# MULTIPHASE PROGRAM FOR INSTITUTIONAL TRANSFORMATION OF THE HEALTH SECTOR
# PHASE I

**(PN-0076)**

## EXECUTIVE SUMMARY

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| **Borrower and guarantor:** | Republic of Panama | | |
| **Executing agency:** | Ministry of Health (MINSA) | | |
| | | **Phase One** | **Phase Two** |
| **Amount and source:** | IDB: (OC) | US$35 million | US$63 million |
| | Local: | US$15 million | US$27 million |
| | Total: | US$50 million | US$90 million |
| **Financial terms and conditions:** | Amortization period: | 25 years | |
| | Grace period: | 3.5 years | |
| | Disbursement period: | 3.5 years | |
| | Interest rate: | Variable | |
| | Inspection and supervision: | 1% of the loan amount | |
| | Credit fee: | 0.75% of the undisbursed amount | |
| | Currency: | US$ Single Currency Facility | |

**Objectives:** This investment loan will help improve the health and quality of life of the Panamanian population, through institutional transformations to enhance efficiency, effectiveness, quality, sustainability, and equity in the organization, delivery, financing, and regulation of health services. To this end, the project will be based on the following specific objectives, to: (i) increase MINSA's capacity to act as the governing and regulatory body for the sector; (ii) increase coverage of basic health care services for groups living in extreme poverty; and (iii) transform management for health service delivery.

**Description:** The program will have two phases. Phase one will last three years and will focus on: (i) proposing and implementing institutional changes in critical areas of sector regulation; (ii) designing and implementing innovations in the delivery of basic health services for the poorest people in Panama; and (iii) launching the decentralization of service management in five of the 14 health regions in the country. Phase two,

which will have an execution period of three years, will promote consolidation of the institutional transformations made under phase one by: (i) extending decentralization to all 14 regions in the country; and (ii) institutionalizing innovations in the delivery of basic services as a way to increase service coverage. Phase one will consist of three components:

**Component 1. Institutional transformation of MINSA as a governing and regulatory body** (US$6.5 million)

MINSA will be transformed through two types of activities: (i) activities to promote transformations within MINSA, including changes in its incentive structure and organizational model, and to improve administrative and technological processes; and (ii) activities to transform policy-making and implementation and outreach activities that will have an impact on sector stakeholders.

For the **internal transformation**, the program will promote: (i) the adaptation of MINSA's organizational structure and model; (ii) advances in information management; and (iii) the development of social marketing strategies as a tool for promoting the program, for strategic management of the changes, and as an intersector health promotion tool.

Regarding **sector institutional change**, the project will focus on: (i) formulating and implementing human resource development policies for the sector, including certification and accreditation, research on health sector performance, and regulation of the pharmaceuticals sector; and (ii) support for intersector coordination between MINSA and the Social Security Administration (CSS), for the specific purpose of preparing and executing a joint master investment plan; and formulating and implementing a rate schedule to standardize service pricing by MINSA and the CSS.

**Component 2. Innovations in the delivery of basic primary care services** (US$24.8 million)

This component will increase coverage of basic health services by providing a comprehensive package of health services (PAISS) to up to 450,000 of the poorest residents in Panama by the end of phase one. The package contains highly cost-effective primary care interventions that will be delivered under contract by various types of noninstitutional organizations (OEs), including NGOs, civic organizations, religious organizations, and cooperatives. To achieve its purpose, the component will conduct the following concurrent

activities: (i) strengthening of stakeholders; (ii) targeting poor communities; and (iii) monitoring and evaluation. Bank financing will decline over time to promote financial ownership by the country.

**Component 3. Transformation of management for health service delivery** (US$11 million)

The objective here is to enhance the efficiency, equity, and quality of service delivery at all institutional levels in MINSA, by changing the rules and incentives governing the relationship between the financing and delivery of services. The basic strategic goals are to begin decentralizing management in five health regions, reorganize the operation and internal relations of regional health care facilities, and promote improved management in five hospitals by developing new management instruments and making data management systems available.

Three subcomponents will be implemented under this component: (i) promote decentralized management, by delegating responsibility for financial management and human resources; (ii) reorganize supply, by implementing pilot service networks; and (iii) improve administrative and clinical hospital management.

**The Bank's country and sector strategy:**

The Bank's strategy for Panama focuses on four priority areas: (i) support for the frontal attack on poverty and for enhancing equity; (ii) promoting economic reforms to spur competitiveness and growth; (iii) consolidation of the regulatory, legal, and institutional framework for sustainable growth; and (iv) institutional reforms to strengthen governance and improve transparency.

The Bank's strategy to support health in the country seeks to improve services, placing emphasis on the poor and institutional transformation of the sector. This strategy promotes a series of changes in resource allocation schemes, financing mechanisms, and building incentives for service management and fosters the specialization of MINSA as the governing and regulatory agency for the sector. Public spending on health is to target the lowest-income segments of the population and help address the great inequalities.

**Environmental and social review:**

The project will incorporate current regulations on environmental permits in all investments in civil works and the procurement of equipment financed with the proceeds of the proposed loan (paragraph 2.51). The project will promote the inclusion of environmental issues in health facility certification and accreditation protocols (paragraph 2.21). The terms of reference for contracts or purchase agreements for goods and services prepared under component 2 will contain

provisions to guarantee compliance by contractors with current environmental regulations (paragraph 3.16). The activities to improve hospital management will include an environmental management module covering waste management and planning, occupational health, and other issues (paragraph 2.59).

**Benefits:** The proposed program will support the delivery of primary health care services to up to 450,000 persons living below the poverty line. The delivery of a package of highly cost-effective interventions aimed at low-income groups, particularly women and children, is a way to target public spending to simultaneously attack the problems of inequality in access and inefficiency in resources allocation. A gender approach will be promoted, both in selecting community organizations and in the design of the package of benefits. The information system will break down the data by gender to gauge the impact of the program on women, in terms of quality and equity.

The indigenous population is also targeted, given its high rate of extreme poverty. The program will allow for consultation with the target groups to adjust the package design and delivery modalities so that delivery of the PAISS will respect and incorporate the specific sociocultural and epidemiological characteristics of indigenous populations.

**Risks:** Groups of health workers may resist the decentralization process and innovations in the delivery of basic health care services for the poor. In the case of the innovations, coverage will be expanded through the PAISS to communities where there are no health services available, either for lack of infrastructure or staffing; the program will thus not directly compete with government health care supply and will not involve closing any MINSA health facilities. Moreover, to minimize the risk of health workers obstructing the activities of the noninstitutional organizations (OEs), the regional offices will receive funds from the fund for integral medical tours (FOGI) to implement activities similar to the delivery of the PAISS, enabling them to respond on equal footing in terms of available inputs. The program will use social marketing resources to inform interested parties that the program objective is to help make public and private services complement each other, not to replace one with the other.

In the case of decentralization, public information management and the social marketing strategy will give MINSA the tools to identify potential risks and respond effectively by training human resources. There is a risk that the health regions may prove resistent to the proposed decentralization if it does not yield tangible results. The program analyzed a menu of options and selected a set of tangible changes desired by the regions in finances and human resources. The

program will promote coalitions among service providers, government, and the public, showing the benefits to each stakeholder and the advantages of working together.

There is a risk that an appropriate understanding may not be reached with the CSS for coordination purposes. The program will support the formulation of technical arguments and identification of a limited number of interface points, to focus the discussion and ensure sufficient quantitative support.

The first phase of the program will be executed during the term of office of the current administration. Preparation of the final report will coincide with the change in government, and there is a risk of delays during the transition process. This risk will be mitigated by: (i) presenting the institutional progress in the sector and the program's contribution; and (ii) presenting a proposal for the new table of benchmarks that reflects recent sector changes and the strategic lines of the incoming administration.

**Special contractual clauses:**

As a condition precedent to the first disbursement, evidence must be submitted that an agreement has been entered into by MINSA and the United Nations Development Programme (UNDP) to carry out financial management activities. The draft agreement must be approved by the Bank before being signed (paragraph 3.9).

Annual technical reviews and a mid-term evaluation must be conducted during program execution (paragraph 3.34).

Consulting services will be hired to conduct a concurrent evaluation of the program, which will include preparing quarterly progress reports on the program (paragraph 3.36).

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

This operation qualifies as a social equity enhancing project, as described in the key objectives of Bank activity set forth in the Report on the Eighth General Increase in Resources (document AB-1704) (paragraphs 4.13-4.14). It also qualifies as a poverty-targeted investment (PTI) (paragraph 4.18). The borrower will not be using the 10 percentage points in additional financing (paragraph 2.63).

**Exceptions to Bank policy:**

The UNDP would be directly hired as specialized agency to carry out financial management activities in support of the UGAF. The UNDP costs would be charged to the local counterpart funding (see paragraphs 3.8 and 3.9).

**Procurement:**

International public bidding will be required: (i) for building works valued at over US$1,000,000; and (ii) procuring goods and related services valued at over US$250,000. There will be an international

request for tenders for consulting services over US$200,000. For lesser amounts, the special procedures contained in Annex D to the loan contract will be applied.

For contracting PAISS services, a registry of qualified firms will remain open during program execution. Fixed budget contracts will be used, as provided for in document GN-1679 on changes to Bank policy on hiring consulting services. Contract amounts will be pre-established by multiplying the predetermined per capita value by the population to be served. Firms will be selected to deliver the services based exclusively on their technical proposal (paragraphs 3.21 and 3.22).

# I. BACKGROUND

## A. The social situation

1.1 In recent years, Panama has achieved sustained economic growth, reflected in improvements to per capita gross domestic product (GDP). In this context, the country prioritized investment in social sectors, which has risen over the last five years at an annual rate of 6.3%. Panama has one of the highest levels of social spending in Latin America (21% of GDP compared to the average of 13.5%). This combination of economic and social policies has helped to maintain employment levels and reduce the number of families living below the poverty line from 44% of the population in 1991 to 37% at the end of 1999.[1]

### 1. Poverty in Panama

1.2 Significant social spending and the drop in the number of families living below the poverty line has not been able to reduce sweeping social inequalities. Over one-third of the population (37% or 1.02 million persons) lives in poverty; of those, nearly half live in extreme poverty.[2] This poverty is concentrated geographically and by ethnicity. Rural areas, which account for 44.4% of the total population, are home to over two-thirds of poor Panamanians (77% or 788,000); of those, almost 91% (467,000) live in extreme poverty. Indigenous persons, who represent 8% of the rural population, have a 95% probability of being poor and 86% of living in indigence. This distribution of poor persons reflects the high incidence of poverty in rural (65%) compared to urban areas (15%).

1.3 Poverty in Panama reflects underlying inequity problems in the distribution of key productive assets, such as human and social capital, employment, and physical and financial assets; this in turn reflects a legacy of bias in the country's economy. Economic bias has been accompanied by distortions and inefficiencies in the distribution of public spending. One example of these inefficiencies in the health sector is that the poorest quintile of the population benefits least from public spending on health services, because of low levels of use and limited access.[3]

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[1] Panama Poverty Assessment. World Bank 2000.

[2] 1997 Standard of living survey (SLS 97). SLS 97 offers an examination of living conditions in the country. These poverty estimates are based on a general poverty line of B905 per person, i.e., B75 per month per person, and an extreme poverty line of B519 per year.

[3] Panama Poverty Assessment. World Bank 2000.

## B. The health sector

### 1. Institutional weaknesses

1.4 The Ministry of Health of Panama (MINSA) is responsible for the care of 34% of the country's population, for which it has an annual budget of approximately US$180 million, accounting for 44% of public spending on health. In recent years, MINSA has begun an institutional transformation process to assume a greater role as the sector's steering and regulatory agency. The process has encountered problems related to the: (i) agency's structure; (ii) intrasector coordination capacity; and (iii) availability of technical tools for regulation.

1.5 **Structure and processes.** Effective exercise of the steering role has been adversely affected by discrepancies among the new functions and structure of the agency, human resources management and training, the making and monitoring of policy, and the availability of support information.

1.6 Regarding the organizational status of MINSA, the most recent institutional analysis[4] shows that the perception of officials is that: (i) the upper organizational structure sets a division of labor that is not consistent with MINSA's priority processes; (ii) the spheres of competence and functions of the different units are not clearly defined; (iii) the lack of precision in the operating responsibilities of the upper units leads to duplication and conflicting spheres of competence; (iv) there is no effective coordination mechanism, which leads to duplications and gaps; and (v) the upper organizational structure of the ministry is not consistent with the budget structure, which, from a practical standpoint, means that the organizational structure differs from the decision-making structure. Because of the above, broad administrative and financial efforts are focusing on organizing the direct delivery of services, at the expense of the organizational efforts required to more effectively exercise regulation and stewardship.

1.7 MINSA has approximately 10,000 permanent officials and 6,000 temporary workers. Human resources management is based on obsolete administrative processes with inefficient, centralized practices that lack adequate computer support, which leads to high administrative costs, inflexibility in personnel management, and slow response time to the demands of the health regions. MINSA is facing two critical challenges in the sector: (i) current legislation requires MINSA to hire all physicians who complete medical school. With 1 physician per 500 inhabitants,[5] concentrated in urban areas and whose numbers are on the rise,[6] the financial absorption capacity will reach unsustainable limits during this decade;

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[4] Jaime Silva. Institutional analysis of MINSA. Consultant's report. 2001.

[5] Rather high by regional standards.

[6] Two new medical schools have opened in the last three years.

and (ii) there is no formal certification and accreditation mechanism for human resources and training institutions to promote improvements in the quality of the professionals and provide ongoing evaluation of their performance.

1.8 MINSA processes administrative and clinical data in all spheres of the agency. There is little organization of the processing of data into information for decision-making, and the process uses numerous database structures and independent processing systems. In addition, systems for integrating and exchanging the information produced at different levels in the sector are lacking. These shortcomings have a direct impact on the administration of MINSA as an organization and on the sector it wants to lead.

1.9 In addition to weak information management, MINSA has faced difficulties in following up on policies and having a base of information obtained through research on the performance of the health system. The Gorgas Memorial Institute for Health Studies (ICGES) has received a mandate from the ministry to develop a research policy and guide the process in coordination with other research institutions. The ICGES has experience in clinical research and public health, but lacks the instruments for conducting research on health systems.

1.10 **Coordination.** MINSA's stewardship is facing a major challenge represented by its relationship with the Social Security Administration (CSS), which covers the remaining 66% of the population. The lack of coordination is illustrated, inter alia, by: (i) the duplication of investments in infrastructure, giving Panama 2.8 beds per 1,000 inhabitants,[7] one of the highest indicators in Latin America; and (ii) cross subsidies due to the lack of a valid registration and financial transaction system on the services one entity provides to the other.

1.11 In the past two years, a joint committee established pursuant to an agreement[8] signed by the two parties presented an initial proposal on coordinating infrastructure investments. However, since there is no formal mechanism to monitor the commitments and adjust the plans, both parties have lost confidence in the process, which has been suspended.

1.12 The system for offsetting costs, designed as a mechanism for conducting financial transactions between the two organizations, for the health care services that one provides to the other, has not led to a permanent, transparent framework agreement that ensures the regular flow of resources. The fact that the system's objective was to execute reimbursements based on the real costs incurred by each organization has led to an ongoing downgrading of the data collection systems and accounting structure of each of the parties. In real terms, although flows requested by MINSA

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[7] Particularly in urban areas.

[8] Institutional coordination agreement between MINSA and the CSS to implement public health reform. 1998.

were approximately US$9 million per year, CSS recognitions in the last three years have been roughly US$3 million per year, not considering available support information.

1.13 Coordination relations between MINSA and the CSS have dealt with health services, without delving into other areas of insurance that the CSS manages, such as pension issues. The CSS continues to be involved in pensions and administration of occupational hazard insurance. Although there is growing debate on the sustainability of the pension system, this issue is not part of the technical and financial interface with MINSA, which focuses primarily on health service delivery.

1.14 **Regulation.** MINSA regulates the pharmaceuticals industry in Panama. In January 2001, the Drug Marketing Law was passed, which gives MINSA responsibilities in the following areas: regulation, ex ante and ex post controls of health registries, quality control, and pharmacovigilance. MINSA has shown limited capacity for policy-making, administrative monitoring, and processing of registries related to the pharmaceuticals sector and now faces the challenge of heading up implementation of the new Law.

## 2. Financing and production of services

1.15 Although 7.5% of GDP is spent on health in Panama (one of the highest rates in Latin America)[9] the system's health results show critical inequalities. While the life expectancy for the general population is 74 years, for the poorest segments it is 63; and while aggregate infant mortality is 17.2 per 1,000 live births, the 40 poorest districts in the country have rates of 40 to 50 per 1,000 live births.

1.16 These inequalities are related to inefficient allocation of spending: 65% is allocated to hospitals, but only 28% to primary care. The fact that the most affluent quintiles of the population use public hospitals primarily, while the poorest quintile most often uses health centers[10] supports the theory of inefficient spending allocation as one reason for the figures on inequality mentioned above. The public network has limited capacity to expand because of the shortage of investment resources in rural areas and the lack of incentives for health workers to move to those areas.

1.17 In real terms, the distortions mentioned above create gaps in health care coverage for poor, vulnerable populations, such as women and children in rural areas.

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[9] These are similar characteristics in Argentina with 10.6% of GDP, Colombia with 9.5%, and Costa Rica with 8.5%.

[10] In all, 15.2% of quintile 1 uses public hospitals, compared to 26.5% of quintile 5. Conversely, 28.9% of quintile 1 uses health centers, compared to 6.5% of quintile 5.

1.18 Although health problems related to communicable diseases persist in poor populations, in Panama the profile of chronic and degenerative diseases and violence is on the rise. Violence is currently the largest public health problem. In the last 20 years, mortality from external causes (related to violence) ranked as the second leading cause of death, with rates ranging from 48.5 to 59.7 per 100,000 inhabitants, only behind deaths from tumors.[11] Infection with the human immunodeficiency virus (HIV/AIDS) is another critical public health problem in Panama. Since 1992, there has been a gradual, significant increase in the number of cases; in 1998 it rose 4.7 times over 1992.[12]

1.19 The Ministry of Health operates over 700 health facilities, including health centers, subcenters and posts, regional hospitals, and national hospitals. There are 14 health regions that operate as the subnational level of MINSA, but they lack the tools and capacity for administrative and budgetary decision-making.

1.20 The regions indicate that the main organizational and administrative problems in their relationship with the central level are: (i) limited implementation of effective decentralization; (ii) weak management training; (iii) lack of coordination of the management information system; (iv) lack of coordination for implementing processes and decision-making; (v) lack of flexibility and autonomy in certain aspects of human resources management; and (vi) lack of financial resources and decision-making capacity to procure inputs.[13]

1.21 For financial management, the regions and hospitals have two financing funds. One, the "working fund," is highly centralized in its execution, and the other, the "administrative fund," is also known as a self-management fund. Funds in the latter are the only resources over which the regional directors and hospitals have discretion to purchase urgently-needed drugs, maintain facilities and equipment, and pay for miscellaneous expenses, such as gasoline, per diems, transportation, etc. Those resources cannot be used to hire personnel.

1.22 Of MINSA's overall budget, 98% is distributed and executed through the working fund, and 2% through the administrative fund. The working fund is distributed roughly as follows: 75% to payroll, 15% to administration, and 10% for inputs, calculated for historic inertia. The administrative fund is provisioned with cost-recovery resources (from charging uninsured patients) and miscellaneous revenue from lottery donations, fines, etc. When those funds are for hospitals, they are managed by hospital directors with some flexibility in "hospital administration funds"; however, when they are for other health agencies, they are administered through "account 210," meaning that prior authorization from the Ministry of

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[11] Health situation in Panama. MINSA 2000.

[12] Health situation in Panama. MINSA 2000.

[13] Francisco Yepes. Analysis of regional decentralization. Intervention alternatives. Consultant's report. 2001.

Finance is required. According to the 2001 preliminary draft budget, 2.4% of total resources go to decentralized management.

1.23 Although there are regional variations, 80% of the budget of a regional office is typically from the working fund and 20% from the self-management fund.

1.24 Data available in the hospital sector reveal that current technical efficiency levels show increased productivity of just over 40%, while revenue remains constant.[14] The lack of delegation of authority, the absence of incentives to reward productivity, and the resulting lack of accountability, and the absence of training for decision-making in health facilities have all been cited as causes for the efficiency problems mentioned above.[15]

1.25 Regarding relations among health facilities within a health region, existing data point to weakness in referral and counter-referral systems, limited coordination capacity to implement joint administrative processes, and the duplication of efforts.

## C. Experience of the Bank and other organizations

1.26 The Government of Panama (GOP) implemented loan operation 803/OC-PN and ATN/JF-6339-PN. There were delays in executing loan operation 803/OC-PN (US$42 million) in 1995 because the new administration presented a request to reformulate it, which took several months to analyze; however in the end the original execution objectives went unchanged. In the next five years (1996-2000), disbursements rose from 1% to 78%, and execution is expected to be completed in December 2001, according to the current annual operating plan.

1.27 General lessons were learned from the project on: (i) the positive role of organized community groups in supporting the management of basic health services, particularly in the project's four health promotion centers; (ii) the need to foster spheres for consensus-building and discussing public information to mitigate the risks involved in implementing innovative initiatives, such as Law No. 28 of CONSALUD,[16] which separates financing from service delivery, or Law No. 27 establishing the Hospital San Miguel Arcángel Foundation (HISMA) and promotes autonomous management of public hospitals; and (iii) the use of the project coordinating unit, which was closely integrated with the MINSA executing units, that guarantees ownership of the changes through realistic annual operating plans and personnel trained to manage procurement processes.

1.28 In particular, the project has supported the development of a new management model for Hospital Cecilio Castillero and Hospital Aquilino Tejeira. Both

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[14] Huget et al. Conceptual proposal for health reform in Panama. Program 803/OC-PN IDB.

[15] Nelson Hernández. Analysis of hospital and service management. Consultant's report. 2001.

[16] Although it was national in scope, it currently only functions for financing HISMA.

institutions have been slow to incorporate technology, and institutional change to improve performance has been unsteady. Preliminary data evaluating implementation of the model reveal at least two reasons for this: (i) the absence of tangible changes in the plan for allocating hospital budgets, without an instrument that relates the proposed goals to the budget delivered; and (ii) lack of coordination between the installation of technologies and training of personnel and lack of staff involvement in the overall process of improving management.

1.29 Operation ATN/JF-6339-PN (US$450,000) allowed for the development of policy instruments to guide health sector reform in Panama. The lessons learned from that operation have made it possible, inter alia, to: (i) identify the technical and political complexity of reform processes; (ii) establish the need to use a gradual approach that extends beyond the efforts of a single administration; and (iii) reveal the fragility of the information system that provides input to the policy-making and monitoring instruments.

1.30 In the context of preparing this operation, the Bank is preparing technical cooperation TC-01-01-02-8-PN, which will be aimed at devising, executing, and evaluating innovations in the supply of basic health care and nutrition services for ethnic Ngöbe-Buglé indigenous populations. In light of the new regulations, coordination with other initiatives the Bank is implementing in this field is guaranteed. Technical cooperation TC-01-04-030 is also being prepared. It is aimed at supporting different groups in the community so they may effectively participate in the design, testing, implementation, and monitoring of a package of health benefits for the poorest populations in Panama.

1.31 MINSA, with financing from the World Bank, is currently executing a program that delivers a package of basic services to poor, rural populations in Panama, by hiring NGO health service providers. The project team has reviewed the relevant documents, the experience gained by the ministry, and the implications for the new operation. In particular, it has examined the supply of NGOs that deliver health services, the mechanisms for convening suppliers, and the hiring process. This review of the lessons learned has enriched the analysis, design, and execution plan of the new operation. Furthermore, the World Bank is financing another reform project that has focused on the region of San Miguelito. The project team and MINSA have agreed that the World Bank-financed project will maintain its focus on legislative and regulatory development and on completing studies on identifying beneficiaries, developing networks, and designing plans to offset costs in that region. The Bank's new operation will be based on the results already achieved and will maintain, in MINSA entities, coordination with the World Bank project.

## D. Country and Bank strategy

1.32 The social policy of the Government of Panama contains four main strategic guidelines: (i) generating more and better jobs; (ii) increasing the population's access to basic social services; (iii) promoting participation by civil society and

decentralizing social programs; and (iv) making social policies and programs financially sustainable.

1.33 To support the government's social agenda, the Ministry of Health defined a medium- and long-term strategic vision.[17] With this as a foundation, it has launched a process to change its role in the sector that seeks, in the long term, to give the subnational levels administrative and financial responsibilities for the delivery of health services and to give health service providers full management autonomy,[18] so that MINSA can focus on its strategic leadership role in the sector. In the short term, MINSA hopes to gear its efforts towards supporting basic care by increasing coverage.

1.34 The strategic vision that MINSA has designed sets long-term objectives and incorporates the menu of options that will gradually need to be implemented to achieve them. Since implementing those options will require a high level of consensus-building, institutional change, and human resources development, MINSA has proposed a flexible, but sustained development framework that will extend beyond the term of a single administration.

1.35 The Bank's strategy for Panama focuses on four priority elements: (i) support for the frontal attack on poverty and for increasing equity; (ii) promoting economic reforms to spur competitiveness and growth; (iii) consolidation of the regulatory, legal, and institutional framework for sustainable growth; and (iv) institutional reforms to strengthen governance and improve transparency.[19]

1.36 The Bank's strategy to support health in the country seeks to improve services, placing emphasis on poor populations and the institutional transformation of the sector. This strategy promotes a series of changes in resource allocation schemes, financing mechanisms, and building incentives for service management, and fosters the specialization of MINSA as the sector's steering and regulatory agency. The proposal is to target public spending on health at the poorest populations and help remedy the sweeping inequalities described above.

1.37 In conclusion, MINSA has charted a course for institutional transformation that should avoid the structural, regulatory, and coordination weaknesses detected, to focus its efforts on stewardship and regulatory leadership for the sector. The setting of long-term objectives will be accompanied by a combination of policy changes, consensus-building, investment, and development of human capital. The order of these is not clearly discernible and will require flexibility in any Bank monitoring. The government's strategy is consistent with the Bank's, in that the project will

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[17] Health policies and strategies. Guidelines for reorganizing the network of services. MINSA 2000.

[18] MINSA would also like to test vertical integration networks among several providers operating in the same territory under the same financial scheme.

[19] Country paper. Panama. IDB 2001.

have to be implemented in successive phases, given the caliber of the transformations planned, the implementation of which will extend beyond the efforts of a single administration.

# II. THE PROGRAM

## A. Objectives and description

2.1 This investment loan will seek to help improve the health and quality of life of the Panamanian population, through institutional transformations to enhance efficiency, effectiveness, quality, sustainability, and equity in the organization, production, financing, and regulation of health services. To this end, the project will be based on the following specific objectives, to: (i) increase MINSA's capacity to play a steering and regulatory role; (ii) increase coverage of basic health care services for populations living in extreme poverty; and (iii) transform management for health services production.

2.2 Table I shows the relationship between the problems identified, the proposed strategy, the related components, and some performance indicators to be achieved during phase one of the program.

**Table II-1**

| Problems | Strategy | Component | Performance indicator |
|---|---|---|---|
| Weakness in the regulation of markets and health protection | Develop instruments for exercising steering and regulatory functions and devise and monitor policies | Component 1 | % of health professionals certified<br>% of health facilities trained and accredited |
| Lack of MINSA/CSS sector coordination | Formalize and support a coordination unit | Component 1 | Rate system implemented |
| Inefficient allocation of expenditure and low coverage of care for rural and indigenous populations | Increasing targeted coverage by delivering the package of cost-effective interventions | Component 2 | Population covered by delivery of packages<br>Health results in the areas served (according to the benchmark and goals) |
| Inefficient health service delivery | Implement mechanisms for decentralization to regions, improve the management of providers, and implement service networks | Component 3 | % of decentralization goals met<br>Performance indicators of the hospitals covered by the program |

## B. Program structure

2.3 **Phase one.** The program is broken down into two phases. Annex III presents a table of the main performance benchmarks that would be achieved in phase one. Phase one will last three years and will focus on: (i) proposing and developing institutional changes in critical areas of sector regulation; (ii) designing and implementing innovations in the delivery of basic health services for the poorest

people in Panama; and (iii) launching the decentralization of service management in five of the 14 health regions in the country.

2.4 **Proceeding from phase one to phase two.** The triggers for processing of phase two will consist of two types of benchmarks: (a) progress in the program components; and (b) overall program execution. With regard to the components, the triggers will be: (i) the population served by component 2 exceeds 50% of the target population, and over 70% of the coverage and performance goals have been met; (ii) substantial progress has been made in strengthening the stewardship and regulatory function of MINSA, including the results of MINSA-CSS coordination efforts; (iii) technical, financial, and political feasibility studies are available on sector reform that will serve as input for discussion on phase two of the program; and (iv) substantial progress has been made in the policy on decentralizing the organization and delivery of services in the five health regions selected.[20] As for overall program execution, the triggers will be: (i) at least 60% of the resources from phase one of the operation have been disbursed; (ii) the Government of Panama has committed to preserving the financing to continue to increase coverage under component 2; and (iii) the commitments regarding appropriate management of accounting, financial, and external auditing execution in the program have been fulfilled.[21]

2.5 The specific indicators that will be evaluated to prepare the performance report and decide on the possible processing of a loan for phase two are listed in Annex IV.

2.6 **Phase two.** Phase two will have an execution period of three years and will promote the consolidation of the institutional transformations achieved in phase one by: (i) extending decentralization to the 14 regions in the country; and (ii) institutionalizing innovations in the delivery of basic services as a way to increase service coverage, by increasing the population covered or expanding the package of services delivered. In addition, the findings of the studies on feasibility of the reform will be used to design transformations in (i) separating financing from deliver of services; (ii) consolidating the autonomy of the institutions for health care service delivery; and (iii) deepening the mechanisms for coordination and possible integration of MINSA and the CSS.

2.7 To achieve the aforementioned objectives, the proposed program will finance technical assistance, training, and investment activities. Three components will be implemented in phase one.

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[20] Includes a review of compliance with environmental protection measures.

[21] Annex IV lists the concrete elements that will be used to assess compliance.

### 1. Component 1. Transformation of MINSA to develop its steering and regulatory role (US$6.5 million)

2.8 This component aims to transform MINSA to develop its steering and regulatory role in the health sector in Panama, including strengthening its capacity for decentralization and contracting basic health care services for the poorest populations. MINSA will be transformed through two types of activities: (i) those aimed at promoting transformations within MINSA, including changes in its incentive structure and organizational model, and at improving administrative and technological processes; and (ii) activities to transform policy making and implementation and interventions that extend outside of MINSA and have an impact on other players in the sector.

#### a. Internal transformation within MINSA

2.9 **Adjustment of the organizational structure and model** (US$1.5 million). Since proper execution of the stewardship role has been adversely affected by the administrative burden of centralized operations, the organizational model will be adjusted to bring MINSA's structure and current operations more in line with the decentralized, stewardship model being promoted. Along these lines, the program will implement four lines of action: (i) aligning the organizational model and organic structure with the decentralized, stewardship model, stressing the contracting of health services; (ii) adapting the nomenclature and hierarchical levels of the MINSA offices to the decentralization approach; (iii) developing the functional content, level of authority, and responsibilities of the health regions in the framework of the new model mentioned above; and (iv) implementing priority processes for MINSA, including administration of human resources and financial management to execute the new organizational model.

2.10 The following activities will be financed: (i) technical assistance for implementing the new decentralized, stewardship model; (ii) consensus-building workshops for presenting and adapting the aforementioned model; (iii) technical assistance for analyzing staffing; and (iv) technical assistance to launch the agreed upon model and execute the implementation plan.

2.11 Regarding priority processes in human resources, the program will: (i) finance the design and presentation of a menu of options to adapt the incentives plan to find human resources in remote areas with limited supply, which supports the expansion of service coverage being promoted in component 2; and (ii) implement changes to human resources management in MINSA to promote decentralization. Regarding financial management, the following will be financed: (i) the design and implementation of a budgeting system that supports decentralization; and (ii) improving the systems for paying for services.

2.12 **Administration of strategic information** (US$800,000). The development of this area of intervention will give MINSA the information it needs for decision making.

Initially, the program will finance a systems plan and strategy that examines: (i) data production and processing sources within the sector; (ii) the computer applications developed directly by MINSA or by external enterprises; (iii) the profile of users of the data; and (iv) existing equipment, both at the central level and in the regions. The systems plan and strategy will examine the information needs of MINSA as a result of its new role in the sector and will propose technical and financial scaling that considers existing progress and identifies a viable plan for managing strategic information.

2.13 As a priority, the technical assistance will focus on managing information to support the following processes, among others: (i) policy monitoring and evaluation; (ii) strengthening epidemiological surveillance systems for emerging communicable and chronic diseases; (iii) management and quality of the health services; and (iv) human resources management. To this end, instruments will be developed, including: (i) national health accounts; (ii) instruments to monitor equity and the impact of health promotion; (iii) national health surveys; and (iv) analysis of the health situation and trends.

2.14 The program will finance technical assistance and workshops to formulate the strategy and develop and implement the systems plan. It will also fund the training package on information management for officials at the central and decentralized levels, as well as the computer applications and the support equipment included in the systems plan.

2.15 **Social marketing** (US$1.2 million). The program will focus on financing social marketing as: (i) a tool for program promotion and strategic management of change; and (ii) an intersectoral tool for health promotion.

2.16 The **strategic management of change** will look at preventing and/or overcoming resistance to change, placing particular emphasis on political management of the following aspects of the transformation: (i) adjustment of MINSA's organizational structure and model; (ii) introduction of public/private complementarity in expanding service coverage; and (iii) decentralization and strengthening of the health regions. At the same time, marketing will be used to establish coordinated, ongoing communication of the benefits achieved by the program, which will forge alliances with social actors based on the objective reporting of achievements. Alliance-building with civil society will be based on a policy prepared to promote social participation. Financing will be provided for the following: (i) technical assistance to prepare the strategies; (ii) internal and external consensus-building workshops; (iii) dissemination workshops; (iv) publications and dissemination of messages through the mass media; and (v) surveys or focus groups to evaluate user satisfaction and society's perception of MINSA's role and of the program.

2.17 Through technical assistance, the program will support the development of social marketing strategies to **promote health** by promoting changes in the population's attitude and behaviors. Technical and financial efforts will focus on two

dimensions: (i) promoting health and community involvement to support the delivery and use of the package of services delivered through component 2 of the program; and (ii) health promotion to tackle at least[22] two emerging public health issues: (i) violence prevention; and (ii) preventing contagion and transmission of the human immunodeficiency virus (HIV). In the case of HIV/AIDS, the program will help strengthen MINSA's capacity to design, execute, and evaluate a strategy for preventing and controlling the epidemic that includes human rights considerations. In both cases, the efforts will be coordinated with other public and private agencies. The program will also support the devising of strategies and dissemination of the messages.

**b. Sectoral institutional transformation**

2.18 **Policy making and implementation** (US$2.4 million). The focus will be on four critical strategic areas: (i) regulation of health professions, by certifying and re-certifying human resources in the sector; (ii) regulating quality in private health facilities through training and accreditation; (iii) investigating health sector performance; and (iv) regulating the pharmaceuticals sector. In all instances, the current situation will be reviewed, and a new policy made and implemented, in accordance with the challenges MINSA is facing.

2.19 Regarding **human resources**, the program will support the creation of a consensus-building forum and mechanism for channeling the funds for reforming the human resources certification and accreditation system (physicians, nurses, and technicians). The financing will be channeled by establishing the fund for the certification and accreditation of human resources (FOCER), which will fund the development and application of initial certification, re-certification, and accreditation instruments for institutions and programs and the execution of continuing education. The Fund will be administered by a collegiate board that will serve as a forum for consensus-building and as a mechanism for allocating the resources. The board will be headed up by MINSA, with direct involvement from representatives of the Social Security Administration (CSS), trade unions, and universities (Universidad de Panamá and private universities). Financing for any activity through the FOCER must be approved by the board.

2.20 The Fund will include two lines of financing. The first, for *consensus-building and design*, will finance technical assistance, events, tours, and dissemination elements to build consensus on and design reform policies at the systems level. The second, for *implementation*, will support the actions agreed upon previously by the board, and will enable public and private entities to compete for funds to carry out these activities. MINSA, the CSS, universities, and professional trade unions will have access to the implementation line. Financing will be provided for technical assistance and equipment.

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[22] Additional topics could be included, particularly noncommunicable diseases with a high prevalence.

2.21 The activities to regulate the **quality of health facilities** will focus initially on developing hospital training protocols and conducting a first round of training in private hospitals at the second and third levels. Financing will then be provided for designing accreditation mechanisms for facilities, which will be done in concert with private service providers. The program will finance technical assistance for the consensus-building meetings, designing the protocols, and an initial round of accreditation for up to five hospitals. The training protocols will enforce environmental licenses provided for under the health code.

2.22 Regarding the **research** policy, the program will support the ICGES in discussing and implementing Panama's Health Research Policy Guidelines,[23] which will be set by consensus and include a line for promoting the development of technology to improve management and evaluate the performance of health services.

2.23 The research policy will emphasize studies related to evaluating the impact of public health interventions, socioeconomic evaluations of the procedures in use in the services, and evaluations of the performance of the health care and service delivery models.

2.24 As part of the effort to **strengthen** MINSA **technically**, the development of the research policy and its investments will place particular priority on financing technical, financial, and political feasibility studies to analyze sector reform alternatives in Panama. The results of the studies will give MINSA a menu of reform options, which is a technical element needed for the discussions on proceeding from phase one to phase two of the program.

2.25 The program will finance technical assistance, observation visits, and the purchase of applications and technological support equipment. It will also finance training for the ICGES team responsible for implementing the research policy, in areas including marketing, applied statistics, and project monitoring and evaluation.

2.26 To promote research in the aforementioned areas and spheres of action, the program will have a research fund (FOI), which public and private entities in Panama can access through invitations to bid. The ICGES will form a project selection committee, chaired by the Minister of Health, that will evaluate proposals and select projects for financing. The resources will be transferred from the program's administrative and financial management unit (UGAF) to the selected entities. The ICGES will prepare operating regulations (OR) governing the operation of the selection committee and the fund.

2.27 Regarding the **pharmaceuticals sector,** the program will finance technical assistance for the regulation and implementation of the new Drug Marketing Law. In addition to the technical assistance for passing the regulations, financing will be

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[23] Prepared by the ICGES and MINSA, 2001.

provided for redesigning processes and training and technological support to conduct the technical controls created under the new law. The program will also finance technical assistance so that MINSA can implement a new strategy for procuring drugs, in light of the new law and the challenges resulting from decentralization.

2.28 **Intersectoral coordination** (US$400,000). The program will finance the launching of a formal intersectoral coordination mechanism between MINSA and the CSS. In phase one of the program, priority will be given to: (i) preparing a joint master investment plan; and (ii) supporting the formulation and implementation of a financial framework that makes it possible to standardize the purchase and sale of services between MINSA and the CSS.

2.29 The **investment plan** will be based on the progress made by the committee that has already been created. The program will finance technical assistance for the initial preparation and annual adaptation of the national study on the supply and demand of health services, which will serve as the basis for the annual talks on the investment plan. Through technical assistance, the program will also support the semiannual review of compliance with the agreements and the establishment of a supraministerial mechanism that lends political viability to the agreements reached between the two agencies.

2.30 Regarding **financial relations** between MINSA and the CSS, the program will support the development of a rate system to regulate transactions between the two agencies, through technical assistance, observation visits, and technological support. The process will begin by drawing up a list of interventions, followed by a comprehensive review of cost studies available in the country, to begin to define an initial list of interventions and their respective rates. The rate system will be reviewed annually, and the program will finance technical assistance for the adjustment process. Up to 40 rates are expected to be set by the end of phase one, representing at least 70% of the volume of transactions. In MINSA, the program will finance training, the installation of computer applications, and the equipment for recording care provided and billing for it. Phase two must show concrete results in streamlining infrastructure investments and the development of the system for the sale of services. The range of topics for coordination will be expanded to include, among others, human resources and drug management.

### 2. Component 2. Innovations in the delivery of basic primary care services (US$24.8 million)

2.31 This component will increase coverage of basic health care services by providing a comprehensive package of health services (PAISS) to up to 450,000 of the poorest residents in Panama by the end of phase one. The package contains highly cost-effective primary care interventions that will be delivered under contract by various types of noninstitutional organizations (OEs), including NGOs, civic organizations, religious organizations, and cooperatives. To achieve its purpose, the component

will conduct the following activities: (i) strengthening of the players involved; (ii) targeting communities; (iii) delivering services; and (iv) monitoring and evaluation.

### a. Strengthening of the players involved (US$700,000)

2.32 **Central ministry of health and health regions**. Responsibility for implementing this component will be shared by MINSA at the central level and the regions involved in extending coverage. Both parties will receive technical assistance and will conduct international observation visits to examine similar experiences. For MINSA at the central level, the technical assistance will focus on aspects of the targeting, contracting, design and adaptation of payment mechanisms and the monitoring of contracts. The regions will initially receive technical assistance on administering the monitoring and oversight system, then in areas similar to those mentioned for MINSA.

2.33 **The supply of noninstitutional organizations (OE).** The study on potential supply conducted during program preparation found that roughly 20 noninstitutional organizations in MINSA's 14 health regions showed interest[24] in participating as health service providers.[25] This review also shows that in addition to the NGOs that have begun to work with MINSA through the project financed by the World Bank, there is a group of organizations, most of which are cooperatives, with the necessary financial position and related experience, whose statutes and business interests make them a real supply interested in participating in the program. Nonetheless, the program's success in the long term depends on maintaining and expanding the existing supply, by offering stable rules to play by and training on specific aspects of administering the delivery of the PAISS. The program will conduct two activities to foster the maintenance and growth of supply: (i) ongoing promotion of the program through social marketing to attract suppliers; and (ii) implementation of a technical assistance package that includes modules on health care protocols, project management, and administration of the contract monitoring system. The program could supply audiovisual and computer support materials.

2.34 **Beneficiaries of the services**. The program will actively promote the involvement of the target communities in aspects of the: (i) design and adaptation of service delivery modalities; and (ii) the social audit as an integral part of the monitoring and evaluation system. The program will finance technical assistance activities to: (i) identify social organizations in the target communities; (ii) disseminate the purposes of the program and participation by organizations; (iii) establish an indicator for the level of organization and preparation of the selected organizations;

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[24] Interest was examined through direct interviews and the documentation submitted by the OEs.

[25] Study on the supply of noninstitutional organizations. Consultant's report. Hedi Dehman. 2001.

(iv) set relevant indicators for monitoring service delivery; and (v) provide technical assistance to the organizations to perform the social audit of service delivery by using the aforementioned monitoring system. The project will adopt the methods and results achieved by technical cooperation operation TC-01-04-03-0, the objective of which is to strengthen local capacity to receive basic health services.

**b. Targeting (US$600,000)**

2.35 The program will distribute the Comprehensive Package of Health Services (PAISS) through geographic targeting, giving priority to the jurisdictions (*corregimientos*) with the least access and household spending on health. The methodology behind the targeting combines data from the National Standard of Living Survey (SLS 97) and data from the 2000 Population Census (see paragraph 3.26 for a more detailed discussion of the targeting methodology).

2.36 Twelve health regions will be eligible for both phases of the program. The two regions in the metropolitan area, given their moderate access to the public supply of services, will only be considered to receive the services described in paragraph 2.39. Jurisdictions that currently receive similar packages through other programs will be excluded. Once the jurisdictions have been prioritized within each district, the communities with very limited access to health services will be selected in such a way that 450,000 persons will benefit from phase one of the program.

2.37 The program will finance technical assistance for adapting the targeting plan at the midpoint and at the end of phase one.

**c. Delivery of PAISS services (US$23.3 million)**

2.38 **The Comprehensive Package of Health Services (PAISS).** The program will deliver the PAISS to the communities selected through the targeting exercise. The generic PAISS contains 19 health activities that fall into three categories: (i) health promotion services; (ii) disease prevention services; and (iii) health care services. PAISS services will stress care for women and children, including additional nutritional services and birthing care. The table below describes the health care services included in the PAISS:

**Table II-2**

| Health promotion services | Disease prevention services | Health care services |
|---|---|---|
| 1. Education on environmental sanitation | 1. Immunizations | 1. Care for morbidity |
| 2. Health education (including prevention of HIV infection) | 2. Prenatal checkups | 2. Labor and delivery |
| 3. Nutritional/food education | 3. Growth and development checkups (0-59 months) | 3. Care for micronutrient deficits in children under five, women of childbearing age, pregnant women, and schoolchildren |
| 4. Organization, training, and advising for community organizations | 4. Monitoring springwater quality | 4. Food supplements for low-weight pregnant women |
| | 5. PAP smears | |
| | 6. Post-partum checkups | |
| | 7. Control of excrement disposal | |
| | 8. Control of waste disposal | |
| | 9. Administration of contraceptives | |

2.39 Variations on the PAISS will be designed to adapt the services to three population groups: (i) rural; (ii) rural indigenous; and (iii) urban fringe. For the two rural categories, the adaptation will focus on including activities related to specific epidemiological patterns. For urban fringe populations, which currently have moderate access to the public supply of services, a package with fewer activities will be considered that is suited to their specific epidemiological conditions. All PAISS activities will be delivered in accordance with the protocols developed by MINSA.

2.40 The program will finance the delivery of the PAISS to up to 450,000 persons by the end of phase one. The average cost of the PAISS has been calculated at US$25[26] per capita per year. The PAISS will be financed with loan and local counterpart resources. To promote the institutionalization of the program, Bank financing will decline over time. The following shows the expected financing plan for the two phases of the program:

[26] Ricardo Bitrán & Cecilia Má. Delivery of the PAISS in Panama and fiscal impact. Consultant's report. 2001.

**Table II-3**

| | Phase 1 | | |
|---|---|---|---|
| Source | Year 1 | Year 2 | Year 3 |
| IDB | 90% | 80% | 60% |
| GOP | 10% | 20% | 40% |
| Population | 115,000 | 215,000 | 450,000 |

2.41 Delivery of the PAISS will be contracted to noninstitutional organizations (OEs) selected beforehand through a public invitation to bid, based primarily on technical criteria. Those criteria will deal with past experience in delivering basic health care services and the proposed coverage expansion related to ten performance indicators. The only financial criterion that will be considered is the acceptance of the per capita dollar figure set by the program. The contract amounts are expected to range from US$150,000 to US$250,000 per year, since contract size will be calculated based on groups of 10,000 beneficiaries. The fluctuation is due to variations in the value of the package, based on the characteristics of the population, and to the possibility that in some areas coverage will not reach 10,000 beneficiaries. For these reasons, it is anticipated that there will be approximately ten contracts in the first year and up to the maximum of 40 by the end of phase one.

2.42 The monitoring indicators are as follows: (i) percentage of children ages 12 to 23 months with the full vaccination program; (ii) percentage of women who have given birth who had five prenatal checkups; (iii) percentage of children ages 36 to 60 months with appropriate height/weight; (iv) percentage of children ages 36 to 60 months with 12 health checkups; (v) percentage of women who gave birth and received ferrous sulphate and folic acid, in accordance with the protocol; (vi) percentage of children under 59 months with moderate malnutrition; (vii) percentage of births attended in an institution; (viii) percentage of women ages 30 to 59 with PAP smears; (ix) percentage of couples who regularly use family planning; and (x) percentage of pregnant women with normal height/weight.

2.43 The population covered will be increased gradually and will be adapted according to annual goals. The following criteria will be applied to define the order in which communities will be added each year: (i) moderately accessible geographically; (ii) remote accessibility; and (iii) level of preparation of civic organizations in the community.

### d. Monitoring and evaluation (US$700,000)

2.44 The program will finance the devising of a benchmark for the ten performance indicators in each community. It will be the basic element for setting rural performance goals, which will be revised annually, and their fulfillment will be a determining factor in the renewal of contracts and the final payment on the contract. Compliance with the protocols and the social audit report will be examined and supervised twice a year. The regional health offices will be actively involved in that

oversight and will benefit from the technologies developed through the concurrent program evaluation.

### 3. Component 3. Transformation of management for health services production (US$11 million)

2.45 The objective here is to enhance the efficiency, equity, and quality of service delivery at all institutional levels in MINSA, by changing the rules and incentives governing the relationship between financing and the delivery of services. The basic strategic goals are to begin decentralizing management to five health regions, reorganize the operation and internal relations of regional health facilities, and promote improved management in the five hospitals, by developing new management instruments and designing and making data management systems available.

2.46 During phase one, this component's activities will focus on the following health regions: (i) Bocas del Toro, (ii) Coclé, (iii) Herrera, (iv) Los Santos, and (v) Veraguas. Coclé and Herrera were selected because they have begun to design and implement regional management processes in their regional hospitals; the program will incorporate that experience. The other three health regions were selected by evaluating three criteria: (i) level of commitment of the regional directors; (ii) supply capacity of existing health facilities in the region; and (iii) level of development of administrative support structures in the regions.

2.47 A two-fold plan will be implemented: firstly, the health regions will be prepared to assume planning, financial management, and oversight responsibilities, bringing decision-making closer to where services are delivered; and secondly, regional health agencies will be supported so they can act effectively within the new decentralization plan and improve their efficiency, effectiveness, and quality indicators. Execution of this component is linked to performance and progress in MINSA's institutional development. The following activities are planned:

#### a. Decentralized management (US$6.2 million)

2.48 The main objective here is to prepare the five health regions to expand their decision-making capacity on financial matters, increase their flexibility in human resources management, with a view to improving service delivery and enhancing efficiency, and gradually assume responsibility for supporting, following up on, and monitoring the coverage expansion activities mentioned in component 2. The program will finance technical assistance for developing instruments and methodologies, training activities, dissemination of results, exchange of experiences, and preparing and publishing educational materials.

2.49 **Financial management**. This component will focus on four specific areas: (i) the gradual local increase in financial use of centralized budget items from the "working fund"; at the end of phase one, the increase in each region is expected to

reach 25%; (ii) enhancing cost-recovery capacity in the regions, to increase the relative weight of the "self-management funds," so that by the end of the program they rise at least 5% in each region over historical levels; (iii) provide the health regions with the same regulations for managing the self-management funds currently being administered by the hospitals, to give them greater flexibility in executing those funds; and (iv) establishment, using program resources, of funds for integral medical tours (FOGI) that enable the regions to increase coverage of basic services, under the same plan as the PAISS, as described in component 2.

2.50 Those funds (FOGIs) will finance four expenditure items that are administered by the regional offices: (i) fuel; (ii) transportation rental; (iii) purchase of inputs; and (iv) per diems. With those funds, the regions can expand coverage to pre-selected communities, using the same methodology that will be applied to the organizations hired to provide the PAISS under component 2. FOGI resources will be transferred to the regional offices, according to a schedule agreed upon with MINSA, following the signature of a performance agreement that will determine the target community, the benchmark, and the goals for expanding coverage. The program monitoring system will audit expenditures and review annual fulfillment of the goals. Bank financing will decline over time, starting at 80% in year one and falling to 40% in year three. Specific regulations on the use of these FOGI will be contained in operating regulations, which will be an integral part of the program operating manual. The services provided through FOGIs will be monitored and evaluated using the same system as for PAISS deliver, as described in paragraphs 2.42 and 2.44.

2.51 The program will provide financing for the Ministry to offer incentives (basic equipment and minor renovations) in those regions that, following the review of the management agreements, show appropriate fulfillment of the agreed upon goals. Those investments will be contingent upon compliance with the environmental licenses provided for under the health code.

2.52 **Human resources management**. Implementation of this component seeks to have the regions assume responsibility for selecting, initiating, and evaluating the performance of personnel and reporting on staff news by the end of the phase. The regional directors will have the possibility of reorganizing the human resources in the region, in coordination with the hospital directors.

2.53 Specifically, technical assistance will be provided for implementation of: (i) organizational manuals in the regions; (ii) a budgeting system, by program; (iii) human resources management manuals; (iv) the design of the cost recovery system; (v) the redesign of and adjustments to the system for managing and decentralizing resources; (vi) preparation of management agreements between MINSA and the regions; (vii) building and operating the FOGIs; and (viii) and the design and installation of the monitoring system.

2.54 Within the general program monitoring and evaluation system, this component will implement its own controls. Technical assistance and training will be financed to: (i) monitor fulfillment of the management agreements between MINSA and the regions; and (ii) gradually increase monitoring of fulfillment of the contracts of the OEs mentioned in component 2.

**b. Reorganizing supply (US$2.5 million)**

2.55 Initially, the project will finance the design, feasibility, and implementation of pilot service networks in the five regions selected. They will be designed as an integrated system of agencies (MINSA, CSS, other providers) responsible for providing a coordinated series of services to a well-defined population. The pilot networks will be based on the integration of administrative (financial management, human resources, strategic planning, management of computer resources, marketing, and quality assurance) and clinical functions (services and emergencies, hospitalization, diagnostic support and services), which will be coordinated among the institutions in the network to generate maximum value added for the system as a whole. The basic improvements will be related to: (i) a better distribution of human resources; (ii) greater flexibility in referrals and counter-referrals; (iii) enhancement of the cost accounting system in the regional sphere; and (iv) decentralization of key elements of financial management to make it better suited to demand.

2.56 The pilot networks will be implemented in two phases: in years one and two of the project, three pilot networks will be designed and launched in the regions of Coclé, Herrera, and Los Santos, and in the second phase (years two and three) this will be done for two pilot networks in the regions of Veraguas and Bocas del Toro. This staggering is advisable due to the institutional weaknesses and geographic characteristics of the regions of Veraguas and Bocas del Toro, which by entering in the second phase can apply the lessons learned and the experience from phase one.

2.57 The program will finance the preparation of basic diagnostic studies by region, the design and implementation of the pilot projects, the development of management instruments to promote the formation and operation of the networks, strengthening of the networks through technical assistance and training at the regional and local levels, and outfitting the information and communications systems.

2.58 The implementation of these integrated network models is expected to generate savings of 5% of the region's budget through better use of human and technical resources. The evaluation of the pilot networks will contribute evidence on the organizational, financial, and health results of the operation of these networks. At the end of the program, an evaluation of the results of the pilot networks will be prepared, together with an expansion proposal that incorporates the lessons learned, bearing in mind the aforementioned financial factors.

### c. Hospital management (US$2.2 million)

2.59 In the Aquilino Tejeira, Cecilio Castillero, Joaquin P. Franco, Luis Fábrega, and Anita Moreno Hospitals, located in the five regions mentioned above, the program will finance the: (i) formulation and implementation of organizational transformation and business development programs; (ii) installation and expansion of information systems to support hospital management; (iii) training programs on health services management aimed at administrative and medical personnel in the hospitals; (iv) environmental management programs;[27] and (v) development of instruments for the administrative management of relations with the regional level and with other members in the service network.

2.60 Financing will be provided under the program for preparing benchmarks in the hospitals that include critical administrative, financial, and clinical indicators to evaluate improvements in performance.[28] The program will also fund the formulation and monitoring of program contracts signed between the hospitals and MINSA, which will include the budget transfer system and the performance goals.

## C. Relationship among the components

2.61 The components were designed with a series of interrelations among their specific activities that seek to generate a harmonious institutional transformation process. Component 2 is in the strategic and financial center of the program; therefore several of the activities in components 1 and 3 seek to provide the information resources, human resources development, and monitoring and oversight that are essential for the successful delivery of the PAISS. Components 1 and 3 are also linked through the human resources and financial management areas, in that the decentralization is supported in MINSA at the central level through developments in these critical areas. The following chart illustrates some of these interrelations.

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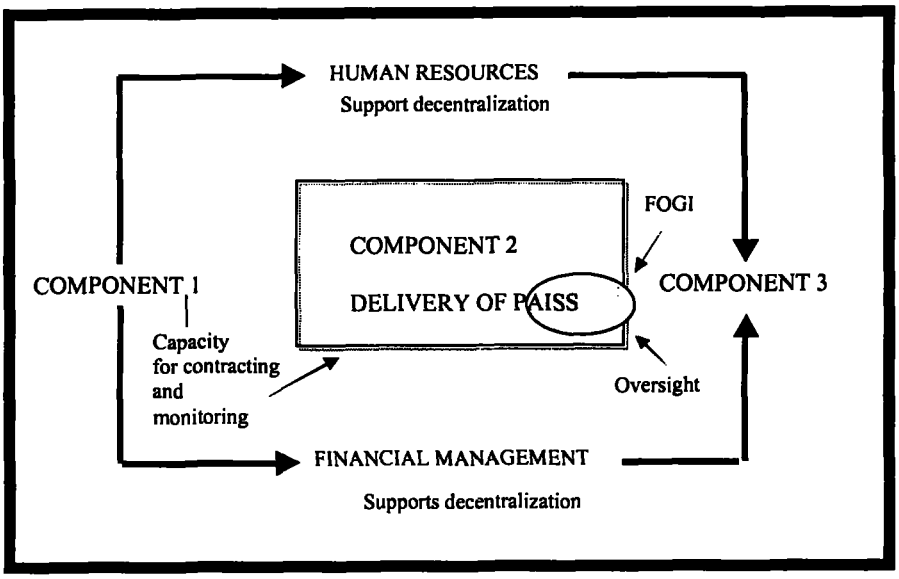
[27] This includes waste management and planning, occupational health, and other topics.

[28] One element of analysis will be the method of evaluating hospital efficiency mentioned in the Background section of this proposal.

**Chart II-1**




## D. Cost and financing

2.62 Table II-4 presents a breakdown of program costs for phase one by component and source of financing.

**Table II-4 (in thousands of US$)**

| COMPONENTS | IDB | LOCAL | TOTAL | % |
|---|---|---|---|---|
| **Component 1. Institutional transformation of MINSA** | **5,527** | **975** | **6,503** | **13%** |
| 1.1 Internal transformation | | | | |
| - Organizational adaptation | 1,314 | 232 | 1,546 | |
| - Strategic information management | 751 | 132 | 883 | |
| - Social marketing | 1,067 | 188 | 1,255 | |
| 1.2 Sectoral institutional transformation | | | | |
| - Policy making | 2,075 | 366 | 2,441 | |
| - MINSA-CSS intrasectoral coordination | 321 | 57 | 378 | |
| **Component 2. Innovations in delivering basic services** | **17,870** | **6,977** | **24,847** | **50%** |
| 2.1 Strengthening the players | 612 | 108 | 720 | |
| 2.2 Development of targeting mechanisms | 48 | 9 | 57 | |
| 2.3 Delivery of PAISS services | 16,598 | 6,753 | 23,351 | |
| 2.4 Monitoring and evaluation | 611 | 108 | 719 | |
| **Component 3. Transforming management** | **10,132** | **876** | **11,008** | **22%** |
| 3.1 Decentralized management | 5,844 | 399 | 6,244 | |
| 3.2 Reorganization of supply | 2,299 | 255 | 2,554 | |
| 3.3 Hospital management | 1,989 | 221 | 2,210 | |
| **Administrative costs** | **658** | **1,999** | **2,657** | **5%** |
| Monitoring and evaluation | 307 | | 307 | |
| Administration | | 1,999 | | |
| Financial auditing | 351 | | 351 | |
| **Subtotal** | **34,187** | **10,827** | **45,014** | **90%** |
| **Financial costs** | | **4,082** | **4,082** | **8%** |
| Interest | | 3,545 | 3,545 | |
| Inspection and supervision (1%) | | 350 | 350 | |
| Credit fee (0.75%) | | 187 | 187 | |
| **Contingencies** | **814** | **90** | **904** | **2%** |
| **Total cost** | **35,000** | **15,000** | **50,000** | **100%** |
| **%** | **70%** | **30%** | | |

2.63 The total cost is estimated at US$50 million, as broken down in Table II-4, and is divided up as follows: (i) US$35 million from the Bank with resources from the Ordinary Capital Single Currency Facility in US dollars; and (ii) US$15 million from the Government of the Republic of Panama.

2.64 Annex V contains a table of costs broken down by component that includes categories for consulting services, training, equipment, delivering PAISS services, and special funds.

2.65 The loan terms are indicated below:

**Table II-3. Loan terms**

| | |
|---|---|
| Source of financing | Ordinary capital (OC) |
| Currency | US$ Single Currency Facility |
| Terms | |
| Amortization period: | 25 years |
| Grace period | 3.5 years |
| Disbursement period | 3.5 years |
| Interest rate | Variable |
| Monitoring and supervision | 1% of the total loan amount |
| Credit fee | 0.75% of the undisbursed amount |

## III. INSTITUTIONAL FRAMEWORK AND PROGRAM EXECUTION

### A. Borrower and executing agency

3.1 The borrower is the Republic of Panama, and the executing agency is the Ministry of Health.

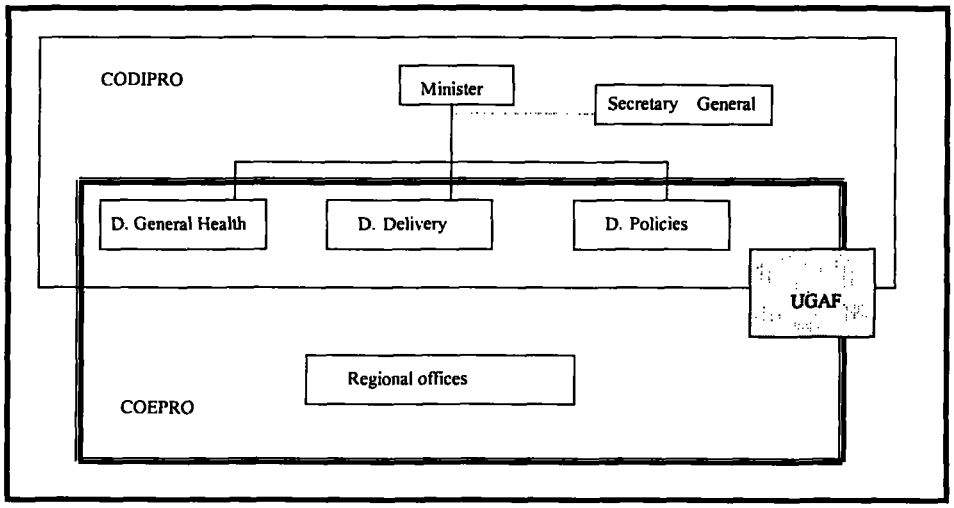
### B. Program administration

3.2 Three MINSA line agencies are technically responsible for the administration and execution of the components: (i) the Policy Office will be responsible for executing component 1; (ii) the General Health Directorate will be responsible for component 2; and (iii) the Service Delivery Directorate will be responsible for component 3. The administrative and financial management unit (UGAF) will deliver services to the offices responsible for execution aspects related to procurements and monitoring program accounting.

3.3 In component 1 the following will be executed by the Ministry of Health office: (i) organizational adjustment of MINSA; (ii) coordination with the CSS; and (iii) social marketing. The sensitivity of the topics and the potential conflicts of interest that could arise within the agency require leadership at the highest level. The Ministry office will have a technical support team to plan and execute these activities.

3.4 The Program Steering Committee (CODIPRO), to be established by ministerial resolution, will be responsible for strategic management of the execution of the components. The Committee will be chaired by the minister of health and composed of the offices and directorates responsible for executing the components, the Secretary General of MINSA, and the Director of UGAF. Executive responsibilities will be assumed through a Program Executive Committee (COEPRO), composed of the national offices and regional directors involved in executing the components. The five directors of the hospitals selected in component 3 may possibly be invited onto the COEPRO, when it is deemed necessary. The national offices will serve as a technical liaison between CODIPRO and COEPRO. The following chart presents the organizational structure, followed by a description of the specific responsibilities of each entity.

**Chart III-1**




3.5 **CODIPRO**. CODIPRO will review the content of the annual operating plans (AOP) presented by the directors heading up the three components, in light of the higher objectives of the ministry and the program's table of benchmarks. This will allow any adjustments to be made in time to ensure coordination and good progress. The committee will hold biannual meetings with an advisory council to examine program progress and propose adjustments. The council will make it possible for interested groups to participate in the program, including trade unions, universities, and particularly the beneficiaries of the PAISS.[29] The strengthened community groups responsible for the social audit will serve as representatives for the beneficiaries. The OM will lay out the council's mode of operation and selection mechanism.

3.6 **COEPRO**. This committee will review the preparation of the AOP for each component and the responsibilities of each of the national and regional offices and will oversee the monthly and quarterly execution of activities. The committee will also review the progress of the performance agreements between MINSA and the regions and fulfillment of the contractual commitments of the OEs. UGAF will provide technical support to CODIPRO and COEPRO.

3.7 **UGAF**. This unit will have two areas of work: (i) contracting; and (ii) finances. It will have an executive director and a maximum of two experts for each area of work. Funds will be provided for four administrative experts who will provide general support for the implementation of key processes. The UGAF will have responsibilities in: (i) implementing an internal control structure that enforces the procedures agreed upon in the program's operating manual (OM); (ii) developing a

[29] Including women's organization.

financial accounting system for program resources; (iii) maintaining separate, specific bank accounts for managing resources from the Bank loan; (iv) receiving and processing bimonthly reports prepared by the regional offices on the execution of FOGIs; and (v) preparing the reports and financial statements required by the Bank. The UGAF will provide administrative and financial support services to the offices responsible for executing the components and will participate on CODIPRO, as a support institution.

3.8 The government has requested that authorization be granted for the UNDP to provide financial management services to support the UGAF. Relations between MINSA and the UNDP will be governed by an administration agreement, the terms of which will be agreed upon by the two parties and approved by the Bank. This request is justified by the successful experience the UNDP has had in Panama when it participated in projects financed by the Bank and other multilateral institutions. The costs of UNDP participation will be covered by the local counterpart funding.

3.9 It is recommended that the government's request for UNDP participation be granted. To that end, as a condition precedent to the first disbursement of the loan proceeds, the government must submit evidence that it has entered into the agreement referred to above, subject to prior approval of the agreement by the Bank.

3.10 **MINSA offices.** The offices responsible for executing the components must prepare the annual operating plans (AOP) and maintain technical leadership of the execution of the respective components. With support from the UGAF and inputs from the monitoring system, they will prepare the quarterly and semiannual progress reports to be presented to the Bank. Those reports will examine the progress of the components in light of the AOP and compliance with the agreed-upon benchmarks.

3.11 **Regional offices.** These offices will be responsible for managing the FOGIs. The FOGIs will be transferred to the regional offices, and their use is contingent upon the provisions of their operating regulations, which will be a key part of the program operating manual. The regional directors will receive support in the form of training on managing the FOGIs, which includes managing the account registers and bimonthly reporting on execution (including supporting documents for expenditures) to UGAF. Its responsibility for managing the resources will include: (i) establishing separate bank accounts for program resources; and (ii) maintaining an accounting system that involves specific account and financial registers for managing program resources that will make it possible to identify financial transactions paid with Bank or local counterpart financing, separate from other expenditures in the region.

## C. Program execution

### 1. General considerations

3.12 Program execution will be guided by an execution plan that was developed during the program preparation phase and was designed based on the logical framework and matrix of annual benchmarks. The execution plan will make it possible to implement the annual operating plans. Program execution will be based on two types of instruments: (i) the program operating manual (OM); and (ii) four operating regulations (OR). These two instruments will serve as a procedural guide for the executing agencies and can be adjusted during the life of the program to incorporate changes that provide greater flexibility in program execution.

3.13 The execution plan includes activities that will be implemented before program eligibility, including the selection and preparation of potential OE candidates for participating in the program and the baseline studies in the target communities, which will serve as the basis for contractual agreements with the selected OEs. The Bank will prepare and approve both the operating manual and regulations before the Executive Committee considers them.

### 2. Operating manual and regulations

3.14 The following is a brief description of the basic features of the OM and OR that will be used:

3.15 **Operating manual.** The manual contains specific aspects of UGAF operations, including the internal control system. It will also contain the specific mechanisms for operations and coordination among CODIPRO, COEPRO, and the regional offices, as well as the operating regulations mentioned in paragraph 3.10. The OM will include environmental management issues in the management agreements signed between MINSA and the hospitals, as described in the paragraph on hospital management.

3.16 **Operating regulations for hiring OEs.** These regulations will indicate the mode of operation for increasing coverage through the OEs. They will contain at least the following: (i) a mechanism for the invitation to present expressions of interest; (ii) selection criteria for providers; (iii) selection procedures; (iv) payment and billing methods; (v) mechanisms for reviewing fulfillment of provisions; (vi) contract preparation; (vii) mechanisms for overseeing fulfillment of contracts; and (viii) a model for monitoring contract performance, which includes the design of formats for collecting information. The OR will include the terms of reference for contracts or purchase agreements for goods and services that are prepared under component 2 and will contain provisions to ensure compliance by the contractors with current environmental regulations.

3.17 **Operating regulations of FOGIs.** The OR will contain: (i) the funds transfer mechanism, including the processing of the management agreement reached beforehand by MINSA and the regional director; (ii) the account to which the funds will be transferred; (iii) eligible expenditure items; (iv) the accounting system; and (v) the mechanism for reporting expenditures, including the characteristics of the supporting documents and the periodicity of their submittal.

3.18 **Operating regulations of FOCER.** These operating regulations will cover: (i) the composition of the executive board; (ii) the board's operating rules; (iii) eligibility criteria for projects to be considered; (iv) the maximum and minimum amounts to be granted; (v) the project selection mechanism; and (vi) the project monitoring procedure and the reports that the beneficiaries must present. FOCER resources will be transferred from UGAF directly to the agencies responsible for the selected projects, following a request from the executive board of FOCER. To be eligible, each project must submit a matrix of results that will serve as the basis for monitoring and evaluation.

3.19 **Operating regulations of the FOI.** These regulations shall contain: (i) the description and mode of operation of the collegiate body that will be responsible for the FOI; (ii) project eligibility criteria; (iii) the project selection mechanism; (iv) the minimum and maximum amounts of financing; and (v) the procedure for monitoring projects and the reports that the beneficiaries must submit. Resources from the FOI will be transferred from UGAF directly to the agencies responsible for the selected projects, following a request from the collegiate body responsible for the FOI. To be eligible, each project must submit a matrix of results that will serve as the basis for monitoring and evaluation. When FOI resources can be used for investments, one eligibility criterion will be environmental feasibility.

### 3. Contracting the PAISS

3.20 Below are other relevant aspects of the execution mechanisms and eligibility criteria.

#### (i) Mechanism for contracting the services

3.21 Bank procedures will be used to contract the services, using the fixed budget selection method, as provided for in document GN-1679 on changes to Bank policy on hiring consulting services. The OEs will be selected through international public bidding, for which MINSA will keep an open registry of pre-qualified firms. The convocation will be within the group of registered firms. The criteria for being part of the registry include proof of: (i) experience and technical capacity in delivering health services; and (ii) sufficient administrative and financial capacity to potentially assume a service contract.

3.22 The invitation to bid on providing services will establish the estimated amount for delivery of the PAISS, depending on the size of the community to be served and the

pre-determined per capita price. Since the per capita price is determined ahead of time, the criterion for selection is the quality of the proposal, without considering price. The selection criteria will include: (i) the capacity of the OEs to serve the entire target population; (ii) the use of innovations in the PAISS service delivery model; and (iii) the goal for increasing coverage proposed in the ten performance indicators (starting from the baseline).

**(ii) Contract execution**

3.23 The OE will provide services in accordance with contract provisions, applying both the technical (related to the care protocols) and administrative, accounting, and financial standards and procedures outlined in the OR. The contracts can be renewed annually, based on the results of the monitoring of fulfillment of contractual commitments. The per capita payment will not contemplate payment for recognized expenses, although the mounting of registry systems for care delivered and resources used will be promoted.

**(iii) Monitoring and evaluation**

3.24 Monitoring and evaluation of PAISS delivery will be based on three modules: (i) fulfillment of the goals related to the ten performance indicators; (ii) enforcement of the care protocols; and (iii) the structured report of the social audit performed by the community receiving the services.

3.25 The monitoring system will use data broken down by gender to gauge the differential impact of PAISS interventions. There will also be information on maternal mortality and access to trained birthing care.

**4. Targeting**

3.26 The targeting protocol identifies the jurisdictions with the lowest levels of access and family spending on health. That protocol—known as the close variables method—is implemented in two phases. The first determines which variables explain access and family spending on health. Using data from the SLS 97, the protocol develops a statistical model to explain access and family spending on health, using a series of variables common to both the SLS and the Population Census. The result is a pair of equations that describe the impact of each variable on access and family spending on health nationwide. The second predicts access and family spending on health at the district and jurisdictional level by applying the equations obtained in the first phase to Census variables. This targeting method makes it possible to predict access and family spending on health at any geographic level, since the Census covers all households in the country. In short, this method transfers the findings from the analysis of SLS 97 to census variables to obtain results at more disaggregated geographic levels.

## D. Procurement of goods, contracting of works, and hiring of consulting services

3.27 International public bidding will be required for: (i) the construction of works valued at over US$1,000,000; and (ii) the procurement of related goods and services valued at over US$250,000. There will be an international open request for tenders for consulting services over US$200,000. For lesser amounts, the special procedures outlined in Annex D of the loan contract will be used.

**Table III-1. Procurement and contracting procedures**

| | Works | Goods and services | Consulting services |
|---|---|---|---|
| **International public bidding or request for tenders** | Over US$1,000,000 | Over US$250,000 | Over US$200,000 |
| **Unrestricted national public bidding** | From US$250,000 to US$1,000,000 | From US$100,000 to US$250,000 | From US$100,000 to US$200,000 (registry of candidates) |
| **National private bidding or pre-qualification** | Under US$250,000 | Under US$100,000 | Under US$100,000 |

## E. Revolving fund

3.28 In accordance with current Bank policy, the revolving fund mechanism will be used, but will be limited to 5% of the total loan amount. UGAF must present semiannual reports to the Bank on the status of the revolving fund for which it is responsible, within 60 days of the close of each six-month period ending on June 30 and December 31.

## F. Recognition of expenditures and retroactive financing

3.29 The proposal does not include retroactive financing of expenditures from the local counterpart or program financing.

## G. Disbursements

3.30 The disbursement period for the financing will be three and a half years, with the exception of the funds for auditing and the concurrent evaluation, which will have a disbursement period of six additional months. Both periods begin on the date on which the loan contract enters into force.

3.31 Bank resources and the local counterpart funds will be deposited in a special account administered by the Ministry of Health. Payments will be made by UGAF for the procurement of goods and services. The cumulative figures on expenditures or investments, reflected in the periodic account execution reports, will solely and

exclusively consider eligible expenditure items that were agreed upon previously with the Bank. MINSA, through UGAF, will keep in its files the originals and/or copies of the contracts, requests, invoices, receipts, payment vouchers, certificates from the providers, and any other document needed to corroborate the information provided in the reports presented to the Bank. The documents must be duly identified and filed and must be provided to authorized Bank officials and the external auditors for examination, at their request.

3.32 The Bank will conduct ex ante technical and financial inspections to examine support documents. The borrower must present the disbursement request together with invoices, receipts, and, when appropriate, a certificate from the supplier. If total individual expenditures are less than the equivalent US$1,000, the borrower can simply present a list of the expenditures. In that case, at the discretion of the representative office, a minimum of 15% of the invoices and receipts must be reviewed at the offices of the borrower. If errors are detected, the percentage of documents to be reviewed shall increase, at the discretion of the staff at the representative office.

3.33 The program disbursement schedule will be as follows:

**Table III-2 Disbursement schedule (in thousands of US$)**

| Source | Year 1 | Year 2 | Year 3 | Total |
|---|---|---|---|---|
| **IDB** | 10,544 | 11,529 | 12,927 | 35,000 |
| **Local** | 2,603 | 3,925 | 8,472 | 15,000 |
| **Total** | 13,147 | 15,454 | 21,399 | 50,000 |
| **%** | 26% | 31% | 43% | |

## H. Accounting and external auditing

3.34 MINSA will establish a standard accounting system for the program accounts that must be implemented in UGAF and in the regional offices executing resources from the FOGIs. The accounting system must make it possible to maintain adequate accounts and registries, in conformity with generally-accepted international accounting practices, reflecting the resources received by source of financing and the use of those funds by UGAF and the regions, by investment category. The executing agency will submit to the Bank the annual financial statements for the program, audited in accordance with the terms of reference approved by the Bank, 120 days after fiscal year-end. They are to be audited by a firm of independent public accountants accepted by the Bank. Payment for the annual audits will be included in the cost of the program to be financed with Bank resources. The audited financial statements must contain a specific section on the audit of the FOCER, FOGI, and FOI funds.

## I. Monitoring and evaluation

### 1. Program start-up workshop

3.35 A program start-up workshop will be held no later than three months after the loan is declared eligible for disbursements. Participants will include MINSA officials from the central and regional levels and UGAF officials; the execution plan, table of benchmarks, and logical framework will be reviewed and adapted in light of the activities conducted previously. This activity will be funded out of the Bank's contribution.

### 2. Annual and midterm reviews and performance report

3.36 During the execution period, MINSA and the Bank will conduct joint annual reviews to evaluate program performance and reach agreements on needed adjustments. The core elements of analysis will be the progress of the execution plan, the AOP, the logical framework, and the matrix of annual benchmarks. Progress in executing the activities in the AOP and its relation to the meeting of the benchmarks will be reviewed every three months by COF/CPN and annually in the technical review mission. Progress in the table of benchmarks and the accompanying indicators will be the core element of both the midterm review and the preparation of the performance report, which will be used to propose moving on to phase two of the program. The project team will conduct the planned reviews, together with consultants, when necessary. This will be covered by the Bank's contribution.

3.37 The content of the performance report will focus on: (i) the analytical review of the results of the annual and midterm reviews; (ii) the analysis of the performance of the executing agency in the administrative and financial execution of the program; (iii) fulfillment of environmental management provisions and goals; and (iv) fulfillment of the elements prompting the movement to phase two, as described in paragraph 2.4 and Annex IV.

### 3. Concurrent evaluation

3.38 The program will finance a concurrent evaluation that must be contracted no later than six months after the date on which the contract takes effect. Its four purposes are to: (i) randomly review compliance with the procedures in the OR; (ii) evaluate fulfillment of the contracts with the OEs, as regards the ten performance indicators, and the results of the social audit; (iii) evaluate fulfillment of the commitments made in the performance agreements between MINSA and the regions; and (iv) transfer technology and procedures to MINSA to institutionalize monitoring and evaluation within the organization. Quarterly reports will be produced.

## J. Special conditions for the disbursements

**Table III-3**

| Condition | Fulfillment | Means of verification |
|---|---|---|
| Evidence that MINSA has entered into an agreement with the UNDP for financial administration, previously approved by the Bank. | Precedent to the first disbursement | Signed agreement |

# IV. FEASIBILITY AND RISKS

## A. Technical feasibility

4.1 There is some recent albeit limited experience in Panama with delivering basic health services to poor populations through noninstitutional organizations (OEs). As part of a rural health program financed by the World Bank, in the past year MINSA has developed methodologies to detect OEs, promote their involvement in coverage extension programs, and contract services. These experiences have begun to build some confidence in MINSA about the possibilities for extending coverage in this way and at the same time have begun to raise the awareness of such providers about the potential of this market in Panama. The sum of these factors is creating an incipient, but positive technical base within MINSA that would be used by the Bank's new multiphase program.

4.2 The composition of and methods for delivering the PAISS have been designed with involvement from representatives of all the health regions in the country, which offers significant technical support for program execution. Since a generic PAISS was designed with variations in content and delivery methods by region, there will be flexibility in delivery and in adapting it to the country's many epidemiological and cultural realities.

4.3 The design of the decentralization component is based on exhaustive technical work performed with the regional directors, which made it possible to identify a group of measures for change in finances and human resources that met two conditions: (i) technical and political feasibility; and (ii) they had a major impact on improving services in the short term. Along these lines, priority was given to tangible measures that turned talk on decentralization into measurable results in service delivery.

## B. Socioeconomic feasibility

4.4 The program's greatest quantifiable socioeconomic impact is related to the increase in health care coverage for the poorest populations in the country who are separated not only by income gaps, but also by significant gaps in basic health indicators.

4.5 The gap in health conditions has an appreciable impact on the burden of disease, as measured by disability-adjusted life years (DALYs). In each country, DALYs quantify the years of healthy, productive life that society loses as a result of premature mortality and disability stemming from acute and chronic health problems in the entire population. In Panama, the burden of disease is not distributed uniformly among its inhabitants, but rather is disproportionately attributed to the poorest populations with the least access to health services, other public services, and infrastructure.

4.6 The consequences of health actions can be measured according to their cost-effectiveness, which relates the cost of an intervention to its effectiveness. Cost is measured in monetary terms, while effectiveness is gauged in terms of the DALYs saved or prevented as a result of the intervention. The more cost-effective an intervention, the more advisable it is to provide it, since it enables society to prevent more DALYs per dollar or balboa spent on health.

4.7 The PAISS that will be delivered under this project has an overall cost-effectiveness quotient for the extension of coverage of US$23 per DALY. In other words, through the delivery of the health care in the PAISS under the project, Panamanian society will spend only US$23 per year of life saved, by preventing premature death and reducing disability.

4.8 This quotient is favorable and makes it possible to characterize this basic package of services as highly cost-effective. This is because the PAISS includes the provision of highly cost-effective interventions, including immunizations, preventive care for mothers and children, and iron and vitamin A supplements.

4.9 In the first year, the benefit of the delivery of the PAISS would be 33,842 DALYs, reaching approximately 110,000 persons. The economic benefit generated by the delivery of the PAISS was calculated as the present value of the DALYs gained, with an annual discount rate of 3%. The present value of the DALYs gained is 3,541,899.[30] It is estimated that the delivery of the PAISS will reduce the current burden of disease in the program's target populations by one-third. This is more favorable than World Bank estimates (1993 Economic Development Report), which calculated that a basic package of US$21.5 in low-income countries similar to Panama would reduce the burden of disease in the country by 16%.

## C. Institutional feasibility

4.10 MINSA's institutional capacity to direct a program of change and execute support activities has been positively enhanced during execution of loan operation 803/OC-PN. Although there was a project coordinating unit (PCU), technical and strategic leadership has been gradually assumed by the line agencies. Regarding financial execution of the resources, the PCU has been able to double the execution of the resources in the last two years, by generating a series of procedures for internal use and for relating to other units in MINSA and in the Panamanian government. One sign of capacity to learn and to reorganize processes was shown in the most recent execution period, when a series of auditing recommendations were satisfactorily resolved. This adoption of best practices, together with the internal control requirements that will be developed in the OM, helps to paint a positive institutional picture of administrative and financial execution.

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[30] Ricardo Bitrán & Cecilia Má. Delivery of the PAISS in Panama and fiscal impact. Consultant's report. 2001.

4.11 During the preparation of this operation, the national offices involved in the process received technical assistance and training to actively participate, with a leadership role, in the design of the operation. This laid the foundation for the program to have ownership, which is critical for program success.

4.12 Furthermore, in light of the institutional weaknesses detected and described in the background section of this document, the program proposes implementing organizational changes in MINSA that offer conceptual elements and new tools to the offices in particular and MINSA in general so that it can provide strategic leadership in the change process and make timely adjustments.

## D. Financial feasibility

4.13 In the first phase, the program will generate recurring expenditures of approximately US$11.7 million, an increase of approximately 6% in the third year, compared to actual sustained increases of over 8% in MINSA's budget in the last decade, which were geared primarily towards maintaining the hospital network, with insufficient targeting of the poorest populations. Over 95% of the program's recurring expenditures will be related to paying the OEs for delivering the PAISS to the poorest populations. Bank financing of these recurring costs will decline over time in the two phases, until it reaches 60% of the total in the final year of phase one. This will enable the Government of Panama to gradually increase the financing of recurring expenditures through the national budget, while stabilizing spending in the five hospitals in the program; it will also obtain net savings of up to 5% in the spending of the service networks that will be tested during program execution.

4.14 Regarding the fiscal impact, recurring costs will generate a real increase of 0.12% of GDP at the end of phase one. This compares positively to the economic benefit generated by the delivery of the PAISS in terms of DALYs, as described in the socioeconomic feasibility analysis.

## E. Social and environmental impact

4.15 **Social impact.** This program supports the delivery of primary health care services to a population of up to 450,000 inhabitants, all of whom live below the poverty line. The delivery of a package of highly cost-effective interventions geared towards the poorest populations, particularly women and children, is a way to target public spending to simultaneously attack the problems of inequality in access and inefficiency in the allocation of resources. A gender approach will be fostered, both in the selection of the type of community organization, and the composition of the benefits package. The information system will disaggregate data to gauge the program's impact on women, in terms of quality and equity.[31]

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[31] Indicators on maternal mortality and access to birthing care will be included, among others.

4.16 The indigenous population is part of the target population in the targeting exercise, given its conditions of extreme poverty. The program will consult with the target populations on adjustments to the design of the packages and the delivery methods, to ensure that delivery of the PAISS respects and incorporates the specific sociocultural features of indigenous populations. The General Health Directorate, which is responsible for executing component 2, will receive support in this area, when deemed necessary. A baseline study will be conducted to guide the delivery of services to indigenous populations and facilitate dialogue between the indigenous communities and MINSA. The study will be contracted as soon as possible.

4.17 **Environmental impact.** The project does not provide for major investments that have a direct environmental impact. However, it will incorporate current regulations[32] on environmental licenses in all minor investments in civil works for basic health centers and purchases of basic equipment financed through the loan (there are investments of roughly US$1,000,000 in component 3, paragraph 2.51). Furthermore, program implementation will make it possible to promote some aspects of environmental management, such as: (i) the inclusion of environmental issues in the training and accreditation protocols for health service facilities; (ii) the terms of reference for contracts or agreements to purchase goods and services that are prepared under component 2 will contain provisions that ensure compliance by contractors with current environmental regulations; and (iii) the activities to improve hospital management[33] will include a module on environmental management that incorporates planning and waste management and occupational health, among other topics. Fulfillment of the environmental management commitments will be a module in the management agreements (paragraph 2.60) to be signed between MINSA and the hospitals.

## F. Social equity and poverty reduction classification

4.18 The rationale for qualifying as a PTI is automatic. The project specifies explicit performance indicators to measure poverty reduction and social equity enhancement (see Annex I).

## G. Risks

4.19 Groups of health workers may resist the decentralization process and innovations in the delivery of basic health care services for the poor. In the case of the innovations, coverage will be expanded through the PAISS in communities where there are no health services available, either for lack of infrastructure or want of personnel, which shows that the program is not in direct competition with government health

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[32] In this case, it is the current health code. The health code will be updated through a simultaneous project being executed with World Bank financing.

[33] This subcomponent provides for US$2.2 million in resources.

care supply and does not propose to close MINSA health facilities. To minimize the risk of health workers obstructing the activities of the noninstitutional organizations (OEs), the regional offices will receive funds from the fund for integral medical tours (FOGI) to implement activities similar to the delivery of the PAISS, enabling them to respond on equal footing in terms of availability of inputs. The program will use social marketing resources to inform interested parties that the program objective is to help make public and private services complement each other, not to replace one with the other.

4.20 In the case of decentralization, public information management and the social marketing strategy will give MINSA the tools to detect potential risks and respond effectively by training human resources. There is the risk of encountering resistance from the health regions to the decentralization proposal if it does not yield tangible results. The program analyzed a menu of options and proposes a set of tangible changes desired by the regions in finances and human resources. The program will promote coalitions among service providers, government, and public opinion, showing the benefits to each party and the advantages of working together.

4.21 There is the risk of not reaching an appropriate understanding with the CSS for coordination purposes. The program will support the devising of technical arguments and the defining of a limited number of interface points, to focus the discussion and ensure sufficient quantitative support.

4.22 The first phase of the program would be executed during the term of office of the current administration. Preparation of the final report will coincide with the change in government, and there is the risk of delays in the process during the transition. This risk will be mitigated by: (i) presenting the institutional progress in the sector and the program's contribution; and (ii) presenting a proposal for the new table of benchmarks that reflects recent sectoral changes and the strategic lines of the new administration.

**Panama**
**Multiphase Program for Institutional Transformation of the Health Sector, Phase 1 (PN-0076)**
**LOGICAL FRAMEWORK**

| | | | |
|---|---|---|---|
| o help improve the integral health and quality of life of the population of the Republic of Panama. | | | |
| e: To enhance efficiency, effectiveness, quality, sustainability, and equity in the organization, production, and regulation of health services. | | | |
| **Project** | **Project 1** | **Project 2** | **Project 3** |
| itutional transformation of NSA to develop its steering and ulatory role.<br>ovations in the delivery of basic mary care services.<br>nsformation and development management for health services duction. | **Purpose**: Enhanced steering and regulatory capacity | **Purpose**: Increased coverage of basic health care services to the poor and vulnerable groups | **Purpose**: Efficiency, effectiven quality in the management and of improved services |
| | **Components:**<br>1. Organizational adjustment<br>2. Information management<br>3. Social marketing<br>4. Policy making<br>5. Intrasectoral coordination | **Components:**<br>1. Strengthening the players<br>2. Targeting<br>3. Delivery of PAISS services<br>4. Monitoring and evaluation | **Components:**<br>1. Decentralized management<br>2. Reorganization of supply<br>3. Hospital management |

| ive Summary | Indicators | Means of Verification | Assumptions |
|---|---|---|---|
| **Project 1: Institutional transformation of MINSA to develop its steering and regulatory role** | | | |
| esponse of enhancing equity, cy, effectiveness, quality, and bility to improve health | | | |
| e:<br>ed stewardship of the sector | By the end of the third year of execution: a national stewardship plan for the health sector is prepared and is being implemented by the end of phase one. | Documents and reports | 1. Stable political and economic context i country.<br>2. Institutional political resolve continues.<br>3. The persons involved have a positive a<br>4. Other institutions that provide informat collaborating: CSS, government and th universities, IDAAN, Comptroller's Of ANAM, and others.<br>5. The personnel trained has job stability, there will not be turn-over.<br>6. There is political awareness of the sect problems, and the social actors involve positive attitude towards consensus-bui |

| | | | |
|---|---|---|---|
| | | | 7. The Legislative Assembly has a clear pi of the legislative and regulatory needs f MINSA to be able to execute a regulato |
| s | | | |
| ganizational adjustment | 1.1 | 1. | |
| ormation management. The tegic information system is rating. | 2.1 At the end of the first half of year two: the system has been designed and is operational. | 2. Document on the design, procedures, and instruments | The persons involved in the information syst have a positive attitude about the innovation retooling. |
| information in the components on formulating, nitoring, and evaluating health icies, public health surveillance, quality of health services, lth promotion, water and ironmental sanitation, human ources, health research, and nology and drugs have been eloped. | 3.1 50% of the data defined in the system according to the plan are available for decision-making in the second half of year two and the remaining 50% in the third year of execution.<br>3.2 Strategic indicators, according to the approved plan, are available for decision-making in the third quarter of year two of execution.<br>3.3 A technological support network, in accordance with the approved plan, is functioning in the third quarter of the second year of execution. | 1. Reports on results<br>2. Reports on indicators<br>3. Terms of reference<br>4. Reports on the installation of teams by the executing unit<br>5. Project progress report | Other institutions that provide information a collaborating: CSS, the government and the universities, IDAAN, Comptroller's Office, ANAM, and others.<br>The personnel trained has job stability, and t will not be turn-over.<br>There are permanent channels of communica between those who produce the information decision-makers ensuring the ongoing implementation of the system. |
| ial marketing | 4.1 Health promotion campaign to support component 2 is being executed at the end of the first half of year one.<br>4.2 Program marketing campaign is being executed from the first half of year one on.<br>4.3 Health promotion plan on HIV/AIDS is formulated by the end of the first half of year one.<br>4.4 Health promotion plan on violence is formulated by the end of the first half of year one.<br>4.5 Plans for HIV/AIDS are being executed by the end of year one. | 1. Copy of the print materials and videos<br>2. Plan is published<br>3. Plan is published<br>4. Plans are being executed.<br>Videos, print materials | |

| | | | |
|---|---|---|---|
| icy-making. Policies are mulated and implemented in the lowing strategic areas: human ources, research, and regulation pharmaceuticals. | 5.1 Policies disseminated and evaluated between the second half of year two and the first quarter of year three.<br>5.2 An increase of x% in supervision of the number of facilities that dispense drugs starting in year two of execution.<br>5.3 Drugs are registered within ten working days, starting in the second year of execution.<br>5.4 An increase of x% in the availability of drugs and inputs in public health institutions starting in the second year of execution.<br>*5.5 30% of eligible personnel is certified halfway through and 60% by program's end.*<br>*5.6 Financial, technical, and political feasibility studies are available to evaluate the reform possibilities, and the menu of options for phase two is completed by the end of the program.* | 1. Policy paper<br>2. Reports, aide-memoirs, and workshops<br>3. Report on supervision<br>4. Time-motion analysis<br>5. Management reports<br>6. Certification records<br>7. Copy of the studies | The political and economic context in the co is stable.<br>Institutional political resolve continues.<br>There is political awareness about human re problems, biomedical technology, and wate sanitation, and the social actors involved ha positive attitude about consensus-building.<br>There is an adequate political context and economic stability in the country.<br>The social actors involved have a positive at<br>The Specialized Institute on Analysis makes procedures more flexible and produces time results.<br>The personnel trained has job stability, and will not be turn-over.<br>There is a mechanism to streamline and gua the payment of those who provide services t MINSA.<br>The providers comply with the time frames established for the delivery of the required d and documentation. |
| asectoral coordination | 6.1 Supply and demand study completed by the end of year one.<br>6.2 Supraministerial mechanism to define the joint MINSA/CSS investment plan by the end of year two.<br>*6.3 List of interventions and 40 rates agreed upon and operational for MINSA/CSS transactions by the end of the program.* | 1. Copy of the study<br>2. Copies of the minutes from that body<br>3. List of interventions and rates. Records of payments between MINSA and the CSS | |

| Narrative Summary | Indicators | Means of Verification | Assumptions |
|---|---|---|---|
| **Project 2: Innovations in the delivery of basic primary care services** | | | |
| esponse of enhancing equity, y, effectiveness, quality, and ility to improve health. | | | |
| nd the coverage of basic care services for vulnerable r populations. | Phase I<br>Additional 500,000 people covered by selected health care activities<br>User satisfaction | 1. Concurrent auditing report<br>2. Report on the user satisfaction survey | The government's social policy as regards th health sector is maintained.<br><br>There continues to be guidance from the 200 Health Policies and Strategies. |
| nmunities selected using eting criteria | Percentage of population covered<br>a. Number and percentage of nonindigenous rural group covered by the program<br>b. Number and percentage of indigenous rural group covered by the program<br>c. Number and percentage of marginal urban group covered by the program<br>d. Percentage of health teams hired<br>e. Verification of priority-setting mechanisms in selected communities<br>f. Verification of incorporation of social auditing | 1. Periodic reports submitted by the providers, by level, as part of the monitoring and evaluation system<br>2. Poverty map<br>3. Record of projects by other institutions (MEF)<br>4. Updated inventory of organized communities (MEF)<br>5. Contract reviews | Workshop for design of the joint OE and MI information system |
| lementation of supervision and nitoring | 2.1 Performance indicators for the external monitoring system | MINSA documents | |
| vider training | 3.1 Percentage of training programs completed | Consultants' report | |
| ease in access to primary health e services: promotion, vention, and recovery | 4.1 Percentage of training programs completed | Consultants' reports<br>MINSA statistics | |
| nership between community anizations and service providers | 5.1 Number and percentage of community organizations involved in service provision | External audit report, CAP survey on organization and user satisfaction survey | Community awareness of and interest in the program is maintained |

| Narrative Summary | Indicators | Means of Verification | Assumptions |
|---|---|---|---|
| **Project 3. Transformation and development of management for health services production** | | | |
| esponse of enhancing equity, cy, effectiveness, quality, and ability to improve health. | | | |
| **e**<br>eve efficiency, effectiveness, lity in management and ed delivery of health services by alizing national services and ing regional services. | At the end of year three of execution: Indicators of decentralization of services in terms of financing and human resources.<br><br>Performance indicators for new service networks (production, yield, and costs)<br><br>Indicators of hospital efficiency and productivity | Surveys<br>Internal and external audits<br>Information system<br>Oversight<br>Information system (winsig)<br>Hospital management information system (803)<br>MINSA medical and statistical records | Political resolve<br>Effective intrasectoral coordination<br>Budget approved and adapted<br>Professional trade unions and organized gro in favor of the program.<br>Community acceptance<br>Sufficient human resources |
| **s** | | | |
| centralized management truments designed and plemented | 1.1 Number of management instruments implemented in the five key regions | Technical reports | Political feasibility<br>Professional trade unions and organized gro in favor of this. |
| gal framework for decentralized nagement has been developed | 2.1 Number of legal documents approved for the sectoral planning system, labor scheme, plan to delegate expenditures, and decentralized financial management | Publication in the Official Journal<br>Ministerial resolutions | |
| man resources trained to use the centralized management truments | 3.1 Percentage of eligible persons trained to use the management instruments | Technical reports on project training<br>Manuals | |
| n on implementing and luating decentralized nagement prepared and plemented | 4.1 Implementation plan prepared<br>4.2 Budgeting system by program implemented for future budgets<br>*4.3 20% financial use in the regions of centralized entries from the working fund by program's end* | 1. Regional audits<br>2. Consultants' reports<br><br>3. Budget execution report | |
| plementation plan for cost overy | *5.1 5% increase in the revenue budget of the region from cost recovery by program's end.* | Regional audits | Coordination among institutions, including t |

| | | | |
|---|---|---|---|
| vice network model defined in five pilot projects. | 6.1 Technical papers validated<br>6.2 Plan of action approved at the regional level | Technical paper published<br>Information systems | Effective intrasectoral coordination |
| gal framework for reorganizing service network is developed | 7.1 Legal documents approved | Technical reports | |
| ruments for the service network del developed and implemented | 8.1 Signature of management agreements with the five pilot regions<br>8.2 Referral and counter-referral strategies. | DIS reports | |
| astructure improved and pted through modernized vices and technology | 9.1 Percentage of facilities where there have been interventions in infrastructure and equipment<br>9.2 Implementation of information systems | Evaluation reports<br>Surveys | |
| urance and financing models for health services are developed implemented | 10.1Technical paper validated<br>10.2Percentage of regions with purchasing model installed<br>10.3Efficiency indicators in the regional operations of service networks, with savings of over 5% | Paper published<br>Technical reports | Effective intrasectoral coordination |
| man resources trained to operate health service insurance and ancing models | 11.1 Percentage of workers trained in financial management<br>11.2Agreements with regional health providers | Technical training reports | Professional trade unions and organized grou in favor of this. |
| spital management models eloped and implemented in ected regions. | 12.1Technical document validated, by facility | Technical paper published | |
| gal framework for hospital nagement is developed | 13.1Legal documents approved on financing and human resources issues | Decrees and/or resolutions, etc.<br>Manuals | |
| spital management instruments eloped and implemented | 14.1Number of management instruments developed<br>*14.2Improvement in productivity statistics of over 10%*<br>14.3Savings in the operating budget<br>14.4Proof that intrahospital mortality and morbidity has dropped | Technical reports on hospital management<br>Consultants' reports<br>Reports from the information system | |

| | | | |
|---|---|---|---|
| nan resources trained in<br>pital management | 15.1 Percentage of workers trained in hospital management, by facility<br>15.2 Performance under an incentives system | Training reports | |

cators in *italics* will be considered to decide on moving from phase one to phase two.

**Multiphase Program on the Institutional Transformation of the Health Sector. Phase I (PN-0076)**
**PROCUREMENT PLAN, BY COMPONENT (in thousands of US$)**

| Component and Activities | Financing | | Method of procurement | Estimated date |
|---|---|---|---|---|
| | IDB | GOP | | |
| **COMPONENT 1. INSTITUTIONAL TRANSFORMATION OF MINSA** | **5,528** | **975** | | |
| Consulting services | | | | |
| - International | 826 | 146 | CB | I - 2002 |
| - National | 630 | 111 | CB | I - 2002 |
| Training | | | | |
| - Courses, seminars | 711 | 126 | NPB | I - 2002 |
| - International | 48 | 9 | CB | I - 2002 |
| - Observation visits | 204 | 36 | CB | II - 2002 |
| Equipment | | | | |
| - Computers | 666 | 118 | IPB | II - 2002 |
| FOCER-FOI Funds | 1,381 | 244 | NPB | II - 2002 |
| Publications and social marketing campaigns | 1,060 | 187 | NPB | |
| **COMPONENT 2. INNOVATIONS IN THE DELIVERY OF BASIC PRIMARY CARE SERVICES** | **17,871** | **6,978** | | |
| Coverage of health services | 16,151 | 6,675 | NRT | I - 2002 |
| Consulting services | | | | |
| - International | 542 | 96 | CB | I - 2002 |
| - National | 370 | 65 | CB | I - 2002 |
| Training | | | | |
| - Courses, seminars | 454 | 80 | NPB | I - 2002 |
| - International | | | | |
| - Observation visits | 128 | 23 | NPB | I - 2002 |
| Publications and media campaigns | 226 | 40 | IPB | I - 2002 |
| **COMPONENT 3. TRANSFORMATION OF MANAGEMENT FOR HEALTH SERVICES PRODUCTION** | **10,131** | **876** | | |
| Consulting services | | | | |
| - International | 2,798 | 206 | CB | I - 2002 |
| - National | 1,766 | 130 | CB | I - 2002 |
| Training | | | | |
| - Courses, seminars | 1,878 | 138 | NPB | II - 2002 |
| - International | 126 | 9 | CB | II - 2002 |
| - Observation visits | 140 | 10 | NPB | II - 2002 |
| Equipment | 1,230 | 90 | IPB | II - 2002 |
| - Computers | 745 | 55 | IPB | II - 2002 |
| FOGI | 932 | 69 | DC | I - 2002 |
| Publications | 292 | 21 | NPB | I - 2002 |
| **ADMINISTRATION** | **658** | **1,997** | | |
| Consulting services | | | | |
| - National | | 1,407 | CB | I - 2002 |
| - International | 307 | | NPB | I - 2002 |
| - Auditing | 351 | | NPB | I - 2002 |
| Operating expenses | | 590 | NPB-CB | I - 2002 |

IPB: International public bidding
NRT: National request for tenders
NPB: National public bidding
CB: Calls for bid from prequalified firms
DC: Direct contracting

# Matrix of Annual Benchmarks

## COMPONENT 1

| tivity | Expected result year 1 | Benchmark (indicator) | Expected result year 2 | Benchmark (indicator) | Expected result year 3 | Benchmark ( |
|---|---|---|---|---|---|---|
| on of MINSA | New structure approved | Ministerial resolution | New job rosters approved | Ministerial resolution | Implementation plan developed | Survey on institu |
| management | Training of 50% of eligible personnel completed | Consultants' reports and user survey | 100% of systems plan implemented | Consultants' reports<br>Surveys conducted | Information reports on national accounts, epidemiological surveillance, and monitoring equity in execution | Information repo |
| of human | Protocols designed and agreed upon | Protocols printed | 30% of eligible personnel are certified | Certification records | 60 % of eligible personnel are certified | Certification rec |
| the Law on | 30% of the planned regulations have been completed and issued | Administrative records | 60% of the planned regulations have been completed and issued | Administrative records | 100% of the planned regulations have been completed and issued | Administrative r |
| rate system | List of interventions agreed upon | List published | | | | |
| | Methodology for setting rates agreed upon | Agreement document | 20 rates agreed upon | List of rates | 40 rates agreed upon | List of rates |

## COMPONENT 2

| ity | Expected result year 1 | Benchmark (indicator) | Expected result year 2 | Benchmark (indicator) | Expected result year 3 | Benchmark (indicator) | Obse |
|---|---|---|---|---|---|---|---|
| rvices to remote g pulations) | Innovative delivery of health services to 115,000 people | 10 traveling health teams are hired and operating | Innovative delivery of health services to 215,000 people | 20 traveling health teams are hired and operating | Innovative delivery of health services to 500,000 people | 50 traveling health teams are hired and operating | One traveli team provi 10,000 pers |
| | Improve the health of the target population and increase its access to primary care | Improve key health indicators and health service access by 30% | Improve the health of the target population and increase its access to primary care | Improve key health indicators and health service access by 50% | Improve the health of the target population and increase its access to primary care | Improve key health indicators and health service access by 70% | Improveme increases (f immunizati or decreases example in of diarrhea under five) |
| d | Implementation of the supervision and monitoring system | External (firm) and MINSA Panama monitoring system contracted and operating | Upgrading of the supervision and monitoring system | External (firm) and MINSA Panama monitoring system contracted and operating | Transfer of the supervision and monitoring system to MINSA | External (firm) and MINSA Panama monitoring system contracted and operating | Includes tra information evaluation, of the result |

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| ity | Expected result year 1 | Benchmark (indicator) | Expected result year 2 | Benchmark (indicator) | Expected result year 3 | Benchmark (indicator) | Obser |
|---|---|---|---|---|---|---|---|
| ontrol | Selection, organization, and training of civil society in the target populations | Community organizations selected, organized, and trained | Social control implemented | Reports from civic organizations on health service providers | Social control implemented and applied to the financing of health service providers | Reports from civic organizations linked to the billing and payment system for the providers hired | |

## COMPONENT 3

| Year 1 | Means of verification | Year 2 | Means of verification | Year 3 | Means of verificatio |
|---|---|---|---|---|---|
| adoption of the d management | Ministerial decision to approve the plan | | | | |
| and operation of ent's monitoring on system | Copy of the contract and deed to begin the consulting services | Monitoring reports on the decentralized management plan | Approval of the report by the program steering committee | Evaluation of the results of the decentralized management plan | Approval of the evaluatio report by the program ste committee |
| adoption of the | Administrative record of approval of the plan by the program steering committee | | | | |
| f 30% of the the training plan | Training reports approved by the steering committee | Execution of 80% of the activities in the training plan | Training reports approved by the steering committee | Execution of 100% of the activities in the training plan | Training reports approved the steering committee |
| the plan for he legal and amework | Administrative record of approval of the plan by the program steering committee | Adjustments to the legal and regulatory framework | Administrative record of approval of the plan by the program steering committee | | |
| t and approval of /or regulatory or sectoral tem, labor scheme, gate expenditures, lized financial | Ministerial decision to approve the legal and/or regulatory framework | | | | |
| f the start-up plan ns | Start-up plan conducted | | | | |
| al manuals region | Administrative record of approval by the program | Manuals implemented in the five pilot regions | Monitoring and evaluation reports | Manuals implemented in the five pilot regions | Monitoring and evaluatio reports |

| Year 1 | Means of verification | Year 2 | Means of verification | Year 3 | Means of verificatio |
|---|---|---|---|---|---|
| | steering committee | | | | |
| ystem, by program, ıe 2003 budget | Ministerial decision to approve the 2003 budget | Budgeting system, by program, applied to the 2004 budget | Ministerial decision to approve the 2004 budget | Budgeting system, by program, applied to the 2005 budget | Ministerial decision to ap the 2005 budget |
| g of the transfer of estimated budget | Budget approved with the addition of the transfers to the regions | Execution of 100% of the resources transferred to the regions | Budget execution reports for 2003 approved by the Comptroller's Office | Execution of 100% of the resources transferred to the regions | Budget execution reports approved by the Comptro Office |
| | | Programming of the transfer of 20% of the estimated budget for 2004 | Budget approved with the addition of the transfers to the regions | Programming of the transfer of 30% of the estimated budget for 2005 | Budget approved with the addition of the transfers t regions |
| ion of the gulations for the ds | Operating regulations for the regional funds adopted and implemented in the regions | | | | |
| 25% of the dget to at least five he operation of the ds | 2002 budget execution reports for the regions approved by the Comptroller's Office | Transfer of 30% of the allocated budget to at least ten regions for the operation of the regional funds | 2002 budget execution reports for the regions approved by the Comptroller's Office | Transfer of 35% of the allocated budget to at least ten regions for the operation of the regional funds | 2002 budget execution re for the regions approved Comptroller's Office |
| urces management | Ministerial decision to approve the human resources management manual | | | | |
| urces management ating | Monitoring and evaluation reports | Human resources management system operating | Monitoring and evaluation reports | Human resources management system operating | Monitoring and evaluatio reports |
| e cost-recovery | Ministerial decision to approve the cost-recovery mechanisms and amounts | Increase of 5% in the region's revenue budget over the historical average from cost recovery | Budget execution reports approved by the Comptroller's Office | Increase of 10% in the region's revenue budget over the historical average from cost recovery | Budget execution reports approved by the Comptro Office |
| management with the five pilot 2002 | Agreements signed | Report on evaluation and compliance with the 2002 agreement and signature of management agreements for 2003 | Report on evaluation and compliance approved by the program steering committee and agreements signed | Report on evaluation and compliance with the 2003 agreement and signature of management agreements for 2004 | Report on evaluation and compliance approved by program steering commit and agreements signed |
| of diagnoses and of three pilot ıe regions of ra, and Los Santos | Approval of the diagnosis and agreements signed among the network service providers | Report on evaluation and compliance with the agreement | Report on evaluation and compliance approved by the program steering committee | Report on evaluation and compliance with the agreement | Report on evaluation and compliance approved by program steering commit |

| Year 1 | Means of verification | Year 2 | Means of verification | Year 3 | Means of verificati |
|---|---|---|---|---|---|
| | | Preparation of diagnoses and formulation of two pilot projects in the regions of Veraguas and Bocas del Toro | Approval of the diagnosis and agreements signed among the network service providers | Report on evaluation and compliance with the agreement | Report on evaluation and compliance approved by program steering commi |
| f management with the seven 2002 | Agreements signed | Report on evaluation and compliance with the 2002 agreement and signature of management agreements for 2003 | Report on evaluation and compliance approved by the program steering committee and agreements signed | Report on evaluation and compliance with the 2003 agreement and signature of management agreements for 2004 | Report on evaluation and compliance approved by program steering commi and agreements signed |
| increase in hospital y, through a 20% bed turnover in the ejeira and Cecilio ospitals | Reports from the information system | Proof that the bed-turnover indicator value is being maintained | Report on monitoring of the management agreements | Proof that the bed-turnover indicator value is being maintained | Report on monitoring of management agreements |
| increase in hospital y, through a 10% bed turnover in the ning hospitals | Reports from the information system | Proof that the bed-turnover indicator value is being maintained | Report on monitoring of the management agreements | Proof that the bed-turnover indicator value is being maintained | Report on monitoring of management agreements |
| | | | | Proof of a 10% drop in intrahospital mortality from the baseline figure | Monitoring and evaluati reports |

## INDICATORS FOR PROCESSING PHASE TWO OF THE PROGRAM

The elements that will prompt the processing of phase two will be that: (i) at least 60% of the resources from phase one of the operation have been disbursed; (ii) the population served by component 2 exceeds 50% of the target population, and over 70% of the coverage and performance goals have been met; (iii) substantial progress has been made in strengthening the stewardship and regulatory function of MINSA, including the results of MINSA-CSS coordination efforts; (iv) the Government of Panama has committed to preserving the financing to continue to increase coverage under component 2; (v) the technical, financial, and political feasibility studies are available on sector reform that will serve as input for discussion on phase two of the program; (vi) the commitments regarding appropriate management of accounting, financial, and external auditing execution in the program have been fulfilled; and (vii) substantial progress has been made in the policy on decentralizing the organization and delivery of services in the five health regions selected.

| **Indicator** | **Rationale for selecting the indicator** |
|---|---|
| *Delivery of the PAISS*<br>1. 25 health teams provide care to at least 225,000 persons<br>2. At least 70% of the goals set for each of the 11 enhanced coverage and performance indicators are achieved. | The increase in coverage is the core of the program, since it directly combats inequity in access to services. |
| *Institution strengthening*<br>1. Certification instruments developed and validated for physicians and nurses.<br>2. 30% of physicians and 25% of nurses have been certified.<br>3. List of interventions and 40 rates are agreed upon and are in use for MINSA-CSS transactions.<br>4. Financial, technical, and political feasibility studies are available to evaluate potential reform possibilities and the menu of options for phase two. | Only by strengthening MINSA can it institutionally manage a long-term reform process, particularly the key elements of sector regulation.<br>The availability of a menu of reform options is essential for discussing the feasibility and characteristics of a second phase. |
| *Transformation of management*<br>1. The transfer of the use of 20% of the centralized budget items in the working fund to the regions has been completed.<br>2. The self-management fund has been increased by at least 5% over historical trends.<br>3. Over 10% improvement in productivity in the five hospitals. | The indicators described are a sign that effective steps have been taken in the decentralization process and in improving hospital management. |
| *Financial aspects*<br>1. Timely presentation of audited financial statements, pursuant to Bank requirements.<br>2. Level of implementation by the UGAF of the recommendations made by the program's external auditors. The audit opinion issued by the program's external auditors will be reviewed.<br>3. Level of compliance by the executing agency with contractual provisions, particularly those related to the local contribution. | The level of commitment to adequate financial management is key for showing the executing agency's institutional commitment. |

RGII-PN190P
PN-0076
Original: Spanish

PROPOSED RESOLUTION

PANAMA. LOAN ____/OC-PN TO THE REPUBLICA DE PANAMA

Multi-Phase Program for Institutional Transformation in the Health Sector - Phase I

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 Panamá, as Borrower, for the purpose of granting it a financing to cooperate in the execution of a Multi-Phase Program for Institutional Transformation in the Health Sector - Phase I. Such financing will be for the amount of up to US$35,000,000, from resources of the Single Currency Facility of the Bank's Ordinary Capital, and will be subject to the "Financial Terms and Conditions" and the "Special Contractual Conditions" of the Executive Summary of the Loan Proposal.