PROGRAM TO UPGRADE HEALTH CARE SERVICES

(GU-0023)

EXECUTIVE SUMMARY

BORROWER AND GUARANTOR:	Government of Guatemala	
EXECUTING AGENCY:	Ministry of Public Finance (MFP), in conjunction with the Ministry of Public Health and Social Welfare (MSPAS)	
AMOUNT AND SOURCE:	IDB:	US$25 million (OC/IFF)
FINANCIAL TERMS AND CONDITIONS:	Amortization period:	20 years
	Disbursement period:	3 years
	Interest rate:	variable *
	Inspection and supervision:	1%
	Credit fee:	0.75%

* According to the terms of the OC/IFF agreement, interest owed, up to 5% per annum of the loan balance, will be paid from the IFF account.

OBJECTIVES: The principal objective of the program to upgrade health care services is to make structural changes in the health care system to enable it to respond effectively to the public's health care requirements. This will be done by designing and introducing policy, organizational, and financial measures to attain the following specific objectives: (a) extend the coverage of basic health care services, particularly to the poorest groups, with the participation of private providers; (b) increase government spending on health and expand the sector's sources of financing; (c) redirect funding to cover the public's health care requirements; and (d) improve the effectiveness and efficiency with which the public health system performs its functions and produces services.

DESCRIPTION: The program has the following components:

a. Institutional structure. Includes restructuring, decentralization, and strengthening of the institutional capacity of the MSPAS, and the establishment of sector coordination mechanisms.

b. Financing, allocation, and use of funds. Includes actions to: increase the budget for the

sector and improve its allocation; redirect public spending by capping spending on hospitals and using the savings to improve the coverage and quality of basic health care services; and adjust the regulatory framework and streamline budget management to attain the sector's objectives.

c. Health care system. Includes actions to: (i) reorient the health care model; (ii) expand coverage and local participation, and provide better access for the poorest groups to basic health care services; (iii) adjust the regulatory framework and step up private sector participation in the delivery and management of health care services.

d. Public hospital services. Includes the organization of independent bodies to administer hospitals, the establishment of management systems and systems for the transfer of budgetary resources that include financial incentives for the proper use and allocation of resources and better cost-recovery systems.

The size and complexity of the proposed program, which outstrips the country's institutional capacity, makes a parallel technical-cooperation program necessary. The technical-cooperation program will fund consultants, training, and equipment, and will make it possible to continue institutional strengthening during the restructuring process and during the implementation of programs to expand health care coverage with private sector participation and programs to boost the efficiency and sustainability of hospital services.

ENVIRONMENTAL CLASSIFICATION: The Environment Committee, at its meeting of February 15, 1994, classified this as a Category II operation.

BENEFITS: Progress in modernizing health system institutions, better allocation and use of public resources on health care, and reorientation of the health care system, giving priority to expanding coverage with a package of basic services by stepping up participation by the private sector in the delivery of services will result in: (a) gains in efficiency and a reduction in the fiscal burden of providing health care services, to improve the sector's financial sustainability; (b) benefits for users in the form of better quality services and improved access by the very poor to basic health care services which respond to the country's need for a healthier populace; and (c) greater institutional and technical

potential within the health care system for developing effective strategies and programs and attracting and allocating funding to enhance public health.

RISKS: The risks entailed in the operation are: failure to take effective measures to expand the government's revenue base, which must be done in order to maintain an adequate macroeconomic framework for the operation; the scant institutional capacity of the sector's organizations; and possible opposition by interest groups to institutional changes and private sector participation in the delivery of health care services.

SPECIAL CONTRACTUAL CONDITIONS: The sector loan contract will contain the special conditions precedent outlined in paragraph 4.13 and in the policy matrix (Annex I). They are too lengthy to include in this summary, but for the purposes of the pertinent resolutions, they are deemed to be set out here in full.

EXCEPTIONS TO BANK POLICY: The requirement for international competitive bidding for the procurement of petroleum and petroleum products will be waived (see paragraph 4.5).

THE BANK'S COUNTRY AND SECTOR STRATEGY: The strategy focuses on: (i) structural reforms to remove obstacles to macroeconomic stability and increase productivity; (ii) the expansion and upgrading of health care, education, and housing for the lowest income groups, through policy and institutional reforms and specific investments; and (iii) strengthening of the administrative and financial capacity of public agencies to make better and more effective use of scarce funds. In the health sector, the strategy is to increase financing and reallocate resources to expand coverage and upgrade the quality of primary health care services.

IMPACT ON POVERTY: By its nature and design, this sector program complies with the poverty-reduction criteria set out in paragraph 2.15 of the report on the Eighth Replenishment, since more than 50% of the potential beneficiaries live in poverty.

I. FRAME OF REFERENCE

A. The economic context

1.1 Guatemala has a population of 10 million and a relatively diversified economy that generates the highest total product in Central America. The country has a broad resource base that could support sustained development. However, over the last two decades, macroeconomic and structural imbalances in a context of extreme poverty and political problems have combined to hold back development. From 1980 to 1990, GDP grew more slowly than the population, leading to a drop in per capita income. Annual investment, public social spending, and real wages deteriorated over the decade and social welfare indicators declined.

1.2 The government that took office in January 1991 inherited an economy in crisis and responded to the situation with a stabilization and structural adjustment program. In 1992, it paid off its arrears with multilateral agencies and regained access to credit. The economy responded favorably to the program. Inflation fell significantly and GDP grew in real terms at an annual average of almost 4% between 1990 and 1992.

1.3 Ever since the political events in 1993, the macroeconomic situation has been fragile, mainly on account of the fiscal situation. In 1994, the combined public sector deficit was 2.7% of GDP or 1.6 points above the target set in the shadow agreement with the International Monetary Fund (IMF), despite the fact that growth in GDP (4%) and the inflation rate (11.6%) remained the same as in 1993.

1.4 A fiscal reform passed by Congress in December 1994 led to the signature of a new shadow agreement with the IMF in 1995. The program envisages 3% growth in GDP and 8% inflation, with international reserve levels holding steady. As a result of the fiscal reform, the tax burden should rise from 6.8% in 1994 to 8% in 1995 and the combined public sector deficit should fall to 1.3% of GDP. In the first half of 1995, GDP grew by close to 4%, inflation was 9.2%, and fiscal revenues exceeded the program's mid-term goals. However, losses in the early months of 1995 brought international reserves down by the end of June to a level almost US$250 million under the target.

1.5 In the short term, there is a risk that capital might flee the country and that the tax revenue goals will not be attained before the general elections in November 1995. In the medium term, the challenge will be to strengthen public finances. Even if the fiscal revenue target for 1995 is attained, Guatemala will continue to have the lightest tax burden in Latin America. The reconstruction of physical infrastructure, investments in the

country's human capital, and costs stemming from potential peace agreements will require considerable fiscal effort.

B. Social sector characteristics

1.6 Guatemala has one of the lowest levels of social welfare and satisfaction of basic needs of any country in Latin America. The results of the 1989 sociodemographic survey 1/ suggest that close to 80% of the population lives in poverty and 60% in such dire poverty that it is unable to meet its basic nutritional requirements. Poverty is worst in rural areas and among the indigenous population.

1.7 One of the most serious problems that the government must surmount if it is to attain its social policy objectives is the traditionally low level of financing for the social sectors, 2/ which is related to their dependency on the State budget and the fact that fiscal revenue accounts for such a small share of GDP (just under 8% in 1993). To consolidate the headway made under the stabilization program, the government devised a sweeping modernization and social progress program for the period 1991 to 1996, whose objectives include providing the most vulnerable groups with better access to social services. The program provides for reforms to boost revenues, control the fiscal deficit, and increase spending on the social sectors. Execution of that program is a basic condition for reforming the financing of the social sectors.

C. The Bank's strategy

1.8 The Bank's strategy for Guatemala assigns high priority to social reform and investment under programs to improve the coverage and quality of education and health care for the poorest groups. The strategy recognizes the importance of continuing the macroeconomic stabilization program and boosting fiscal income, which would allow for higher investments in the social sectors. The Bank's support for this objective has taken the form of a financial sector loan approved in December 1993 (which has been totally executed and disbursed) and an investment sector program slated for approval in 1996. On the sector level, the strategy gives priority to the correction of inefficiencies in fiscal spending on health care and education, increased funding, and better quality primary health care services. The health care services program proposed here is part of this strategy.

1/ "Profile of Poverty in Guatemala: 1989 National Sociodemographic Survey", National Statistics Institute and the United Nations Population Fund.

2/ From 1980 to 1993, spending on health fell from 1.9% to 1% of GDP, and its share of total public spending shrank from 12.5% to 9%.

II. THE HEALTH SECTOR

A. General situation

2.1 The health status of Guatemalans compares unfavorably with the situation in other Latin American countries with similar development levels. In 1989 (the most recent year for which official statistics are available), life expectancy at birth was 63 years, the mortality rate was 7.2 per 1,000, the infant mortality rate was 57 per 1,000 live births, and maternal mortality was 9.3 per 10,000 live births. 3/ Health conditions are significantly worse among some socioeconomic groups with lower education and income levels, particularly the rural and indigenous populations.

2.2 Among the chief causes of death, the prevalence of infectious diseases and illnesses associated with lack of environmental sanitation and poor nutrition is an indicator of the poor health of the population and the lack of effectiveness of the health care system. Over 64% of total deaths in the country are caused by infectious, nutritional, and perinatal diseases. In 1989, diarrheas (30%), acute respiratory infections (23%), perinatal diseases (20%), and malnutrition (4%) were the main causes of infant mortality. Mortality among children under five was 102 per 1,000 and, with the exception of perinatal disease, was due to the same causes as for infants.

2.3 The impact of poverty on the health of the population is aggravated by shortcomings in the implementation of government policy and in the resulting allocation of funds. The health care services of the Ministry of Public Health and Social Welfare (MSPAS) and the Guatemalan Social Security Administration (IGSS) are supposed to attend to the entire population, with the MSPAS responsible for serving individuals who are not covered by the IGSS. In practice, the MSPAS covers about 30% of the total population and the IGSS less than 15%, mainly in urban areas. Private health care services cover between 8% and 12% of the total population, also mainly urban and earning relatively higher incomes. These figures suggest that close to 40% of the population has no access to formal health care services and that this 40% is poor and at greatest risk.

2.4 As a component of its social policy, the government's health care policy, as set out in the MSPAS document entitled *Lineamientos de Politica de Salud 94-95* [Health Policy Guidelines 94-95], is geared to the problems in the sector and is reflected in the program

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3/ Information on health indicators varies significantly depending on the source. For example, the infant mortality rate is reported as ranging anywhere from 40 to 70 per 1,000 live births.

discussed here. The policy proposes to boost the sector's efficiency and coverage, and its priorities are preventive and primary health care, with stress on the poorest and most vulnerable groups.

2.5 To attain these goals, significant, interdependent, and sustained changes are required in policies, institutions, finances, and services, with reorganization needed on all levels. The following section identifies the main problems in the sector.

B. Main problems

1. Institutional problems

2.6 **Sector coordination.** The Guatemalan health sector is marked by the absence of a clear division of responsibilities with regard to management of the sector and satisfaction of the health care requirements of the different population groups. Excessive centralization and complicated bureaucratic and legal structures afflict the public sector, and there is no regulatory framework governing the delivery of health care services by the private sector. The result is lack of coordination in the public sector, which contributes to inadequate coverage in particular for the very poor, the high cost of services, underuse of installed capacity, and unnecessary duplication of investments and services for wealthier groups. However, the development of services by providers outside government in small-scale isolated projects cannot contribute substantially to the establishment of a stable system of services to improve the public's health.

2.7 **The Ministry of Health.** The MSPAS formally heads the sector, devises and executes policy, manages the bulk of sector funding, and executes public health programs and health care programs for low-income groups. Its action in these fields is inefficient, ineffective, and inequitable. The Ministry suffers from a lack of capacity to formulate and execute policies and programs that respond effectively to the public's health needs. Its main institutional problems are: lack of a clearly defined mission; heavy involvement in the production of goods and services not subject to competition; complicated organization, high degree of centralization, and bureaucratization; lack of resources and systems for policy formulation, programming, regulation, supervision, and control; and weaknesses in its management capacity and ability to administer funds and delegate responsibilities on all levels. These problems affect its ability to exercise national leadership in the sector and limit its capacity to respond to the health requirements of local communities and to manage at the level of health districts and service establishments.

2. Sector financing and spending

2.8 Government funding for the health sector has traditionally been low and it has been inefficiently and inequitably allocated internally. Because MSPAS spending is so low and not concentrated on effective low-cost actions, it has little impact on health conditions. In terms of targeting spending to specific low-income groups or geographic areas that are focuses of poverty, where government action is most necessary, its presence is scarcely felt. The redistributional impact of government spending on health is minimal.

2.9 Public funds are poorly allocated among the different activities, and favor curative hospital care over preventive care. Geographically, spending is focused on the metropolitan region and favors urban over rural areas, investments are unnecessarily duplicated, and subsidies and the best services go to higher income groups. Spending centers on investments in physical infrastructure and personnel rather than on essential medical inputs and maintenance of facilities and equipment.

2.10 Government spending on health is insufficient, given the country's serious health situation, and the problem worsened during the economic adjustment process in the 1980s. From 1980 to 1993, the MSPAS's spending on health fell from 1.9% to 0.9% of GDP and shrank as a percentage of total public spending from 12.5% to 9%. In real terms, per capita spending on health by the MSPAS fell by 50% over the period under consideration, to about US$8 in recent years. Per capita spending on the primary care level was just over US$2. This is significantly lower than the minimum of US$12 required to deliver a basic package of core services on the primary care level in low-income countries. 4/

2.11 Guatemala ranks among the three Latin American countries that allocate the smallest share of GDP to health care. However, spending on health as a percentage of total government spending compares favorably with countries having similar development levels. This is because government revenues account for such a small part of GDP (less than 10% in the 1980s). It is expected that the government's share will rise with the current fiscal reforms, but not quickly or significantly. The government's plan for 1991-1996 (PLADES) recognizes the need to spend more on the sector and proposes a goal of 2% of GDP for health spending in 1996. Recent studies on the economic and fiscal situation and outlook estimate that this target could be attained by the year 2000. The political viability of reorienting public spending on

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4/ The 1993 *World Development Report* estimates an average cost of US$4 for public health activities, and US$8 for essential clinical services in low-income countries (per capita GDP of under US$635).

health to reflect the government's objectives will depend on the extent of the increase in government revenues.

2.12 Low government spending is compounded by inequitable allocation that is inconsistent with the nature and seriousness of the country's health problems. In 1992, over 70% of the MSPAS budget was allocated to city hospitals, while the funds earmarked for core primary health care services were paltry. There is no correlation between resource allocation and the country's epidemiological profile, in which diarrheal, respiratory, and infectious diseases and malnutrition are the chief causes of illness and death in almost all age groups. It is crucial to redirect public sector spending to respond to health problems. The alternative of broadening coverage and meeting the health care requirements of low-income groups is not financially viable if current patterns of sector development, which emphasize free services provided by public institutions, high-cost technology, and hospital-based curative care, continue.

2.13 Even though it does not have much money to spend, the MSPAS's budget performance has been poor, owing to legal and bureaucratic stumbling blocks in the public sector and the Ministry's deficient administrative capacity. The current process of budget preparation and execution results in delays and wastes MSPAS resources. The problems are as follows. In the absence of a system to monitor and evaluate spending by outputs, budget execution is centralized in the Ministry of Public Finance (MFP) and is strictly regulated to control transfers of funds between items and prevent misappropriation. This rigid approach applies also to budget preparation, with funds being assigned to many units and to many specific items. The MSPAS also centralizes its role in budget preparation and execution. The mechanisms it uses for allocating resources bear no relation to output or performance, adequate information is not available on the different levels of execution, and the MSPAS has very little capacity to program or administer funds at the district and service delivery levels, with the exception of hospitals. This skews spending in relation to budget allocations even further. Changes in the regulatory framework and MFP procedures that affect the entire public sector are necessary to address this problem.

3. Health care systems

2.14 The MSPAS's current health care model does not respond to the needs of the majority of Guatemalans. Its main features are: (i) over-centralization; (ii) lack of articulation among institutional care levels; (iii) predominance of hospital-based actions; (iv) physician-based, and preferably hospital-based, treatment; (v) stress on predominantly curative care; (vi) channeling of the supplies of health care services without regard for demand, differences in epidemiological profiles, or the ethnic or cultural conditions of the local population; and (vii) high costs stemming from the use of

complex technologies that are unsuitable for solving the problems. The results of adhering to this health care model can be seen in the organization of the health care system, the allocation of its resources, and the health status of the populace.

2.15 The rural population has much less access to health care services than the urban population. Estimates suggest that over two thirds of the rural population have no access at all to essential health care and environmental sanitation services. Health care systems in rural zones are not very functional, their activities do not extend outside health establishments into the community, health clinics and centers frequently suffer from a lack of equipment and inputs, core staff, and work regulations, and the referral systems between primary and secondary care levels do not work.

2.16 The health authorities have recently approved a new health care model to serve as the conceptual framework that will guide the reorientation of public health care services, the allocation of funding, and programs to extend coverage in the country's health districts.

4. Private sector participation

2.17 The poor performance of public institutions in improving the health of Guatemalans and the need to redirect funding from curative services into public health care are the rationale behind the search for cooperative strategies for private participation to improve the efficiency and effectiveness of the country's health care system. Traditionally, Guatemalans have interpreted the constitutional declaration that health is a public right to mean that health care services should be provided free of charge by public institutions. For their part, public institutions have not seen any advantage in private cooperation (for-profit or nonprofit) and have certainly not given consideration to private sector participation as the provider of services or administrator of government-funded public establishments. Legal and institutional obstacles stand in the way of private sector participation in the financing, administration, and delivery of health care services. They have impeded the use of market incentives, the introduction of more competition to stimulate the efficiency and quality of services, and the development of concrete mechanisms for private participation (agreements, management contracts, etc.) in order to make use of the private sector in redirecting resources to core health care services, expanding coverage, and improving the efficiency and quality of health care services.

2.18 Nonetheless, Guatemala has a private sector that is very active in health care. Private for-profit medical services are concentrated in Guatemala City and are available in other urban areas. Nongovernmental organizations (NGOs) have a significant presence in some communities in different parts of the country. Moreover, there has been some experience with public/private cooperation in

the administration and delivery of health care services, which could potentially make a significant contribution to the objectives of health sector development, if an adequate framework of laws and incentives is established for private sector participation.

5. Hospitals

2.19 Hospitals absorb a large part of government spending owing to their inefficient use of public funds and the absence of alternative financial mechanisms. Generally speaking, the MSPAS's hospitals are not well stocked with medications and suffer from poor maintenance, chronic absenteeism, and chaotic organization of clinical services. These shortcomings contribute to a general belief among Guatemalans that MSPAS hospitals provide poor quality medical care. Consequently, these hospitals are underused despite their good geographic accessibility.

2.20 The basic studies conducted during preparation of the program proposed here indicate that internal systems for the distribution of medications are flawed and result in losses of over 30% of the sums spent on medical supplies. Failure to observe purchasing and procurement regulations means that most establishments pay from two to four times the average international price for medical and pharmaceutical supplies. Wide differences have also been observed in unit costs between hospitals of the same level of complexity, which suggests inefficient use of funds. The MSPAS's two tertiary level 900-bed hospitals, the Roosevelt and San Juan de Dios, are cases in point. The average cost of an outpatient consultation and laboratory tests for an ambulatory patient at Roosevelt is just a fraction of the cost of the same service at San Juan de Dios. However, the cost of a normal delivery at Roosevelt is five times higher than at San Juan de Dios. Similarly, large variations in unit costs have also been observed in many secondary-level regional hospitals.

2.21 The lack of financial alternatives also contributes to high public spending on hospitals. The MSPAS hospitals recover less than 1% of their costs through patient fees. However, public charity hospitals and NGOs that serve the low-income population recover from 8% to 64% of their costs through patient fees. Surveys of low-income Guatemalans show that they make heavy use of private medical services and are willing to pay for them.

2.22 Poor administration and deficient budget practices contribute to the inefficient use of funds. The administrative structure is not conducive to cost control, increased production, or better quality. Hospital administrators do not have the authority, incentives, training, or information necessary to introduce the necessary control and supervision systems.

2.23 Hospital budgets in Guatemala are not effective tools for encouraging efficiency; on the contrary, they offer incentives to

"maximize" and even to overspend the budget. Budgets are based on historical financing levels, political and professional pressure, and the availability of funds. Specific criteria, such as costs and production, do not influence the budget process. Inefficient hospitals are frequently rewarded with additional subsidies, while more efficient establishments that generate budget surpluses are punished by being denied access to the funds they did not use up. Despite their demonstrated inefficiency, Roosevelt and San Juan de Dios are examples of hospitals that frequently obtain additional funds from the MSPAS, over and above their original budgets. The inevitable result is a reduction in the funding available for other establishments and services in the system.

III. PROGRAM TO UPGRADE HEALTH SERVICES

A. Objectives

3.1 The main objective of the program to upgrade health care services is to improve the health of Guatemalans by making MSPAS services more efficient and effective. Attainment of this objective will require institutional and policy changes in the health sector. Adjustments in the regulatory framework and in the public sector's resource management procedures are also necessary but are beyond the control of the health authorities and bring components bearing on modernization of the State into play, with the focus on the health sector.

3.2 The program seeks to redefine the role of the MSPAS, reallocate financing, and redirect the health care system towards the universal provision of a package of basic services to attend to the population's main health problems, while attempting to increase the productivity and quality of the services delivered.

3.3 The proposed operation will be the first stage in the process of modernizing and strengthening the sector, which will probably require more than a decade to complete. Therefore, the present operation will lay the groundwork for subsequent programs, conditional upon its satisfactory execution, which will be aimed at complementary reforms in the health sector and in the public sector in general.

3.4 Parallel to this program, the World Bank is preparing a technical-cooperation operation with the Ministry of Public Finance to introduce a comprehensive financial administration system in the public sector, which would use the health sector as a pilot case. The World Bank and the IDB have cooperated in preparing the program and are coordinating the financial elements of the health sector in their respective operations.

B. Structure and components

3.5 The program has been organized into four components to cover the sector's main problems analyzed in chapter II, i.e.: (a) institutional structure – to boost coordination in the sector, strengthen the MSPAS, and improve its performance; (b) financing and allocation of funds – to increase government spending levels, streamline execution, and redirect spending into highly cost-effective services; (c) health care systems – to reshape the health care model and extend the coverage of core health care services through private providers, with stress on the poorest groups; and (d) public hospital services – to boost their efficiency and financial sustainability.

3.6 The size and scope of the changes in administration, policy, and the health care model called for in the proposed program make it necessary to introduce some of the program's activities in the form of pilot programs in a few geographic areas. The pilot programs will be carried out in three departments which are also MSPAS health districts: Escuintla, Chiquimula, and Alta Verapaz. Certain activities relating to the following components will be centered on those districts: (a) restructuring and strengthening of the MSPAS; (b) financing, allocation, and use of funds; and (c) health care systems.

3.7 The specific components of the proposed program and the corresponding policy measures (which are consolidated in the policy matrix contained in Annex I to this document) are discussed below.

1. Institutional structure

3.8 The shortcomings of public sector health care institutions in formulating and executing policies and programs, defining priorities for health care activities and services for different population groups, using public sector funds, and delineating the field of action for the private sector have been determining factors in the limited impact of the sector on improving the health status of Guatemalans (see paragraphs 2.6 and 2.7).

a. Sector coordination

3.9 The purpose of this activity is to define institutional organization and coordination in the sector. It includes a definition of the role of the MSPAS with regard to other institutions and the private sector in formulating policies, delivering and supervising health care services, and coordinating public sector investments and programs to improve the allocation of sector resources and the effectiveness of services. Legislation will be passed defining the functions of health sector institutions, establishing a mechanism and authority for coordination of MSPAS and IGSS programs, and defining private sector participation in the delivery of health care services. The program calls for the introduction of a bill on coordination in Congress (first tranche), its implementing regulations (second tranche), and the establishment and operation of a coordination mechanism on the national level (third tranche).

b. Restructuring and strengthening of the MSPAS

3.10 The objective is to strengthen the institutional capacity of the MSPAS, by beefing up its regulatory role and decentralizing its administrative role to the different health districts. This includes execution of a plan of action for the restructuring and institutional strengthening of the MSPAS during the entire program

(i.e. associated with each of the three tranches). 5/ The plan of action includes: (a) entry into effect of the new legislation amending the Health Code and the ministerial decree defining the immediate organizational changes to be made in the MSPAS; (b) suspension of hiring at the central level of the Ministry and approval of a program to downsize its staff; (c) preparation of operating regulations for the MSPAS, including administrative decentralization in the three pilot program districts (Alta Verapaz, Escuintla, and Chiquimula). 6/

2. Financing, allocation, and use of funds

3.11 Redirecting the allocation of public sector resources — from curative services in hospitals to basic services in rural and marginal urban areas — is a major step in responding to the health problems of poor and high-risk groups. However, given the scant funding currently earmarked for the sector, the gains in efficiency resulting from this reorientation will not be sufficient to improve the quality of care (see paragraphs 2.8 to 2.13).

5/ The activities in this component, which will be supported under the technical-cooperation project associated with this operation, include: (a) establishment of a new organization with a simplified structure geared to the MSPAS's leadership role in the sector, the strategy of decentralizing and reorienting the sector's health care service systems, and a more modern concept of the role of the State and health care administration; (b) decentralization or elimination of the MSPAS units that produce goods and support services that can be delivered or administered more efficiently by other agents; (c) administrative decentralization to the health districts and their establishments (in line with greater community and private sector participation in the administration and delivery of services) with priorities focused on basic health care services; and (d) strengthening for the MSPAS through downsizing of its personnel and better management and financial administration systems to boost efficiency at all levels of its technical and administrative structure and in its health care establishments. Annex II contains a summary of the plan of action, and Annex III describes the technical-cooperation program.

6/ The purpose of administrative decentralization is to spur changes in the health care system by boosting the capacity for resource administration and public/private cooperation, bringing responsibility for the programming and provision of services closer to program beneficiaries and gradually handing their delivery over to the private sector. Decentralization of health districts and their health care establishments, together with changes in budget preparation and execution, will make it possible to carry out programs to reorient health care systems and expand coverage with the private sector participation proposed by the program for these pilot health districts.

3.12 The activities in this component are intended to attenuate these two problems by promoting an increase in public funding for the sector and greater efficiency and equity in the use of funds, by realigning public spending in the health sector and improving MSPAS budget performance.

a. Budget increase and reorientation

3.13 This activity is aimed at increasing the financing for basic services in the sector and improving MSPAS budget performance. The first goal will be to finance the marginal cost of the package of basic health care services. To do so, the program proposes an increase in real terms of 12% in the MSPAS total budget prior to release of the first tranche, and 20% prior to the second and third tranches. By redirecting public spending, these increases will be used to finance the activities proposed with regard to the expansion of coverage and improvement in basic health care services.

b. Better budget performance

3.14 Aside from the scarcity of funding for the MSPAS, its budget performance has been poor. Legal and bureaucratic obstacles in the public sector, lack of autonomy in budget execution, and the poor administrative capacity of the MSPAS compound the situation.

3.15 This program activity is intended to simplify and streamline budget preparation and execution of the MSPAS through measures to decentralize the administration of funds to the three pilot health care districts and establish budget performance targets. Under the program, a plan of action will be implemented to adjust the systems for preparation, performance, and control of the Ministry of Public Finance's budget, including: (a) the entry into effect of ministerial decrees that modify the rules governing the use of the private funds of health care establishments and revolving funds, and that create a budget item to permit the pilot health care districts to contract NGOs and other private providers of basic services; and (b) adjustment of the rules for presentation of a simplified budget on the central level and in the three pilot districts, reducing the number of specific items and budget units. 1/

3.16 The program also establishes incremental goals for budget performance in the three pilot health care districts (70% between the first and second tranches, and 80% between the second and third tranches of the loan). In addition, the program will monitor

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1/ Execution of the comprehensive financial administration program for the MFP, supported by the World Bank, and the institutional strengthening program for the MSPAS will also help to attenuate these problems.

spending patterns, stressing investments in sanitation and priority health care programs in the three pilot districts and discouraging transfers from the preventive care program (first-level curative and preventive care) to the curative program (hospital services) [second and third tranches].

3. Health care systems

3.17 Guatemala's health care system stresses centralized, hospital-oriented, and curative care. The results of this system are reflected in the organization of the health care system, the allocation of its resources, and the health status of the population (see paragraphs 2.14 to 2.18). As one of the program's actions, the health authorities have recently approved a new health care model to serve as the conceptual framework that will guide the reorientation of health care services and programs to extend coverage in the country's health care districts. 8/ This component includes the redirection of health care systems to expand the coverage of a basic package of health care and environmental sanitation services 9/ to include the poor population in three health care districts, with nongovernmental participation in service delivery.

a. Redirection of health care systems in the health care districts

3.18 The main short-term action in Guatemala's health care strategy should be to channel public funding into core public health and clinical services. The program will define and adapt this basic package of services and introduce the necessary changes into the health care systems in the three pilot health care districts (Escuintla, Chiquimula, and Alta Verapaz). The pilot programs will be used as the testing ground for programming, evaluating, and adjusting the proposed system. 10/

8/ The guidelines of the new health care model defined by the government favor: (a) actions to foster good health, self care, and disease prevention; (b) tailoring of health care activities to the epidemiological profile and local sociocultural conditions; (c) selection of a basic package of core health care services that are effective in terms of costs and satisfy users' demands; (d) priority for ambulatory and home care; (e) use of local health teams to provide services (e.g. nursing assistants, community health workers, rural health technicians); and (f) participation by the private sector in the delivery of services.

9/ This core package includes public health programs and essential clinical services.

10/ There are about 1.6 million people in the departments concerned, 70% of whom live in extreme poverty.

3.19 The parallel technical-cooperation component will finance activities linked to the final design of the system in each district, promotion of local participation, project monitoring and evaluation systems, training for community health care personnel, and basic equipment and inputs for that personnel. At the same time, the institutional and financial reforms that will permit administrative decentralization, the reallocation of funding for health care services, and the introduction of public/private cooperation strategies to improve the efficiency and financial sustainability of extending coverage to the poor will be carried out in these districts.

3.20 The program will include a plan of action to reorient health care services in the three districts, including: (a) definition of a package of essential health care services; (b) design of the system for delivering those services, including training human resources for local health teams, improvements to the physical infrastructure, basic equipment for health centers and clinics, and a system for supplying medical inputs on that level; (c) definition of the activities of the public and private sectors; (d) the project execution plan; and (e) the monitoring and evaluation system.

b. Private sector participation

3.21 The purpose of this subcomponent is to relieve the public sector of the burden of production activities and to achieve significant gains in efficiency, quality, and coverage of the health sector in the medium term, by establishing strategies for cooperation between the public and private sectors. The strategies are based on successful experiences in Guatemala (e.g. NGOs working in the health field) and existing private capacity in the country's health sector (see paragraphs 2.16 and 2.17).

3.22 The activities proposed in the program are intended to establish a regulatory framework for private activity in the sector and strengthen the programs to redirect services and extend coverage by using private delivery systems and introducing competition into public health care services. The parallel technical-cooperation operation will support the design and execution of these activities.

3.23 Regulatory framework. To empower private sector participation in the financing, administration, and delivery of health care services, the program includes entry into force of legislation on associations that will facilitate the establishment of public/private partnerships and entities involving different groups, including communities, to enable them to gain access to social compensation funds and execute health programs.

3.24 **Extension of coverage in rural communities.** To increase the participation of communities, cooperatives, and NGOs in the provision of basic health care services, agreements will be concluded with associations, communities, and municipalities for the administration of health centers and clinics. Communities will be able to contract private providers of basic health care services and the MSPAS will be able to contract NGOs to provide services in specific communities. Communities and municipalities will organize to prepare and execute health and environmental sanitation programs with resources from the Social Investment Fund (FIS). 11/ The program's conditions require that agreements be concluded between the MSPAS and the FIS and between the MSPAS and NGOs (at least eight prior to the third tranche) and that monitoring and evaluation systems be established.

3.25 **Health care services for farm workers.** To speed up the extension of basic health and environmental sanitation services to plantation workers and their families, 12/ the program calls for NGOs to deliver the basic package of services, with the financing to be shared by the plantation owners and the MSPAS. The program requires execution of a plan of action to establish a pilot program under which agricultural enterprises in Alta Verapaz enroll in private basic health care plans. The program includes approval of these pilot projects and the signature of agreements to cover at least 10 plantations with over 250 workers, using two or more different health care providers.

3.26 **Health care services for workers in the urban informal sector.** The purpose of this activity is to prepare a demonstration project to cover a segment of the urban informal sector, chiefly microentrepreneurs, employees, and their families. 13/ The activities will be carried out in Guatemala City and involve two components: (a) savings and loan associations whose members represent potential demand for the service; and (b) organized groups of providers (physicians, clinics, or hospitals) who will

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11/ These projects will be carried out in the three pilot health care districts, with financing from the government through the MSPAS district office or the Social Investment Fund and participation by the communities or municipalities, and will also be supported with funds from the parallel technical-cooperation program.

12/ This population is estimated to number close to 800,000, and is partly composed of indigenous peoples and migrants who work predominantly on plantations on the coast during the planting and harvest seasons for the main crops, and who do not have access to basic health care services.

13/ Estimates suggest that one fourth of Guatemala's economically active population works in the informal sector, which contributes about 34% of GDP.

provide the health care services. 14/ The program calls for studies on the demand for health care services by microentrepreneurs and their employees and on the market of providers and health care prepayment plans in Guatemala City, and preparation of a design and plan of action for a pilot project in a subsequent stage.

4. Public hospital services

3.27 Spending on curative services in public hospitals absorbs close to 70% of MSPAS spending on health care. Nonetheless, the establishments are extremely underused, partly because the quality of their services has been steadily declining. The hospitals, in turn, are conspicuous for their inefficiency and wastefulness (see paragraphs 2.18 to 2.22). This situation leads to political support in urban areas for the frequent hospital crises to be solved by reallocating funds to hospitals to the detriment of spending on basic health care services at the primary level.

3.28 The actions proposed under this component are aimed at improving the efficiency, quality of care, and financial sustainability of hospital services, by making them administratively independent and placing caps on government spending to finance their services. The measures include giving administrative autonomy to private not-for-profit entities (e.g. councils, associations); the introduction of cost-recovery systems which provide subsidies for the poor; the establishment of systems for the transfer of government funds which include financial incentives for use and allocation of resources; management support for hospital administration; the establishment of systems for the purchase, procurement, and distribution of medications; the development of effective quality control systems; and the contracting of support services. Greater participation by the private sector in hospital administration and financing will free up funds for basic health care services.

3.29 Prior to release of the second tranche of the loan, a plan of action will be carried out to establish pilot projects in at least one national hospital and one hospital in one of the three health districts that will include: a government resolution modifying the criteria and procedures for setting fees in health care

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14/ There are a number of associations of microentrepreneurs in Guatemala and at least two prepayment plans interested in participating in this project. The main role of the associations of microentrepreneurs is to establish risk groups of members seeking health care services and to collect the premiums to purchase services from providers (similar to HMOs). The latter would be contracted by the association of microentrepreneurs and be given a per capita payment for each member. The possibility will be explored of having the MSPAS subsidize premiums for low-income members (subsidy for demand).

establishments; formalization of agreements between the administrative units of the two hospitals selected and the MSPAS and the MFP; approval of changes to the current regulations governing the establishment and operation of administrative structures. Prior to the third tranche, pilot projects will be introduced in two other hospitals belonging to the national network.

3.30 During the program, the process of reassigning personnel will be initiated and the mechanism for transferring government funding will be gradually changed. Prior to the second tranche, a budget cap will be set for all hospitals. Prior to the third tranche, budgets will be designed for the hospitals with independent administrations to reflect the cost of services, and afterwards a payment system will be designed to reflect income from the services. By the end of the program, independent administrations and cost-recovery systems will have been established in four hospitals, and progress will have been made in establishing management and control systems, reorganizing medical services, and initiating a payment system for transfers of government subsidies.

C. Technical-cooperation program

3.31 The rationale for the parallel technical-cooperation program lies in the nature of the proposed reforms, the legal constraints, and the inadequate initial capacity of the public and private sectors to carry out the proposed actions.

3.32 The proposed program of activities is substantial. The MSPAS and its health establishments do not currently have the staff, resources, or management systems needed to adequately carry out the new functions and activities proposed in the program. Introduction of the changes to strengthen the institutional capacity of the public sector and to upgrade its services must surmount problems relating to the availability of human and financial resources, lack of flexibility in using budgetary funds, rigid personnel administration regulations, and resistance by unions to the downsizing of staff and to contracting professionals with the qualifications needed for their new functions. This becomes more significant in light of the scope of the institutional reorganization of the MSPAS and its decentralization. Accordingly, there is a substantial need for technical cooperation to hire consulting firms and specialized agencies to support the process of change in the public and private sectors. To make a start on institutional strengthening and execution of the programs to expand coverage, local personnel will be trained and local consultants hired for periods of one to two years until such time as policy changes to replace technical-cooperation funding with government funding have been put in place.

3.33 The technical-cooperation program will be executed over three years. The funds will be used to finance consulting services

(mainly local), equipment, and inputs, to support the following: (a) reorganization of the MSPAS, including the design and execution of the plans to reorganize, decentralize, and technically and administratively strengthen the MSPAS in the three pilot departments; (b) reorientation of health care delivery services, including the extension of coverage, the design and introduction of a new health care model, promotion and technical support for the training of nongovernmental entities to deliver services, and the design, monitoring, and evaluation of projects that make use of the private sector to deliver basic health care services; (c) the strengthening of public hospitals, including the establishment of independent hospital administrations and support for their management of programs to improve the efficiency and quality of care at selected hospitals.

3.34 Preference will be given to local consulting firms and specialized agencies so that the expertise gained will remain in the country. Consulting activities include a strong training component for local counterparts and personnel from institutions in the sector. One of the criteria for evaluating the performance of the firms will be the quality of the training they provide for local personnel. Annex III gives a fuller description of the technical-cooperation program and presents the costs.

D. Expected results

3.35 The following main results should be achieved by the end of the program: (a) progress will have been made in institutional modernization by establishing a legal framework and plans for coordinating the MSPAS's restructured and partially decentralized health care system; (b) government funding for the MSPAS will have increased and will be redirected into core health care and environmental sanitation services; (c) the health care system will have been reformed, with funds reallocated to the universal provision of a package of basic services in three departments, and public/private cooperation and community participation strategies will have been implemented in the delivery of services targeted to specific population groups; (d) the public sector will have the capacity to develop effective strategies and programs and its execution capacity and that of NGOs on the local level will have been built up; (e) hospital services will have improved in at least one national and three regional hospitals, with the establishment of new administrative structures, cost-recovery systems, sale of services to third parties, contracts with the private sector for support services, and the introduction of effective internal control systems.

3.36 In essence, the success of the program will be measured by how well it attains the more general objectives of efficiency, equity, quality, and financial sustainability. Table 1 shows the expected impact of the larger activities of the program on those objectives. Many of the activities have been designed to relate to at least two objectives.

Table 1
IMPACT OF PROGRAM ACTIVITIES ON PROGRAM OBJECTIVES

COMPONENT	SUBCOMPONENTS - MAIN ACTIVITIES	OBJECTIVES			
		Extension of coverage to low-income groups	Efficiency in allocation	Technical efficiency	Financial sustainability
I. INSTITUTIONAL STRUCTURE	A. SECTOR COORDINATION				
	- Definition of the role of each subsector	-	X	-	X
	B. RESTRUCTURING AND STRENGTHENING OF THE MSPAS				
	- Administrative reorganization	-	-	XX	-
	- Decentralization	X	X	XX	X
II. FINANCING, ALLOCATION, AND USE OF FUNDS	A. BUDGET INCREASE, REDIRECTION, AND EXECUTION				
	- Budget increase	XX	XX	X	XX
	- Redirection of funds	XX	-	-	-
	B. STREAMLINING OF BUDGET EXECUTION				
	- Decentralization and flexibility of financial flows	X	XX	XX	-
III. HEALTH CARE SYSTEMS	A. REORIENTATION OF HEALTH CARE SYSTEMS IN THE PILOT DISTRICTS				
	- Application of a basic package	-	XX	X	XX
	- Application of methods for organization and delivery	XX	XX	-	XX
	B. PRIVATE SECTOR PARTICIPATION				
	- Extension of coverage to rural communities and farm workers	XX	XX	XX	X
	- Core services for the urban informal sector	XX	XX	XX	X
IV. PUBLIC HOSPITAL SERVICES	A. IMPROVEMENT IN EFFICIENCY, QUALITY, AND SUSTAINABILITY				
	- Public/private structures for hospital administration	-	-	XX	-
	- Cost recovery	-	-	XX	XX
	- Private sector contracts for support services	-	-	XX	X
	- Systems to improve efficiency and quality	-	-	XX	X

XX = significant impact X = moderate impact - = insignificant impact

IV. PROGRAM FINANCING AND EXECUTION

A. Program financing

4.1 The program will be financed with US$25 million from the Bank's ordinary capital, under the Intermediate Financing Facility. It is structured in three tranches to be disbursed as follows: the first tranche would be US$10 million, the second US$5 million (tentatively in the third quarter of 1996), and the third US$10 million (tentatively in the third quarter of 1997). In view of the scope and complexity of the reforms to be carried out under the program, a three-year disbursement period is recommended to allow for unforeseen events that might cause delays.

4.2 The financial terms and conditions for the prospective loan are: amortization in 20 years with a five-year grace period; interest at the Bank's standard variable rate, except that payment of part of the interest, up to a maximum of 5% per annum of the loan balance, will come from IFF account resources; credit fee of 0.75% on the undisbursed balance; and an inspection and supervision fee of 1% of the total loan. Disbursements of the loan depend on compliance with the specific conditions for each tranche. The loan will be disbursed through a special account in the Bank of Guatemala, to be opened and operated in a manner satisfactory to the Bank.

B. Program and project execution

1. Executing agency

4.3 The Government of Guatemala will be the borrower of the prospective loan. The Ministry of Public Finance (MFP), in conjunction with the Ministry of Public Health and Social Welfare (MSPAS), will be responsible for program execution. The MFP will be the executing agency in charge of project disbursements, i.e., authorized imports of goods from Bank member countries made by the public and private sectors. The operation will be supervised by the project team, in cooperation with the Bank's Country Office in Guatemala.

2. Disbursements, procurement, and retroactive financing

4.4 The loan proceeds will be used to finance the FOB cost of authorized imports, or the CIF cost if freight is included. Disbursements under each tranche will be made against the presentation of import documents by the MFP, which will be responsible for coordinating and compiling the pertinent documentation and for preparing and submitting withdrawal requests under the loan. The MFP will keep the import documentation on file for examination by authorized Bank personnel and the auditors.

4.5 Procurement of goods using loan proceeds will be made in accordance with standard Bank procedures. For amounts of over US$5 million,

international competitive bidding will be required. For petroleum and its by-products, a Bank mission to verify procurements in November 1992 found that despite the fact that imports over US$5 million from some supplier countries did not adhere strictly to Bank procedures, they did comply with acceptable commercial practices and were carried out efficiently at market prices (for immediate delivery). This situation is comparable to what the Bank has found in other sector adjustment operations. Based on the recommendations contained in the above-mentioned mission's report, it is recommended that international competitive bidding not be required for the import of petroleum and its by-products, provided they are from a member country of the Bank and that payments are made during the loan period (see paragraph 4.7).

4.6 Public sector procurement involving less than US$5 million will be made in accordance with national procedures, provided they are consistent with the Bank's procurement policy. Small purchases by the private sector will be made in accordance with acceptable commercial practices and, when possible, quotes will be obtained from suppliers in at least two of the Bank's member countries.

4.7 Loan disbursements will follow the Bank's policies for sector loans, which allow for retroactive financing of authorized expenditures made within six months prior to the date on which the loan contract becomes effective, with total retroactive financing limited to 50% of the total loan. The date of an expenditure for the purposes of this condition will be the value date (or a similar concept) on which funds were remitted to the foreign supplier.

3. Records, auditing, and control

4.8 For each disbursement, the project executing agency will provide documentation listing the goods imported during each period, the country of origin, and the date and value of the transaction so that the expenditures can be reimbursed by the Bank. For accounting and control of these transactions, the borrower will open an account in the Bank of Guatemala, maintain project accounting records, prepare and submit disbursement requests, present the list of transactions deemed to be authorized, and keep all the pertinent documentation on file.

4.9 Within 90 days after the final disbursement of each tranche, the borrower will present the Bank with a statement of account for that tranche, prepared in accordance with terms of reference agreed upon with the Bank and duly audited by a firm of independent public accountants designated by the borrower and acceptable to the Bank.

4. Inspection and supervision

4.10 The Bank will establish the inspection procedures necessary to ensure satisfactory program execution, and the borrower will cooperate fully for that purpose. The Bank will receive the

equivalent of US$250,000 from the loan for inspection and supervision.

4.11 The borrower and the Bank will hold meetings at the request of either of the parties to exchange views on headway in the program, compliance with the conditions for release of each tranche, and the consistency between the economic policy framework and the program. The borrower agrees to provide the Bank, prior to each meeting, with a report containing the level of detail that the Bank considers reasonable on progress in the program and compliance with the conditions, to enable the Bank to study it and prepare its comments.

5. Loan conditions and disbursement schedule

4.12 During program implementation, an appropriate macroeconomic framework must be maintained as a condition precedent to each disbursement of the loan. As indicated, the government has signed a shadow agreement with the IMF for 1995. After that date, the Bank and the IMF will determine measures for monitoring macroeconomic performance.

4.13 The specific conditions that must be fulfilled prior to release of the first, second, and third tranches, in each aspect of the program, are discused below.

Conditions precedent to release of the first tranche

a. A bill on health sector coordination, which defines the institutions that make up the national health care system, the role of public and private institutions, and the mechanism for coordinating the sector's investment and operating programs is to be submitted to Congress.

b. Execution of the plan of action to restructure and strengthen the MSPAS, based on the timetable and targets agreed upon with the Bank, including: (i) submission to Congress of a bill to amend the Health Code; (ii) entry into effect of a ministerial decree modifying the regulations governing the central level of the MSPAS and the three health care districts chosen for the pilot project, including decentralization; (iii) suspension of hiring at the central level of the MSPAS; (iv) commencement of the operations of the program's transition coordination unit, in accordance with the terms agreed upon with the Bank.

c. Approval by the MFP of the MSPAS's preliminary draft budget containing: (i) an increase of 12% in real terms over the budget allocated for 1995; and (ii) redirection of spending into basic health care services.

d. Execution of the plan of action to simplify and streamline MSPAS budget preparation and execution, based on the timetable

and targets agreed upon with the Bank, including: (i) the entry into effect of a ministerial decree modifying the rules for using the private funds of health care establishments and the rules for the use and replenishment of revolving funds; (ii) the entry into effect of a ministerial decree establishing a budget item to permit the health districts to contract NGOs and other private providers of basic services; and (iii) implementation of the rules for the presentation of a simplified budget at the central level and in the three health care districts, reducing the number of specific items and budget units.

e. Agreement on a plan of action to redirect health services in the three health care districts, including: (i) changes in the health care model; (ii) definition of a basic package of services; (iii) approval of plans for community and NGO participation; and (iv) design of a monitoring and evaluation system.

f. Execution of a plan of action to promote and establish other forms of joint public/private financing and delivery of services in the health care districts, based on the timetable and targets agreed upon with the Bank, including: (i) approval of the plan of action for the three health care districts; (ii) signature of a cooperation agreement between the MSPAS and the FIS; (iii) approval by the MSPAS and the MFP of the standard agreements between the MSPAS and NGOs; and (iv) proposal for a law to facilitate the participation of private providers of health services (associations act).

g. Agreement on a plan of action to establish a pilot program to enable agricultural enterprises in Alta Verapaz to enroll in private health care plans.

h. Approval by the Bank of terms of reference for designing and establishing pilot projects to develop and experiment with options for setting up mixed public/private administrative structures with the purpose and authority to spur greater efficiency and quality (e.g. administrative councils, NGOs, or other forms of association).

Conditions precedent to release of the second tranche

a. Implementation of the regulations governing sector coordination.

b. Execution of the plan of action to restructure and strengthen the MSPAS, based on the timetable and targets agreed upon with the Bank, and including the startup of the program coordination unit under the terms agreed upon with the Bank.

c. Approval by the MFP of the MSPAS's preliminary draft budget for the following year, containing: (i) an increase of 20% in real terms over the budget of the preceding year; and (ii) redirection of spending into core health care services.

d. Satisfactory execution of not less than 70% of the MSPAS budget for the three health care districts in the interval between the first and second disbursements, in accordance with the structure agreed upon with the Bank, including: (i) the elimination of transfers from the preventive care program to the curative care program; and (ii) execution of the investments in sanitation and priority health care programs in the three health care districts.

e. Execution of the plan of action to simplify and streamline MSPAS budget preparation and execution, based on the timetable and targets agreed upon with the Bank, including an evaluation of the efficiency of the rules governing budget execution (and modification if necessary).

f. Execution of the plan of action to redirect health care services in the three health care districts, based on the timetable and targets agreed upon with the Bank.

g. Execution of the plan of action to promote and establish other joint public/private forms of financing and delivering services in the health care districts, based on the timetable and targets agreed upon with the Bank, including the submission to Congress of the associations bill.

h. Execution of the plan of action for the provision of health care services to farm workers in Alta Verapaz by the MSPAS, including the preparation of terms of reference for designing the program and a survey of farms and farming populations in Alta Verapaz.

i. Approval by the Bank of the terms of reference for: (i) studies of the demand for health care services by microentrepreneurs and their employees and savings and loan associations in Guatemala City; and (ii) a market study of health care providers and prepayment plans in Guatemala City.

j. Execution of the plan of action to establish pilot projects in at least one national hospital and one hospital in one of the three health care districts, based on the timetable and targets agreed upon with the Bank, including: (i) the entry into effect of a government resolution modifying the criteria and procedures for setting fees in health care establishments; (ii) signature of agreements between the administrative boards of the two hospitals selected and the MSPAS and the MFP; and (iii) approval of amendments to the regulations governing the establishment and operation of administrative structures.

Conditions precedent to release of the third tranche

a. Startup of the health sector council and the coordination mechanisms.

b. Execution of the plan of action to restructure and strengthen the MSPAS, based on the timetable and targets agreed upon with the Bank, including: (i) entry into effect of the amendments to the Health Code; (ii) preparation of draft regulations governing the organization of the MSPAS, including delegation of authority to administer human and financial resources (except for hiring) to the three health care districts; (iii) approval by the MSPAS of a program to downsize its staff.

c. Approval by the MFP of the MSPAS's preliminary draft budget for the following year, containing: (i) an increase of 20% in real terms over the previous year's budget; (ii) redirection of spending into basic health care services; and (iii) establishment of an early retirement fund to facilitate the MSPAS's program to downsize its staff.

d. Satisfactory execution of not less than 80% of the budget of the MSPAS as a whole and of the three health care districts (in accordance with the structure agreed upon with the Bank) in the interval between the second and third disbursements, including: (i) the elimination of transfers from the preventive care program to the curative care program; and (ii) execution of the investments in sanitation and priority health care programs in the three health care districts.

e. Execution of the plan of action to simplify and streamline MSPAS budget preparation and execution, based on the timetable and targets agreed upon with the Bank, including an evaluation of the rules governing budget execution (and modification if necessary).

f. Execution of the plan of action to redirect health care services in the three health care districts, based on the timetable and targets agreed upon with the Bank.

g. Execution of the plan of action to promote and establish other public/private forms of financing and delivery of services in the health care districts, based on the timetable and targets agreed upon with the Bank, including: (i) signature of at least eight agreements with NGOs for the provision of services; (ii) establishment of a monitoring and evaluation system; and (iii) entry into force of the associations act.

h. Execution of the plan of action for the provision of health care services for farm workers in Alta Verapaz by the MSPAS, based on the timetable and targets agreed upon with the Bank, including the approval of pilot projects and signature of

agreements to cover at least 10 farms with more than 250 workers, using at least two different providers, on the basis of prior studies.

i. Agreement on the design and implementation of a pilot project for coverage of the urban informal sector, on the basis of prior studies.

j. Execution of the plan of action, based on the timetable and targets agreed upon with the Bank, to: (i) establish pilot projects in at least one national hospital and one hospital among those located in the three health care areas, including the establishment of systems for cost contributions and execution of the program to downsize staff in those hospitals; and (ii) establishment of pilot projects in two additional hospitals in the national network, including the signature of agreements between the administrative units of said hospitals and the MSPAS and the MFP.

6. Technical-cooperation program

4.14 The main purpose of the technical-cooperation program is to support the preparation and execution of the organizational and financial changes and the new health care delivery systems provided for in the main program. The specific objectives include provision of technical and administrative support for the restructuring and decentralization of the MSPAS, introduction of a basic package of services, targeting of services to low-income groups, contracting of basic services with the private sector, and improvement of the performance of the MSPAS's network of hospitals. The total cost of the program is an estimated US$15.5 million (including US$13.5 million financed by the IDB). The plan of operations is presented in detail in Annex III.

4.15 The technical-cooperation program includes the following components:

1. A coordination unit that will cooperate with the different health entities in implementing the necessary structural changes and also provide administrative, financial, and technical support for the program to upgrade health care services.

2. Technical and administrative strengthening of the MSPAS in its restructuring process, as defined in the health sector loan.

3. The introduction of a basic package of services in selected branches of medicine, aimed at mother and child care, including the contracting of private sector providers of basic health care services for the target population.

4. Strengthening of the network of public hospitals by improving the efficiency, quality, and financial sustainability of the services provided, while also redirecting those services to neglected low-income groups.

V. PROJECT VIABILITY AND RISKS

A. Benefits and risks

5.1 It is expected that the program to upgrade health care services will improve the efficiency, equity, and financial sustainability of the MSPAS and will have an appreciable impact on the health status of the low-income target population directly affected. Even more important, however, is that the program will set the stage for public/private cooperation to channel more funds, expand coverage, and execute effective programs that are broader in scope and respond to the public's health care requirements. During program execution, monitoring and evaluation systems will be developed to chart progress in the delivery of health care services. The program is designed to have a clearly redistributive effect in behalf of the low-income population. Extension of coverage focuses on extremely poor geographic areas and a large majority of the direct beneficiaries are poor.

5.2 There are two kinds of risks in the proposed operation: those related to the overall macroeconomic framework, and those related to specific sector policies. Continuation of the economic adjustment and restructuring process and the fiscal reform, in particular, is crucial for underpinning stability, increasing the sector's budget, and redirecting public spending on health, which are the conditions of the sector program. There is a risk that the current political situation will make it difficult to maintain the existing program with the IMF and the commitments under other adjustment programs with the World Bank and the IDB.

5.3 The government is aware of these risks and has taken steps to attenuate them. As was mentioned earlier, it has signed a shadow agreement with the IMF, which calls for the adoption of stabilization measures at the macroeconomic level. The World Bank's State modernization program, which establishes incentives to attain greater economic efficiency, is currently being restructured so that it can be restarted. In December 1994, Congress passed a tax reform that will help to maintain the fiscal balance and general macroeconomic stability.

5.4 With regard to the specific policies contained in the program, there is a risk that the government will be unable to make the political decisions necessary to implement it. A further risk lies in the difficulties that the government may encounter in obtaining a consensus on the changes in policy and institutional structures, since they affect interest groups with political influence, such as the urban middle class, health sector unions, groups in the medical profession, and importers and distributors of medicines, while the direct beneficiaries of the reforms are poor, disorganized, and have little political voice. To reduce this risk, the program

requires the government to enact legislation or issue regulations prior to the third tranche to enable the program's objectives to be attained.

B. Impact on low-income groups

5.5 The distribution of income and wealth in Guatemala has always been very lopsided. The most recent government statistics indicate that 80% of the population live below the poverty line and that two thirds of the population live in extreme poverty. The deterioration in economic conditions over the last 10 years, exacerbated by cuts in public spending, have hit low-income groups very hard, particularly indigenous peoples living in rural communities. As a result, Guatemala's social indicators are among the worst in the Americas. Infant mortality rates are nearly double those in other countries of the region. Fifty-two percent of the population is illiterate (70% lives in rural areas) and 60% of children under three present signs of malnutrition.

5.6 To a large degree these conditions are a result of the low levels of social spending in the past, especially in the recent past. 15/ Earlier attempts to improve social conditions in the country have been frustrated owing to the lack of commitment to social development, particularly with regard to underprivileged groups such as the indigenous population. The social objectives of the current government and its initial success in achieving economic stabilization and implementing adjustment measures (despite being in the minority in Congress) are encouraging signs that it will also be capable of carrying out its social program.

5.7 Given these circumstances, it is extremely difficult to make an exact evaluation of the impact of the sector program on low-income groups. However the program to upgrade health care services is targeted to poverty, as defined in paragraph 2.15 of the report on the Eighth Replenishment of Bank Resources, since it is estimated that over 50% of the potential beneficiaries are poor. The program contains four components. Two of them are downstream activities aimed at specific low-income groups. The health care systems component will extend coverage by the public and private sectors to communities where poverty is widespread, in particular rural areas with large numbers of migrant farm workers and the urban informal sector. According to the Bank's most recent estimates, 75% of the rural population and 51% of the urban population are classified as poor. The latter figure suggests that more than 50% of the beneficiaries in the urban informal sector are poor. The public

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15/ In 1991, total central government spending on all social sectors (including health, education, and social security) in Guatemala accounted for about 3.3% of GDP in comparison with about 15% in Costa Rica.

hospital services component is intended to improve the efficiency and quality of the MSPAS's hospital services. Since the poverty index in Guatemala was 56% in 1993, it is estimated that a higher percentage of poor people will be the potential beneficiaries of this component's activities. The other two components — institutional structure and the financing, allocation, and use of resources — are upstream activities that are not targeted to providing services for specific groups. However, they will lay the financial and organizational groundwork for effective extension of coverage. The activities in question include: an increase in the funding for health care which is to be channeled into basic services; streamlining of administrative and financial procedures; restructuring of the MSPAS; decentralization of planning responsibilities to the health care districts, and the promotion of community participation in decision making.

C. Environmental impact

5.8 Guatemala is richly endowed with natural resources, including rain forests and subtropical forests and a wide range of plant and animal biological diversity. However, the country is facing serious environmental problems, many of which are characteristic of the countries of the region, including deforestation, soil erosion, water pollution, and air pollution in the capital city. These problems are aggravated by population growth, which places additional pressure on natural resources (particularly the deforestation of land susceptible to erosion) and translates into widespread poverty, including malnutrition, vulnerability to diseases, and the growing risk of natural disasters.

5.9 Although Guatemala has environmental protection legislation, its oversight institutions lack the capacity to carry out their mandates. On the national level, the country has no clear environmental strategy and there is no planning system to establish priorities in this regard. The country is unable to finance, or even prepare, environmental protection projects. On the local level, citizens are largely unconscious of environmental problems or of the need to take collective action to conserve the country's natural resources.

5.10 The Bank has financed some environmental protection operations in Guatemala, particularly the program to manage natural resources in the Alto Chixoy valley which was approved in December 1991 (loan 871/SF). The Bank is also preparing an environmental program for the metropolitan area (GU-0073) and a program for sustainable development in Petén (GU-0081). However, it is evident that broader measures are required to raise social awareness of the environment and to strengthen the institutions responsible for implementing environmental policy. With this in mind, in 1992 the Bank approved a technical-cooperation program to develop a national environmental plan of action, whose main objectives are to:

(a) strengthen the technical, logistical, and planning capacity of the environmental protection agency (CONAMA); (b) launch a campaign to raise public awareness regarding the need for sustainable development and to involve the public in environmental protection; (c) prepare a program to establish environmental investment priorities; and (d) study investment priorities in other sectors (agriculture, transportation, and energy, for example) to identify potential environmental problems and devise solutions.

5.11 The program proposed here has no physical components and will not have any direct or indirect environmental impact. At its meeting of February 15, 1994, the Bank's Environment Committee classified the program in Category II.

VI. RECOMMENDATIONS

6.1 As described in this document, the program complies with the Agreement Establishing the Bank and with the report on the Eighth General Increase in the Resources of the Bank. Accordingly, it is recommended that the Bank approve the loan and to that end the resolutions attached as appendices are hereby submitted to the Board of Executive Directors for consideration.

GUATEMALA: PROGRAM TO UPGRADE HEALTH CARE SERVICES
POLICY MATRIX

OBJECTIVES	PRIOR TO FIRST TRANCHE	PRIOR TO SECOND TRANCHE	PRIOR TO THIRD TRANCHE
STITUTIONAL STRUCTURE			
ECTOR COORDINATION			
n the sector's institutional organization oordination system and define the role of ctor.	Submission of a health sector coordination bill to Congress that identifies the institutions that comprise the national health care system and defines the role of public and private institutions and the mechanism for coordinating sector investment and operations programs.	Entry into force of the sector's coordination regulations.	Initiation of operations of the health sect council and the coordination mechanisms
ESTRUCTURING AND STRENGTHENING OF THE MSPAS			
gthen the institutional capacity of the AS by beefing up its regulatory role in the and decentralizing administration to the care districts.	Execution of the plan of action for restructuring and strengthening the MSPAS, on the basis of the timetable and targets agreed upon with the Bank, including: (a) submission to Congress of the bill amending the Health Code; (b) entry into force of the ministerial decree amending the MSPAS regulations at its central level and in the three health care districts, including decentralization; (c) suspension of hiring at the MSPAS's central level; (d) startup of operations of the program's transition coordination unit in accordance with the terms agreed upon with the Bank.	Execution of the plan of action for restructuring and strengthening the MSPAS, on the basis of the timetable and targets agreed upon with the Bank, including the startup of the program coordination unit's operations in accordance with the terms agreed upon with the Bank.	Execution of the plan of action for restructuring and strengthening the MSPA the basis of the timetable and targets agr upon with the Bank, including: (a) entry force of the Health Code amendments; (b) preparation of draft regulations for th MSPAS organization, including delegatio the administration of financial and human resources (except appointments) at the le the three health care districts; (c) approv the MSPAS of a staff downsizing program
NANCING, ALLOCATION, AND USE OF RESOURCES			
CREASE, REDIRECTION, AND EXECUTION			
se the budget of the MSPAS, redirecting t public spending/investment towards ealth care services. In 1995, the MSPAS was 10% higher in real terms (excluding s and transfers) than the budget executed MSPAS in 1993. This increase was ed to primary health care while hospital ng was reduced.	Approval by the MFP of the preliminary draft budget of the MSPAS which contains: (a) an increase of 12% in real terms over the budget allocated for 1995; and (b) redirection of spending towards basic health services.	Approval by the MFP of the preliminary draft budget of the MSPAS for the following year, containing: (a) an increase of 20% in real terms over the budget for the immediately preceding year; and (b) redirection of spending towards basic health care services.	Approval by the MFP of the preliminary d budget of the MSPAS for the following ye containing: (a) an increase of 20% in real terms over the budget for the immediately preceding year; (b) redirection of spendin towards basic health care services; and (c) establishment of an early retirement fu make possible the MSPAS staff downsizing program.

GUATEMALA: PROGRAM TO UPGRADE HEALTH CARE SERVICES
POLICY MATRIX

OBJECTIVES	PRIOR TO FIRST TRANCHE	PRIOR TO SECOND TRANCHE	PRIOR TO THIRD TRANCHE
		Satisfactory execution of not less than 70% of the MSPAS budget for the period between the first and second disbursements under the program, allocated to the three health care districts (according to the structure agreed upon with the Bank), including: (a) elimination of transfers from the preventive program to the curative program; and (b) execution of investments in sanitation and priority health care programs in the three health care districts.	Satisfactory execution of not less than 80 the MSPAS budget for the period betwe second and third disbursements under th program, allocated for the MSPAS as a v and for the three health care districts (according to the structure agreed upon the Bank), including: (a) elimination of transfers from the preventive program to curative program; and (b) execution of investments in sanitation and priority hea care programs in the three health care di
TREAMLINING OF BUDGET EXECUTION			
mline MSPAS budget execution through tralization of budget preparation and tion.	Execution of the plan of action to simplify and streamline MSPAS budget preparation and execution, on the basis of the timetable and targets agreed upon with the Bank, including: (a) entry into force of a ministerial decree that amends the regulations for the use of private funds of health establishments and for the use of revolving funds and their replenishment; (b) entry into force of a ministerial decree that establishes the budget item to allow the health care districts to hire NGOs and other private basic health care service providers; and (c) adjustment of regulations for presenting a simplified budget at the central level and in the three health care districts, reducing the number of specific items and budget units.	Execution of the plan of action to simplify and streamline MSPAS budget preparation and execution, on the basis of the timetable and targets agreed upon with the Bank, including evaluation of the efficiency of the regulations governing budget execution (and modification if necessary).	Execution of the plan of action to simplif streamline MSPAS budget preparation a execution, on the basis of the timetable a targets agreed upon with the Bank, inclu evaluation of the regulations governing b execution (and modification if necessary).

GUATEMALA: PROGRAM TO UPGRADE HEALTH CARE SERVICES
POLICY MATRIX

OBJECTIVES	PRIOR TO FIRST TRANCHE	PRIOR TO SECOND TRANCHE	PRIOR TO THIRD TRANCHE
HEALTH CARE SYSTEMS			
REORIENTATION OF HEALTH CARE SYSTEMS IN THE THREE DISTRICTS SELECTED			
rientation of departmental health care ems in accordance with an approach that ades: identification of a basic package of ic health services and clinical services; hasis on cooperation between the public private sectors; experimentation with vative methods of delivering and financing ices and paying providers; establishment of ic administrative and technical structure; em for accrediting and monitoring iders; and design of preventive and notional programs.	Agreement on a plan of action to reorient health care services in the three health care districts, including: (a) changes in the health care model; (b) identification of a basic package of services; (c) approval of community and NGO participation schemes; and (d) definition of the monitoring and evaluation system.	Agreement on the plan of action to reorient health care services in the three health care districts on the basis of the timetable and targets agreed upon with the Bank.	Agreement on the plan of action to reor health care services in the three health c districts on the basis of the timetable an targets agreed upon with the Bank.
PRIVATE SECTOR PARTICIPATION			
e use of the private sector to extend rage to specific population groups with ic/private financing through:			
xtension of basic health care services to population groups through providers.	Execution of the plan of action to promote and establish other forms of public/private financing and delivery of health care services, on the basis of the timetable and targets agreed upon with the Bank, including: (a) approval of the plan of action for the three health care districts; (b) signature of the cooperation agreement between the MSPAS and FIS; (c) approval by the MSPAS and the MFP of the standard agreements between the MSPAS and the NGOs; and (d) proposal on the content of a law to facilitate the participation of private health care providers (associations act).	Execution of the plan of action to promote and establish other forms of public/private financing and delivery of health care services, on the basis of the timetable and targets agreed upon with the Bank, including submission to Congress of an associations bill.	Execution of the plan of action to promo establish other forms of public/private fi and delivery of health care services, on t basis of the timetable and targets agreed with the Bank, including: (a) the signatu at least eight agreements with NGOs for delivery of services; (b) establishment of monitoring and evaluation system; and (c into force of the associations act.

GUATEMALA: PROGRAM TO UPGRADE HEALTH CARE SERVICES
POLICY MATRIX

OBJECTIVES	PRIOR TO FIRST TRANCHE	PRIOR TO SECOND TRANCHE	PRIOR TO THIRD TRANCHE
Extension of basic health care services to n workers and their families by NGOs and ate providers.	Agreement on a plan of action for establishing a pilot program to enable agricultural enterprises in Alta Verapaz to enroll in private basic health care plans.	Execution of the plan of action for delivery of health care services to farm workers in Alta Verapaz by the MSPAS, including drafting of terms of reference to design the program and survey of the farms and their inhabitants in Alta Verapaz.	Execution of the plan of action for deliv health care services to farm workers in A Verapaz by the MSPAS, on the basis of timetable and targets agreed upon with t Bank, including the approval of pilot pro and signature of agreements to cover at 10 farms with over 250 workers, using at two different providers, on the basis of previously conducted studies.
Extension of basic health care services to the n informal sector through private ayment plans.		Approval by the Bank of the terms of reference to conduct: (a) studies on health care service demand among microentrepreneurs and their employees and savings and loan associations in Guatemala City; and (b) a market study on health care providers and prepayment plans in Guatemala City.	Agreement on the design and implement of a pilot project to cover the urban info sector on the basis of previously conduct studies.
PUBLIC HOSPITAL SERVICES			
rovement of the management, efficiency, ncial sustainability, and quality of care in ital services.	Approval by the Bank of the terms of reference to design and establish pilot projects in which options will be developed and tested regarding the establishment of public/private administrative structures that have incentives and authority to stimulate increased efficiency and quality (e.g. administrative councils, NGOs, or other forms of association).	Execution of the plan of action to establish pilot projects in at least one national hospital and one hospital among those located in the three health care districts, on the basis of a timetable and targets agreed upon with the Bank, including: (a) entry into force of a government resolution amending the criteria and procedures for setting fees at health care establishments; (b) formalization of agreements between the administrative units of the two hospitals selected and the MSPAS and the MFP; and (c) approval of amendments to the regulations in force for setup and operation of administrative structures.	Execution of the plan of action, on the b a timetable and targets agreed upon with Bank, to: (a) establish pilot projects in one national hospital and one hospital a those located in the three health care di including establishment of systems for contributing to the costs and execution o program to downsize staff at these hospi and (b) establish pilot projects at two additional hospitals in the national syste including the signature of agreements be the administrative units of those hospital the MSPAS and the MFP.

MINISTRY OF PUBLIC FINANCE
GUATEMALA, CENTRAL AMERICA

President Enrique V. Iglesias
Inter-American Development Bank
Washington, D.C. 20577

Mr. President:

Within the context of the Guatemalan government's economic policy, execution of an economic modernization program has been given priority. The main objective of the program is to maintain sustained growth in the levels of economic activity by making the allocation and use of the State's resources substantially more efficient. As a result of this program, the gross national product grew and inflation dropped, giving rise to macroeconomic stability.

The central government's financial problems during the course of 1994 provided evidence of a high degree of dependence on short-term financing resources and of the difficulty of reducing the floating debt that had increased significantly at the end of last year. This situation was the result primarily of a low level of tax receipts, in particular income tax and value added tax. In the former case, the Constitutional Court had resolved, in the early part of the year, to eliminate withholding and payments on account, which caused receipts from income taxes to fall by over Q 330 million.

The above-mentioned events resulted in effective receipts of approximately Q 5,054,600,000, i.e., a tax burden in 1994 of 6.8%, 1.1% below the 1993 figure. The preliminary numbers at December 1994 show a central government deficit of Q 1,053,900,000 (1.4% of GDP). Despite this sharp fall in tax receipts in 1994, the deficit remained similar to the previous year's (1.5% of GDP), basically as a result of the policy adopted by the government to cut public spending while favoring investment, which recorded a level of execution of about 89.6%.

The macroeconomic prospects for 1995 are favorable primarily as a result of the tax reform passed by the Congress on November 30, 1994, which is expected to bring in tax receipts of Q 6,726,100,000. The above will be helped by the fact that tax evasion was made a criminal offense and by proposed improvements in the Tax Code and tax administration, particularly in the area of customs and the strengthening of internal revenue control, which will contribute to achieving a tax burden of close to 8.2%, without taking into account the change in the VAT rate from 7% to 10%.

At the same time, the government has initiated a frontal attack on poverty, particularly in behalf of the most vulnerable population groups

with the lowest indices of human development, where health and education services are inadequate in terms of quality and quantity, and in which children, young people, and adults show signs of malnutrition.

This government action is based on a social policy that promotes productive job creation, particularly in the rural areas, fosters the reduction of protein and calorie deficiencies among preschoolers and schoolchildren, encourages access to educational services, and advocates solving health and environmental problems. In addition, it seeks to protect extremely poor infants and families at social risk, who because of the political violence that has affected the country over the last few years, live as refugees in other countries or have been displaced from their place of origin.

To achieve the social development objectives, the program to upgrade health care services is proposed. It seeks to support the restructuring and strengthening of the Ministry of Public Health and Social Welfare and to carry out projects to improve health care services and expand coverage.

Within this context, the Government of Guatemala is convinced that the process of strengthening the Ministry of Public Health and Social Welfare will reinforce its institutional action for the purpose of improving and expanding the population's access to health care services. By introducing structural changes into the system, the program will help make the system more effective and efficient, will allow increased levels of public spending in the sector and will enable its sources of financing to be augmented. At the same time, the coverage and quality of basic health care services for the country's poorest groups will be expanded. This will all be feasible with the participation of the community itself and private agents.

It is obvious that, as things stand, the Government of Guatemala does not have the financial resources to sustain the process. It is therefore requesting supplementary financial support from the Inter-American Development Bank to allow it to carry out the program to upgrade health care services that is described and placed in context below.

I. THE SOCIAL SITUATION IN THE COUNTRY

A. Human Development Index

According to the 1993 Human Development Index (HDI) of the United Nations Development Programme (UNDP), in 1992, Guatemala earned a rating of .489 with respect to a maximum index equivalent to the unit (1.000). This figure, slightly below the middle point, ranked the country 113 out of a total of 173 nations, placing Guatemala among the group of "countries with low human development".

This information highlights the relative lack of development of the country in the areas of social policy, school enrollment, literacy rates, level of environmental sanitation, percentage of public spending on education and health, food security, wage and employment levels, social status of women, child survival and development, gender disparities, differences between rural and urban areas, and level of social participation, among others.

In view of the significant existing social imbalances – land tenure, income distribution, unemployment, underemployment, and marginality, scant public spending on social programs, their structure and traditional concentration on major urban centers, and the difficulties faced by the rural population and particularly the indigenous population in gaining access to such programs – there is no doubt that there is a very deep gap in human development terms between the rural and urban populations and between the various ethnic groups and regions.

In Central America, Guatemala holds the second-to-last place in terms of overall human development. Honduras is last. The country is .363 points below Costa Rica, .249 below Panama, .200 below Belize, .14 below El Salvador, and 0.11 below Nicaragua.

B. Health status of the Guatemalan population

The health status of the Guatemalan population is deficient. Life expectancy at birth is 63 years, the mortality rate is 7.2 per 1,000, the infant mortality rate is 57 per 1,000 live births, and maternal mortality is 9.3 per 10,000 live births.

Health conditions are significantly worse among population groups with lower education and income levels, which are largely comprised of residents of rural areas and indigenous people in particular.

Among the chief causes of death, the prevalence of infectious diseases and illnesses associated with lack of environmental sanitation and poor nutrition is an indicator of the poor health of the population and the ineffectiveness of the health care and environmental sanitation systems. Over 64% of total deaths in the country are caused by infectious, nutritional, and perinatal diseases. Diarrheic diseases (30%), acute respiratory infections (23%), perinatal diseases (20%), and malnutrition (4%) were the main causes of infant mortality.

The majority of these deaths could be prevented through basic sanitation, immunizations, and other basic health care services, at a relatively low cost. However, over the last 20 years, very little progress has been made in reducing the significance of these diseases as a cause of death. As a result, the health status of Guatemalans compares unfavorably with that of other countries in Latin America with similar levels of development.

II. THE PROGRAM TO UPGRADE HEALTH CARE SERVICES

The overall objective of the program to upgrade health care services is to improve the health of Guatemalans by strengthening the process of expanding coverage of basic health care services and by making the technical, administrative, and financial capacity of the Ministry of Public Health and Social Welfare (MSPAS) as effective as possible. This will be achieved through the design and implementation of policy, institutional, and financial reforms, to achieve the specific objectives of: (a) improving the effectiveness and efficiency with which the public health system performs its functions and produces services; (b) increasing government spending on health and expanding the MSPAS's sources of financing, to ensure its sustainability; (c) redirecting the allocation of resources to cover the public's health care requirements; and (d) extending coverage of basic health care services to the poorest population groups, with participation by private providers.

To achieve these specific objectives of the program, a series of measures are proposed that have been organized under four components: (a) institutional structure; (b) financing of the MSPAS and allocation of resources; (c) health care systems; and (d) public hospital services. The scope of these components is described below.

1. INSTITUTIONAL STRUCTURE

The shortcomings of the public health sector institutions in the formulation and execution of policies and programs, identification of priorities in health care activities and in the services available to various population groups, use of public sector resources, and delineation of the private sector's field of action have been a determining factor in the limited impact the sector has had in improving the population's health.

A. Sector coordination

The objective of this activity is to define the sector's institutional organization and coordination system. This includes defining the role of the MSPAS with respect to other institutions and the private sector in the formulation of policies, delivery and supervision of health care services, and coordination of public sector investments and programs, to improve the allocation of the sector's resources and the effectiveness of its services.

To this end, a law would be enacted to identify the functions of the institutions in the health sector, establish the coordination mechanism and authority for programs of the MSPAS and the Guatemalan Social Security Administration (IGSS), and define private sector participation in the delivery of health care services.

The program includes presentation of the coordination bill to Congress, regulations, and establishment and operation of the coordination mechanism at the national level.

B. Restructuring and strengthening of the MSPAS

The objective is to strengthen the institutional capacity of the MSPAS and support its regulatory role in the sector and administrative decentralization to the health care districts. This includes execution of a plan of action for the restructuring and institutional strengthening of the MSPAS during the entire course of program execution. The plan of action includes: (a) entry into force of the act amending the Health Code and of the ministerial decree that defines the immediate changes to be made in the organization of the MSPAS; (b) suspension of hiring at the MSPAS's central level and approval of a program to downsize its staff; (c) preparation of the MSPAS's operating regulations, including administrative decentralization in the three pilot health care districts (Alta Verapaz, Escuintla, and Chiquimula).

2. FINANCING, ALLOCATION, AND USE OF RESOURCES

The reorientation in the allocation of public sector resources – from curative services in hospitals to basic services in rural and marginal urban areas – is an important step towards responding to the health problems of groups that are poor and at greatest risk. The resources currently allocated to the sector are so scant, however, that resulting gains in efficiency would not be enough to improve the quality of care.

The activities in this component are aimed at alleviating these two problems by expediting the increase in the amount of budgetary resources allocated to the sector and instituting increased efficiency and equity in the use of the resources, through a reorientation of public spending in the health sector and improved budget performance by the MSPAS.

A. Increase, reorientation, and execution of the budget

This activity tries to achieve an increase in the level of financing for basic health care services and improved MSPAS budget performance. The first target would be to finance the marginal cost of the basic package of health care services. The program thus calls for a 12% increase in real terms of the total MSPAS budget in the first year (first tranche of the financing) and 20% prior to the second and third tranches.

By adjusting public spending, these increases would be allocated to finance the activities proposed for expansion of coverage and the improvement of basic health care services.

B. Streamlining budget execution

Although the MSPAS budget is small, its performance has been poor, partly because of legal and bureaucratic obstacles in the public sector, the lack of autonomy in budget execution, and the limited administrative capacity of the MSPAS.

The purpose of this activity is to simplify and expedite preparation and execution of the MSPAS's budget by decentralizing resource management to the three pilot health care districts and establishing budget performance goals. Under the program, a plan of action would be carried out to adjust the budget preparation, execution, and control systems of the Ministry of Public Finance, which would include: (a) entry into force of ministerial decrees that amend regulations on the use of the private funds of health care establishments and on the use of revolving funds and that establish the budget item to allow the health districts to hire NGOs and other private basic health care service providers; and (b) adjustment of guidelines for submitting a simplified budget at the central level and the pilot health care district level, reducing the number of specific items and budget units.

The program also establishes incremental goals for execution of the amounts allocated to the three pilot health care districts (70% between the first and second tranches, 80% between the second and third tranches of the disbursement) and to the MSPAS as a whole (80% between the second and third tranches).

The program also monitors the composition of the expenditures, emphasizing investments in sanitation and priority health care programs in the three pilot districts and blocking transfers from the preventive program (curative and preventive services at the basic level) towards the curative program (hospital services, for the second and third tranches).

3. HEALTH CARE SYSTEMS

The country's health care system emphasizes centralized, hospital-based, drug-based, and curative care, the results of which have affected the organization of the health care system, the allocation of its resources, and the health of the population. Recently, as one of the actions under the program, health authorities approved changes in the health care model to devise the conceptual framework that will guide the reorientation of the health care systems and the programs for the expansion of coverage in the health care districts. This component includes reorientation of the health care systems to extend coverage of the basic package of health and environmental sanitation services to the poor population in the three health care districts, with participation by the nongovernmental sector in the delivery of services.

A. Reorientation of the health care systems in the three districts selected

The most important measure in Guatemala's health care strategy in the short term must be to channel public financial resources to ensure that the population receives a basic package of public services and clinical health care services. The program activities are designed to draw up and adapt the package of basic services and make the required changes in the health care system in the three pilot health care districts (Escuintla, Chiquimula, and Alta Verapaz). This pilot program will constitute the basis for programming, evaluating, and adjusting the proposed system.

The parallel technical-cooperation operation will finance activities connected with the final design of the system in each district, the promotion of local participation, the project monitoring and evaluation systems, community staff training, and basic equipment and inputs for such staff.

As part of the program, a plan of action would be executed to reorient health care services in the three districts, which includes: (a) description of the package of essential health care services; (b) design of the delivery system for those services; (c) identification of the activities to be conducted by public institutions and the private sector; (d) project execution strategy; and (e) the monitoring and evaluation system.

B. Private sector participation

The purpose of this subcomponent is to relieve the public sector of production activities and significantly improve efficiency, quality, and coverage in the health care sector in the medium term by setting up frameworks for cooperation between the public and private sectors. The design of those frameworks is based on successful experience in Guatemala (with NGOs involved in health care for example) and the capacity of the existing private health care providers in the country.

The activities proposed under the program are designed to establish a regulatory framework for private providers, strengthen the programs for reorientation of services and expansion of coverage through private participation strategies, and introduce some competition in public health care services. The design and execution of these activities would be supported with the technical-cooperation funding proposed under this operation. The activities include: (a) regulatory framework: entry into force of an associations act that will facilitate the establishment of associations and public/private entities by various groups, including communities, to allow them access to sources of social equalization funding and to execute health care programs; (b) expansion of coverage in rural communities: agreements with associations, communities, and municipal governments for the administration of health centers and

clinics; hiring by the communities of private providers to deliver the health care services in the basic package; hiring of NGOs by the MSPAS for delivery of services in specific communities; and organization of communities and municipalities to prepare and execute health and environmental sanitation services with FIS resources. Program conditions require agreements between the MSPAS and the FIS and between the MSPAS and the NGOs (at least eight prior to the third tranche), and the establishment of a monitoring and evaluation system; (c) health care services for farm workers: implementation of strategies for delivery of basic health care services by NGOs and funding shared by employers and the MSPAS. The program requires execution of a plan of action to establish a pilot program enabling agricultural enterprises in Alta Verapaz to enroll in private basic health care plans, including approval of pilot projects and signature of agreements to cover at least 10 farms with over 250 workers, using at least two different providers; and (d) health care services for workers in the urban informal sector: drafting of a demonstration project to cover a segment of the country's urban informal sector, comprised primarily of microentrepreneurs and their employees and families. The activities will be conducted in Guatemala City.

4. PUBLIC HOSPITAL SERVICES

Although expenditures for curative services in public hospitals account for close to 70% of MSPAS health care spending, these hospitals are underused, in part because the quality of their services has been steadily declining. At the same time, the hospitals are very inefficient in the use of services and are very wasteful. This situation generates a climate of political support in urban areas for the frequent hospital crises to be solved by reallocating resources away from basic health care services at the primary level.

The measures proposed under this activity are designed to improve the efficiency, quality, and financial sustainability of hospital services by making their management independent and placing caps on government spending to finance their services. These measures include the establishment of administrative autonomy for private nonprofit entities (i.e., councils, associations), the implementation of cost-recovery systems that include protection for the poor; the establishment of systems for the transfer of budgetary resources that include financial incentives for proper use and allocation of resources; management support for hospital administration; the establishment of systems for the purchase, procurement, and distribution of medications; the establishment of effective quality control systems; and the hiring of support services. Greater participation by the private sector in hospital management and financing will free up funds for basic health care services.

Under the program, a plan of action will be implemented prior to release of the second tranche to set up pilot projects in at least one

national hospital and one of the hospitals located in the three health care districts. The plan of action will include: entry into force of a government resolution amending the criteria and procedures for setting fees at health establishments; formalization of agreements between the administrative units of the two hospitals selected, the MSPAS, and the Ministry of Public Finance; approval of changes to existing regulations for the setup and operation of administrative structures. In addition, prior to release of the third tranche, pilot projects will have been set up in two other hospitals in the national system.

III. CONCLUSION

The Government of Guatemala undertakes to execute the program to upgrade health care services inasmuch as it is convinced that the program represents the most effective and efficient way to improve the population's access to health care services and to ensure that the benefits reach the most vulnerable groups. The Government of Guatemala hopes that the Inter-American Development Bank will decide to provide financial support to make the execution of the program described above possible.

I appreciate the Bank's support for the program to upgrade health care services and for the Guatemalan people in particular.

PROGRAM TO UPGRADE HEALTH CARE SERVICES
TECHNICAL-COOPERATION PLAN OF OPERATIONS

COUNTRY:	Guatemala
PROJECT TITLE:	Program to support upgrading of health care services
GENERAL OBJECTIVE:	To support the restructuring and institutional strengthening process and the projects to upgrade health care services and extend coverage proposed in the program.
BENEFICIARIES:	Clients of health care services, NGOs that deliver health care services, and the MSPAS
EXECUTING AGENCY:	The Ministry of Public Health and Social Welfare (MSPAS)
EXECUTION PERIOD:	Three years
COST AND FINANCING:	The total cost is US$15.5 million of which the Bank will finance US$13.5 million.
TERMS AND CONDITIONS:	The loan from the Bank will be drawn on the Fund for Special Operations.

Amortization period:	25 years
Disbursement period:	3 years
Interest rate:	variable
Inspection and supervision:	1%
Credit fee:	0.75%

ENVIRONMENTAL CLASSIFICATION:	The environmental classification of the health care services program that this technical-cooperation project is intended to support is category II.
BENEFITS:	Gains in efficiency in the health system, benefits for users of health care services in the form of better quality services and increased access by the very poor to basic health care services.
RISKS:	The same as for the program to upgrade health care services.
RESPONSIBILITY:	Basic: Country Office in Guatemala Technical: RE2/SO2

I. THE PROGRAM

1.1 The proposed loan to upgrade health care services focuses on strengthening and modernizing the MSPAS. To attain those objectives, it will be necessary to prepare, implement, and supervise actions to boost the MSPAS's current technical and administrative capacity.

1.2 This technical-cooperation project will support those activities which, in turn, will serve as the basis for sustaining and designing the policy changes and institutional strengthening described in the loan proposal for the program to upgrade health care services.

1.3 The technical-cooperation project will have four subprograms, which are all based on the need to support the sweeping changes to be made under the program, through advisory services on technical and administrative aspects, training, and the provision of equipment needed to implement that program.

Subprogram I. Project coordination unit

1.4 **Objective.** The coordination unit will have two main objectives: (1) to provide technical advice to the different health care entities in implementing structural changes; (2) to provide administrative, financial, and technical support for the implementation of technical-cooperation activities.

1.5 **Activities.** The program proposes to launch a long-term process to upgrade the MSPAS, and its ultimate goal is to improve and expand the coverage of basic health care services. To facilitate implementation of the program, a coordination unit will be established to: (i) guide program development and coordination; (ii) review the recommendations and action plans resulting from specific studies; (iii) deal with organizational and policy problems that affect program execution; and (iv) prepare guidelines for monitoring the pertinent actions.

1.6 **Structure.** The unit will be managed by a senior local project coordinator working in close cooperation with the principal technical advisor, who will be an international consultant. Local and international consultants will also be hired to work in close cooperation with the MSPAS at the central and departmental levels, and with the Ministry of Public Finance. The UNDP will act as purchasing agent for the technical-cooperation project.

1.7 **Equipment.** The counterpart financing will be used for office space, vehicles, and basic office supplies. Project funds will be used to purchase computer equipment and programs. Office staff

will be financed using a combination of project and counterpart funds.

1.8 **Subprogram financing.** The total cost of the subprogram is US$1.7 million, which will be financed as follows:

SUBPROGRAM I. COORDINATION UNIT			
	IDB	Government	Total
Consultants 1/	$1,431,497	$103,150	$1,534,647
Equipment	$10,350	$185,220	$195,570
Total	$1,441,847	$288,370	$1,730,217

Subprogram II. Support for the restructuring of the Ministry of Public Health and Social Welfare (MSPAS)

1.9 **Objective.** This subprogram will provide technical and administrative support for the MSPAS to carry out its restructuring, in the manner defined in the program to upgrade health care services.

1.10 **Components.** This subprogram will have the following components:

I. Restructuring of the central level of the MSPAS
II. Reorganization and institutional strengthening of the pilot districts
III. Financial decentralization
IV. Training for the central level
V. Studies related to the program

1.11 **Description.** The institutional changes included in the program redefine the role of the MSPAS with regard to its administrative structure, methods of designing and delivering health care services, and the system of payment to providers of services. These changes require restructuring of the Ministry's functions at the central level, decentralization in the decision-making process and, particularly, a general improvement in its technical and administrative capacity. In this context, and as a key element in the implementation of this institutional strengthening program in Guatemala, the technical-cooperation component will provide the assistance needed by the MSPAS to improve its performance as an operating unit and its staffing at the central level and in the health care districts included in the program. This can be

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1/ The amount budgeted for consultants from IDB funding includes approximately US$455,000 for the contracting of a purchasing agent to facilitate the hiring of consultants and procurement of equipment for the technical-cooperation project.

achieved by making significant changes in organizational structure, redefining administrative functions, and decentralizing certain financial, supervisory, and administrative responsibilities. An on-site training component and grants for advanced academic training in health care administration will also play a significant role in attaining the goals of this subprogram.

1.12 **Structure.** The activities in each component of this subprogram will be carried out in parallel with the reorganizational changes to be made as part of the program's conditionality. Local consultants will be hired to carry out the components to restructure the central level and the health care districts. By virtue of the reallocation of budget targets consistent with loan resources, it is expected that most of these professionals can be contracted by the MSPAS to continue the functions described herein after the technical-cooperation project has ended. The training component will be carried out by one or more local consulting firms.

1.13 Computers, transportation, and communications equipment and the office support necessary for the efficient operation of the reorganized ministerial units will also be financed.

1.14 **Subprogram financing.** The total cost of the subprogram is US$3.6 million, which will be financed as follows:

SUBPROGRAM II. REORGANIZATION OF THE MINISTRY OF PUBLIC HEALTH				
	Component	Consultants	Equipment	Training	Total
I.	Restructuring of the central offices	$378,000	$441,700	$0	$819,700
II.	Reorganization of the three districts	$550,200	$484,500	$0	$1,034,700
III.	Financial decentralization	$323,880	$0	$0	$323,880
IV.	Training	$0	$0	$491,460	$491,460
V.	Sector studies	$890,000	$0	$0	$890,000
	Total	$2,142,080	$926,200	$491,460	$3,559,740

Subprogram III. Expansion and redirection of health care services

1.15 **Objectives.** This subprogram will (i) introduce a basic package of services for selected branches of medicine, focusing on mother and child care; and (ii) contract private sector providers of basic health care services for the target population.

1.16 **Components.** This subprogram will have the following components:

I. Strengthening of health programs
II. Training for midwives and community children's health workers
III. Introduction of health care for farm workers
IV. Contracting and training of private sector health care providers
V. Introduction of health care coverage for the urban informal sector

1.17 **Description.** This subprogram will provide advisory services for the design and introduction of primary health care services, and staff training at the decentralized level. The health care programs included in the decentralization process and supported by this technical-cooperation project will focus on women, children, basic nutrition, sanitation, and disease control. This subprogram will also provide support for the adaptation and introduction of a health services network in each area.

1.18 The second component will provide training for midwives and providers of children's health care services, offering the skills and methods needed to implement the package of primary health care services. Equipment will be procured to support the primary health care package that will be included in the training component. Each person trained under the program will be given a basic childbirth medical kit. The subprogram will also finance supplies for midwives and nutritional supplements for pregnant women, nursing mothers, and children.

1.19 The third component will facilitate support activities for the expansion of health care coverage for migrant farm workers. Training will be offered in the provision of these services to NGOs and to the MSPAS's own personnel. Plantation owners will largely finance the operating costs of providing the services through a prepayment mechanism. The MSPAS will be responsible for recruiting, accrediting, monitoring, and evaluating the NGOs.

1.20 The fourth component will underpin the support, design, and implementation of a system to contract a package of basic services to be offered by private health care providers (NGOs, community groups, and other organizations), with special emphasis on rural areas. MSPAS district officials will manage the contracting process and monitor services. Training will be provided for private sector groups, MSPAS contract managers, and rural communities.

1.21 The fifth component — to extend basic health care services to the urban informal sector — will study the feasibility of establishing

a prepayment system to finance and provide a package of basic health care services for the informal sector.

1.22 **Structure.** These components will be executed by local and international consultants, with the active participation of community groups and NGOs.

1.23 **Subprogram financing.** This subprogram will cost US$6.3 million, distributed as follows:

SUBPROGRAM III. EXPANSION AND REDIRECTION OF HEALTH CARE SERVICES				
	Component	Consultants	Equipment	Training	Total
I.	Strengthening health care programs	$1,566,600	$1,284,000	$0	$2,850,600
II.	Training of midwives and children's health workers	$0	$0	$595,000	$595,000
III.	Extension of health care services to farm workers	$786,150	$8,250	$174,820	$969,220
IV.	Contracting and training of private-sector companies in basic health care services for rural communities	$1,091,130	$30,000	$181,187	$1,302,277
V.	Extension of health coverage to the informal sector	$587,375	$0	$0	$587,375
	TOTAL	$4,031,255	$1,322,250	$951,000	$6,304,472

Subprogram IV. Hospitals

1.24 **Objectives.** This subprogram is intended to improve the efficiency, quality, and financial sustainability of the country's hospital services, while redirecting and reallocating services to neglected low-income groups.

1.25 **Components.** This subprogram has two components:

I. Improvement in the administration of national and regional hospitals
II. Improvement in hospital administration at the primary level

1.26 **Description.** The components involve a series of activities to improve the efficiency, equity, sustainability, and quality of health care services in a group of preidentified national and regional hospitals. An effective administrative system will be designed which combines efficient public and private administration in establishing cost-recovery systems, contracting and tendering of hospital goods and services, implementation of measures to govern

the purchase and distribution of pharmaceuticals, and better organization and delivery of medical services. It will include development of a system of payments to hospitals that incorporates incentives for production and efficiency. The activities will also include advisory services and training.

1.27 **Structure.** This component will contain activities to strengthen the areas mentioned in the previous paragraph in at least one national and three regional hospitals. Advisory services and training will be provided by local and international consultants and consulting firms. Financing for equipment includes hardware and management information software programs and office equipment such as cash registers, with a view to improving financial management.

1.28 **Subprogram financing.** This subprogram will cost US$3.1 million, distributed as follows:

SUBPROGRAM IV. HOSPITALS				
Component	Consultants	Equipment	Training	Total
I. MSPAS national and regional hospitals	$1,247,935	$164,635	$1,091,300	$2,503,870
II. Hospitals: basic level	$349,575	$0	$205,062	$554,637
Total	$1,597,510	$164,635	$1,296,362	$3,058,507

II. SCALE AND FINANCING

2.1 The IDB will provide US$13.5 million in reimbursable financing for this technical-cooperation project, to be drawn on the ordinary capital under the Intermediate Financing Facility. The technical-cooperation project will be executed over two years and will cost a total of US$15.5 million. Counterpart financing will be approximately US$1.9 million, or 12% of the total cost of the operation. Table I shows the estimated scale of the operation by subprogram and source of financing. Table II provides further details.

TABLE I. SOURCES OF FINANCING BY SUBPROGRAM (US$ thousands)

SUBPROGRAM	TOTAL COST	IDB LOAN	GOVERNMENT
I. Coordination unit	1,719.8	1,431.8	288.4
II. Reorganization of the MSPAS	3,559.7	2,895.7	664.0
III. Expansion and redirection of services	6,304.4	5,518.3	786.1
IV. Hospitals	3,058.5	2,908.5	150.0
V. Financial costs	894.2	790.0	104.2
Interest	654.5	654.5	0
Credit fee	104.2	0	104.2
Inspection and supervision	135.5	135.5	0
Total 2/	15,547.2	13,554.5	1,992.7
Percentage	100.0	88.0	12.0

TABLE II. SPENDING BY SUBPROGRAM, COMPONENT, AND SOURCE OF FUNDING

SUBPROGRAM/COMPONENT		TOTAL COST	IDB	GOVERNMENT
I.	COORDINATION UNIT	1,730,216	1,441,847	288,369
II.	REORGANIZATION OF THE MSPAS	3,559,740	2,895,760	663,980
Component 1	Restructuring of the central office of the Ministry of Health	819,700	809,500	10,200
Component 2	Reorganization and strengthening of three districts	1,034,700	689,800	334,900
Component 3	Financial decentralization	323,880	78,000	245,880
Component 4	Training	491,460	428,460	63,000
Component 5	Studies related to the program	890,000	890,000	0
III.	REDIRECTION OF HEALTH CARE SERVICES	6,304,472	5,518,372	786,100
Component 1	Strengthening of health programs	2,850,600	2,562,500	288,100
Component 2	Training	595,000	517,000	78,000
Component 3	Health care for farm workers	969,220	829,220	140,000
Component 4	Contracting of private providers of basic services for rural communities	1,302,277	1,162,277	140,000
Component 5	Training for the informal urban sector	587,375	447,375	140,000
IV.	HOSPITALS	3,058,507	2,908,507	150,000
Component 1	Strengthening of MSPAS hospitals	2,503,870	2,363,870	140,000
Component 2	Administration of health centers	554,637	544,637	10,000
	TOTAL	14,652,935	12,764,486	1,888,449

2/ Differences between the breakdown and the totals are due to rounding.

SUMMARY OF THE PLAN OF ACTION

HEALTH CARE SYSTEMS: PRIVATE SECTOR PARTICIPATION EXTENSION OF BASIC SERVICES TO FARM WORKERS

Prior to the first tranche:

- Agreement on plan of action.

Prior to the second tranche:

- Preparation of terms of reference for the survey of the farms and their inhabitants in Alta Verapaz.
- Preparation of the terms of reference to design the project.
- Definition of the basic package of services covered by the project.
- Approval of the project by the MSPAS.
- Setup of a technical support team to prepare the project.
- Identification of the administrative unit responsible for the project.

Prior to the third tranche:

- Signature of agreements to cover at least 10 farms using at least two providers.
- Survey of the farms and their inhabitants in Alta Verapaz.
- Preparation of project design, including guidelines and procedures.
- Preparation of the procedural manual for selecting, hiring, and evaluating providers, etc.
- Appointment of administrative and technical staff responsible for project execution at the MSPAS.
- Approval of the community workers training program.
- Preparation of the water and sanitation expansion subprogram.
- Allocation of budget for pilot projects.
- Preparation of the information and promotion plan.

- Design of the information, monitoring, and evaluation system.
- Estimate of project implementation costs.

HEALTH CARE SYSTEMS: PRIVATE SECTOR PARTICIPATION
EXTENSION OF BASIC SERVICES TO RURAL GROUPS

Prior to the first tranche:

- Approval of the plan of action for the three districts.
- Signature of cooperation agreement between the MSPAS and FIS.
- Presentation of the proposed contents of the associations act.
- Setup of a legal team to establish guidelines for the act.

Prior to the second tranche:

- Submission to Congress of the associations bill.
- Identification of the financing source, item, and mechanisms.
- Authorization for district chiefs to sign agreements, manage funds, and pay private providers.
- Identification of requirements for provider accreditation.
- Preparation of a lobby plan of action for approval of the associations act.
- Preparation of an information and promotion plan for NGOs.

Prior to the third tranche:

- Signature of agreements with at least eight NGOs.
- Establishment of the monitoring and evaluation system.
- Entry into force of the associations act.
- Allocation of resources for project execution.
- Preparation of the plan for providing training and advisory services for NGOs and community health workers.
- Identification of a system for referrals to MSPAS health units.

- Estimate of implementation and execution costs.
- Publication of operating regulations and manual to solicit and contract services.
- Design of the basic service package.

HEALTH CARE SYSTEMS: PRIVATE SECTOR PARTICIPATION
EXTENSION OF BASIC SERVICES TO URBAN INFORMAL SECTOR

Prior to the first tranche:

[no activity envisaged]

Prior to the second tranche:

- Approval of the terms of reference for a study of demand for health care services.
- Approval of the terms of reference for a market study of health providers and prepaid plans.

Prior to the third tranche:

- Preparation of the design and plan of action to develop a pilot project.
- Design of a computerized information system.
- Identification of mechanisms and procedures to transfer an MSPAS subsidy to users.
- Identification of criteria for choosing participants (affiliates).
- Definition of the certification and accreditation process for prepaid plans and affiliated providers.
- Definition of mechanisms to avoid adverse selection and losses in the use of services covered by the plan.
- Definition and costing of services covered by the plan.
- Design of the system for collecting, channeling, and monitoring premiums paid by associations of microentrepreneurs.
- Preparation of quality and usage control systems.

SUMMARY OF THE PLAN OF ACTION

PUBLIC HOSPITAL SERVICES

Prior to the first tranche:

- Preparation of terms of reference for designing and setting up public/private administrative structures to manage hospitals.

Prior to the second tranche:

- Entry into force of a government resolution on the charging of fees.
- Formulation of agreements between the MSPAS and the pilot hospitals.
- Approval of amendments to existing regulations (hospital by-laws) in the pilot hospitals.
- Definition of the regulations and procedures to regulate the setup of hospital administrative units.
- Design of the appropriate mechanism for transferring nonpersonnel costs to pilot hospitals.
- Definition of the methodology to be used by hospital administrative units in managing public employees.
- Drafting of terms of reference to analyze personnel downsizing options.
- Establishment of general and flexible guidelines for allowing each hospital to make operational decisions on the setting of fees and use of earnings.
- Establishment of rules and procedures for cost recovery system oversight.
- Preparation of the terms of reference for a study on medication, medical materials, and equipment procurement and distribution systems.

Prior to the third tranche:

- Establishment of pilot projects in project hospitals.
- Signature of agreements between the administrative units of the project hospitals and the MSPAS and MFP identifying areas of responsibility (for transfer of funds, monitoring, etc.).

- Establishment of systems to perform activities related to cost recovery: billing, collection and payment, fees, socioeconomic evaluation, and use, management, and control of funds generated.

- Design of a budget transfer system that takes into account costs and production.

- Design of a computerized information system for the hospitals.

- Approval and execution of a personnel downsizing plan.

- Preparation of the plan of action for hiring private sector support services.

- Establishment of procurement and distribution systems (inventory control, medication purchasing and distribution systems, etc.).

- Preparation of a plan to improve the use of resources in the production of clinical services.

- Preparation of feasibility studies at the pilot hospitals on private rooms and the sale of services to third parties.

HEALTH CARE SYSTEMS:
READJUSTMENT OF HEALTH CARE SYSTEMS

Prior to the first tranche:

- Preparation and approval of the plan of action that defines the health care model, the basic health care package, and the monitoring and evaluation system.

- Approval of frameworks for community and NGO participation in the delivery of basic health care services.

Prior to the second tranche:

- Initiation of activities in each of the three districts.

- Hiring of consultants to support program execution.

- Establishment of the monitoring and evaluation system.

- Establishment of the training component.

- Implementation of mechanisms for collective participation in decision-making.

SUMMARY OF THE PLAN OF ACTION

Prior to the third tranche:

- Satisfactory progress in the execution of the program agreed upon with the Bank in the three districts.

FINANCING, ALLOCATION, AND USE OF RESOURCES: INCREASE, REORIENTATION, AND EXECUTION OF THE BUDGET

Prior to the first tranche:

- Approval by the MFP of the preliminary draft budget for 1996 pursuant to the level and structure agreed upon with the Bank.
- Proper allocation of resources to begin execution of the restructuring, decentralization, and pilot projects in the three health care districts.

Prior to the second tranche:

- Approval by the MFP of the preliminary draft budget for the following fiscal year pursuant to the level and structure agreed upon with the Bank.
- Satisfactory execution of not less than 70% of the MSPAS budget for the period between the first and second disbursements under the program according to the structure agreed upon with the Bank.
- Proper allocation of resources to continue execution of the restructuring, decentralization, pilot projects in the three health care districts, and staff downsizing.
- Preparation of procedures and regulatory framework for the early retirement fund.
- Estimate of the cost of continuing with the restructuring, decentralization, pilot projects in the three health care districts, and staff downsizing over the following fiscal period.
- Estimate of the cost of beginning execution of pilot projects at the hospitals.

Prior to the third tranche:

- Approval by the MFP of the preliminary draft budget for the following fiscal year according to the level and structure agreed upon with the Bank.

- Satisfactory execution of not less than 70% of the MSPAS budget for the period between the first and second disbursements under the program according to the structure agreed upon with the Bank.

- Proper allocation of resources to continue execution of program activities.

- Establishment of an early retirement fund.

- Allocation of sufficient resources to begin execution of pilot projects at the hospitals.

FINANCING, ALLOCATION, AND USE OF RESOURCES: STREAMLINING BUDGET EXECUTION

Prior to the first tranche:

- Entry into force of a ministerial decree that amends the regulations for the use of the private funds of health care establishments and for the use of revolving funds and their replenishment.

- Entry into force of a ministerial decree that establishes the budget item to allow the health care districts to hire NGOs and other private basic health care providers.

- Adjustment of regulations for presenting a simplified budget at the central level and for the three health care districts, reducing the number of specific items and the budget units.

- Establishment by the MFP of a financial administration unit to work with the health sector.

- Approval of a plan of action to decentralize budget execution.

Prior to the second tranche:

- Evaluation of the efficiency of the regulations governing budget execution (and modification if necessary).

- Identification of indicators for monitoring management in the districts and hospitals.

- Identification of the methodological foundations for the hospital discharge costing system and for the per capita costing of the basic health care package.

- Initial costing in pilot hospitals and districts.

SUMMARY OF THE PLAN OF ACTION

- Presentation of the budget under the resource allocation mechanism (MAR) scheme agreed upon with the Bank.
- Adjustment of the amount and period for replenishment of the revolving funds for districts and hospitals.
- Design of a payment scheme for budget execution.
- Preparation of a basic inventory and purchasing system.
- Training in the use of SIAF in the districts and hospitals.
- Training in auditing and financial oversight functions.
- Establishment and strengthening of finance departments in the pilot hospitals and districts.

Prior to the third tranche:

- Evaluation of the efficiency of the regulations governing budget execution (and modification if necessary).
- Monitoring and evaluation of health indicators.
- Transfer of resources to pilot hospitals and districts based on hospital discharge and per capita costs (basic health care package).
- Adoption of SIAF's accounting system, pilot hospitals.
- Setup of a payment scheme.
- Financial audits of pilot hospitals and districts.

INSTITUTIONAL STRUCTURE
RESTRUCTURING THE MSPAS

Prior to the first tranche:

- Submit a health sector coordination bill to Congress.
- Submit a bill to amend the Health Code to Congress.
- Entry into force of the ministerial decree amending the regulations at the central and health care district levels of the MSPAS, including decentralization.
- Suspension of hiring at the central level of the MSPAS.

- Startup of operations of the program's transition coordination unit in accordance with the terms agreed upon with the Bank.
- Inclusion in the MSPAS's 1996 budget of the provisions necessary to begin the administrative restructuring process.
- Agreement on the specific programs for restructuring the central offices and health care districts of the MSPAS.

Prior to the second tranche:

- Startup of the program coordination unit's operations pursuant to the terms agreed upon with the Bank.
- Opening of line items for the new MSPAS units.
- Review of the human resource hiring process.
- Formulation of the human resource development and training strategy.
- Drafting of the MSPAS staff training program consistent with the restructuring.
- Preparation of the incentive system to retain qualified staff.
- Freezing of positions at the central level.
- Establishment of the medication supply and distribution system.
- Development of specific programs for the reorganization of MSPAS branch offices.
- Hiring of consultants to perform a study on the infrastructure and equipment maintenance system.
- Hiring of consultants to design the computer information system and the monitoring and evaluation system.
- Hiring of consultants to prepare a study on the restructuring of MSPAS branch offices that produce materials and services.

Prior to the third tranche:

- Entry into force of Health Code amendments.
- Preparation of draft regulations on the organization of the MSPAS.

SUMMARY OF THE PLAN OF ACTION

- Delegation of the administration of financial and human resources (except appointments) at the level of the three health care districts.
- Approval by the MSPAS of a staff downsizing program.
- Drafting of a budget consistent with the MSPAS's new organizational structure.
- Implementation of maintenance, information, supply, and evaluation systems.
- Startup of execution of the restructuring of the units producing materials and services.
- Startup of execution of the staff downsizing plan.
- Execution of the training program.

INSTITUTIONAL STRUCTURE
DECENTRALIZATION OF THE MSPAS HEALTH CARE DISTRICTS

Prior to the first tranche:

- Agreement on the plan of action and specific programs for the reorganization of the Escuintla, Alta Verapaz, and Chiquimula districts.

Prior to the second tranche:

- Delineation of the process of integrating/separating areas of responsibility for the accounting, finance, procurement, and inventory functions.
- Adoption of the new functional organization chart.
- Staff assignments.
- Drafting of programming methodology and guidelines for local services.
- Design of budget administration, administration, and information management systems.
- Preparation of a training program.
- Allocation of financial and human resources.
- Establishment of the systems.

Prior to the third tranche:

- Delegation of human and financial resource management to the districts.
- Establishment of the incentive system for recruiting and retaining staff in the districts.
- Execution of the training program.
- Implementation of the budget administration, administration, and information management systems.

PROPOSED RESOLUTION

GUATEMALA. LOAN ___/OC-GU TO THE REPUBLICA DE GUATEMALA
(Health Services Improvement Program)

The Board of Executive Directors

RESOLVES:

That the President of the Bank, or such representative as he shall designate, is authorized, in the name and on behalf of the Bank, to enter into such contract or contracts as may be necessary with the República de Guatemala, as Borrower, for the purpose of granting it a financing to cooperate in the execution of a Health Services Improvement Program. Such financing will be for the amount of up to US$25,000,000 or its equivalent in other currencies, except that of Guatemala, which are part of the Ordinary Capital resources of the Bank, and will be subject to the "Special Contractual Conditions" and the "Terms and Financial Conditions" of the Executive Summary of the Loan Proposal.

PROPOSED RESOLUTION

GUATEMALA. PARTIAL PAYMENT OF INTEREST ON LOAN NO. ___/OC-GU TO THE REPUBLICA DE GUATEMALA

(Health Services Improvement Program)

The Board of Executive Directors

RESOLVES:

1. That the President of the Bank, or such representative as he shall designate, is authorized, in the name and on behalf of the Bank, as administrator of the Intermediate Financing Facility Account, hereinafter referred to as the "Account", to enter into such contract or contracts as may be necessary with the República de Guatemala, as Borrower, and to adopt other pertinent measures to use the resources of the Account to pay a part of the interest due by the Borrower on outstanding balances of the loan authorized by Resolution DE- /95, for financing part of the cost of a Health Services Improvement Program, hereinafter referred to as the "approved loan." Such part shall represent up to 5% per annum on the outstanding balances of the loan.

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

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

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

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

PROPOSED RESOLUTION

GUATEMALA. REIMBURSABLE TECHNICAL COOPERATION NO. ___/OC-GU TO THE REPUBLICA DE GUATEMALA FOR A HEALTH SERVICES IMPROVEMENT PROGRAM

The Board of Executive Directors

RESOLVES:

1. That the President of the Bank, or such representative as he shall designate, is authorized, in the name and on behalf of the Bank, to enter into such agreements as may be necessary and to adopt such measures as may be pertinent for the execution of the plan of operations referred to in Document PR-_____ which comprises the proposal for a loan and a reimbursable technical cooperation with the República de Guatemala for the financing of a Health Services Improvement Program.

2. That up to the sum of US$13.554.500, or its equivalent, is authorized for the purposes of this resolution, chargeable to the Bank's Ordinary Capital.

3. That the above-mentioned sum shall be provided on a reimbursable basis, according to the terms and conditions set forth in the agreement to be entered into for this operation (hereinafter the "Reimbursable Technical Cooperation Agreement").

4. That the Reimbursable Technical Cooperation Agreement shall be signed simultaneously with Contract ___/OC-GU.

PROPOSED RESOLUTION

GUATEMALA. PARTIAL PAYMENT OF INTEREST ON REIMBURSABLE TECHNICAL COOPERATION NO. ___/OC-GU TO THE REPUBLICA DE GUATEMALA

(Health Services Improvement Program)

The Board of Executive Directors

RESOLVES:

1. That the President of the Bank, or such representative as he shall designate, is authorized, in the name and on behalf of the Bank, as administrator of the Intermediate Financing Facility Account, hereinafter referred to as the "Account", to enter into such contract or contracts as may be necessary with the República de Guatemala, as Borrower, and to adopt other pertinent measures to use the resources of the Account to pay a part of the interest due by the Borrower on outstanding balances of the reimbursable technical cooperation authorized by Resolution DE- /95, for financing part of the cost of a Health Services Improvement Program, hereinafter referred to as the "approved loan." Such part shall represent up to 5% per annum on the outstanding balances of the loan.

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

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

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

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