PROGRAM FOR INSTITUTIONAL REORGANIZATION AND EXPANSION OF BASIC SERVICES IN THE HEALTH SECTOR

(HO-0032)

EXECUTIVE SUMMARY

BORROWER AND GUARANTOR:	Republic of Honduras	
EXECUTING AGENCY:	Secretariat of Health (SS)	
AMOUNT AND SOURCE:	IDB:	US$36.0 million (FSO)
	Local counterpart funding:	US$ 4.0 million
	Total:	US$40.0 million
FINANCIAL TERMS AND CONDITIONS:	Amortization period:	40 years
	Grace period:	10 years
	Disbursement period:	5 years
	Interest rate:	1% during grace period and 2% thereafter
	Inspection and supervision:	1% of loan amount
	Credit fee:	0.5% on undisbursed balances

OBJECTIVES: The objectives of the program are: (i) to help set the stage (from an institutional, methodological, and management standpoint) to enable the Secretariat of Health (SS) to design and implement the reform of the health sector in the medium term, and (ii) in the short term, to improve the quality of services and to strengthen and promote health education through expanded access to primary health care services.

DESCRIPTION: The program is designed as a long-term transition project to carry out the institutional reform of the SS, complementing activities initiated under the technical cooperation for the public sector reform program (PRSP/CTPRSP: PR-967/SF-HO and PR-968/SF-HO), resolves existing health problems, and prepares institutional capacity for the future reform of the sector.

With respect to the first objective, the program will help: (i) to complement the institutional reorganization of the SS through financing for activities geared to rationalizing and restructuring the ministry's technical and administrative systems; (ii) to undertake a pilot plan for hospital reform that includes activities of restructuring, modernizing management, reinforcing autonomy at six

hospitals including actions to rehabilitate and outfit three hospitals and to strengthen the national emergency system at three other existing hospitals to initiate the reform; and (iii) to develop the necessary technical and management capacity for the sector so that it can carry out the program and set the stage for an operation for reform of the sector in the future. This would be achieved through technical assistance and three sector studies.

As to the second objective, the program seeks to resolve health problems affecting mainly the poor, women, and children, with financing for activities that would: (i) expand the access program with basic services; and (ii) bolster three public health programs. (health education, epidemiologic surveillance with a focus on AIDS control, and nutrition improvement).

The program is structured around two components:

A. **Component to develop the basis for reform of the health sector (US$24,800,000)**, which would be effected through three activities:

   (a) Institutional reorganization of the Secretariat of Health, for the purpose of modernizing the institution and making it more efficient. This would be achieved through restructuring at the central level (confirming the hierarchical structure of the SS, improving and decentralizing systems for administration of human resources, procurement, and budget), and readjusting the institutional policies of the sector including a redefinition of institutional roles, the creation of mechanisms for coordination between the SS and Social Security and the Private Sector, and the development of mechanisms for accreditation of establishments to improve the quality of health care.

   (b) Pilot program for hospital reform to finance the development of a new model for hospital organization and care that would be carried out under a pilot plan at six hospitals structured around: (i) the strengthening of hospital autonomy taken to mean the decentralized management of the budget, personnel, and the procurement system; participation by civil society through

support committees or boards; introduction of cost recovery mechanisms; execution of management contracts between the SS and the hospital and the hiring of general services (cleaning, supervision, etc.) that would be offered by the private sector; (ii) modernization of management at six hospitals including the development of new management systems, information management, personnel and procurement management, accounting, budget, quality control, transport, and communications and maintenance; (iii) physical and operational rehabilitation and basic reconditioning of three hospitals; (iv) the development of a national emergency system using existing infrastructure at three hospitals; and (v) the application of environmental safety measures.

(c) development of institutional operating capacity. The Program Coordinating Unit (PCU) will be in charge of implementing the program and preparing documentation and establishing methodologies that provide technical underpinning for future reform of the sector including the hiring of consulting services to perform mid-term and final evaluations. The Unit will also be responsible for supervising three sector studies: **promoting participation by the private sector** as service provider, analysis of the **Social Security** health system, and analysis of **domestic violence** as a health problem.

B. **Primary health care strengthening component (US$9,400,000).** This component is designed to improve protection of population groups at social and epidemiologic risk (the poor, women, and children) through financing for two activities:

(a) expanding the Access Program to population groups lacking basic service coverage (30% of the population, or approximately 45% of municipalities in the country) including the strengthening of management at the local level, participation by civil society, restructuring of the benefits system, and

(b) strengthening of three public health programs concerned with health education,

epidemiologic surveillance to target disease prevention and control, with a special focus on controlling AIDS in pregnant women, and nutritional improvement (micronutrient supplementation and breast feeding).

ENVIRONMENTAL CLASSIFICATION: The Environmental Summary of the program showed that its environmental effects would be favorable since hospital personnel would received training in procedures to prevent and provide protection against sanitary waste as well as environmental protection measures with a focus on the control of liquid and hospital waste (see paragraph 4.11 and environmental summary). Moreover, given the nature of the program, virtually all of the activities are intended to have an impact on the social conditions of the most vulnerable human groups such as the poor, women, and children. An analysis of the beneficiaries (paragraph 4.26) shows that the program targets mainly the very poor. The impact on women and children is accorded priority under the program since the activities of the primary health care strengthening component (paragraph 2.19) under the "expanded Access Program" target mainly women and children, with the expectation of reducing mother and child mortality rates. Likewise, the public health strengthening actions will benefit groups at risk (women and children) through health education, epidemiologic surveillance, nutrition improvement for pregnant women and children under six and the control of AIDS in HIV infected pregnant women. The program entails health education and health care with special activities for indigenous populations (paragraph 2.19.b). The three hospitals selected for rehabilitation and reconditioning were given priority owing to their support for the Access Program and their scheduled health care programs for women (pregnancy, birth, postnatal care, reproductive health, and breast feeding) and for children (growth and development, immunization, basic care). The program encompasses a study on domestic violence that focuses on the health of women and children and identifies strategies for sector care.

BENEFITS: The program targets the majority of its benefits to the population living in poverty and at greatest epidemiologic risk. The estimated number of beneficiaries is 2,590,000 (47% of the country's population) of whom 920,000 are children under six (70% of that age group) and 555,000 women of child-bearing age (46% of that group). The Access Program will expand coverage of basic services to 80% of municipalities. The program would also bring other

benefits resulting from the improved institutional efficiency, which would have positive effects on productivity and return on investment.

RISKS: The uncertainty associated with the program has to do with its financial sustainability. Public spending on health is low and poorly targeted. In this context, the program's structure has been designed to improve the targeting of public spending and make it more efficient. The operational weaknesses of the SS are a problem entailing some risk for the execution of the program. The coordinated and complementary actions of the CTPRSP and the program are positive steps for minimizing this potential risk.

THE BANK'S COUNTRY AND SECTOR STRATEGY: The Bank's strategy in Honduras is geared to poverty reduction, development of human capital, institutional strengthening and support for modernization of the State. In health, the Bank's strategy centers on improving the efficiency, effectiveness, and equity of the system.

IMPACT ON POVERTY: The program satisfies the Eighth Replenishment criteria, inasmuch as it targets geographical areas where the majority of the population can be classified as poor. The initiatives proposed assign priority to preventive measures that will have maximum external positive impact on the health of the population in general, with special emphasis on the human groups at greatest risk – women, children and the poor.

SPECIAL CONTRACTUAL CONDITIONS:

Conditions precedent to the first disbursement

The following requirements must be met prior to the first disbursement: (i) the Project Coordinating Unit (PCU) must have been formed with local and essential personnel in accordance with the structure already agreed on with the Bank (see paragraphs 3.4 and 3.5); (ii) the Annual Plan of Operations (APO) for the first year of execution must have been submitted as indicated in paragraph 3.10 of the document; and (iii) the final terms of reference for the performance of the activities envisaged in the APO for the first year must have been submitted.

Special conditions for disbursement of funding for investment in hospitals

The disbursement of financing for the overall rehabilitation of three hospitals and the strengthening of the national emergency system at three others are predicated on fulfillment, to the

Bank's satisfaction, of the activities and conditions described in paragraphs 2.9 to 2.15 of the present document.

Other conditions

The following documents must be submitted 30 days before the mid-term evaluations (to be completed 30 months after the effective date of the loan contract): report on the general status of the program; analysis of the performance of the activities included in the approved APOs and a proposal for the next phases.

The loan contract will also include the standard Bank clauses concerning, inter alia, audits, reports, inspections, loan evaluation, procurement of goods, services contracts for construction works and hiring of consultants.

EXCEPTIONS TO BANK POLICY: None.

PROCUREMENT CONDITIONS: International competitive bidding will be required for contracts valued at more than US$250,000 in the case of services and US$1 million in the case of goods. Paragraph 2.22 gives a breakdown of the direct costs of the program by investment and the tentative procurement plan is presented in Annex III.

I. FRAME OF REFERENCE

A. Economic context

1.1 After a decade of economic instability – characterized by fluctuations in GDP, unemployment, large fiscal deficits and heavy external indebtedness – a stabilization and structural adjustment program was launched in 1990 with the backing of an IMF enhanced structural adjustment facility (ESAF) and multilateral banks. In 1994 Honduras approved a law on the restructuring of revenue mechanisms and the reduction of public expenditure, and proposed fiscal discipline measures to cope with the country's financial deficit. In 1995 the government approved (with IDB financing) the Public Sector Reform Program (PRSP) (operation 967/SF-HO) for modernization of the State, which included technical cooperation funding (PR-968/SF-HO), abbreviated herein as CTPRSP, for institutional reform in four sectors: health, education, natural resources, and communications. Adoption of the PRSP and CTPRSP measures was considered a prerequisite for improving public administration. The government accordingly designed its economic policy with the aim of ensuring sound management of fiscal, monetary and exchange-rate policies.

B. Social context

1.2 Honduras is one of Latin America's poorest countries, with per capita GDP of US$650 (1994). Around 70% of all households and 67% of the population are living in poverty. Honduras shares with Guatemala (1989) the greatest degree of income inequality in Central America including Panama (Gini: 0.59). 1/ Population growth has fluctuated in recent years (1990-1995) between 2.8% and 3.1% per annum, while the country's economic growth rate has ranged between 2.1% and 2.5%. Honduras presents a low level of human development, reflected in inadequate health and education conditions and the marginalization of women. Public social expenditure on education and health in 1994 was approximately 4.9% of GDP and 2.5% of GDP, respectively. 2/

1.3 The population was estimated to number 5.5 million in 1996. For administrative purposes, the country is divided into 18 departments and 297 municipalities. In terms of population age structure, the population is very young (43% under 15 and 5% over 60 years old)

1/ IDB. RE2: Las economías de los países centroamericanos [The Economies of the Central American Countries]. Nov. 1996.

2/ There are variations in the available data on the amounts of social spending on education and health and the percentages of GDP and central government expenditure these figures represent. The figures given here are indicative of those derived from various sources.

and rural (some 20,000 small hamlets) with a high fertility rate (5 children/woman). Interpretation of the health indicators reveals the prevalence of communicable diseases, associated with such adverse factors as poverty, poor environmental sanitation, malnutrition and lack of access to services. The values of the indicators have to be taken as indicative due to an estimated 30% underreporting of vital events, but overall they are considered unsatisfactory. 3/ Malaria, malnutrition and AIDS are specific health problems. 4/ Domestic violence is a serious problem, with a total of 11,142 attempted murders having been reported in 1994, marking an increase of about 10% annually. The perception of the Health Secretariat Family Advisory Board and different NGOs 5/ is that, even without specific data, it is evident that domestic violence is a very serious concern which is affecting women's and children's development.

1.4 **Female underemployment and unemployment** figures are high. In 1994 women accounted for 28% of the labor force, below the average for Central America. This marginalization is more evident in rural and poorer urban areas where problems of access to education and health services and mounting violence are more acute. This shows up in negative indicators such as high maternal mortality, low rate of hospital care for childbirth, the high fertility rate (6.4 children per woman in rural areas), and a low percentage (45%) of the female population in family planning programs.

1.5 **Ethnic groups** account for approximately 300,000 of the country's population. The eight indigenous peoples are the Garífuna, Tolupán or Xicaque, Misquitas, Lencas, Chortis, Tawahka, Pech, and Negros Isleños, the four first-named being the largest among them. In general, these groups live in areas of the country where poverty is most pronounced, and residents lack proper access to basic services and have sparse public health program coverage.

1.6 The **demand** for health services is strongest for public institutions, with the private use of services being somewhat distorted by pharmacy spending (not entirely on health care). This was ascertained from two surveys conducted in the past five years.

3/ Life expectancy: 67 years; maternal mortality rate: 180 per 100,000 live births; infant mortality: 45 per 1,000 live births; under-five mortality: 55 per 1,000; chronic malnutrition in children under 5: 39%; low birthweight: 11%; annual visits to doctors/clinics per capita: 0.6; coverage of care at childbirth: 48%; and access to services: 70%.

4/ The IDB is financing a nonreimbursable technical-cooperation operation (ATN/SF-4687-HO) of US$1.8 million for AIDS prevention and control.

5/ Asociación Cristiana de Jóvenes; Asociación Desarrollo Poblacional; Asociación Planificación Familia, etc.

The first, the 1992 Living Standards Survey 6/, revealed that 60% of people seek care, when they are ill, from public facilities (Secretariat of Health and Honduran Social Security Administration), whereas 33% turned to the private sector (including pharmacies) and 7% utilized other services.

1.7 The second survey, done in 1996 by the Japan International Cooperation Agency ("Health Master Plan for the Year 2010"), 7/ interviewed 2,500 households and found that, for outpatient care, 48.3% of families used Secretariat of Health (SS) facilities, 34.2% used private services, and 3.1% went to Social Security Administration (IHSS) establishments. For hospitalization, 80% of families used SS facilities, 10.4% went to private hospitals, and 6.4% used IHSS hospitals. Over half (60%) of respondents stated that they were willing to pay directly or indirectly.

C. The Honduran health sector

1.8 Honduras's health sector has been predominantly public, with a stationary social security system and an incipient private sector. The bulk of the sector's resources are derived from general taxes, with financial allocation mechanisms based on delivery by public providers (SS and IHSS). The State, through the SS, finances sector operations and performs the functions of policy and standard-setting, organization, and care delivery.

1.9 The sector's main problems have had to do with: (i) low health expenditure; (ii) inadequate institutional organization; (iii) weaknesses in management systems such as management information, specifically as regards unit costs of services; (iv) inefficient resource use, due particularly to centralization, lack of management capacity on the part of personnel and lack of institutional coordination; (v) low coverage of basic services and programs, affecting 30% of the population (corresponding to about 45% of the country's municipalities); (vi) an inefficient care delivery system characterized by a centralized, uncoordinated, intramural, treatment-centered model; and (vii) severely deteriorated and outmoded hospital plant.

1.10 The system is inequitable, because of the large percentage of the population without access to basic services and programs and the inadequate allocation of public expenditure, with the largest share of the budget being assigned to curative care.

1.11 The system is also inefficient due to: (i) concentration in the SS of policy- and standard-setting, financing, organization, and service delivery functions; (ii) scant involvement of other

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6/ SECPLAN. Household Living Standards Survey. 1992.
7/ Japan International Cooperation Agency. Health Master Plan. Honduras. 1996.

institutions in service delivery; (iii) a care delivery model based on public establishments, with little participation by civil society; and (iv) poor treatment outcomes because of management weaknesses and severely deteriorating hospital plant.

1.12 The present system will be financially unsustainable because it is based on the preponderant role of the State. Public expenditure on health is low and produces little return as a result of budget constraints, a lack of cross-sectoral coordination, and inadequate resource allocation and use.

1.13 The **sector** is made up of the Secretariat of Health (SS) - formerly the Ministry of Health, the Social Security Administration (IHSS), and private sector.

a. The **SS** is the policy-setting and oversight agency for the sector. It is organized in two levels: central (Office of the Secretary and policy directorates) and local (9 regions subdivided into 18 departments and two metropolitan areas). Coverage is approximately 45%, through a network of 917 establishments, 890 (97%) of them for primary care and 27 hospitals.

b. The **IHSS** takes in about 10% of the country's total population, with coverage for the insured, his spouse (maternal care) and children up to age 12. It operates three hospitals and 12 clinics, and has problems associated with low coverage and financing. The basic contributory wage ceiling was set at 600 lempiras in 1962, which has hampered revenue collection and expansion of coverage.

c. The **private sector** covers an estimated 20% of the population and is made up of: (i) private for-profit services through 55 clinics; (ii) prepaid care, with scant coverage (five insurance companies with around 14,000 members); and (iii) private nonprofit services run by NGOs. 8/

8/ A total of 263 NGOs are active in Honduras, 102 of which are involved in health care, but only 30 of them coordinate their activities with the ministry.

D. Financing of the health sector

1.14 The most salient features of health-sector finance in Honduras are that it is predominantly public; budgets are inadequate; 9/the spending structure is inefficient; and it relies heavily on external aid, which has funded between 15% and 25% of total sector outlays. A comparative analysis of total health expenditure (public and private) as a percentage of GDP in the countries of Central America including Panama reveals that, apart from Costa Rica (9.18% of GDP) and Panama (8.67%), spending on health is low, the lowest levels being recorded in Guatemala (5.03%) and Honduras (5.68%). 10/ Comparing public health spending in Honduras with expenditures elsewhere in the region, Nicaragua, Costa Rica, and Panama report higher levels than Honduras (4.2%, 7%, and 6.8% of public expenditure, relative to GDP). El Salvador is on a par with Honduras. Only Guatemala is lower, at 0.9% of GDP. 11/

1.15 The **structure of public health sector financing by object of expenditure** is summarized in the following table:

APPLICATION OF FUNDS: Programs	1994 and (1996) percentage		OBJECT OF EXPENDITURE	1994 and (1996) percentage	
Primary health care	42	(46%)	Personal services	59	(53%)
Hospital care	43	(39%)	Materials and supplies	32	(37%)
Administration	12	(11%)	Nonpersonal services	8	(8%)
Human resources	3	(4%)	Maintenance	1	(2%)
TOTAL	100	(100%)		100	(100%)

* The allocation to primary care programs has been increased and expenditure on personal services has been reduced as a result of the country's decision to carry through the modernization of the State program.

1.16 The SS operates a **cost-recovery system** through the hospital network, with rates that are more symbolic than aimed at true financial sustainability (there are no sound service-costing information systems in place). In 1995 approximately 2% of the SS's hospital budget was collected through the hospital system.

9/ (i) Public spending on health care as a percentage of GDP has not risen above 3% in the past five years; in 1995 it stood at 2.5% of GDP. (ii) Per capita annual allocations have traditionally been low (US$20-US$25). (iii) Health expenditure has not been a steady percentage of the central government budget, having ranged from 6% to 11%.

10/ Data from R. Govindaraj, cited in André Medici: A Saúde em Honduras, 1995.

11/ Ruta Social. Honduras: El gasto social y su eficiencia. July 1996.

1.17 As for **private expenditure** on health, data on the gross value of private sector output for 1995 according to Central Bank estimates were analyzed, on the basis of which a total annual expenditure of US$34 million was calculated. It is estimated that this spending breaks down three ways as follows: private hospitals and clinics (54%); expenditures in pharmacies (40%), and private insurance (6%).

1.18 The following table presents a breakdown of total sector expenditure in 1996. These outlays represent an annual per capita allocation of US$38.

SOURCE	US$	PERCENTAGE
Ministry of Health	75,230,000	43.5
Social Security	22,200,000	12.8
External aid	41,700,000	24.1
Private sector	33,900,000	19.6
TOTAL	**173,030,000**	**100.0**

E. The country's strategy for the health sector

1.19 The health authorities' strategy aims 12/ are quality improvement and health promotion and education, by expanding access to basic services. Five priority guidelines will be pursued for the institutional reengineering of the SS: (i) institutional reorganization by way of geographical/political departmentalization and adjustments to the care model at the community level and for outpatient and hospital services; (ii) deconcentration of resources to strengthen the local (departmental and municipal) level and development of a health co-management process, as the Access Improvement Program is expanded; (iii) management development for staff and health institutions, including modernization of administration and procurement systems; (iv) financial sustainability of the model, and (v) review and reformulation of plans and programs.

1.20 The care model will be reorganized at two levels: at the community level, by way of the Access Improvement Program, stressing health promotion and education; and at the institutional level, by reorganizing the care delivery network on two fronts – urban and rural. At the rural level, the primary-care network of CESARs, CESAMOs, and district hospitals would be revamped as part of the departmentalization of services. At the urban level, national and regional hospitals would be revamped, with special attention to strengthening emergency care facilities, with remodeling and

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12/ Honduras: Secretariat of Health. A New Health Agenda. February 1998.

reorganization of the current infrastructure. This service-network reorganization includes changes in functional structure (hospital autonomy) and care delivery, including availability of a "basic package" and use of other organizational modalities for service delivery (NGOs, etc.).

1.21 In 1995, with financial assistance from the Swedish International Development Authority (SIDA), the SS launched the Access Improvement Program (Access Program) in four health districts that took in 60 municipalities in socioeconomically backward areas selected for the pilot program. 13/ This experiment begun with SIDA has been continued with support from USAID, UNICEF and PAHO, with priority being assigned to:

a. **Deconcentration of services**, conceived as a gradual process to strengthen the local level (departments, districts, municipalities). Management systems (information, procurement, programming, supervision, evaluation) were to be deconcentrated at the municipal level, and care delivery would be strengthened at the municipal level.

b. **Participation by civil society**, with the objective of strengthening local development. Participants in this process are community groups and agencies and official organizations (Local Development Committees, Health Committees). The Health Committees draw up their plans on the basis of SS resources and standards and with community input.

1.22 **The basic health package**, devised to answer the needs of the various segments of the population, was designed by reference to criteria having to do with beneficiary population, care delivery modality, content and cost. Its content varies depending on local conditions, and includes immunizations, child development and reproductive health services, care at childbirth and control of disease patterns.

1.23 An evaluation of the Access Program 14/ reveals that there have been improvements with respect to coverage, efficiency, and financing: (i) in terms of coverage, accessibility for municipalities rose from 45% in 1994 to 58% in 1996, and is expected to rise again to 63% by 1999, with external resources; (ii) as for efficiency, the program has helped in the deconcentration of programming and evaluation of activities; civil-society participation in planning and management (Health Committees) and

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13/ The Access Program prioritizes communities with high levels of poverty, that are predominantly rural and have less access to health services.

14/ SIDA: Mid Term Review of the Swedish Support to the Health Sector in Honduras, El Salvador and Guatemala. September 1996.

partnerships with NGOs; and the development of new care modalities such as mobile surgery and home visits; and (iii) in terms of financing, the program has drawn its funding from three sources. Under the 1996 budget arrangement, it was financed by the SS (50%), external aid (40%), and the community (10%). The SIDA, USAID, UNICEF and PAHO resources are programmed up to 1999, by which time coverage would be 63% of municipalities.

THE ACCESS PROGRAM: COVERAGE AND RESOURCE PROGRAMMING THROUGH 1999

Access Program	Number of Municipalities	Population	External aid (US$mill.)	SS (US$mill.)	Community (US$mill.)	Total (US$mill.)	Per capita (US$)
SIDA	106	2,020,000	3.2	4.0	8.0	8.0	3.96
USAID	64	1,412,000	3.6	4.5	9.0	9.0	6.37
PAHO/UNICEF	18	363,000	1.0	1.2	2.0	2.4	6.61
With Access	188	3,795,000	7.8	9.7	1.9	19.4	5.11
Without Access	109	1,700,000					

1.24 The activities of the Access Program have been split – for cost purposes – into two components: (a) preparation of the program: organization, training and formation of committees (for local development, health, water supply); and (b) delivery of the basic package, including essential clinical services. The financial evaluation of the Access Program shows an average annual per capita expenditure of about US$8 (US$2 for the preparation component and US$6 for the basic package).

F. The Bank's sector strategy

1.25 In view of Honduras's low level of human capital development, widespread poverty, inefficient public spending, low returns on investment, and severe financial constraints stemming from the budget deficit and heavy external debt service, the strategy mapped out by the Bank focuses on the following: (i) human capital development; (ii) making investment more productive; and (iii) easing the State's financial constraints. Priorities for human capital development are poverty reduction programs and action in the education, health, and nutrition sectors. 15/ The Bank is in fact currently assisting institutions that are executing social investments; two loans of this kind were approved in 1995, for the Honduran Social Investment Fund (948/SF-HO) and the Family Assistance Program (949/SF-HO). The strategy aim for the health sector is to lay the groundwork for sector reform by funding activities that will help institutions operate more efficiently,

15/ Country paper. GN-1876. June 1995.

target public spending to basic services, strengthen cost-recovery mechanisms, and encourage the private sector to become involved.

1.26 Technical-cooperation activities for the Public Sector Reform Program served to launch the process of reorganizing the Health Secretariat, with the aim of standardizing government structures. Some highlights of this process were:

a. The **institutional restructuring** of what was then the Ministry of Health into the Secretariat of Health, with the reporting structure proposed by the Modernization of the State Commission and the Public Administration Act.

b. Preparation of the **Census of Health Personnel**. The number of employees declined from 16,366 in 1994 to 13,581 in 1996.

c. Development of the **procurement system** has been started with the creation of the Special Procurement Department under the Office of the Administrative Manager in the new SS organization chart.

d. The **deconcentration of budget execution** has begun in two regions, an administrative and financial information and management system (SIAF) having been developed to serve as a basis for government accounting and financial reforms. This is a first step toward deconcentration of budget work.

e. **Gradual reallocation** of the SS budget toward primary care services.

f. **The Honduran Institute for Rehabilitation of the Handicapped** has been made part of the new SS structure.

G. The program strategy

1.27 The problems described in paragraphs 1.9 to 1.12 above show that the present system is not financially sustainable. Accordingly, the proposed program has been designed to finance activities that can strengthen institutional efficiency, as a requisite for sector reform. The aim of the program strategy is to reallocate public spending on health and make it more efficient, and to resolve problems of accessibility and management development. These changes in the sector would be implemented in three stages (see table below): (a) at the first stage, corresponding to the Public Sector Reform Program technical cooperation (CTPRSP), initial changes were made in the central SS structure; (b) the second stage, corresponding to the program proposed herein, will develop the institutional reform of the SS and complete changes in its structure; rewrite sector policies; expand coverage; and tackle problems of inefficiency and mistargeting of expenditure through hospital reform; and (c) the third stage, to be implemented through

a **health sector reform**, will convert the present predominantly public system to a mixed public-private system.

STAGES IN THE TRANSFORMATION OF THE HEALTH SECTOR

Stage 1 CTPRSP	Stage 2 SS INSTITUTIONAL REFORM	Stage 3 FUTURE SECTOR REFORM
RESTRUCTURING OF HEALTH MINISTRY: Min.restruc.guidelines Create Procurement Department Budget deconcentr. 2 regions Procurement deconcent. 2 regions Personnel census SOCIAL SECURITY: Study of Social Security model for pension system	RESTRUCTURING OF SS: Reorg. central level of SS Redefine role of institutions Deconcentr. of resources to reg/local levels STRENGTHENING PRIMARY CARE: Expand Access Program Strengthen 3 preventive programs HOSPITAL REORGANIZATION: Reform 6 hospitals Strengthen mgt. 6 hospitals Rehabilitate 3 hospitals Emergency systems in 3 hospitals PRODUCE SECTOR STUDIES: Private sector participation Social Security: health system Domestic violence	RESTRUCTURING OF SECTOR: Consolidate restr. roles Decentralize resources to local level IHSS: Implement recommendations CONSOLIDATE PRIMARY CARE: Consolidate Access Program Strengthen 4 preventive programs Decentralize services to local level REORGANIZE INSTITUTIONS/ SERVICES: Consolidate hospital reform Strengthen hospital management Improve hospital care outcomes

1.28 The intent of the **future sector reform** is to modify the basic functions of the system, to make optimum use of resources by differentiating the functions of policy- and standard-setting, financing, organization, and care delivery, as illustrated in the following table.

CHARACTERISTICS	PRESENT SYSTEM	FUTURE SYSTEM
1. SYSTEM MODEL	1.1 Public	1.1 Mixed
2. REGULATION, POLICY AND STANDARD SETTING	2.1 Responsibility of SS 2.2 Institutional segmentation 2.3 Effective at program level	2.1 SS responsibility 2.2 SS sets policies/standards and evaluates 2.3 Effective at instit. level
3. FINANCING	3.1 Source of funds: State 3.2 Allocation to public providers 3.3 Incentives for public providers	3.1 Source of funds: mixed 3.2 Allocation management contracts 3.3 Incentives for diff. providers
4. ORGANIZATION AND COORDINATION	4.1 Public provider criteria 4.2 Demand/supply mismatch 4.3 Intramural modality	4.1 Public and private providers 4.2 Demand and supply in balance 4.3 Intra and extramural modality
5. CARE DELIVERY	5.1 Curative model 5.2 Public providers 5.3 Traditional modalities: office/clinic visits and hospitalization	5.1 Integrated model: preventive and curative 5.2 Public and private providers 5.3 Innovative modalities

H. Health-sector work of other international agencies

1.29 **USAID** has actions programmed through the year 2000, in the form of the following operations: (i) Health Sector II for primary care (immunization, diarrheal disease control and rural environmental sanitation); (ii) Population Sector III, with family planning activities; and (iii) support for the Access Program. The **World Bank** is implementing a Nutrition and Rural Health Program, set to conclude in 1998, which entails: (i) support for the Family Assistance Program in the form of nutrition activities; (ii) installation of rural water and latrine systems; (iii) supply of medication at the primary level; and (iv) strengthening of basic services (construction of 30 new health centers and rehabilitation of 130 existing centers). A study produced by the World Bank 16/ examines the following questions: (i) new challenges in the sector; (ii) modernization of Health Ministry financial management; (iii) the co-payment system; and (iv) efficiency in public service delivery. That paper complements the studies that are planned in the program proposed herein to build an empirical and methodology base for the future health-sector reform. The **Swedish Government, PAHO, USAID and UNICEF** are supporting the Access Program. In 1996 the **Japan International Cooperation Agency** (JICA) completed a sector study aimed at improving the health situation by the year 2010. Other countries (European Union, Spain, Canada, Norway, Korea, etc.) are also providing assistance for the health sector.

16/ World Bank. Report No. 17008-HO. Improving access, efficiency and quality of care in the health sector. October 31, 1997.

II. THE PROGRAM

A. Concept and objectives

2.1 The program is conceived as a long-range transition process, complementing work begun under the IDB-funded Public Sector Reform Program technical cooperation (CTPRSP) that has been under way since 1996. The aims of the transition process supported by this program are: (i) in the short term, resolve the health problems of the most at-risk groups (the poor, women, children), and (ii) in the medium term, foster health-sector reform.

2.2 The **objectives of the program** are to: (i) help build institutional capacity, methodologies, and management foundations for designing the sector reform and carrying it through; and (ii) improve service quality and strengthen health promotion and education by extending coverage with primary health-care services at the community level and through outpatient and basic hospital services. In pursuit of these objectives the program will: modernize the structure of the Secretariat of Health (SS); reallocate public spending on public-health interventions and basic services; diversify care delivery using different providers; and reorganize hospital services.

B. Structure of the program

2.3 The design of the program takes into account current circumstances in the health sector: (i) it recognizes what is achievable in light of the situation in the sector; (ii) it builds on the dynamic of State restructuring set in motion by the CTPRSP; (iii) it will strengthen SS institutional capacity; (iv) it will use innovative approaches, making the greatest possible use of the sector's potential; and (v) it will be implemented using a flexible, sequential approach so that it can be adjusted as conditions change in the future.

2.4 The program has two components. Component 1 is for development of the foundations of sector reform, and component 2 will strengthen primary health-care services. The components are made up of a set of actions that have been selected to effectively address the problems described in paragraph 1.9. To address **equity problems**, the primary-care strengthening component will expand coverage, improve the health of the population, and reallocate public monies to benefit the poor. Problems of **institutional inefficiency** will be addressed in the component for development of foundations for health-sector reform, by way of the institutional reorganization of the SS (rewriting of policies and changes in central level systems) and the start of hospital reform (changes in the organization of services). Taken together, these activities will make for better use of resources and more efficient public spending.

1. Component 1: Development of foundations for the health-sector reform (US$24.8 million)

2.5 This component complements the CTPRSP activities. Its objectives are to help modernize the SS and prepare the future sectorwide operation. The activities planned to that end are grouped in three subcomponents: (a) reorganization of the Health Secretariat; (b) pilot program for hospital reform; and (c) development of institutional operating capacity.

a. Subcomponent 1a: Institutional reorganization of the Secretariat of Health (US$1.4 million)

2.6 The objective of this subcomponent is to improve institutional efficiency by funding activities to: (i) reorganize the central level of the SS (standardizing reporting structure, upgrading and decentralizing personnel management systems, procurement management at the local level, and budget management at the regional, departmental, and hospital level); and (ii) revamp the sector's institutional policies, redefining institutional roles, adding to Health Code regulations, regulating private service contracting systems, regulating SS-IHSS coordination arrangements, and setting standards for accreditation and authorization of health-care establishments.

2.7 The outputs of this subcomponent will be: (i) consolidation of the SS structure; (ii) institution of a personnel administration system; (iii) entry into operation of a specific procurement apparatus; (iv) deconcentration of budgeting in two health regions; (v) deconcentration of procurement in two health regions; (vi) framing of an institutional strategy for the sector, delineating policy and regulatory functions, financing, organization, and care delivery; (vii) submission of draft regulations and resolutions for the administration and enforcement of the Health Code (general regulations for hospitals and regulations for the special procurement apparatus); (viii) a strategy for contracting private services; and (ix) a strategy for SS-IHSS coordination.

b. Subcomponent 1b: Pilot hospital reform program (US$17.9 million)

2.8 This subcomponent seeks to improve hospital **efficiency** and **quality of care**. Its specific objective is to begin the process of revamping the SS hospital network through a pilot program in six existing hospitals, to be selected by reference to specific eligibility criteria (see paragraph 2.14). The hospital reform will entail changes in: (i) organizational structure of the establishments, to assure efficiency and civil-society involvement, and (ii) the care model, with priority to developing new modalities that can raise productivity and improve quality through initiatives

involving home and outpatient care and emergency care in the hospital network.

2.9 This subcomponent will finance five sets of activities:

a. **Development of hospital autonomy.** The program will fund activities for six hospitals: (i) institution of a mechanism for decentralized decision-making on budget management, procurement, and personnel administration, in accordance with SS technical standards, guidelines of the Modernization of the State Program, and local conditions; (ii) diversification of providers, involving other institutions (service contracts with the private sector); (iii) participation by civil society (formation of committees/boards as support structures for hospital management); (iv) adoption of cost-recovery mechanisms, devising fee schedules for services; (v) hiring of general services (cleaning, security) from the private sector (NGOs, employee co-ops, etc.) to make for greater competitiveness; and (vi) developing a hospital funding scheme that gives more responsibility to the community (work of committees or boards), to clients through cost recovery, and to the hospital itself, in terms of greater efficiency.

b. Establishment of **systems to modernize management** at six hospitals. The program will fund the following activities: (i) management information (a management tool that relates resources to outputs and costs); (ii) personnel administration (recruitment, hiring, and training and generation of incentives); (iii) input procurement (application of the basic table; purchasing, storage, and control of prescription drugs); (iv) accounting based on unit costs by output center; (v) financial management aimed at improving budgeting and budget execution; (vi) quality control based on protocols and other mechanisms for assessing the quality of care, including formation of technical committees, quality circles, and hospital accreditation procedures; (vii) transportation required for the referral system to be workable and provide support at the primary care level; (viii) communications systems for the interaction of hospital staff within their own establishments and with other hospitals; and (ix) maintenance services, through the assignment of core plumbing, electrical, air-conditioning, and environmental safety personnel and the contracting of private services for more complex maintenance tasks.

c. **Complete rehabilitation of three existing hospitals** (including replacement of basic equipment), civil works to repair or replace the hospitals' electrical, sanitation, water, air-conditioning, steam, and medicinal gas plant.

d. **Strengthening the national emergency care system**, adjusting the current emergency infrastructure at three hospitals, specifically to remodel or rehabilitate, reorganize, and/or re-equip the hospitals' electrical, sanitation, and air-conditioning plant and other facilities.

e. **Environmental safety** actions in six hospitals, with training activities and control of liquid and hospital wastes, plus protective measures for natural disasters.

2.10 The activities funded under the pilot hospital reform program would be carried out sequentially, to be able to assess outcomes and make changes as problems are identified. These evaluations will be the basis for adjusting the proposed hospital reform model, so that the reform, management modernization initiatives, and physical investments will dovetail properly and best practices can be generated for replication in other hospitals in the network.

2.11 A study conducted to ascertain the state of the hospital system revealed a dearth of civil-society involvement, centralized resource management at the regional or central SS level, budget execution based on historical accumulation, deficient cost-recovery mechanisms, weak management capacity, no management systems (information, cost accounting, maintenance, etc.), an intramural care model, little coordination without support for the basic services network, deteriorating physical plant (60%), and obsolete equipment (70%).

2.12 On the basis of the functional diagnosis of the hospital system, priorities were analyzed by reference to geographic selection criteria (health regions) and socioeconomic level of the population, health status, and accessibility. Selection criteria also were devised for hospitals, based on their performance (use and quality of care), efficiency (length of stay, occupancy, hospital mortality), condition of physical plant (deterioration and obsolescence) and organization of the establishment.

2.13 An indicative sample was analyzed, on the basis of the foregoing criteria, to rank the hospitals and their technological efficiency and estimated average capital and operating costs. Comprising the sample were five area hospitals (Danli, Santa Bárbara, La Esperanza, Tela and Trujillo) and two regional hospitals (Occidente and Atlántida) that have a nationwide catchment area. To analyze these establishments, studies were done of efficiency (use, output, return on resources), performance and treatment outcomes (quality of care, complexity and support for the primary level), organizational structure, staffing, and deterioration and physical and functional obsolescence.

2.14 To receive funding under the program, hospitals must meet the following eligibility criteria:

a. Demand for services: (i) adequate utilization ratios (occupancy 60% or higher); (ii) catchment area with a rural population; (iii) support for the Access Program; and (iv) support for primary health-care referrals.

b. Hospital reform must have begun – as described in paragraph 2.8 – with an emphasis on management autonomy (decentralized management of budget, personnel and procurement), formation of a hospital board or committee, existence of a management contract with the health ministry, outsourcing of general services, and a cost-recovery proposal.

c. Modernization of the hospital's management must have begun, in the form of application of the nine management systems listed in paragraph 2.8.

d. An economic viability study must have been submitted for the proposed investment, using a cost-effectiveness approach and offering an analysis of the current situation and projections for the with-project and without-project scenarios (see Annex II).

e. For the national emergency system, a hospital must also demonstrate that it has (i) basic emergency care already in place (premises, equipment, staff) and (ii) general hospital services support.

2.15 Expected outputs of the pilot hospital reform are development of organizational methods that can help determine best practices, for replication in other Honduran hospitals.

c. Subcomponent 1c: Development of institutional operating capacity (US$5.5 million)

2.16 The specific objective of this subcomponent is to ensure that the program will operate effectively and produce the information needed to formulate a future health-sector reform program. The actions planned for the subcomponent are as follows:

(i) Institutional support for the program

2.17 The program will provide resources for its optimum execution, including funding for a Coordination Unit that will prepare, coordinate, and carry out the program, and also to lay the groundwork for the future health-sector reform operation (management information system, costing system, evaluation of the hospital model, analysis of study findings, etc.). Also to be funded are specific consulting assignments (environmental, design, equipment, construction supervision), the hiring of an agency to

expedite procurement of goods and services, and the hiring of an international consultant to assist the Coordination Unit and coordinate the sector studies.

(ii) Sector studies

2.18 The program will fund three studies, which will complement studies produced by other international agencies (PRSP, World Bank, JICA, etc.) and serve as a foundation for the future health-sector reform. The studies planned include: (i) a strategy for **promotion of the private sector**, with an analysis of private-sector involvement in service organization and delivery; identification of NGOs that are working in the health area and how their work is coordinated with SS programs; feasibility of the various care models and outsourcing of services in hospitals; and strengthening NGO participation in actions to expand the Access Program; (ii) analysis of the **social security** health system, including: knowledge about the current state of the IHSS health system and prospects (population with coverage; services; activities; efficiency of the supply: resources, outputs, returns; annual operating and maintenance costs; mechanisms for coordination with the SS and private sector), and feasibility of extending the system's coverage to more areas and people using its own funds, under contracts with the SS, and/or through contracts with the private sector; and (iii) an analysis of **domestic violence** as a health issue, with operational research to characterize the problem and its magnitude; determine the main conditioning factors; assess different initiatives now being essayed (SS family counseling services, work of NGOs) and present a feasibility proposal for addressing the problem.

2. Component 2: Strengthening primary health care (US$9.4 million)

2.19 This component seeks to make the system **more equitable**. Its objectives are to strengthen the local level to encourage people to take responsibility for their health, make basic services more accessible, improve health conditions in the population at greatest epidemiologic and social risk, and target public spending to programs that afford the strongest positive externalities (public health). It will fund the following activities: (a) expansion of the Access Program to approximately 90 new municipalities, as a way to support health promotion and education activities, and (b) strengthening of three national-level preventive and health-promotion programs (health education, epidemiologic surveillance, and nutrition improvement), with particular attention to AIDS control in pregnant women.

a. Expansion of the Access Program will increase coverage to 80% of the country's municipalities, funding activities for community organization and delivery of a basic health care

package. The focus will be on deconcentration of services, civil society participation, and reorganization of the network of health-care establishments. In selecting localities to benefit from these efforts priority will be given to those which (i) have high maternal and child mortality rates; (ii) are home to households having three or more unmet basic needs; (iii) do not have access, because of their geography, to basic health services; (iv) have largely rural populations, and (v) have communities motivated to participate.

b. Actions planned for the strengthening of public health programs are: (i) **health education**, through a strategy to promote joint problem-solving by the public and the services, with distinct measures for indigenous groups, respecting their cultural values; special attention will be given to training (community leaders, basic care personnel and NGOs) and dissemination of information to the general public to encourage a healthy lifestyle (personal health and health of the collective), raise awareness of factors associated with disease patterns, domestic violence, and reproductive health matters; (ii) **epidemiologic surveillance**, including improvement of the disease control system, reequipping of nine regional laboratories and blood banks, and supply of equipment to control disease patterns (about 40 microscopes); support for the National AIDS Control Program, as a follow-on to the IDB-funded technical cooperation operation ATN/SF-4687-HO, developing a targeted care strategy to protect HIV-positive pregnant women, and (iii) **nutritional improvement** for women and children under six, to address nutrition deficiencies (blindness, iron-deficiency anemia, endemic goiter). The two strategies to be pursued are micronutrient supplements (vitamin A, iron, iodine) and promotion of breastfeeding.

2.20 Expected outputs of the primary-care component are: (i) extension of the Access Program to about 90 municipalities currently not covered, and (ii) strengthening at the national level of three public health programs (health education, epidemiologic surveillance, and nutrition improvement).

C. Cost and financing of the program

1. Cost and financing

2.21 The program will cost US$40 million, broken down as follows:

Cost Table
(US$000 equivalent)

	EXPENDITURE ITEM	IDB	LOCAL	TOTAL	%
1.0	**Foundations for sector reform**	**23,100.0**	**1,700.0**	**24,800.0**	**62.0**
	Reorganization of SS	900.0	500.0	1,400.0	
	Hospital reform	17,900.0	0.0	17,900.0	
	Development of institutional capacity	4,300.0	1,200.0	5,500.0	
2.0	**Strengthening primary care:**	**8,400.0**	**1,000.0**	**9,400.0**	**23.5**
	Expansion of the Access Program	4,000.0	1,000.0	5,000.0	
	Strengthening of public health program	4,400.0	0.0	4,400.0	
3.0	**Reimbursement of PPF**	**298.0**	**0.0**	**298.0**	**0.7**
4.0	**Unallocated**	**3,142.0**	**730.0**	**3,872.0**	**9.7**
5.0	**Financial charges:**	**1,060.0**	**570.0**	**1,630.0**	**4.1**
	5.1 Interest	700.0	0.0	700.0	
	5.2 Credit fee	0.0	570.0	570.0	
	5.3 Inspection and supervision	360.0	0.0	360.0	
	TOTAL	**36,000.0**	**4,000.0**	**40,000.0**	**100.0**
	PERCENTAGE	**90.0**	**10.0**	**100.0**	

2. Apportionment of program resources

2.22 Following is a breakdown of the direct costs of the main program actions, by intended use:

(US$000 equivalent)

COMPONENT	CONSULT-ANCIES	TRAINING	CIVIL WORKS	HOSPITAL/ PROG. EQUIPMENT	SUPPLIES	PCU EVAL.	TOTAL
Foundations for sector reform	5,300.0	300.0	10,100.0	7,200.0	900.0	1,000.0	24,800
Strengthening primary care	1,200.0	700.0	-	800.0	5,700.0	1,000.0	9,400
TOTAL (US$000)	**6,500.0**	**1,000.0**	**10,100.0**	**8,000.0**	**6,600.0**	**2,000.0**	**34,200**
Percentage	**19.0%**	**2.9%**	**29.5%**	**23.4%**	**19.3%**	**5.9%**	**100%**

Civil works and hospital equipment include the cost of environmental safety equipment and facilities.

3. Scaling of the program

2.23 The public sector's financial position, counterpart requirements, SS operating capacity, and an assessment of local experience were taken into consideration in deciding on the scale of the program.

Component selection was based on concentrating resources on the most cost-effective activities.

4. Financing of the program

a. Bank funds

2.24 The Bank will provide financing in the amount of US$36 million (90% of the total cost) in accordance with its rules for social programs and projects targeting low-income groups. 17/ The terms and conditions of the Bank's loan would be as follows:

Source of funds:	Fund for Special Operations
Amortization period:	40 years
Grace period:	10 years
Interest rate:	1% during the grace period and 2% thereafter
Credit fee:	0.50% on undisbursed balances
Inspection and supervision:	1% of the loan amount

b. Counterpart funding

2.25 The counterpart funding will amount to US$4 million, which represents 10% of the total cost of the program and an average disbursement of US$800,000 per year. These funds will be provided by the Government of Honduras through budgetary appropriations to the SS.

D. Preparation of the program

2.26 A number of studies done by Honduras on the following subjects were taken into account in developing the proposed program: modernization of the State; institutional restructuring; feasibility of the PRSP; health policies; the Access Program, and public health programs. Also reviewed were studies done by other agencies (PAHO, JICA, World Bank, USAID, etc.) that helped delineate the state of the sector, its main problems and possible approaches for addressing them.

2.27 The project team and the country technical team were assisted by consultants in specific areas (financial, economic, environmental). That support was the foundation for devising technical requirements for the program proposed herein. An analysis was done of SS funding and eventual costs of the program activities, an evaluation of the Access Program, and studies on use and efficiency of SS facilities.

17/ The Bank's percentage share is in accordance with the rules in documents AB-1704 and GN-1964, which allow up to 10 additional percentage points for Group D countries.

III. INSTITUTIONAL FRAMEWORK AND EXECUTION OF THE PROGRAM

A. General aspects of program execution

1. The borrower and executing agency

3.1 The borrower will be the Republic of Honduras and the executing agency the Secretary of Health (SS). The SS has a two-tier structure: (i) the **central level**, made up of the Office of the Minister with various national directorates with responsibility for policy making and for regulation, planning and evaluation of programs; and (ii) the **local level**, which comprises 9 regions, 18 departments, 2 metropolitan areas, and 41 health districts as administrative units within the country (generally departments), with 297 municipalities at the basic level where the health system carries out the activities and meshes with other institutions of society.

3.2 The restructuring of the MH at the central level, which was initiated by the CTPRSP and will be continued under the program, will reduce the existing administrative rigidities, and bring about the modernization of the SS, thus contributing in turn to the development of more efficient management options. The reallocation of personnel will permit better adaptation of the Secretariat's structure and development of a more efficient personnel administration program. In addition, when the procurement department is fully functioning, a useful management tool will be available that will help considerably to further deconcentrate procurement to regions and establishments.

2. Responsibility for program execution

3.3 To determine how the execution of the program would be organized and carried out, the Bank's prior experience in health projects in Honduras (PR-441/SF-HO and PR-791/SF-HO) was analyzed and the recommendations of the ex post evaluations of these projects 18/ were studied. On the basis of these experiences, it is proposed that a project coordination unit (PCU) be set up, as part of the SS. This PCU would be a structure linked with the health authorities, the Bank, and other sector institutions, and responsibility will be shared with the different ministry departments and units (subsecretariats, etc.). The PCU will operate under new modalities which could serve as an alternative management model for the SS.

18/ IDB. OEO. OER-50/87. Ex post evaluation. Honduras: PRONASA. April 1987.

3.4 Responsibility for both execution and administration of program resources will lie with the SS through the project coordination unit. The PCU will concentrate on activities that ensure the feasibility of a future sector reform operation (targeting regulation, organization and financing of the sector, private sector participation in the delivery of services, defining the role of the IHSS, etc.). The PCU will form part of the Secretariat's structure without being subject to all of its administrative procedures for implementing the actions involved, thereby facilitating the mobilization of resources to enable the SS's different executing units to carry out the programmed activities efficiently. The PCU will report to the Minister of Health and will be headed by a technical coordinator. To perform its work, the PCU will work closely with the different ministry units and departments at both the central and local level in order to ensure the viability of the specific components. The time set for execution is five years.

3.5 The structure of the PCU has been based on the following considerations: minimizing the number of permanent staff during program execution; allocating sufficient funding for hiring personnel to prepare any additional outputs that may be required; and working closely with SS units and departments. The structure of the PCU comprises: (i) its management, under the Technical Coordinator, and (ii) two line structures, the Health Area and the Administrative and Financial Area. In addition, two committees will be formed, one for the programming of activities (Technical Committee) and another for the bidding process (Procurement Committee). The total number of permanent staff will be 11, seven of whom will be professionals and four support staff. The professionals will comprise one technical coordinator, one administrator, one accountant, one assistant accountant, two public health specialists (one in programs and one in hospital financial administration) and one economist. The unit will be strengthened with international consultants and will use the services of a procurement agency.

B. Execution of the program components

3.6 The PCU will be responsible for implementation of the two program components:

1. Execution of the health reform development component

3.7 Different modalities will be used to implement this component: (i) for the institutional restructuring of the Ministry, a consulting firm will be hired and assistance will be provided by the Administrative Department and the SS Subsecretariat of Sector Policy; (ii) for the hospital reform pilot program, two consulting firms, a construction firm, and two individual consultants will be hired, for the environmental protection and equipment outfitting programs, and support will be provided by the SS Subsecretariat for

Services Network; and (iii) for the development of institutional operating capacity the personnel assigned to the PCU will be available, and individual consultants will be hired to perform three sector studies.

2. Execution of the primary health care strengthening component

3.8 Two modalities will be used to implement this component: (a) individual consultants will be hired to monitor the access program, and (b) a consulting firm specializing in public health programs. Two Subsecretariats of the SS (Population Risks and Services Network) will participate in this component.

C. Plan of execution of the program

1. Execution modality

3.9 The program will be implemented by means of a modality that ensures flexibility and monitoring, and makes it possible to modify existing situations at any given moment. The intention is to use an **"annual programming and evaluation"** method that will make it possible to design a plan of activities aligned to each time period, with a predetermined aim and approach. The basis of this execution modality will be the **Annual Operating Plan (APO)**.

3.10 The Annual Operating Plan will describe each component in detail: (i) the activities that are programmed; (ii) the requirements that need to be fulfilled; (iii) the resources that will be used for these actions; (iv) the schedule; (v) the monitoring and control indicators; (vi) the final terms of reference for the consulting services; and (vii) in the case of civil works, the APO will also have to take into account the functional programming, the engineering design, the equipment program and the environmental protection measures. At the end of the year, the APO will be evaluated by the PCU and the Bank as part of an ongoing program monitoring process.

2. Programming of execution

3.11 The program will be executed with the assistance of consulting firms and individual consultants, as well as the resources of the PCU itself according to the following tentative timetable:

COMPONENT	CONSULTING FIRM	CONSTRUCTION COMPANY	INDIVIDUAL CONSULTANT
HEALTH REFORM DEVELOPMENT			
* Institutional reorganization of SS	1	-	-
* Pilot reform 6 hospitals			
— Autonomy 6 hospitals	1	-	-
— Management modern. 6 hosp.	1	-	-
— Rehabilitation 3 hospitals	-	1	-
— Reconditioning 3 hospitals	-	-	1
— Environmental safety 6 hosp.	-	-	1
— National emergency system	1	-	-
* Develop. institutional capac.			
— Private sector study	-	-	4
— Social Security Health Study	-	-	5
— Domestic violence study	-	-	5
IMPROVING PRIMARY HEALTH CARE			
* Access Program	-	-	4
* Public health programs	1	-	-
PCU INSTITUTIONAL SUPPORT	2	-	14
TOTAL	**7**	**1**	**34**

3.12 The financing for the physical investment in the program for the rehabilitation and outfitting of three pilot hospitals and for three hospitals in the national emergency system will be provided in three instalments disbursed on the following conditions:

(a) The first disbursement of up to 15% of the total amount of the physical investment will be made when it has been demonstrated that: (i) the economic viability study for each hospital has been concluded in accordance with the guidelines set out in Annex III; and (ii) the activities relating to the autonomy of the pilot hospitals (decentralization of the budget, the supply system, and hospital personnel); the Support Committee or Board is up and functioning; and the cost recovery system is in place.

(b) The second disbursement of up to an additional 15% of the total physical investment will be made when it has been demonstrated that the management modernization systems have been established: (i) information management, (ii) personnel management; (iii) procurement; (iv) accounting; (v) financial management; (vi) quality control; (vii) transport; (viii) communications; and (ix) maintenance.

(c) The third disbursement of the remaining financing will be made when it has been demonstrated that a consulting firm in charge

of preparing the operational programming and the corresponding designs has been hired.

SEQUENCE OF ACTIONS

PROGRAM COMPONENT	YEAR 1	YEAR 2	YEAR 3	YEAR 4	YEAR 5
REFORM OF THE SECRETARIAT					
Institutional reform SS	▬	▬	▬		
Hospital autonomy	▬	▬	▬		
Management modernization	▬	▬	▬		
Rehabilitation hospitals		▬	▬	▬	▬
Reconditioning hospitals				▬	▬
Emergency systems		▬	▬	▬	
Environmental safety					▬
Sector studies	▬	▬	▬		
REFORM PRIMARY CARE					
Access program	▬	▬	▬	▬	▬
Public health programs	▬	▬	▬	▬	▬
EVALUATION		■ ■	▬	■ ■	■ ■

D. Monitoring and evaluation

3.13 To ensure continuous monitoring of the program, a mechanism has been designed which comprises: (i) annual programming and evaluation, to be measured by the APO; (ii) mid-term evaluation that will permit evaluation of the process; and (iii) final evaluation of results. The monitoring would be based on the sequential programming of actions and the achievement of the milestones set (benchmarks) (Annex I).

3.14 Program execution will also include a mid-term evaluation to be performed 30 months after the effective date of the contract to analyze the extent to which the program goals have been accomplished, paying special attention to its design, approach, objectives and key activities such as support at the local level and the reforms of the care model and hospitals. This phase represents a cut-off point that will enable the PCU and the IDB to analyze jointly the situation in order to determine the future steps. To this end, the borrower, through the executing agency, will submit the pertinent documents to the Bank at least 30 days prior to the date of the mid-term evaluation (i.e. report on the general status of the program; analysis of the completion of the activities included in the approved operating plans; and a proposal for the subsequent phases, including a review of the lessons learned and the results of the studies to help with the design of the future reform of the sector). During the mid-term evaluation, it will be necessary to verify the fulfillment of:

(a) the hospital eligibility criteria (2.14);

(b) the implementation of the reform at six pilot hospitals (2.9)

(c) the implementation of the management modernization systems at six pilot hospitals (2.9); and

(d) the preparation of the sector studies.

3.15 Given the importance of the monitoring system, the plan is to hire an institutional advisor who, together with the economists and other PCU consultants, would start to build the data base required for the evaluation of the program, verify compliance with the eligibility criteria and coordinate the sector studies with the guidelines for the future reform of the sector.

3.16 For the special evaluation, two consultants will be hired (one local and one international) for approximately 18 months: 10 months for the local consultant and 8 months for the international consultant. These consultants will be responsible to the PCU management, the SS and the Bank for submission of the corresponding reports. The executing agency will be required to submit to the Bank the methodology, indicators and evaluation results within two months of completion of each phase.

E. Other aspects of program execution

1. Disbursement schedule

3.17 The funds for the program will be disbursed according to the following general schedule:

SOURCE	YEAR 1	YEAR 2	YEAR 3	YEAR 4	YEAR 5	TOTAL	%
IDB	3.6	9.2	11.0	9.0	3.2	36.0	90.0
LOCAL	0.4	0.8	1.0	1.0	0.8	4.0	10.0
TOTAL	4.0	10.0	12.0	10.0	4.0	40.0	100.0
%/YEAR	10.0	25.0	30.0	25.0	10.0	100.0%	

2. Advance of funds

3.18 The bank may authorize disbursements of up to 5% of the loan (US$1.8 million) as an advance to cover the initial costs incurred in the first 120 days of the program.

3. Retroactive financing

3.19 It is recommended that up to US$298,000 in expenditures incurred by the National Technical Group (PCU) of the SS in the 12-month period prior to approval of the loan be recognized as retroactive financing chargeable to program funds. These expenditures must relate to the preparation of technical documentation required to determine the feasibility of the program (PPF/011-HO).

4. Physical commencement of works

3.20 The deadline for physical commencement of the works will expire 36 months after the eligibility date of the loan.

5. Contracting of works and procurement of goods and services

3.21 The tenders for the civil works connected with the rehabilitation of three hospitals will be issued either as individual packages for each hospital or by means of one combined contract for all three, as detailed in the respective APO. The Bank's rules and procedures. International competitive bidding will be required for procurement of goods valued in excess of US$250,000. For the selection and contracting of consultancy services financed fully or partially with loan funds, the Bank's procedures for selection of consulting firms or individual experts shall be followed, and no provisions may be set that would restrict or prevent participation by consultants from the Bank's member countries. International competitive bidding will be required for contracts in respect of civil works exceeding US$1 million.

6. External audit

3.22 The borrower, through the executing agency (SS), shall submit the financial statements of the program annually to the Bank for the duration of the program. These financial statements shall be audited by a firm of independent auditors acceptable to the Bank.

7. Supervision of the program

3.23 The Bank's Country Office in Honduras, with the help of headquarters (RE2/SO2), will supervise and monitor the program. Within the first three months of the program, a technical start-up mission will be carried out to support compliance with conditions precedent and to jointly develop the final version of the APO for the first year.

IV. VIABILITY, BENEFITS AND RISKS OF THE PROGRAM

A. Viability of the program

1. Design of the program

4.1 The program – as a transition project – will initiate the transformation of the present public system into a future "mixed" system with greater private-sector involvement. Its components have been designed to support equity and efficiency, taking into consideration the critical problems that affect the health of the population most at risk, in particular women and children. In this connection, priority will be given to using public resources to target the poorest groups by means of actions aimed at creating a more positive environment for them (equity principle). To accomplish this, the program emphasizes public health actions such as health education, epidemiologic surveillance and nutrition improvement. The program also proposes actions to make more efficient use of public resources through the restructuring of the SS, support for local management and hospital reform (efficiency and quality principle). The reform of the health care model being proposed through the restructuring of services, public health programs and expansion of the Access Program, takes into account the needs of the communities and develops new modalities – involving various suppliers – for delivery of health services (based on the principles of financial sustainability and competitiveness).

2. Institutional viability for the execution of the program

4.2 The implementational structure of the program is appropriate for the SS's operating capacity within the context of the program for modernization of the State and takes into consideration the comments made on previous projects in Honduras. A coordination unit is being designed within the ministry to ensure proper coordination with the SS's other units and departments and to help prevent bureaucratic delays. The PCU will be supported by international consultants and consideration is being given to hiring a "procurement agency" to facilitate execution.

4.3 The execution modality adopted envisions a combination of resources that will include six specialized consulting firms and 34 individual consultants during the five-year execution period. The program's operating approach is based on a programming and evaluation methodology, which ensures flexibility and adapts the program to national realities, without losing sight of its objectives and aims. The monitoring arrangements will enable continuous tracking that will start with the APO (evaluation of activities), continuing with the mid-term evaluation (process

evaluation) and concluding with the final evaluation (performance evaluation).

B. Benefits

4.4 The primary care programs (access and public health) will have a positive impact owing to the increased focus on basic services, the rationalization of demand for hospital services, avoidable disease prevention and attention to the problem of nutritional deficiencies which adversely affect human development. Moreover, the intangible benefits of health education actions, especially as regards basic environmental sanitation, AIDS control, reproductive health, nutrition, violence prevention, etc., will help to improve the quality of life in general and health in particular.

4.5 Regarding hospital reform, the introduction of new management systems, development of hospital autonomy (decentralized management of budget, personnel, and procurement) and the application of cost recovery will result in better resource utilization, will increase efficiency and quality, and should help to develop a financing system incorporating greater community participation. The outsourcing of certain general services will spur a process of competitiveness among potential private providers.

4.6 The actions described will produce the following benefits: (i) the coverage of basic SS services will be considerably expanded from 45% in 1994 (without the Access Program) to 63% by 1999 (with the Access Program funded by ASDI, USAID, PAHO, and UNICEF) and 80% of municipalities by 2002 with execution of the Bank's program; and (ii) hospital care which, with the rehabilitation of three pilot hospitals will have an estimated 660,000 beneficiaries, including those in areas receiving the primary care provided by the hospital.

C. Risks of the program

4.7 The institutional weakness of the SS could act as a constraint on the program. This situation would be remedied by means of the coordinated actions and the execution modality adopted. Ensuring the financial sustainability of the program is a problem that was considered in planning the operation. The program has been designed to make expenditure on health more efficient by means of changes in the way things are done and in the service-delivery model, and to bring about a greater measure of responsibility by the community for the care of its health. In addition, this structure should minimize program operating expenses.

D. Impact of the program in terms of the mandates of the Eighth Replenishment

1. Impact on low-income population

4.8 The operation conforms to the requirements of the Eighth Replenishment in that it involves investments that will raise the living standards of the poor population. In this regard, it meets the two criteria established since geographically it targets poor beneficiaries (poverty level of 70%). 19/ In addition, the program includes actions in priority areas such as nutrition, human capital development and promotion of the private sector.

2. Impact on women

4.9 Females make up 49% of the population of Honduras, with a high fertility rate and inadequate nutrition levels among pregnant women. The beneficiaries targeted by the program will be women of childbearing age and children under six. The women's care model is a valuable tool that will serve to guide the reorganization of services and set standards for integrated care for women. The model aims: (i) to transform the maternal and child care approach into care for women, children and adolescents; (ii) to incorporate the topic of intrafamily violence as a health problem; (iii) to promote better nutrition for women; (iv) increase care during childbirth; and (v) strengthen reproductive health actions. The program will further promote development of women through basic and advanced training for personnel, using activities geared to empowering their role in society by converting them into receivers of services and promoters of a better lifestyle who are able to introduce and develop solutions in health matters.

3. Impact on indigenous population

4.10 The program will better the health conditions of the country's indigenous groups since it will help to develop a positive scenario for them. The fact is that the Access Program and public health programs, and specifically the health education component, will develop a differentiated strategy that promotes specific solutions for the indigenous population. The strategy of working jointly to resolve problems is consistent with the principles of self-determination, respect for cultural traditions and health care set forth in the Health Initiative of the Indigenous Peoples of the Americas.

19/ Poverty was measured on the basis of the 1988 population census data using the Unmet Basic Needs methods applied by the FHIS and the "poverty line" approach.

4. Environmental feasibility

4.11 The program will have a positive impact on environmental conditions since environmental safety measures will be implemented for each pilot hospital to be rehabilitated. These measures will center on: (i) liquid waste disposal and control through a pretreatment mechanism; (ii) hospital waste control by procurement of equipment (gloves and personal protection gear; bags for sorting wastes; protected carts and vehicles for waste collection; and installation of an incinerator); and (iii) training of general services personnel in environmental protection in matters connected with identification, production, composition, and risks of hospital wastes and measures to control it. This training will focus on medical waste management (waste management planning and maintenance of the facilities).

E. Economic viability of the program

1. General evaluation criteria

4.12 The criteria used to perform the economic evaluation of the program is an approximation of the cost-effectiveness analysis, which seeks to assess the impact of the program on the health of the beneficiary population vis-à-vis the cost of service delivery. To evaluate the effectiveness of the activities involved in the various components, the reduction in the "morbidity loan" was used as a basic indicator 20/. The YLLs used to evaluate the program followed (with allowances being made in each case) the methodology developed for rural areas in Colombia because it has a similar epidemiologic structure. 21/ They were derived from the rates per thousand inhabitants and adjusted down to take into account the difference in maternal and infant mortality, risk factors, and the attitudes of the population to the use of health services.

2. Evaluation of the Basic Service Access Program

4.13 As noted earlier, the geographical and socioeconomic conditions of Honduras, the proportion of the population that is rural, and its population distribution have limited access to health services, with the result that there are low levels of service use, high percentages of self-diagnosis, and precarious conditions of mother and child health and high mortality rates.

20/ The morbidity burden expresses the adjusted value of the potential years of life lost to premature death, measured in terms of disability-adjusted life years (DALYs), or healthy years of life lost to an illness (YLL).

21/ World Bank: Investing in Health, 1993. Colombia: Ministry of Health: The Disease Burden, Bogota, 1994.

4.14 Various alternatives were studied in seeking a solution to the problem of making health service more readily available to the approximately 30% of the population and 45% of municipalities now without coverage: (i) supporting the public system through the construction of new centers and the use of more health personnel; (ii) contracting private service providers; and (iii) expanding the coverage of the Access Program with public and private services. The first two alternatives were ruled out since they represented a continuation of the earlier low service model. Also, they did not guarantee equity and were not financially sustainable since they would create greater budgetary problems for the Secretariat. The third alternative was considered viable, in light of the favorable evaluation of the Access Program which had been supported by various external aid agencies (ASDI, USAID, PAHO, and UNICEF). These evaluations revealed a substantial improvement had occurred in the health of the target population and the institutional viability of the implementation strategy as a result of community involvement. Coverage for municipalities rose from 45% in 1994 to 58% in 1996, and is projected to improve to 63% by the end of 1999. There were plans to expand the Access Program to 90 municipalities not yet covered, and would therefore be in a position by the end of the program to broaden access to 80% of municipalities in the country. This is the least-cost option (an average of US$8.00 per package) well below the estimated international per capita cost of US$12.00 published in the "Investing in Health". 22/

4.15 The economic evaluation of the Access Program was performed on a per beneficiary basis. Five modalities for delivery and basic service packages were evaluated, mainly for women and child population groups 23/. The table below clearly shows that the more complete and more comprehensive the package of services is, the greater the effectiveness of the modalities, i.e. the number of healthy years of life contributed by each modality.

MODALITY	I	II	III	IV	V
YLLs per 1,000 inhabitants	16.17	21.35	22.65	23.41	55.03
YLLs per capita	0.01617	0.02135	0.02265	0.02341	0.05503
Per capita cost in US$	4.00	5.00	6.00	8.00	10.00
YLLs per US$	0.40%	0.43%	0.38%	0.29%	0.55%

22/ World Bank, 1993.

23/ The effectiveness of each modality or "package" was estimated according to the number of YLLs gained by each beneficiary based on the delivery modality and was compared to the corresponding cost.

4.16 All of the modalities (I to V) under the interventions proposed in the Access Program are effective, i.e. they all increase the beneficiary's healthy years of life, the more comprehensive the package of services is. However, a comparison of the unit costs of each modality shows that modality V is the most cost-effective since 0.55% of healthy years would be gained for each dollar invested. In addition to effectiveness, the quality of service would improve especially in terms of mother and child care with coverage for children under six increasing from 212,100 in 1995 to 450,954 by 2002. Coverage of births would also increase, from 34,817 in 1995 to 67,499 in 2002. The outpatient surgery modality initiated under the Access Program (468 operations in 1996) would reduce the likelihood of disability and death. Hence, the program will lower the maternal mortality indicators from 180 to 150 per 1,000 live births (lb), infant mortality from 45 to 35 per 1,000 lb, mortality for children under six from 55 to 45 per 1,000, the malnutrition rate in children under six from 39% to 35%.

3. Evaluation of the relevance of public health programs

4.17 The three programs – health education, epidemiologic surveillance, and nutritional improvement – are an important addition to the Access Program. These initiatives will increase the effectiveness of the primary care interventions strengthening component. The public health programs will benefit considerably in YLLs with respect to the principal causes of doctor's visits and the delivery of defined the basic package. The table below shows the benefits in YLLs that would accrue under the program.

MORTALITY	DISEASE BURDEN. YLL/1,000 inhabitants
1. Acute diarrheic disease	4.77
2. Acute respiratory infection	8.66
3. Vaccine preventable diseases EPI	0.79
4. Nutritional deficiencies	2.60
5. Pregnancy- and birth-related infections	1.29

4. Development of a methodology for economic evaluation of hospital rehabilitation

4.18 One of the conditions determining the effectiveness of the Access Program is the existence of problematic hospital care outcomes in the project area, that are able to respond to the referral and counter-referral system at lower levels. At the present time, the system is not functioning because of the limited response capacity of hospitals that come under the Secretariat. This constraint is the result of administrative and operational shortcomings as well as the precarious nature of the physical infrastructure, all of

which is reflected in low coverage and underutilization of installed capacity.

4.19 the hospital reform pilot program will fund activities to develop the autonomy of six hospitals and upgrade their management and to rehabilitate three of these hospitals. The objective of the program is to develop integrated and sequential organizational methodologies to produce "best practices" that would make it possible to replicate the program in other hospitals in the network. The pilot hospitals that the program would target need to fulfill the criteria described in paragraph 2.14, being existing establishments in which the organizational changes and physical activities would be carried out (rehabilitation works for the physical plant and facilities and reconditioning) to improve their efficiency, quality, and financial sustainability.

4.20 The methodology used to justify for the investment in the hospitals will be based on the cost-effectiveness of the activities to be carried out under the program. The justification for the investment in each of the three pilot hospitals will be based on: (a) the analysis of resources, production, and return; and (b) the degree of effectiveness of the actions.

(a) Analysis of **resources, production, and return**. The analysis will be done taking into account the rate of utilization of the hospitals, and comparing them to the requirements derived from the epidemiologic profile of the population in the project area. To quantify the healthy years of life gained by the beneficiary population treated and cured in the hospitals, the actual production and return will be estimated for each establishment in terms of its principal activities (outpatient visits, hospital discharges, and surgery) and the YLLs will be calculated per 1,000 inhabitants for each type of intervention and cause of disease. These rates will be multiplied by the number of cases cured to obtain the total number of years gained in scenarios with and without the project.

The comparison of the scenarios "with" and "without" the project will make it possible to determine whether the hospital reform pilot component will produce greater efficiencies in the use of resources since the productivity of the resources could be calculated annually and the number of years gained and savings per YLL ascribable mainly to timely treatment for the women and child populations. The projected unit costs for each type of intervention will be based on an analysis of the scenario with the project assuming that such costs will decline as a result of improvements in hospital efficiency and productivity and the use of new options such as outpatient surgery.

(b) **Analysis of the effectiveness of the investment in hospitals.** The methodology used here is based on an analysis of the cost-effectiveness of the investment proposed for each of the three hospitals that are to be rehabilitated. The economic analysis will have to be presented as one of the eligibility criteria for the hospital pilot program (paragraph 2.14) and should include a comparison of the present situation with the projected situation for each hospital (with and without the project). The design and content of the cost-effectiveness study for each hospital is presented in Annex II.

F. Financial feasibility of the program

4.21 The analysis of the financial feasibility is based on: (i) the historical variations in the current expenditure of the central government and of the SS (excluding transfers to other agencies and institutions); (ii) a projection of the SS's current expenditure; and (iii) calculation of the incremental operating and maintenance costs that would be generated by the program. It was determined that in the past ten years the historical annual increase in the SS's current expenditure represented 6% of the national budget. Moreover, according to the program financial data, the maximum incremental recurrent expenditure will gradually grow over the program to a maximum of from US$3.1 to US$3.5 million annually equivalent to 2.6% to 2.9% of the SS's current expenditure. Accordingly, a comparison of the SS's current expenditure, the incremental expenditures and the savings that will result from enhanced internal efficiency make it possible to conclude that the program will not adversely affect financing in the sector.

4.22 It should be noted that the program design favors better targeting and efficiency of resource use. In this respect, its financial sustainability is based on: (i) reallocation and targeting of the SS's expenditure; (ii) implementation of a cost-recovery system based on user ability to pay; (iii) contributions from the community and municipalities as a form of collaboration in the care of their health; and (iv) external financing furnished by various international agencies.

4.23 The financing system employed for the Access Program would continue the approach begun in 1995 in which the SS financed 50% of the cost and the rest was covered by gradual participation by the community. It is estimated that as the Access Program becomes consolidated the contributions could reach the following levels: (i) Secretariat, 40%; (ii) community and municipalities, 20%; (iii) cost recovery, 5%; and (iv) external support, 35%.

4.24 Regarding the financing of hospital operating costs, it is felt that with the hospital reform better productivity would be achieved with higher yields estimated at 83% for external consultations; 37% for hospital discharges; and 103% for surgery. This hospital

reform would produce greater internal efficiency which would lead to a change in the financing model based on: (i) a higher user contribution through cost recovery (approximately 5% to 10%); (ii) a community contribution through committees or boards, which could represent 10% to 15%; and (iii) the SS contributions which would make up 75% to 80% of the budget.

INCREMENTAL OPERATING COSTS OF THE PROGRAM 24/

YEAR	CENTRAL GOVT US$'000s	MH US$'000s	INCREASE IN MH BUDGET		INCREMENTAL COSTS	
			US$'000s	%	S$'000	%
1994	338.0	62.9				
1995	390.1	69.4	6.5	9.4		
1996	404.5	75.2	5.8	7.7		
1997	489.8	83.9	8.7	10.4		
1998	599.9	90.3	6.4	7.1	0.5	0.6
1999	728.0	98.3	8.0	8.1	0.8	0.8
2000	891.6	105.3	7.0	7.2	1.7	1.6
2001	1,092.2	110.8	7.0	6.2	2.3	2.0
2002	1,319.2	119.6	7.3	6.1	3.1	2.6

G. Availability of local counterpart funding for program execution

4.25 The program requires the borrower to contribute US$4.0 million over a five-year period, representing an average of US$800,000 per year and peaking at US$1,000,000 in the third and fourth years. This increase is feasible given the government's policy of stepping up its contribution to the social sectors within the framework of the existing fiscal policy and taking into account the meeting of the budget commitments deriving from the PRSP. The financing for the local counterpart will be obtained from the SS budgetary allocations.

24/ For the MH figures, current transfers to other institutions were excluded.

	1998	1999	2000	2001	2002
COUNTERPART (a)	0.4	0.8	1.0	1.0	0.8
SS BUDGET (a)	90.3	98.3	105.3	110.8	118.1
Percentage	0.43%	0.81%	0.95%	0.90%	0.67%

(a) US$ millions

H. Analysis of beneficiaries

4.26 The program will benefit 2,590,000 persons (47% of the country's population) of whom 920,000 will be under age 6 (70% of the country's population under 6) and 555,000 will be women of childbearing age (46% of all women in this age group). The program will be applied nationwide and geographically to all municipalities, thereby meeting the requirements of the Eighth Replenishment and Document GN-1964. 25/ The poverty map of Honduras 26/ was used for targeting the program. The Access Program will benefit the population living in deepest poverty and mainly in rural areas with less access to health services. This program – while nationwide in scope – is aimed primarily at the regions where poverty is most pronounced, as indicated in the table below:

REGION	POPULATION	RURAL POPULATION	RURAL POP. WITH 3 UBNs	% RURAL POP. WITH UBNs
1	101,712	69,125	52,230	75.6
3	228,933	162,705	33,556	20.6
4	398,757	270,017	193,803	71.7
6	430,115	243,444	94,203	38.7
7	134,610	100,694	79,979	79.4
8*	48,350	37,713	26,776	70.9
TOTAL	1,342,477	883,698	480,547	54.3

* Region 8 is inhabited mainly by indigenous peoples.

25/ GN-1964-2. Review of the system for classifying IDB loans for poverty in accordance with the Eighth General Increase in Resources. New version, April 17, 1997.

26/ Office of the President of the Republic, Fondo Hondureño de Inversión Social II (FHIS-II). Poverty map I.

LOGICAL FRAMEWORK: BENCHMARKS

JECTIVES	INDICATORS		MEANS OF VERIFICATION	ASSUMPTIONS
	PRESENT SITUATION	PROGRAM GOAL		
el of health of the ulation and the ciency of the lealth	Aim is to improve the indicators of: **HEALTH STATUS:** 1. Maternal mortality 180/1000 live births 2. Infant mortality: 45/1000 live births 3. Mortality among children under 5: 55/1000 4. Malnutrition among children under 5: 39% **HEALTH MANAGEMENT:** 1. Municipalities with access program: 58% 2. Municipalities with health committees: 58% 3. Municipalities with "basic package": 58% 4. Municipalities with mobile surgery: 10% 5. Hospitals w/reform: 0 6. Hospitals w/boards: 0 7. Hospitals w/mgmt systems: 0	 150/1000 lb 35/1000 lb 45/1000 35% 80% 80% 80% 30% 6 6 6	The integrated health information system will ensure timely identification of vital facts and the principal indicators of health status and management. The epidemiologic surveillance system will provide regular and continuous information on the occurrence and notification of diseases and mortality rates. The hospital management systems will provide the tools for evaluating hospital management and reform.	The reorganization of the h system will rationalize the u resources and public exper particular. The reform of the care mod stress prevention, promote culture and expand coverag services and basic program improving the level of healt The decentralization of serv permit better allocation of a resources to the epidemiolo structure at the local level. The management training a lishment of management sy the local level will favor opt resources and human deve The hospital reform will imp internal efficiency.

JECTIVES	INDICATORS		MEANS OF VERIFICATION	ASSUMPTIONS
	PRESENT SITUATION	PROGRAM GOAL		
d modernize sector mprove equity, quality ustainability of the	Aim is to improve the indicators of: **HEALTH POLICIES:** 1. Allocation of public expenditure to primary care: 46% 2. Hospitals with cost-recovery system: 0 3. Coordination with IHSS: Informal 4. Coordination with private sector: Informal **HEALTH SERVICES:** 1. Immunization coverage among children under 6: 80% 2. Consultations/person/year: 0.4 3. Coverage childbirth care: 48% 4. Reproductive health coverage of women of childbearing age: 45% 5. Population with access to SS care: 45% 6. Hospitals with quality control: 1	 50% 6 Formally established Formally established 90% 0.6 60% 55% 60% 6	The annual operating plans form the mechanism for monitoring the reorganization of the SS. The mid-term evaluation will enable analysis of the course followed and the fulfillment of the objectives of the reform of the SS, preparation of the documentation of underpinning the future sector reform program. The hospitals' medical records and statistics are an important source of continuous and permanent information on institutional efficiency and the quality of services.	The political commitment to the health system is based demarcation of the roles of institutions. This will promp private sector participation, bring about greater compet financial sustainability and quality care for users. The increased percentage expenditure allocated to ba will improve the equity of th The availability of an institu regulatory framework with defined policies will preven duplication of roles and imp efficiency and financial sus The provision of integrated services with different provi help to improve the equity financial sustainability of th system.

JECTIVES	INDICATORS		MEANS OF VERIFICATION	ASSUMPTIONS
	PRESENT SITUATION	PROGRAM GOAL		
TIVITIES				
1: PREPARATION TH SECTOR	**COST (US$24.8 million)**	**DATE COMPLETED**		
orm of the Ministry:	US$1.4 million	Year 2		
on at the central level ion of institutional on systems: procurement; tion of budget to two ns.	New structure functioning Proposed institutional strategy for sector Admin. personnel deconcentration system Procure. manag. deconcentration system Budget manag. deconcentration system		Annual plan of operations. Consultants progress reports. Mid-term evaluation.	The consulting services wil available as programmed i annual operating plan. The PCU will have taken ca necessary coordination witl Ministry Office and other S
regulation: d composition of institutional roles. pital regulations. strategy for SS and s. contracting private	Proposed new institutional roles for sector Proposed general regulations for hospitals Proposed services coordination SS-IHSS Proposed coordinated services SS-private sector		Annual plan of operations. Consultants progress reports. Mid-term evaluation.	

JECTIVES	INDICATORS		MEANS OF VERIFICATION	ASSUMPTIONS
	PRESENT SITUATION	PROGRAM GOAL		
TIVITIES	COST	DATE COMPLETED		
pital reform	US$17,900	Year 3		
t autonomy at tion of resources n of supply by civil society y of general services	Autonomy introduced at 6 hospitals		Annual plan of operations. Consultants progress reports. Mid-term evaluation.	The reorganization and mo of hospitals will permit dec of responsibilities, reduce b and favor use of resources accordance with the prevai circumstances. The partici civil society will ensure that establishments are manage according to the communit
t modernization in Design and of 9 management formation, personnel on, accounting and n, budget, t, transport, ions, quality, and e	Management systems introduced at 6 hospitals	Year 3	Annual plan of operations. Consultants progress reports. The hospitals' medical records and statistics will furnish relevant information on patient care	The information and cost re systems will provide docum required to reform the SS a prepare the future operatio reform.
n of 3 hospitals sical plant ties and ng	Rehabilitation of physical plant, facilities, and reconditioning of 3 hospitals	Year 4	Annual plan of operations. Consulting reports. Mid-term evaluation. Architectural designs and program equipment	The participation of the priv will reduce the role of the S help establishments to bec financially sustainable.
ergency system	Remodeling, restructuring, and reconditioning of emergency services	Year 4	Environmental report on control of liquid hospital waste	
tal safety 6 hospitals	Environmental safety measures introduced at 6 hospitals			
f institutional capacity	US$5,500,000			
ecution (PCU)	Coordinating Unit functioning Studies conducted			

ECTIVES	INDICATORS		MEANS OF VERIFICATION	ASSUMPTIONS
	PRESENT SITUATION	PROGRAM GOAL		
IVITIES	COST	DATE COMPLETED		
2: ING OF PRIMARY E	US$9,400,000	Year 5	Annual plan of operations. Consultants progress reports. Mid-term and final evaluation.	The expansion of the Acces and priority accorded to pre health promotion programs improve the equity of the he system.
f Access Program:	US$5,000,000	Year 5		
preparation c package	72 more municipalities with Health Committees and basic package		The program evaluation system is designed to verify fulfillment of the expanded Access Program.	The strengthening of health epidemiologic surveillance, nutritional improvement pro be factors that help to reduc conditions adversely affecti health of high-risk populatio (the poor, women, and chil
of public health	US$4,400,000	Year 5		
ation ic surveillance and rovement	Public health programs implemented		The epidemiologic surveillance system will furnish pertinent information on programs to promote preventive health.	

ECONOMIC APPRAISAL OF THE PROGRAM

EX ANTE COST-EFFECTIVENESS ANALYSIS FOR HOSPITAL STRENGTHENING PROJECTS

METHODOLOGY NOTE

I. Conceptual Considerations

1.1 The aim of cost-effectiveness analysis (CEA) in health projects, as is the aim of cost-benefit analysis, is to seek maximum efficiency in achieving a project's objectives. CEA is an analytical technique that compares a project's costs with the benefits it will yield. In contrast to cost-benefit analysis, in which benefits are measured in the same unit as costs, costs in CEA are expressed in monetary units whereas benefits or effects on the health of the target population (or any other relevant output that is difficult to express as a clear quantity) are ordered or ranked.

1.2 CEA is an alternative approach adopted in health projects to get around certain limitations of cost-benefit analysis. It helps measure how effectively a health project achieves its ultimate goal, which is to keep the target population healthy; it sidesteps problems of subjectivity and of the underestimating of benefits and impact in health interventions when they cannot be reduced to monetary terms. Nevertheless, recent empirical advances in CEA and cost-benefit analysis in the health-care field, using a broad social perspective, have narrowed the distinction between the two techniques. On the cost side, indirect economic effects that were not looked at in traditional CEA are now added in, and some economic benefits have been treated as negative costs. This evolution makes the term cost-effectiveness analysis even more appropriate, since the basic thrust is still a comparison of resources (net cost) by unit of health outcome.

1.3 CEA is a way of tackling the complicated task of social project appraisal. With this tool, analysts can assess different decision or implementation choices for resource allocation, comparing their impact and efficiency against the monetary cost of each. In this sense, identifying technically viable alternatives is a cornerstone of CEA, whether evaluations are done ex ante or ex post. Likewise, when the main health outcomes/impacts of alternatives can be compared by reference to a single nonmonetary measure, the comparison is done through the cost-effectiveness ratio, whereby alternatives can be ranked by magnitude of resources (costs) required for each to achieve one unit of output.

1.4 A decision arrived at through a CEA exercise rests on the core economic principle of opportunity cost: where resources are limited, they must be allocated so as to yield the greatest number of output or benefit units, whatever the value of the unit. In other words, if there are alternative avenues for achieving a project's objectives, the analysis can identify the optimum choice, to minimize costs for a certain level of output or maximize benefits/effects for a pre-determined cost level.

1.5 CEA does have some limitations that make it not directly applicable in many situations. In contrast to cost-benefit analysis, CEA does not lend itself to comparisons of projects or programs that pursue different objectives (because the measures of effectiveness or outputs differ), unless they can be standardized using a common denominator such as likelihood of disability and death that both programs seek to avert. Nor can CEA evaluate intrinsic value: it cannot answer the question of how much to spend yearly for each year of life saved. Like all project appraisal techniques, CEA is sensitive to uncertainty and to the validity of the data and assumptions used.

II. General Procedure for Cost-effectiveness Analysis

CEA for health projects follows a logical sequence, the following being the key steps:

2.1 **Diagnosis of catchment area** (socioeconomic, demographic, and epidemiological-health profile of catchment area).

2.2 **Diagnosis of current state of the hospital.**

2.3 **Analysis and projections of health services available in the catchment area.**

2.4 **Analysis and projections of potential and effective demand for health services.**

2.5 **Analysis and projections of gaps in health services in the catchment area.**

2.6 **Identification and priority ranking of problems and objectives.**

2.7 **Translating objectives into operational dimensions or targets.**

2.8 **Identification of alternative project implementation approaches.**

2.9 **Identification of costs of technically viable alternatives selected for analysis.**

2.10 **Measurement of resources (direct and indirect costs), in monetary terms, for selected technically viable alternatives, at market and social prices.**

2.11 **Identification of benefits of the technically viable alternatives selected for analysis** (tangible and intangible benefits of the selected alternatives; incremental benefits – comparison of with-project and without-project scenarios).

2.12 **Evaluation and selection of the optimum solution** (comparison of alternatives over the useful life of the project for execution and operation, to select the most cost-effective option).

2.13 **Development of the final project plan.**

2.14 **Calculation of project finance needs** (revenue and cost flows: monetary benefits and costs at market prices, to determine financing requirements for project implementation and subsequent operation).

TENTATIVE PROCUREMENT PLAN FOR GOODS AND SERVICES

MAIN PROCUREMENT ITEMS	FINANCING	METHOD	PREQUALI-FICATION	DATE (1st/2nd half of year)
I. CIVIL WORKS REHABILITATION PHYSICAL PLANT ENVIRONMENTAL INSTALLATIONS: Hiring of construction firm **Total US$10,100,000**	IDB 100%	International call for proposals	YES	I/2000
II. EQUIPMENT AND SUPPLIES FOR: Public Health Program Management and hospitals program **Total US$14,600,000**	IDB 100%	Restricted call for proposals and International call for proposals	NO	II/1998 II/1999 II/1999
III. CONSULTING FIRM SERVICES: Reorganization of health ministry Reorganization primary care services Hospital management Hospital system reform Designs Supervision **Total US$5,800,000**	IDB 100%	International call for proposals	YES	II/1998 II/1998 II/1998 I/1999 I/1999 I/2000
IV. INDIVIDUAL CONSULTANT/TRAINING SERVICES: Access Program Equipment program Environmental safety Studies **Total US$1,700,000**	IDB 80% Govt. of Honduras 20%	Restricted call for proposals	NO	II/1998 II/1999 I/2000 II/1998
V. ADVISORY SUPPORT TO PROGRAM COORDINATION UNIT AND PROGRAM EVALUATION **Total US$2,000,000**	IDB 70% Govt. of Honduras 30%	Restricted call for proposals	NO	I/1998 II/2000
ESTIMATED TOTAL: US$34,200,000				

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HO-0032
Original: Spanish

PROPOSED RESOLUTION

HONDURAS. LOAN ___/SF-HO TO THE REPUBLICA DE HONDURAS
(Program for Institutional Reorganization and Extension of Basic Services of the Health Sector)

The Board of Executive Directors

RESOLVES:

That the President of the Bank, or such representative as he shall designate, is authorized, in the name and on behalf of the Bank, to enter into such contract or contracts as may be necessary with the República de Honduras, as Borrower, for the purpose of granting it a financing to cooperate in the execution of a Program for Institutional Reorganization and Extension of Basic Services of the Health Sector. Such loan will be for the amount of up to US$36,000,000, or its equivalent in other currencies, except that of Honduras, which are part of the resources of the Bank's Fund for Special Operations, and will be subject to the "Special Contractual Conditions" and the "Terms and Financial Conditions" of the Executive Summary of the Loan Proposal.