detailed below, agreed upon as triggers, have been reached. These benchmarks, which are presented in the logical framework, have been identified as the main indicators of progress in reform. It is expected that the evaluation of the achievement of these triggers will be done toward the middle of the third year.<sup>1</sup> However, some triggers may be reached before the evaluation takes place.

TRIGGER	VERIFICATION AND EVALUATION MECHANISM	JUSTIFICATION FOR SELECTING THE TRIGGER
<p>Maternal and child health care coverage (SMI) operating in the 15 departments financed by the IDB loan, with the following results:</p> <ul style="list-style-type: none"> <li>a) During the program, trained health care personnel have attended at least 232,000 births, which is equal to 80 percent of births among expectant mothers participating in the SMI.</li> <li>b) At least 403,000 of participating children have up-to-date immunization schedules, equal to 95 percent of participating children.</li> <li>c) At least 50 percent of the target population of each department is participating in the SMI.</li> </ul>	<p>Mid-term evaluation of the SMI (paragraph 2.19).</p> <p>Consolidated reports prepared for each of the Regional Health Departments (DISA), in the agreed format, as well as proof that the coverage and activity data have been verified by periodic random sample auditing.</p>	<p>The SMI is the main component of the program. The level of its performance will be measured through coverage indicators commonly used for maternal and child care. The SMI will reach its maximum coverage in the second phase of the program (year 5).</p>

<sup>1</sup> The figures regarding coverage of the SMI and the number of institutions administered under the CLAS system as presented in the logical framework have been modified to reflect this fact. These targets may be up to 10% less.

TRIGGER	VERIFICATION AND EVALUATION MECHANISM	JUSTIFICATION FOR SELECTING THE TRIGGER
<p>Global proposal developed for mobilizing and allocating public financial resources to ensure the sector's financial sustainability, and an action plan for implementing it has been approved by the Ministry of Health (MINSA) and the Ministry of Economy and Finance (MEF).</p>	<p>Document with the proposal and action plan submitted to the Council of Ministers by MINSA and MEF.</p> <p>The documentation for this proposal must include the following considerations (paragraph 2.20):</p> <ul style="list-style-type: none"> <li>a) Identification of efficiencies and savings with the public subsector, mainly at the hospital level, which will make it possible to reallocate resources to maternal and child health care, public health actions, and other priority interventions.</li> <li>b) Development of a fee policy along with effective mechanisms for exempting the most impoverished for services not included in the SMI.</li> <li>c) Development of a methodology for geographic allocation of the subnational resources that favors the most impoverished and most vulnerable departments.</li> <li>d) Adaptation of the mechanism for payments to providers and of the performance indicators used in the management agreements, developed based on the results of experiments now under way, which make it possible to reward efficiency in public spending.</li> </ul>	<p>The development of a new financing policy is essential for guaranteeing access to health care services in a sustainable manner. The action plan will be implemented in the second phase of the program, and therefore preparation of that action plan is considered a fundamental preparatory activity.</p>
<p>Proposal for incorporating new groups with the ability to pay into the paying plan, and development of an action plan for implementing the proposal.</p>	<p>Document with the proposal and action plan validated by the Commission for Monitoring Social Security and Health Care (COMSSS) and approved by MINSA.</p>	<p>Expansion of coverage of the paying plan will make it possible to increase the targeting of public spending on the impoverished population. The action plan will be implemented in the second phase of the program.</p>

TRIGGER	VERIFICATION AND EVALUATION MECHANISM	JUSTIFICATION FOR SELECTING THE TRIGGER
	The proposal must contain the evaluation of at least two pilot projects regarding the incorporation of groups of independent workers, and must set specific goals for coverage (paragraph 2.23).	
Law concerning the organization and functions of MINSA approved and in effect.	Decree-law published.  The law must reflect at least the following guidelines (paragraphs 2.26 and 2.27): a) MINSA specialization in guidance activities within the sector; b) clear definition of the functions and responsibilities at the central and subnational level, including the local level; c) integration of the vertical programs targeting the maternal and child population.	Strengthening the leadership role of MINSA will facilitate the formulation and implementation of sector policies allowing for increased efficiency and equality of services. The restructuring of MINSA as a function of the new law will be implemented in the second phase of the program.
Increase in the number of primary-level health care institutions administered under the CLAS model from 372 to 750 in the departments financed by the IDB loan.	Documentation of shared administration agreements and management contracts between the CLAS and MINSA and/or local governments.	Creation of the CLAS is the main strategy for modernizing the management of public health care institutions and guaranteeing community involvement.

### Evaluation meeting

The meeting to evaluate the results of the second year will serve as the basis for planning the evaluation of the program's triggers. During that meeting, the date on which the evaluation is expected to occur shall be set. Given the projections for program implementation, it is expected that the evaluation will take place in July or August of the third year. This will make it possible to rely on the audited financial statements of the program for the second year of its implementation.

In preparation for the evaluation meeting, the executing agency, with the support of the Program Coordinating Unit (UCP), will prepare a report on the status of the triggers. This report will be submitted to the Bank at least one month before the meeting.

Representatives of the various operational levels of MINSA responsible for implementation will participate in the evaluation meetings, as well as representatives selected by the Regional Health Departments (DISA) and a selection of Local Health Care Administration Committees (CLAS). Representatives of the Ministry of Economy and Finance will also participate. For the Bank, the country office and the members of the project team assigned to the program will attend.

The results of the evaluation will be discussed with the country's authorities, which will include: the high-level management of MINSA, representatives of the MEF, the president of the Commission for Monitoring of the Modernization of Social Security, and the president of the Coordination Unit for the Modernization of the Health Public Subsector.

### LOGICAL FRAMEWORK

OBJECTIVES	INDICATORS	MEANS OF VERIFICATION	CRITICAL ASSUMPTIONS
Rate of health of the maternal population	<ul style="list-style-type: none"> <li>- National maternal mortality rate reduced from 265 per 100,000 live births to 128 per 100,000 in 2005</li> <li>- National child mortality rate reduced from 47.9 per 1,000 live births to 33 per 1,000 in 2005</li> </ul>	<ul style="list-style-type: none"> <li>- MINSA statistics</li> <li>- National Demographics and Health Survey (ENDES), 2000 and 2004</li> <li>- Project Monitoring and Evaluation System</li> </ul>	
Quality, effectiveness, sustainability of health care for the maternal and child	<ul style="list-style-type: none"> <li>- SMI operating in 15 departments with at least 205,000 expectant mothers and 515,000 children participating by the end of 2002 (these figures represent 82% and 85%, respectively, of the target population).</li> <li>- During the last three years of the program, trained health care personnel will have attended at least 314,000 births, equivalent to 80% of births among covered expectant mothers.</li> <li>- At least 489,000 of the covered children are up-to-date with their immunizations, equivalent to 95% of covered children.</li> <li>- The public treasury is financing 40% of SMI variable costs in 2002.</li> </ul>	<ul style="list-style-type: none"> <li>- MINSA statistics and budgets implemented</li> <li>- National Health Care Spending Accounts</li> <li>- National Standards of Living Surveys, 1999-2002</li> <li>- Project monitoring reports</li> </ul>	<ul style="list-style-type: none"> <li>- Availability and subsidy for health care services will be sufficient to motivate the use of services and reduce the maternal mortality rate</li> <li>- Government's commitment to the targeting of interventions to vulnerable populations</li> </ul>
<b>ON COMPLETION OF THE PROJECT</b>			
Improvement in services (a) Working with standardized protocols, procedures, and prevention/promotion	<ul style="list-style-type: none"> <li>- 75% of expectant mothers participating in the SMI have received four prenatal exams</li> <li>- 80% of the health care personnel has been trained in the standard protocols of the SMI.</li> </ul>	<ul style="list-style-type: none"> <li>- MINSA reports and project monitoring reports</li> </ul>	<ul style="list-style-type: none"> <li>- Continuity in health policy of the 2000 government.</li> <li>- The SMI strategy is sufficient to increase the use of services and improve the supply of those services</li> </ul>
Access to care for widely-dispersed populations living in the pilot areas	<ul style="list-style-type: none"> <li>- Pilot programs in Huanuco and Amazonas evaluated, and plan for expanding the model of care to widely dispersed populations developed.</li> </ul>	<ul style="list-style-type: none"> <li>- MINSA reports and project monitoring reports</li> </ul>	<ul style="list-style-type: none"> <li>- The traveling team model is sufficient to increase the use of clinical services and achieve the expected results</li> </ul>

OBJECTIVES	INDICATORS	MEANS OF VERIFICATION	CRITICAL ASSUMPTIONS
Environmental conditions	<ul style="list-style-type: none"> <li>- Waste management system operative at all institutions covered by the project</li> <li>- Number of communities that have received training in disinfecting water and food.</li> </ul>	<ul style="list-style-type: none"> <li>- MINSA reports and project monitoring reports</li> <li>- <i>Statistics from the epidemiological monitoring system</i></li> </ul>	<ul style="list-style-type: none"> <li>- Communities participate actively in environmental health programs</li> <li>- Weather conditions remain stable</li> </ul>
SMI departments are equipped to provide the services	<ul style="list-style-type: none"> <li>- Number of institutions with the capacity to offer the plan of benefits at various levels of complexity.</li> </ul>	<ul style="list-style-type: none"> <li>- MINSA reports and project monitoring reports</li> </ul>	<ul style="list-style-type: none"> <li>- Public investment system operates smoothly</li> </ul>
<u>Development of policy</u>			
Policy instruments that are able to target public spending to the most vulnerable populations and regions	<ul style="list-style-type: none"> <li>- Action plan for implementing the proposal for mobilizing and allocating public resources approved by MINSA and MEF</li> <li>- Strategy for incorporating informal workers into the paying plan developed and a minimum of two pilot projects implemented and evaluated.</li> </ul>	<ul style="list-style-type: none"> <li>- MINSA, MEF, and COMSSS reports, and project monitoring reports</li> </ul>	<ul style="list-style-type: none"> <li>- Stable macroeconomic situation</li> <li>- Government commitment to the targeting of public spending</li> <li>- It is financially feasible for EOPS to sign up independent workers at prices under current schemes</li> </ul>
<u>Institutional Modernization</u>			
Institutionalization process initiated	<ul style="list-style-type: none"> <li>- System of public investment in health care established and operational at MINSA and resources allocated</li> <li>- Vertical programs relating to maternal and child health care are integrated</li> <li>- Preliminary draft law regarding the organization and functions of MINSA prepared</li> <li>- Public monitoring subsystems for maternal and perinatal mortality and communicable diseases functioning.</li> <li>- Number of primary-level institutions administered under the CLAS model increased from 372 to 823.</li> </ul>	<ul style="list-style-type: none"> <li>- MINSA, MEF reports, and project monitoring reports</li> </ul>	<ul style="list-style-type: none"> <li>- MINSA leadership manages to reach consensus on institutional reform</li> <li>- The public investment system can be extended to investments outside the program</li> <li>- The CLAS management model can feasibly be extended into a national system if there is sufficient regional capacity to establish a network of integrated services</li> </ul>
Activities are presented in the annexes in the technical archives of the project (graphs 3.29 and 3.30, and the annexes for specifications)			



OBJECTIVES	INDICATORS	MEANS OF VERIFICATION	CRITICAL ASSUMPTIONS
<p>h</p> <p>ements</p> <p>d services for the various</p>	<p>Amounts disbursed for program administration:</p> <p>Year 1            US\$690,000</p> <p>Year 2            US\$440,000</p> <p>Year 3            US\$660,000</p>	<p>Program accounting records</p>	<p>The national counterpart contribution is budgeted and allocated to the program according to the agreed amounts and</p>
	<p>Amounts disbursed for operation of the SMI</p> <p>Year 1            US\$12.0 million</p> <p>Year 2            US\$24.2 million</p> <p>Year 3            US\$37.4 million</p>	<p>Program accounting records</p>	<p>The program's records will be kept in appropriate manner, and will be at the discretion of the Bank.</p>
	<p>Bidding completed or under way up to the amount of:</p> <p>Year 1            US\$8.2 million</p> <p>Year 2            US\$10.9 million</p> <p>Year 3            US\$5.3 million</p>	<p>Program administrative and accounting records</p>	
	<p>Consulting and support services contracts completed or under way, up to the amount of:</p> <p>Year 1            US\$1.5 million</p> <p>Year 2            US\$2.6 million</p> <p>Year 3            US\$2.3 million</p>	<p>Program administrative and accounting records</p>	



## **MATERNAL AND CHILD HEALTH CARE COVERAGE (SMI)**

Maternal and child health care coverage (SMI) is an integral strategy for financing and providing health care services that seeks to eliminate the economic and sociocultural barriers that prevent low-income mothers and children from using maternal and child health care services, while also promoting improvement in the capacity and quality of those services.

### **GENERAL PROPOSAL OF THE SMI**

To contribute toward improving maternal and child health in Peru, through a financial and service-providing strategy that guarantees access of poorly protected mothers and children to more and better mother and child health care services, both or treatment and for prevention/health promotion. The SMI is intended substantially to eliminate the economic and sociocultural barriers that prevent mothers and children from lower income families from receiving the health care services they need, while the same time promoting improvement in the capacity and quality of those services. In the long term, the SMI will create conditions for the sustainability of the health care system for populations that do not have access to private systems.

### **SPECIFIC OBJECTIVES OF THE SMI**

1. To increase coverage of expectant mothers through complete prenatal examination (at least four exams, performed by competent health care personnel).
2. To increase coverage of childbirths attended by competent health care personnel.
3. To increase coverage of mothers after childbirth, with institutional care (by competent health care personnel, up to six week following childbirth).
4. To reduce the incidence of premature births and low birth weight.
5. To reduce early in-hospital neonatal mortality, related minimally to asphyxia at birth or infection.
6. To increase coverage of children with integral health care services (growth and development exams, complete vaccinations, calorie and micronutrient nutritional supplements, and timely and effective treatment of common diseases, particularly diarrhea and acute respiratory infections).
7. To increase the number of mothers after childbirth who have adopted some family planning method of their own choice.

### **SMI TARGET POPULATION**

The goal of the SMI is to provide benefits, by way of priority, to mothers in rural areas, impoverished mothers in urban areas, and mothers who do not use maternal and child services because they are unaware of them or because of poverty. In quantitative terms, the

annual target population of the SMI at the national level is 532,716 expectant mothers and 1,312,699 children under the age of four years, which is approximately 80 percent and 60 percent (respectively) of the total maternal and child population that is expected to have a guaranteed plan of health care provided by institutions of Ministry of Health. The expansion of the SMI must be gradual, with seven departments in the first year of the project, expanding to the entire country in the fifth year of the project.

#### **SERVICE PROVISION COMPONENT**

**SMI benefits plan.** The following integral maternal and child health care services must be provided for the beneficiary population:

1. Institutional prenatal examination (oriented toward determining obstetric risk), integral health care for the expectant mother, nutritional micronutrient supplements, preparation for childbirth and breast feeding, and prevention of neonatal tetanus.
2. Institutional care for childbirth in accordance with obstetric risk, when possible using methods that are culturally accepted in the region, provided in a timely manner and under optimal transportation and accompaniment conditions for the woman giving birth when necessary, owing to limitation of the care provided at the institution.
3. Institutional care following childbirth (up to six weeks following childbirth), oriented toward preventing complications, assisting with the start and continuation of breast feeding, and supplying nutritional supplements to the mother. Financed from other sources, the services must include family planning counseling and services freely chosen by the participating woman.
4. Medical care for diseases, emergencies, and complications that the mother experiences during or as a result of the pregnancy, birth, or puerperium period.
5. Basic neonatal care for healthy newborns, including effective assistance with the start of breast feeding and medical care for emergencies and complications that arise in the newborn.
6. Integral health care for pre-school children, including growth and development examinations, nutritional counseling and supplements, vaccinations, and care for common childhood illnesses, up to the age of three years.
7. Transfer of the participating individual to another institution, if required for solving the health problem for which treatment is being provided (provided that the institution is located within the geographical area in which the participating individual lives).

The package will finance services, medications, and supplies for each covered intervention. Additionally, a clinical training program will be financed for providers in SMI departments in the health-care protocols for women and children that are relevant to the SMI benefits package.

## FINANCIAL AND ADMINISTRATIVE COMPONENT

The outlines of the financial proposal of the SMI are based on the principles of effectiveness, the quality, and sustainability. The overall financial strategy for the health-care coverage is as follows:

**SMI participation premiums.** Expectant mothers and children may participate in the SMI at no cost if they live in the rural area or settlement. In urban areas, they will pay a participation premium that is less than current prices for maternal and child health care services.

**Modality and rules for SMI payments to providers.** Providers of maternal and child health care services will receive payments from the SMI through management agreements that will set quality and production goals for one or more of the following:

1. For signing up expectant mother or children with the SMI; this payment will be retrospective.
2. For prenatal examinations and for healthy child examinations; part of this payment will be made in advance, and the remainder when the service cycle has been completed (four prenatal examinations per expectant mother, etc.).
3. For other services such as complications of pregnancy, childbirth care, complications of childbirth, post natal care, complications during the post natal period, care for the newborn, complications in the newborn, health problems of children under the age of four years. Payment for care for normal childbirth and care for healthy newborns will be provided in accordance with the care given. Payment for other services will be made in accordance with the particular diagnosis.

The amounts to be reimbursed for any of the three-month allergies described above will be determined based on fee schedule. These fees, equaling US\$61.40 per expectant mother and US\$33.60 per child, have been developed based on cost studies conducted in 1998-99. These figures will be reviewed and adjusted during the course of the project to reflect the real costs of providing the SMI package.

Given the limitations over reimbursements system for services and the danger of excess demand in urban areas, the modalities for payment will also be reviewed in the course of implementation. Additionally, during the second year of the project the feasibility of two other schemes is scheduled to be tested in urban areas having considerable managerial capacity: (a) transferring a lump sum to a service network, and (b) a system of vouchers for public or private maternal and child services.

The management agreements between the SMI and the institutions will provide incentives for achieving the goals associated with a group of quality and production indicators, while always protecting the rights of the consumer, such as: reaching a certain number of births attended at institutions; keeping the proportion of cesarean births within a technically

acceptable margin (disincentives for exceeding the margin); reaching a certain percentage of children through full healthy child examinations; and pursuing and maintaining indicators for the quality of care.

**Supply guarantee.** An initial fund will be established that will make it possible to provide sufficient supplies and medications for institutions, in accordance with their analytical capacity. To that end, the SMI will provide the institutions with a formulary of medications and inputs, organized by diagnosis, in accordance with the health care protocol. The health care institutions will have autonomy with regard to procuring medications and medical supplies, through the CTAR, DISA, or CLAS directory; however, institutions must make a commitment to maintain an adequate and permanent stock of medications and supplies. The SMI will encourage health care institutions to have packs or pouches containing the medications and supplies needed for certain maternal and child health care services, such as a Childbirth Pack, for example.

## COMMUNICATIONS COMPONENT

**Objective.** This component is important both for the successful operation of the SMI in the short and medium term, and for its long-term sustainability. The role of this component is to minimize the sociocultural barriers and lack of information that prevent expectant mothers from using maternal and child services, and the same time promoting among them healthy habits that will help reduce foreseeable risks.

Through social marketing techniques, the community will be informed of the existence of this health care coverage, and participation by the beneficiary population will be promoted. Participating women will be informed of the rights and duties that they take on when they join the SMI, so that they would use the system well. The social marketing goal of the SMI will be to obtain the highest possible number of participants within the target population, and to achieve good standards of use of the system.

Through health promotion activities, an effort will be made to promote understanding and healthy attitudes and practices among women of childbearing age with regard to their reproductive health. An effort will also be made to value the status of women so that family members (particularly the husband) and the community will pay greater attention and will place greater importance on taking care of the health of the mother, particularly during pregnancy and childbirth. Women, the family, and the community will be educated with respect to the importance of maternal health, the risks that all women incur during pregnancy and childbirth, and the actions that must be taken when any emergency or complication arises.

Health promotion activities will be implemented with the involvement of local NGOs, basic community organizations, and civil society, in general. A concerted effort is required on the part of health care promoters, midwives, volunteers, and other community agents with a genuine interest in maternal and child health, and who are capable of conducting effective activities in the community.

## **MONITORING AND EVALUATION COMPONENT**

Reliable, effective, and low-cost methods will be used to measure the progress of the SMI measuring maternal mortality is difficult because maternal deaths may occur outside the context of health-care institutions and are not reported, or because they are recorded incorrectly intentionally (abortions, for example), or unintentionally (when it is not known whether a woman is pregnant at the time of death, for example).

In order to reduce maternal mortality, it is more important to understand why a death occurred than to maintain precise statistics on how many maternal deaths have occurred. Case studies provide very valuable information for health care personnel, information that helps to determine whether, for example, death occurred because of a delay in seeking care or because the care given was inadequate.

Monitoring selected process indicators, for example the proportion of births under institutional care, can show more reliably whether or not the SMI is working, since the greater the use of good maternal and child health care services, the lower the rate of maternal mortality of the period these process indicators, carefully selected and collected in a timely manner using valid methods will serve to develop, implement, and evaluate the guidelines and strategies of the SMI. In the first year of the project, an evaluation of the program's impact will be developed.

**Operational research.** The new information needed must be collected in a prospective manner through operational research targeting specific subjects and conducted over a short period of time. A list of research subjects must be developed and updated continuously. Qualitative and quantitative methods will be appropriate. The results of this research will be provided quickly to the interested parties so that they can be used for redesigning or reformulating the guidelines and strategies that are being implemented.

## **ORGANIZATIONAL CONSIDERATIONS**

**Relationship of the SMI to the maternal and child health care program.** At all times, the SMI will use the technical standards and materials approved for the maternal and child health care program, thereby emphasizing the governmental nature of the program. The role of this coverage program is to purchase maternal and child health care services for the participating population, whereas the role of the maternal and child health care program is to provide standards and guidelines and to implement actions required to guarantee the quality and timeliness of maternal and child services.

**Relationship of the SMI to the DISA.** There must be an operational unit of the SMI in each DISA. This unit must function in such a way that it handles most reimbursement procedures without needing to contact the central level. Only claims that exceed a certain amount or those relating to cases requiring technical consultation will be forwarded to the central level of the SMI.

**Relationship of the SMI to health care institutions.** The SMI will foster the organization of health care institutions into networks or consortia (the latter indicated institutions in the shared administration plan, CLAS). Additionally, it will foster an increase in the number of institutions in CLAS, since that plan facilitates the future implementation of regulations aiming at increasing efficiency in spending and controlling excess costs.



## TENTATIVE PROCUREMENT SCHEDULE

Principal procurements of the program	Financing	Method	Prequalification	Dates
<b>CONSTRUCTION</b> (For an aggregate amount of US\$15.7 million)				
<b><u>Year 1 (US\$4.2 million)</u></b>	95% IDB	LCB	No	II/00
Health Centers: Three calls for approx. US\$2.3 million	95% IDB	LCB	No	II/00
Local Hosp./Support: Three calls for approx. US\$600,000	95% IDB	LCB	No	II/00
<b><u>Year 2 (US\$ 7.7 million)</u></b>				
Health Posts: Four calls for approx. US\$2.8 million	95% IDB	LCB	No	I/01
Health Centers: Three calls for approx. US\$3.1 million	95% IDB	LCB	No	II/01
Local Hosp./Support: Five calls for approx. US\$1.8 million	95% IDB	LCB	No	II/01
<b><u>Year 3 (US\$ 3.8 million)</u></b>				
Health Posts: Four calls for approx. US\$1.1 million	95% IDB	LCB	No	I/02
Health Centers: Four calls for approx. US\$1.6 million	95% IDB	LCB	No	II/02
Local Hosp./Support: Two calls for approx. US\$1.1 million	95% IDB	LCB	No	II/02
<b>GOODS</b> (For an aggregate amount of US\$8.7 million)				
Year 1 - Three lots of medical equipment, approx. US\$2.7 million	95% IDB	ICB	No	II/00
- One lot of computer equipment, approx. US\$500,000	95% IDB	ICB	No	I/00
- One lot of communications equipment, approx. US\$800,000	95% IDB	ICB	No	II/00
Year 2 -Two lots of medical equipment, approx. US\$3.2 million	95% IDB	ICB	No	I/01
Year 3 -Two lots of medical equipment, approx. US\$1.5 million	95% IDB	ICB	No	I/01
<b>CONSULTING AND SERVICES</b> (For an aggregate amount of US\$6.4 million)				
Year 1 - Four competitions for approx. US\$986,000	75% IDB	ICB	Yes	I and II/00
- Eleven competitions for approx. US\$478,000	75% IDB	LCB	Yes	I and II/00
Year 2 - Various competitions for approx. US\$2.6 million	75% IDB	ICB/LCB	Yes	I and II/00
Year 3 - Various competitions for approx. US\$2.3 million	75% IDB	ICB/LCB	Yes	I and II/00

ICB = international competitive bidding

LCB = local competitive bidding

DATE = Quarter of the year in which the event occurs

PROPOSED RESOLUTION

PERU. LOAN \_\_\_\_/OC-PE TO THE REPUBLICA DEL PERU

(Health Sector Development Program – Maternal and Child Health Insurance  
First Phase)

The Board of Executive Directors

RESOLVES:

That the President of the Bank, or such representative as he shall designate, is authorized, in the name and on behalf of the Bank, to enter into such contract or contracts as may be necessary with the República del Perú, as Borrower, for the purpose of granting it a financing to cooperate in the execution of the Health Sector Development Program – Maternal and Child Health Insurance (First Phase). Such financing will be for the amount of up to US\$87,000,000, from the Single Currency Facility of the Ordinary Capital resources of the Bank, and will be subject to the “Terms and Financial Conditions” and the “Special Contractual Conditions” indicated in the Executive Summary of the Loan Proposal contained in Document PR-\_\_\_\_\_.