PROJECT TO SUPPORT MODERNIZATION OF THE MINISTRY OF PUBLIC HEALTH AND SOCIAL ASSISTANCE

(ES-0053)

EXECUTIVE SUMMARY

BORROWER:	Republic of El Salvador	
GUARANTOR:	Republic of El Salvador	
EXECUTING AGENCY:	Ministry of Public Health and Social Assistance (MSPAS)	
AMOUNT AND SOURCE:	IDB:	US$20.7 (OC)
	Local counterpart funding:	US$ 5.4
	Total:	US$26.1
FINANCIAL TERMS AND CONDITIONS:	Amortization period:	25 years
	Disbursement period:	4 years
	Grace period:	4 years
	Interest rate:	variable
	Inspection and supervision:	1.0%
	Credit fee:	0.75%
	Currency:	US Dollars - Single Currency Facility

OBJECTIVES: The long term goal of the project is to improve the health of low-income Salvadorans. This will be done by supporting the Government's strategy to improve the efficiency, equity and quality of MSPAS's health services through the implementation of institutional, policy and service delivery change.

The Project's objectives are: (i) to improve efficiency, efficacy and equity of services for the most disadvantaged population in two pilot areas; (ii) to increase the responsiveness of the ministry to local demands while streamlining procedures and establishing financial accountability in accordance with the Public Sector Modernization Program through the reorganization of key ministerial functions; and (iii) to strengthen the capacity of MSPAS to fulfill its policy-making, regulatory, evaluative and coordinating functions. This will be accomplished through complementary investments in technical assistance, training, service delivery recurrent cost support and equipment.

DESCRIPTION:

The project consists of two components:

Component I: Pilot Interventions to Reform the Health Care Delivery System (US$17.5M: 67.0 Percent of Total Project Cost) support the development of integrated health care delivery networks. The networks will provide services to the poor as results-oriented financial incentives are introduced into the delivery system. The project finances the provision of a package of basic health services for the poor, unserved and underserved population in San Miguel and Santa Ana by contracting providers from both the public and private sectors on results-oriented contracts. In addition, two public hospitals will be transformed into model facilities that are governed autonomously and employ modern management tools. The project will finance technical assistance, training, and basic equipment. Investments in medical equipment for hospitals financed during the execution of the project will be tied to the prior implementation of management reforms and improvements in financial, administrative and clinical systems (par. 3.32).

Component II: Modernization of Key Functions at the Central Level (US$4.3M: 16.5 percent of Total Project Cost) has two subcomponents. The first supports reorganization and decentralization of national health programs and the financial management system; introduction of a demand-driven medical supply and drug procurement and distribution system; adaptation of the national system of human resource management; and implementation of monitoring and evaluation capacity. The second supports strengthening of the Ministry's role by improving its regulatory capacity and establishing mechanisms for sectoral coordination and communication. This component finances technical assistance, training, equipment and materials.

ENVIRONMENTAL/ SOCIAL REVIEW:

The Project Report was reviewed by the Committee on Environmental and Social Impact (CESI/TRG) on December 15, 1997. No Environmental and Social Impact Report (ESIR) was requested or prepared. The environmental impact is expected to be negligible as there is no infrastructure investment. Medical wastes will be addressed by ES-0074, with which this project is closely coordinating (par. 4.10).

BENEFITS:

The project will improve the health status of the target population through the reduction of infant and intrahospital maternal mortality by 15 and 20 percent, respectively, and by the extension of

primary health care coverage by 60 percent by the end of the project. The quality of health services for the poor will be enhanced through the introduction of standardized therapeutic protocols, an accreditation system, and quality incentives to providers.

The overall benefit of the project is to provide a new, results-oriented model of health care financing, administration, and service delivery. The project will improve efficiency and equity of GOES resource allocation within the MSPAS, raise the cost-effectiveness of service provision, and reduce the financial burden on the poor by (i) reorienting financial flows toward primary care; (ii) introducing results-oriented incentives; (iii) defining and supporting a cost-effective basic package of services; (iv) increasing efficiency in the medical supply system; and (v) strengthening cost-recovery programs while protecting the poor.

RISKS:

The March 1999 elections may result in changes in the Government's project team that could delay project implementation. Attempts to mitigate the situation include discussions with the medical association, an internal communications strategy for Ministry staff, and an external strategy for the general population to consolidate support for project objectives. The project also promotes consensus-building through the intrasectoral committees at the national and departmental levels. Moreover, the PCU will be integrated with ongoing ministerial responsibilities.

Election campaigning has already begun and this may lead to greater volatility in policy-making and implementation which could result in the introduction of policies that conflict with or contradict project activities.

The weak institutional capacity of MSPAS both to absorb increased demand and to make managerial change is a risk to successful implementation. The project seeks to mitigate this by establishing an effective referral system to channel demand, and by supporting the reorganization and restructuring of MSPAS at the central level so as to carry out its appropriate institutional roles. Training and technical assistance will be provided to strengthen MSPAS's implementation capacity.

EXCEPTIONS TO BANK POLICY:

None.

THE BANK'S COUNTRY AND SECTOR STRATEGY:

The Bank's country strategy is to support sustained development in a competitive economy by means of: (a) social sector reforms and local development; (b) environment and sustainable development; (c) enabling private investment and promoting key activities; and (d) modernizing the State, including privatization and private investment in infrastructure. This project contains activities and instruments that contribute to health sector reform and local development as well as modernization of the State.

In the health sector, the Bank supports increased efficiency, equity and quality in the delivery of health services through the implementation of reform. This project lays the foundation for future sectoral reform.

SPECIAL CONTRACTUAL CONDITIONS:

Prior to first disbursement, the Borrower must present evidence that (i) it has created the PCU with minimal staff for initial project execution (par. 3.10); and (ii) it has presented to the Bank and the Bank has approved the final version of the Operating Manual (par. 3.12).

During project execution all new investment in hospital equipment purchase and rehabilitation in the pilot Departments and calls for bids for such equipment with project resources will be subject to the successful completion of performance targets agreed with the respective hospital (par. 3.32).

POVERTY TARGETING:

The proposed project qualifies as poverty-targeted under the Eighth Replenishment (GN-1964-3) because it supports the delivery of primary health care services to beneficiaries below the poverty line. (par. 4.1)

RECOGNITION OF EXPENDITURES:

It is proposed that up to US$250,000 in expenses incurred prior to the loan's approval to contract consulting services, establish the PCU and procure equipment may be recognized as payable with resources of the loan provided that the expenses were incurred subsequent to December 1, 1997, and in accordance with the Bank's rules and guidelines for procurement of goods and services (par. 3.14).

PROCUREMENT:

International competitive bidding will be required for the procurement of goods and related services over US$250,000 and for consulting service contracts over US$200,000. For procurement under the amounts for which international competitive bidding is required, the following procedures described in Annex D of the loan contract will apply: a) national competitive bidding for goods and related services

from US$150,000 to US$249,999 and consulting firm contracts from US$100,000 to US$199,999; and b) private competitive bidding for goods and related services less than US$150,000 and consulting service contracts less than US$100,000. The Executing Agency may, following Bank procedures, contract the services of a specialized institution or consulting firm to act as procurement/contracting agent for acquisitions and contracts in amounts of US$50,000 or more. (par. 3.16)

I. HEALTH SECTOR BACKGROUND 1/

A. Introduction

1.1 The health conditions of El Salvador have improved in the 1990s as a result of government and nongovernmental efforts, yet the major causes of disease and death remain primarily infectious and communicable diseases (diarrheal and acute respiratory) and trauma. The health system provides insufficient population coverage and inadequate quality of care because it remains stifled by inefficiency and inadequate financing. This is manifested in inappropriate administrative methods, maldistribution of financial and human resources, and the lack of institutional and individual incentives to ameliorate the situation.

1.2 This project is an initial step in a long term process of developing the building blocks for much needed sectoral reform for which the necessary preconditions do not yet exist. The Ministry of Public Health and Social Assistance (MSPAS) has affirmed its willingness to address the above problems and to change its administrative, financing, and service delivery mechanisms to create the conditions for sectoral reform. 2/

B. Health Situation

1.3 Although health indicators have improved in recent years, El Salvador's infant mortality rate remains relatively high (41 per 1000 live births) compared to the Latin American average, but is comparable to other countries in the region. It has one of the highest fertility rates in Latin America (4 children per woman), and the second highest teen pregnancy rate, which has led to a high rate of institutional maternal mortality (68 per 100,000 live births). Thirty percent of pregnancies occur in women under age 20. Estimates suggest that 40% of pregnant women receive no prenatal care nor are attended in childbirth by any type of trained health worker. The implications for the MSPAS and this project are clear: focus on maternal-infant and reproductive health.

1.4 The major causes of death and disease, principally preventable acute respiratory infections and diarrheal disease, remain those of an underdeveloped country. 3/ At the same time, there has been increase in chronic degenerative diseases as well as violence and accident related health problems, particularly in the cities.

1/ The Technical Files contain more detailed social, economic and health sector overviews.

2/ In public meetings held in November 1996 between the Minister and representatives from the major sectoral institutions, NGOs, international organizations, professional associations, unions, medical schools, and various levels of the MSPAS administration, the Minister has committed to "modernizing" the MSPAS to establish a foundation for sectoral reform. He has since reiterated this position in writing to the international organizations and bilateral donors, and asked for their help in funding the modernization project. A Policy Letter is in the Project Files.

3/ The causes of these diseases are beyond the scope of both this project and any health system, but some of the more direct causes are addressed in two other projects: ES-0074 Decontamination of Critical Areas and ES-0068 Potable Water and Sewerage Program.

Therefore, it is also important to improve and rationalize hospital service delivery. Given that the 1996 poverty rate is 58 percent of the total population, and the rural rate reached 70.7 percent, it is vital for the MSPAS and this project to concentrate on a basic package of primarily preventive, but also curative services.

C. Policy and Regulatory Framework

1.5 **Policy Framework**: The Government, the various political parties, professional associations in the health field and much of the general public recognize the need for health sector reform, yet the GOES is justifiably hesitant to launch into sector wide reform, which is a very difficult and complicated undertaking. Although there is consensus on the need for change, there is no consensus on the precise nature of that change. An exhaustive analysis of the health sector, ANSAL, 4/ was completed in 1994 under the joint auspices of USAID, PAHO, the World Bank and the IDB, but the wide-ranging reforms suggested were too broad and not accepted by all GOES and sectoral actors at that time. The reforms suggested by ANSAL include unification of the sector, compulsory national health insurance, privatization of public hospitals, decentralization to municipalities, reorganization of the Ministry, provision of a basic package of primary health care services, increased user fees for hospital services, an essential drugs program, and incentives to staff. Currently the MSPAS vision of the future includes all of the above activities, perhaps with a different design, except privatization of hospitals.

1.6 **Intrasectoral Fragmentation**: There is little coordination among the various sectoral actors, both within the public sector and between the public and private sectors. Although the MSPAS is the normative institution, each institution (the Salvadoran Social Security Institute [ISSS], the health programs of the autonomous state water and electric agencies [ANDA, and CEL], and those of the military and teachers [Sanidad Militar, Bienestar Magisterial]) develops and implements its own policies, plans and programs.

1.7 **Absence of an Accreditation System**: There is little monitoring and no accreditation of either public or private health care establishments; thus, a plethora of small private clinics have been established without adequate quality control by the MSPAS. Moreover, the quality of services across MSPAS establishments varies considerably in the absence of standards, quality enhancement activities and systematic monitoring.

D. Institutional and Financial Issues

1.8 **Institutional Weakness**: MSPAS is characterized by centralized and ,at times, arbitrary decision-making; bureaucratization; micromanagement; ineffective internal communication and

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4/ ANSAL is the Health Sector Assessment Project of El Salvador.

coordination among divisions; inadequate policy making capacity; and insufficient administrative capacity to execute well the diverse functions under its purview.

1.9 **Lack of Accountability and Ineffective Financial Management**: There are no performance standards with regard to quality and productivity, nor are there adequate incentives or sanctions to elicit more efficient and/or better quality performance. Historic budgets rather than budgets linked to results tend to promote this inefficiency. The lack of adequate parameters for the determination of health unit budgets has led to inefficient use of resources and the assignment of a high proportion of resources to hospital activities rather than primary care, which is contrary to the population's health needs as reflected in the epidemiological profile. Bureaucratic processes and rigidity in budget administration have led to delays in execution. Diverse sources of funds have not been managed in a coordinated manner. There is no cost recovery policy, and, as a result, each institution uses arbitrary criteria.

1.10 **Inadequate Material and Human Resource Management Systems**: Centralized decision-making, high distribution costs, long lead times for delivery, and little maintenance of products in stock are among the obstacles to optimal use of resources. There are no incentives to elicit commitment from employees and improve their efficiency and productivity. There are no adequate mechanisms for job evaluation, promotion, and career development. Much personnel policy rigidity results from the strictures of the GOES Salary Law for civil servants.

1.11 **Government Health Financing and Expenditures**: The health sector suffers from long term underfinancing. The GOES dedicated only 1.4% of GNP to health in 1996 (11.7% of the national budget), only a slight increase over the percentage for the past five years. Total health spending, including the private sector and social security, raises the percentage to 4.9 for 1995, but that is considerably less than the 6.2% Latin American average. MSPAS implicitly subsidizes the ISSS by not recovering costs from ISSS patients who use MSPAS facilities.

1.12 Public spending in health is financed principally through the National General Fund (75.6%). There is a high degree of dependence on foreign aid (19.3%), although this amount is diminishing yearly. Cost recovery accounts for only 5.1% of revenues.

E. Service Organization and Provision

1.13 **Supply and Demand**: Health provision is characterized by inequitable access and coverage. Despite the fact that the MSPAS

is supposed to cover the poor, 5/ many low income Salvadorans go to the private sector for their health care. The 1996 Household Survey indicates that 21.8 percent of the poor who sought medical attention in the previous 30 days went to the private sector despite the financial burden this entails. Three percent went to NGOs providing health care, 10.6 percent went to ISSS, and 64.6% actually went to MSPAS establishments.

1.14 With no effective cost recovery system, as well as other deficiencies, MSPAS targeting is poor. Of all Salvadorans seeking health services, 31.2% of the non-poor go to MSPAS facilities and 35.5% go to one of the 137 health sector NGOs, thus utilizing scarce resources ostensibly designated for the poor. Medical resources, both human and physical, are concentrated in the San Salvador Metropolitan Area (AMSS). Despite this concentration of resources, 37% of the extremely poor in the AMSS sought private medical care, thereby demonstrating MSPAS's failure to cover a fair proportion of its target population.

1.15 **Productive Inefficiency**: MSPAS facilities, particularly hospitals, suffer from low internal efficiency. Data on costs are incomplete and there are no systematic data on case-mixes, individual caseloads, outcomes, quality of care, and patterns of referral. There is no functioning referral system, resulting in an overuse of hospital facilities for primary care. Forty-four percent of the MSPAS doctors are contracted for only two hours per day. Moreover, no system of institutional or individual incentives links productivity to health outcomes and to a more efficient use of resources. National health programs are centralized yet uncoordinated, thus leading to a duplication of efforts and poor utilization of resources.

1.16 **Lack of Patient Satisfaction Results in Financial Burden**: The fact that twenty-two percent of the poor seek health care in the private sector rather than the MSPAS facilities, when they cannot even purchase the basic market basket of food, indicates both user dissatisfaction and a considerable financial burden.

F. Government Strategy in the Sector

1.17 **Social Development Strategy**: The GOES has made poverty alleviation the center piece of its social development policy. This strategy is guided by three major policy initiatives: (i) targeted resource allocation to address the basic needs of low-income populations; (ii) institutional modernization to strengthen capacity to plan and provide quality social services in an efficient and effective manner; and (iii) decentralization of service delivery aimed at reorienting the role of the line ministries while devolving greater

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5/ The extreme poor are those unable to purchase the basic food basket and the relative poor are those unable to purchase the basic basket of goods and services (household incomes of less than 1924 colones in rural areas and 2498 in urban areas).

decision-making authority to subnational entities, organized communities and the private sector.

1.18 **Modernization of the Public Sector Program (PMSP)**: The GOES has made modernization of the public sector a strategic priority. The goal is to downsize the role of the State to conduct only those activities appropriate in a market economy; to make government more effective and efficient; to create a new user-oriented organizational culture; and to foment human capital development. As a result, the PMSP includes programs of institutional restructuring; modernization of the financial administration system and the procurement system; and reform of customs and tax systems. Moreover, the PMSP promotes the reduction of bureaucracy, decentralization and reform of the civil service system. It is precisely within this framework that the GOES seeks to promote the modernization of the health sector, particularly the MSPAS.

1.19 **Strategy for the Modernization of the Ministry of Public Health**: Within the overall framework of modernization of the State, the Government seeks to initiate a process of modernization within MSPAS that would ultimately lead to health sector reform. During a preliminary phase, the GOES aims to (i) reorganize the key functions of the MSPAS; (ii) plan, test, evaluate and implement innovative strategies in the organization, financing and provision of health services; and (iii) strengthen the role of the MSPAS within the health sector by improving its capacity to oversee, regulate and evaluate health programs. This strategy follows a basic premise of the ANSAL report: eventual unification of the health sector, as well as many of the recommendations.

1.20 **Bank Experience in the Sector and Lessons Learned**: The last health sector loan, 604/SF-ES, was approved so long ago (1980) and for such a different purpose (infrastructure) that Bank experience is no longer relevant. The proposed project will build on the more recent experiences of the World Bank, USAID, GTZ, UNICEF and PAHO in the health sector, as well as Bank experience in the education sector in El Salvador. The main lessons learned from the World Bank project are: (i) provide continuing training and technical assistance to strengthen institutional capacity; (ii) maintain flexibility to adjust components to changing situations; (iii) reform organization, administration and financing in order to expand coverage. 6/ In addition, lessons from 879/OC-ES Modernization of Basic Education suggest that execution should be coordinated by a PCU that is integrated into the Ministry's structure and uses line Ministry personnel.

6/ The World Bank, "Implementation Completion Report: El Salvador Social Sector Rehabilitation Project," (Loan 3348/ES) June 19, 1997, pp. 11-12.

G. Bank Strategy in the Sector

1.21 Through this project, the Bank is assisting the GOES prepare the platform for a subsequent health sector reform through concrete pilot experiences to improve the organization and organizational culture, administration, financing and delivery of health services, and to redefine and restructure the functions of the central level Ministry. This project is also assisting the GOES develop a strategy for sectoral reform through technical assistance for sector consensus-building and coordination and studies aimed at developing a plan for future change. At the same time, the project targets vulnerable groups -- the poor, particularly women and children-- and contributes to the GOES poverty alleviation strategy. If successful, the pilot is expected to be replicable to the rest of the MSPAS system and thus lead to a larger program that the Bank could support in the future.

H. Donor Coordination

1.22 Bilateral and multilateral agencies coordinating with MSPAS in the implementation of their modernization program include USAID, PAHO, and the German cooperation agencies, GTZ and KfW. Representatives of these agencies meet regularly with the project team leader to discuss coordination. USAID has offered advance funding for technical assistance or training needed prior to first disbursement of the IDB loan. GTZ, USAID, and PAHO have also agreed to coordinate technical assistance and training where possible to optimize resources and maximize impact. The World Bank collaborated in the initial design of the predecessor to this project, a sectoral reform project, but later withdrew when sectoral reform was no longer the immediate goal. Nonetheless, the WB provided some funds for technical assistance after withdrawing from the project.

II. THE PROJECT

A. Objectives

2.1 **Goal.** The long term goal of the project is to improve the health of low-income Salvadorans. This will be done by supporting the Government's strategy to improve the efficiency, equity and quality of MSPAS's health services through the implementation of institutional, policy and service delivery change. The project is the first step in a modernization process that will lay the foundation for health sector reform.

2.2 **Objectives.** The Project's objectives are: (i) to improve equity, efficiency, and quality of services for the most disadvantaged population in two pilot areas; (ii) to increase the responsiveness of the ministry to local demands while streamlining procedures and establishing financial accountability in accordance with the Public Sector Modernization Program through the reorganization of key ministerial functions; and (iii) to strengthen the capacity of MSPAS to fulfill its policy-making, regulatory, evaluative and coordinating functions.

2.3 This four-year project supports the long term strategies of the GOES and MSPAS, oriented toward the development of a policy framework in which: (i) institutional roles of the public and private sectors are redefined; (ii) mechanisms of intra-sectoral linkages are established; (iii) service provision and finance are separated; and (iv) local level responsibilities are strengthened to achieve qualitatively improved outcomes for increased numbers of the disadvantaged through greater autonomy and efficiency.

B. Project Overview

2.4 As can be seen in Table 1, the project responds to a set of over-arching problems in the health sector and builds on many of the recommendations of ANSAL. The project, however, is a modest beginning in a longer term strategy for confronting these major issues, and is intended to jump-start the process of modernization.

2.5 At the primary health care level, the project will support development of a new model of financing and delivery. Within two pilot areas, both public and private sector providers will be reimbursed for the provision of a basic package of services through a capitation system. Contracts with private sector providers and performance agreements with Ministry units will specify clear indicators of both the quality and quantity of services to be rendered.

Table 1: Matrix of Sector Problems and Project Objectives

Health Sector Area (By Component)	Principal Sector Problem Identified	Project Objectives and Strategy	Components and Subcomponents
Organization of health care delivery system and service provision model	- Inequitable access and coverage - Limited cost effectiveness -Low internal efficiency and dysfunctional referral system -Little continuity of care -Low user satisfaction	Development and implementation of health care provision model that supports decentralization and modernization in service networks by level of attention. Focus on organizational and management change, financial management, and service delivery mechanisms using management by objectives.	Pilot Interventions to Reform the Health Care Delivery System Component I -Modernization of Primary Health Care Units (Subcomponent A) -Modernization and Institutional Strengthening of Pilot Hospitals and Innovations in Organization of the Health Care System (Subcomponent B)
Institutional structure and managerial capacity of MSPAS as key policy and regulatory entity	-Weak management and institutional capacity -Lack of accountability and ineffective financial management system -Inadequate material and human resource management systems -Inefficient resource allocation -Little monitoring and evaluation capability -No accreditation system and minimal regulatory framework -Limited intrasectoral coordination and communication	Strengthen institutional capacity of MSPAS as sectoral leader through restructuring of key administrative systems at central level (finance, human resources, evaluation, and medical procurement), introduction of management by objectives, decentralization of provision, and pilot testing separation of finance from service provision. Strengthen MSPAS' normative, regulatory, and integrating capacity through technical assistance to improve policy and regulatory functions, support for public-private sector communication and coordination, and development of an accreditation system.	Modernization of Key Functions at the Central Level Component II Reorganization of key administrative subsystems in MSPAS (Subcomponent A) Redefinition and Strengthening of Regulatory, Normative and Coordinating Functions of MSPAS (Subcomponent B)

2.6 At the secondary care level, the project will introduce a series of administrative and clinical changes to improve hospital efficiency, managerial autonomy and the quality of care. Changes include a results-oriented payment system, cost-containment through the establishment of a clear referral and counter-referral system and a reorganized medical supply system, equitable cost-recovery from

third-party insurers, standardized treatment protocols, and the development of medical audits for quality control.

2.7 Changes introduced in health care provision at the local level are intended to drive the introduction of management and organizational change at the central level of MSPAS. The changes will not only respond to the exigencies of local level demand, but also to redirect MSPAS toward its appropriate normative and regulatory roles. Restructuring of key functions of the central level ministry will be both bottom-up (responding to the local level) and top-down (responding to the aims of the Public Sector Modernization Program). These innovations aim to strengthen MSPAS' sectoral leadership role in policy formulation and program management. At the same time, they promote decentralized program implementation. Moreover, the changes introduce: (i) modern financial management based on an integrated and decentralized model of budget formulation, execution, and control; (ii) incentive-based human resource management; (iii) monitoring and evaluation capabilities; and (iv) local-needs based procurement, inventory, and distribution of drugs and medical supplies using standardized therapeutic protocols and product lists, and transparent and cost-effective procedures.

2.8 These changes are intended to initiate the process of broader policy reform within the health sector. It is expected that at the end of this project, several key ingredients necessary for the Government's longer term strategy for health sector change will have been achieved. These include: (i) the initiation of a primary care model that separates the provision of services from health care finance through the pilots; (ii) greater hospital autonomy through the increased hospital-level control, authority, and responsibility for human resource and financial management and the introduction of results-oriented management; (iii) an alteration of both the organizational culture and structure of MSPAS that will streamline financial, human resource, and medical supplies systems, provide a national level capacity for evaluation and sector planning, and an information system to provide appropriate inputs for decision-making; and (iv) a revised MSPAS with clear normative and regulatory roles and the capacity and framework for sector leadership and coordination. These changes will provide the platform for sector level dialogue on policy reform and will provide the impetus for greater integration of health care provision and financing among the Social Security Institute, MSPAS, and the private sector.

C. Geographic Focus

2.9 The new health service delivery model will be pilot tested in 10 primary care health units and the principal hospital in two of the 14 Departments, Santa Ana and San Miguel, where 17% of the total population reside. The principal criteria guiding the selection of these two Departments and their respective principal hospitals include the following: (i) poverty level; (ii) health conditions of

the population; (iii) total population; (iv) quality and content of an initial hospital modernization plan as a proxy for willingness to change; (v) existing management capacity (both were regional headquarters in prior administrative divisions); (vi) efficiency and quality of health services; and (vii) presence and participation of NGOs in the health sector. Table 2 presents summary indicators for the two Departments.

Table 2: Characteristics of Pilot Departments

Department	Departmental Population and % of National (1992)		Infant Mortality (Per 1000 live births) 1993	Hospital Maternal Mortality (per 100,000 live births) 1997	% Urban Population	Hospitals	Health Units
San Miguel	455,000	8%	61	95	46.2	3	34
Santa Ana	522,000	9%	45	68	44.8	3	30
National	5,758,000	100%	41	68	50.0	30	350

2.10 While the pilots focus on two Departments, the project will have national impact in several ways as well. First, support for reorganization and strengthening of normative, administrative and regulatory functions of the central level will have a positive impact on health services throughout the country. Second, the development, implementation, and evaluation of the health service delivery model has important demonstration effects for the entire country. It is expected that evaluation, revision, and eventual adoption of the model will improve health care delivery within an alternative policy framework and paradigm.

D. Project Description

1. Component I: Pilot Interventions to Reform the Health Care Delivery System (US$17.5M: 67.0 Percent of Total Project Cost)

2.11 **Objectives:** This component will support the implementation of pilot experiments in the Departments of Santa Ana and San Miguel. The pilots will develop health care delivery networks in which there is clear linkage and referral between primary and secondary levels. The purposes are: (i) to make better quality and more cost-effective basic services available to the poor; (ii) to induce efficiency through results-oriented incentives to providers in a pluralistic health care network; (iii) to extend coverage; and (iv) to test alternate financing and organizational mechanisms.

a. Subcomponent Ia: Modernization of Primary Health Care Units

2.12 This subcomponent supports administrative and service provision innovations in 20 health units (10 in each Department), including the production of: (i) demand-focused health provision and administrative processes; (ii) new organization and management

systems; and (iii) qualitative improvements in the work and patient environment.

2.13 Specifically this subcomponent will finance technical assistance to MSPAS to help them develop and implement: (i) mechanisms for quality improvements in health care provision and administrative systems; (ii) cost recovery systems (from third party insurers and through minimal copayments) while assuring adequate protection for beneficiaries; (iii) results-oriented human resource management; (iv) management information systems; (v) local management of medical and drug supplies; (vi) and continuing education programs.

2.14 The project will support a pluralistic system of health service delivery based on the provision of a defined package of basic services to a geographically defined population. 7/ Private sector providers, both NGOs and for-profits, will be eligible to compete with public providers for the provision of the package. Results-oriented service contracts will specify both the quality and quantity of services to be provided.

2.15 The project will finance technical assistance, studies, training, materials, and equipment. These inputs will be utilized to refine the final content of the Basic Health Plan, provide the model modernization and action plans for hospitals and health units; conduct a baseline study for monitoring project effectiveness; develop promotional material for potential providers and consumers; provide clinical and managerial training and technical support, materials, and equipment to providers; develop the capitation system and the registry to be introduced; design the cost recovery systems at the local level; provide the design for the information system necessary for the registry, capitation, and referral systems; assist in refining hiring, evaluation, and other personnel actions at the local level; and provide the evaluation of the pilots and primary attention model.

2.16 Moreover, the project will subsidize the delivery of a basic package of health services to a geographically-defined population through the financing of agreed action plans with MSPAS health units and contracts with private sector providers. The agreements will be made between the MSPAS and 10 health units/providers in each of the two pilot Departments and payment will be made on a per capita basis. The subsidy for the basic package is $23. The Departmental Directorates will serve as the financer for unit level service provision, in a sense "purchasing" services from these providers. Financial transfers from the Departments to the participating units will occur three times a year on a per capita basis. A sum (approximately 10%) will be held by the Departments

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7/ The package includes maternal-child health care and reproductive health (pre- and post-natal care, institutional childbirth, birth spacing, cervical-uterine and breast cancer screening), well-baby and child care, health education, dentistry, and preventive as well as curative consultations for adults and senior citizens. The Project Files contain a complete description and costing of the basic package.

to be transferred to units upon successful evaluation of performance (annually). These monies will provide reasonable discretionary control to health unit directors to finance health-related improvements as they see fit.

2.17 These transfers to pilot units will parallel the existing system of transfers to public health units, with the exception that the amount ($23), the payment form (per capita) and partial discretionary use are linked to management and quality improvements at the unit level. The Bank will provide a declining portion of the subsidy to participating health care units across the life of the project, and the portion provided by the MSPAS will increase correspondingly. 8/ It is expected that these (20) units will have a functioning cost recovery system; improved quality of clinical and administrative services as measured both by technical assessments and user satisfaction indicators; partial discretion over local expenditures; and the capacity for hiring, evaluation and (when necessary) discharging of personnel will be strengthened.

b. Subcomponent Ib: Modernization and Institutional Strengthening of Pilot Hospitals and Innovations in Organization of the Health Care System

2.18 The objective of this subcomponent is to introduce management, financing and organizational change in the San Juan de Dios Hospitals, the two principal Departmental hospitals in Santa Ana and San Miguel, to improve the quality, efficiency, and financial solvency of hospital services. Institutional improvements focus on improvements within each of the sets of institutions, and the project will introduce improvements in the linkages among institutions within a network of public and private health care providers. These hospitals will serve as models for management changes elsewhere in the MSPAS network.

2.19 Management interventions in hospitals will be made in both clinical and non-clinical areas. The project will finance technical assistance to assist MSPAS to: (i)develop mechanisms for semi-autonomous hospital governance and improve internal management structures; (ii) introduce performance agreements to improve accountability, productivity, and the quality of care; (iii) develop and implement a local demand-driven system to manage pharmaceutical and medical supplies; (iv) improve the financial management, accounting and auditing systems; (v) link and update internal information systems; (vi) assess clinical and management training needs and propose and implement continuing education programs; (vii) revise and implement a new cost recovery system with adequate protection for the poor; (viii) develop instruments for the contracting out of support services; and (ix) define roles and linkages within a provider network. The project will finance

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8/ For a detailed description, see "Estimating Costs for Pilots of Primary Care" in the Project Files.

the necessary training, studies and some basic equipment to support these activities. Investments in medical equipment for hospitals financed during the execution of the project will be tied to the prior implementation of management reforms and improvements in financial, administrative and clinical systems.

2.20 Primary, secondary and tertiary care providers will be linked through a referral and counter-referral system that defines levels of attention, appropriate resources, and responsibilities for each level. A results-oriented payment system will be introduced for the "purchase" of hospital services by Departmental Offices for the primary care units.

2.21 This component will finance the design of an information system to support the systems of patient referral and financial administration necessary for integrating the health units and hospitals. This entails the development of information systems for the identification and classification of the beneficiary population and for improving cost recovery.

2. Component II: Modernization of Key Functions at the Central Level (US$4.3M: 16.5 percent of Total Project Cost)

2.22 **Objectives**: This component has two principal objectives. The first is to redesign and reorganize key functions of the central ministry in response to demand created by changes in service delivery at the hospital and health unit level and in accordance with the aims of the Public Sector Modernization Program. The second is to strengthen the Ministry's normative role within the health sector by improving its regulatory capacity and sectoral coordination and communication. This component finances technical assistance, training, equipment and materials through activities in two subcomponents.

a. Subcomponent II.a: Reorganization of Key Administrative Subsystems in MSPAS

2.23 Reorganization of key functions at the central level is based on the long term goal of eventually separating finance from service provision and making Department Directorates purchasers of services. Current strategies include: (i) decentralization of management and operational responsibilities for service provision to the local area network (hospitals and integrated health units); and (ii) restructuring of MSPAS' role as the lead institution for policy-formulation, regulation, and sectoral coordination and communication.

2.24 This subcomponent will support five major activities:

(i) Modernization and Reorganization of MSPAS Health Programs

2.25 The project will provide technical assistance to change the organization and functioning of national programs. Service interventions will be determined locally using participatory methods, but will be based on international standards of cost-effectiveness.

2.26 The project will provide technical assistance to strengthen the decentralized management of programs and the corresponding design of service provision, regulation and program activities. The project will support reorganization of the central level division devoted to human health, as required by these changes.

(ii) Design and Implementation of Modernized Financial Management System

2.27 The project will provide technical assistance, training and logistical support to MSPAS for the development and implementation of financial management systems to improve the efficiency, transparency and responsiveness of the central finance system. These systems will be consistent with the national program for Integrated Financial Management (SAFI) and will facilitate financial transfers. With this support the project will contribute to: (i) reorganization of financial management within MSPAS; (ii) deconcentration of the budgetary process from the Ministry of Finance to MSPAS; (iii) simplification of budgetary management procedures; (iv) reduction of delays and bottlenecks in approvals and payments to providers; (v) a program of long-term training for both central and local financial management personnel; and (vi) introduction of results-oriented, formula-based transfers to hospitals and local health units (diagnostic related groups and per capita).

(iii) Reorganization of the Central Medical and Pharmaceutical Supply System

2.28 The project will provide technical assistance, information systems and training to make the procurement and distribution systems demand-driven, and thus respond to service provider needs. Financing will be provided for the following:

1. system design, testing, evaluation and implementation;
2. redesign of the objectives, functions, procedures, and organization of the central level supply, procurement, inventory and distribution systems; and
3. introduction of quality control and regulatory procedures for medical and pharmaceutical supplies, such as accreditation, certification, revised and standardized product lists and standardized therapeutic protocols.

(iv) Modernization of Human Resource Management

2.29 The project will provide technical assistance and logistical support for Ministry-specific adaptations to and the implementation of the national system of public human resource management (Civil Service law reform and SIRH). The project will assist MSPAS to update their inventory of human resources; carry out a needs assessment; establish position profiles; restructure recruitment, hiring, advancement, and termination practices and procedures; test alternative models for the contracting of personnel; strengthen information technologies for human resource management; and establish support systems for human resource management.

(v) Design and Implementation of a Monitoring and Evaluation System for MSPAS

2.30 The project will provide technical assistance for development of overall monitoring and evaluation capacity and for testing the effectiveness of the health service models developed under the project and monitoring project advances. Efficiency and quality indicators will be developed for a base line study to be conducted at project initiation as well as subsequent evaluation.

b. Subcomponent II.b: Redefinition and Strengthening of Regulatory, Normative, and Coordinating Functions of MSPAS

2.31 This subcomponent will provide technical assistance to initiate the process of reform and the strengthening of the policy-making and execution capabilities of MSPAS as sector leader, as well as the regulatory functions of the ministry. In addition, activities under this subcomponent will support strengthening of intra- and inter-sectoral coordination and communication. Through the financing of consulting services, training, equipment, and material, this subcomponent focuses on four principal activities:

1. **Strengthening the regulatory and policy-formulation capacity of MSPAS**, in accordance with its normative and oversight functions, through the introduction of new organizational structures, support for increased public-private sector communication, and training for policy and regulatory functions;

2. **Development of an institutional accreditation system** to assure that both public and private service providers meet minimum quality standards. This entails the establishment of an accreditation body, policy formulation, development, testing and implementation of standards and protocols, training of evaluators, database creation and pilot testing the system;

3. **Strengthening of sector level coordination** through the provision of technical assistance, studies and training for the creation and implementation of a *Comité Intrasectorial de Salud* at the national level and local *Comités Técnicos Directivos* in each Department. These committees will stimulate broader sectoral initiatives through the commissioning of studies and the provision of a *forum* for sectoral coordination and consensus building. Moreover, they will serve as mechanisms for community participation and for interaction among community-level and other actors in the health sector;

4. **Design and implementation of an institutional and social communication strategy** to improve understanding and participation among sector actors and public opinion in the process of sector modernization. The project will provide technical assistance and logistical support to MSPAS for the design and implementation of (a) a public awareness campaign to communicate the modernization program to sectoral actors, particularly MSPAS employees, and to inform the general public, particularly users of MSPAS services; and (b) feedback mechanisms for monitoring and evaluating both communication strategies and civil society demands for health sector improvements.

E. Linkages among Components

2.32 Modernization of the provision of health services in El Salvador requires an integrated approach, linking actions at the decentralized level to actions aimed at broader sectoral reform. While this project is intended to support a modest beginning in a much broader and longer term strategy of sector modernization, the various components and subcomponents are linked. The project is based on both a logical and chronological sequence of actions where local level change in service delivery drives change at the central level. However, these linkages among activities are sufficiently independent to allow for progress in some subcomponents while other subcomponents and activities may be delayed.

2.33 At the base of the project is the introduction of a new service delivery system in two pilot Departments that tests the separation of finance and provision of services in a decentralized manner. The pilots introduce functional and structural change in local networks of service delivery involving the reorganization and introduction of management innovations in principal hospitals and their (geographically) related local health units.

2.34 More equitable, better quality, and more efficient health care begins with the strengthening of the organization, management, and service delivery at the primary care level and the creation of increased access to quality care through the opening of the primary care system to alternative providers (Component Ia).

2.35 While strengthening of primary care is at the root of this project, it is equally important to strengthen and differentiate between primary and secondary care, and to strengthen the organizational, management, financial, and qualitative capacity of hospitals within these pilot areas (Component Ib).

2.36 These changes at the pilot level require concomitant reorganization and modernization of management forms and technologies, improved and alternative financial management and transfer systems, the strengthening of human resources, alternative systems for facilitating the supply, procurement,and distribution of medical and pharmaceutical supplies, and appropriate information systems to implement the reforms in an integrated fashion. The reorganization of MSPAS at the central level is necessary to assure the sustainability of the restructuring of the health care provision system (IIa).

2.37 At the same time, modernization requires redefinition and strengthening of the role of MSPAS as policy-formulator, regulator, and as facilitator of a continuing process of sectoral change. In addition, there is a need to strengthen the coordination and communications role of MSPAS within the sector and with the larger society (IIb).

F. Project Costs and Financing

2.38 **Project Costs.** Total project costs including contingencies are estimated to be US$26.1 million, of which $US20.7 million will be financed through the proposed loan. See Table 3 for the breakdown of project costs by component and subcomponent and Table 4 for projected costs by category of expenditure. The cost estimates for all activities are derived from action plans and corresponding levels of effort prepared for each of the project activities. These action plans can be found in the project files.

Table 3. Project Costs and Financing Plan
(US$ millions)

CATEGORIES	BID	LOCAL	TOTAL
Component 1: Implementation of Pilots of Health Care Attention	**$ 10.2**	**$7.3**	**$17.5**
Subcomponent 1.a.1: Cost of Paquete Básico	$ 7.2	$5.1	
Subcomponent 1.a.2: Implementation of Model at Primary Health Care Units:	$ 1.0		
Subcomponent 1b: Hospital Modernization and Linkages in the Health Care Sector	$ 2.0		
Component 2: Institutional Restructuring and Modernization of MSPAS	**$ 4.3**		**$4.3**
Subcomponent 2a: Reorganization of Key Functions of MSPAS	$ 2.8		
Subcomponent 2b: Strengthening Normative, Regulatory, and Supervisory Functions of MSPAS	$ 1.5		
Contingencies	$ 1.0		$1.0
Administration and Supervision (including fees for short-term consultancies, External Audits and procurement agent)	$ 2.7		$ 2.7
Sub-Total	$18.2	$ 5.4	$23.6
Financial Costs:	**$ 2.5**		**$ 2.8**
Interest	$ 2.3		$ 2.3
Commitment fees	--	$ 0.3	$ 0.3
Inspection and supervision	$ 0.2		$ 0.2
TOTAL	**$20.7**	**$ 5.4**	**$26.1**
Percentage	**79.1**	**20.7**	**100**

2.39 **Financing Plan.** The IDB loan of US$20.7 million represents 79.1 percent of total project costs. The Government would finance US$5.4 million, or the equivalent of 20.7 percent of total project costs. This financing structure was agreed with the Government in negotiations because it represents gradually increased government financing of recurrent costs of providing the Basic Package of Health Services so as to make project changes in primary health care sustainable.

2.40 The proposed loan would be authorized under the following terms:

Loan Amount	US$20.7 million
Amortization period	25 Years
Disbursement period	4 Years
Interest rate	Variable
Inspection and Supervision	1% of the Loan
Credit fee	0.75% annually on undisbursed balance

Table 4: Project Costs by Category of Expenditure (US$000)

COST CATEGORY	Year 1	Year 2	Year 3	Year 4	Total	Percentage
Consultants:	700	900	1,000	850	3,450	16.6
Local					1,750	
International					1,700	
Training	400	400	400	20	1,400	6.8
Equipment and Material	500	800	900	400	2,600	12.6
Medical Equipment	---	50	50	---	100	.4
Operating Costs:	500	700	800	500	2,500	12.1
PCU Personnel	350	400	400	300	1,520	
Equipment Maintenance and Operating Cost	150	300	400	200	1,530	
Financial Costs	100	350	720	1,130	2,300	11.1
Other Costs	30	40	40	40	150	.7
Cost of Basic Package in Pilots	1,200	2,200	2,100	1,700	7,200	34.8
Contingencies	250	250	250	250	1,000	4.8
TOTAL	3,680	5,590	6,260	5,170	20,700	100%**

**Does not equal 100% due to rounding

III. PROJECT EXECUTION

A. Organizational Structure for Project Implementation

1. The Borrower and the Executing Agency

3.1 The Borrower will be the Republic of El Salvador and the Executing Agency will be the Ministry of Public Health and Social Assistance. MSPAS, as the principal institution of the sector, is organized into three levels: (i) the central level, consisting of the Office of the Minister, line Directorates, and associated dependencies; (ii) the departmental level, which consists of the 18 Departmental Directorates; and (iii) the local level, consisting of health establishments-hospitals and primary health units.

3.2 The MSPAS will establish a Project Coordinating Unit (PCU) to carry out and coordinate project execution and disbursements to participating entities in accordance with established plans of action. This unit will report directly to the Director General of Health (DGS).

2. Project Coordinating Unit (PCU)

3.3 The strategic considerations underpinning the design of the PCU are to keep the unit size to a minimum and to involve line MSPAS personnel in implementation under the technical coordination of PCU staff so as to build institutional capacity and assure project ownership. PCU consultants will be contracted for two-year terms. Where necessary, the PCU will contract additional outside experts to implement specific tasks.

3.4 The functions of the PCU are to: (i) prepare action plans for each component in an efficient and timely manner in coordination with the relevant units of MSPAS; (ii) conduct and supervise project implementation; (iii) prepare and submit to the Bank all relevant documentation; (iv) coordinate technical assistance and contract and supervise relevant technical personnel, consultants, and firms during project implementation; (v) be responsible for contractual compliance; (vi) carry out administrative, financial, logistical, and procurement tasks as required for effective project implementation; (vi)coordinate and conduct periodic evaluations; and (vii) disseminate information about the project.

3.5 The Minister will designate an Executive Director (ED) who will appoint an Administrative Coordinator (AC) for the Administrative Unit (AU). These appointments will be made following Bank procedures and with the no objection of the Bank.

3.6 The PCU will be staffed by eight full time technical specialists and three administrative support persons (2 secretaries and an assistant) paid through the project. These personnel will be hired over the course of the first year of the project and/or as project

demands require. All PCU personnel will be hired according to Bank procedures and with no objection of the Bank. As the need arises, the ED is authorized to contract, with the no objection of the Bank, short-term experts for specific tasks. A graphic representation of the PCU is in the Project Files.

3. Technical Unit

3.7 The ED will be responsible for coordination and supervision of all technical activities, and will be assisted by two full time Technical Specialists (TS) who will be responsible for implementation of Subcomponents Ia and Ib and Component II. Periodically an evaluation specialist will be contracted to establish baseline studies, progress indicators, and contract required evaluation studies. The ED, will name the various specialists under his/her charge. Finally, the TU will contain three full-time MSPAS functionaries designated by their respective unit heads in conjunction with the ED. Two of these functionaries will be counterparts for the Departmental activities (Component I), and the third will be the counterpart to the TS responsible for MSPAS reorganization (Component II).

3.8 The Administrative Coordinator (AC) will facilitate administrative and financial support for all project activities, including accounting, disbursements, administrative record keeping, contracts, and related activities. This Unit will review all contracts and make payments as approved by the ED and relevant technical staff. In addition to two assigned national counterparts, the AU will be staffed by three professionals (accounting, procurement, and budget) designated by the AC with the approval of the ED. If additional personnel are needed under short-term contracts, the ED will solicit and justify additions for the no objection of the Bank.

3.9 The AC will establish a Committee on Procurement to provide oversight and review of all national and international firm contracts, assure that Bank norms and guidelines are met, and preside over all public acts related to the offering of bids. The Executing Agency may, however, following Bank procedures, contract the services of a specialized institution or consulting firm to act as procurement/contracting agent for acquisitions and contracts in amounts of US$50,000 or more.

3.10 As a condition prior to first disbursement, the Borrower will present evidence to the Bank that it has created the PCU and has staffed it with the minimum number of personnel required to commence project execution: the ED, AC, and budget officer.

B. General Operational Guidelines

1. Action Plans

3.11 Project activities have been defined by action plans prepared for each of the components and subcomponents of the project. These action plans will serve as guides for project execution and will be subject to annual revision within the PCU. These action plans are available in the project files.

2. Operational Regulations

3.12 All functions, activities, and procedures of the PCU will follow operational regulations stipulated in the Operations Manual. A final version of the Operations Manual for the PCU will be agreed upon between the Borrower and the Bank as a condition of first disbursement. The Operations Manual will be subject to periodic revision under the project as deemed necessary by the PCU and the Bank.

3.13 Operational regulations within the Operations Manual will be established for Subcomponents Ia and Ib, and subject to periodic revision.

3. Recognition of Prior Expenses

3.14 It is proposed that up to US$250,000 in expenses incurred prior to the loan's approval to contract consulting services, establish the PCU and procure equipment may be recognized as payable with resources of the loan provided that the expenses were incurred subsequent to December 1, 1997, and in accordance with the Bank's rules and guidelines for procurement of goods and services.

4. Counterpart Funds

3.15 The contribution to the program from the Government of El Salvador will be the equivalent of US$5.4 million; i.e., 20.7% of the total cost, and will be used to partially finance the basic package of health services. Since the mechanism for financing this item contemplates a progressively larger contribution from the Government which will begin to be made in the second of the four years of disbursement, it is anticipated that the counterpart contributions will be assigned as follows:

Year 1	There will be no investments
Year 2	US$0.7 million
Year 3	US$2.2 million
Year 4	US$2.5 million
Total GOES contribution	US$5.4 million

5. Procurement

3.16 Procurement of goods and services will be done in accordance with Bank guidelines. International competitive bidding will be required for the procurement of goods and related services over US$250,000 and for consulting service contracts over US$200,000. For procurement under the amounts for which international competitive bidding is required, the following procedures described in Annex D of the loan contract will apply: a) national competitive bidding for goods and related services from US$150,000 to US$249,999 and consulting firm contracts from US$100,000 to US$199,999; and b) private competitive bidding for goods and related services less than US$150,000 and consulting service contracts less than US$100,000. The Executing Agency may, following Bank procedures, contract the services of a specialized institution or consulting firm to act as procurement/contracting agent for acquisitions and contracts in amounts of US$50,000 or more.

Table 5: PROJECTED PROJECT DISBURSEMENT
(in millions of US dollars)

Source	Year 1	Year 2	Year 3	Year 4	Total	%
IDB	3.7	5.6	6.2	5.2	20.7	79.3
Local	---	.7	2.2	2.5	5.4	20.7
Total	3.7	6.3	8.4	7.7	26.1	100
%	14.2	24.1	32.2	29.5	100.0	

C. Execution of Individual Project Components

3.17 Upon initiation of the Project, the PCU and the Bank will organize two launch workshops, one for staff of the PCU and the other for department chiefs and other relevant personnel (Departmental, local) for activities to be initiated under the First Year Action Plans. A Committee on Modernization (CM) will be established, presided by the Vice Minister and consisting of the ED of the PCU (as Executive Secretary of the Committee), the Director General of Health (DGS), the Director for Strategic Planning and Modernization (DPEM), the Director of Administration (DA), and the Chief of Finance (CF) as permanent members. In addition, periodic and temporary Committee membership by other MSPAS personnel will be established as the relevance of their participation is determined by Project issues.

3.18 The purpose of the Committee is to provide advice and counsel to the Minister as a means for the internal coordination of the project and a means for resolving issues and problems in an opportune manner. The agenda for meetings will be determined by the Committee and as necessary for project implementation.

1. Execution of Component I: Pilot Interventions to Reform the Health Care Delivery System

3.19 A Technical Committee for Pilot Implementation (TCPI) will be established, presided by the ED and consisting of the two TS for Component I, the Departmental Directors and the hospital directors as permanent members. The TS for Component II and other MSPAS personnel will participate as appropriate. The TCPI will divide into two ad-hoc Working Groups (WG), one for each pilot Department, under the coordination of the ED, for Department specific implementation support. The principal function of the TCPI will be to coordinate implementation of the new model of attention in the two pilots through the: (i) revision and adjustment of the implementation of action plans; (ii) monitoring the participation of primary health units and hospitals; (iii) organization of training and information for personnel of the units and hospitals; (iv) informing the Committee on Modernization of activities on a periodic basis (to be determined); and (v) all other activities required for the effective implementation of Component I. The first substantive activity of the TCPI will be to review action plans for the Component prior to submission to the PCU for review and approval. This Committee will also review and recommend participation of primary health care units in project financing upon submission of documentation by the TS responsible for funding of primary units.

3.20 The TCPI is responsible for the technical promotion, evaluation, initial selection, and processing of all subprojects (health care units), and submission to the AU of appropriate documentation for financing. Selected primary health care units will participate in project financing of the Basic Health Package (BHP) on a decreasing financial scale over the life of the project, with a maximum of financing for four years by the Project (See Project Files).

3.21 Annual action plans will estimate the necessary counterpart funding required under the Project to assure full financing for the primary health care units participating in the Project. The final version of the Operations Manual will specify the procedures, timing and duration of funds provided to primary health care units for the BHP and procedures for assigning counterpart funds.

a. Execution of Subcomponent Ia. Modernization of Primary Health Care Units

3.22 The first phase of this component calls for the PCU to contract for the design and promotion/dissemination of a plan for modernizing primary health care service delivery and related performance agreements. To be eligible for participation, the primary health unit must submit a simple action plan. In the two Departments, the TCPI will identify eligible units within the public sector and will promote possible participation of NGOs and private providers. Based on annual selection of units to participate, the TS responsible for subcomponent Ia will initiate training, action plan

revisions, and implementation of the modernization plan, subject to prior approval by the PCU.

3.23 Each subproject has three stages: (i) initial selection based on submission of simple action plans; (ii) provision of technical assistance and training to the health unit for the revision and implementation of action plans; and (iii) implementation of new organizational characteristics and financing and provision programs. A flow chart of activities in the development of the primary care model is in the Project Files.

3.24 Selection of service providers will be carried out in accordance with transparent eligibility criteria and procedures acceptable to the Bank and set forth in the Operations Manual. For the initial selection, the PCU will promote and identify the participation of all service providers, with criteria for selection to include: (i) the demographic and socioeconomic characteristics of the population; (ii) indicators of levels of coverage; (iii) tentative action plans; and (iv) relative absorptive capacity for modernization of the health unit. Rank order scores for potential participants will be established and selection will be based on availability of funds (year 1) and qualifying units.

3.25 Once units have been selected, a performance agreement incorporating an action plan will be signed between the unit and the PCU establishing the evaluation criteria, implementation responsibilities for MSPAS and the PHU, and actions to be realized during the year. These performance agreements will specify implementation plans, clinical and administrative objectives and financial and population (coverage) targets. Subsequent selections for new participants will be based on revised and refined selection criteria, and will require that first-year participants be evaluated for renewal. Renewal and selection will be conducted annually and will be subject to the no objection of the Bank. The project envisions a rolling participation of PHU, where the number of participant institutions in the second year will increase while the relative proportion of Bank financing for existing participant institutions under the project will decline.

3.26 Beyond year 1 of project execution, mechanisms for the introduction of a capitation system, the participation of non-public entities (NGOs, private providers), the development of mechanisms for partial cost recovery, and the development of information systems for the identification of beneficiaries will be initiated. The same selection procedure and eligibility criteria described in paras. 3.24 and 3.25 will be utilized.

b. Execution of Subcomponent Ib. Modernization and Institutional Strengthening of Pilot Hospitals and Innovations in Organization of the Health Care System

3.27 An internal Working Group on Hospital Modernization (WGHM) will be established for each hospital. It will be coordinated by the

Hospital Director and consist of the TS from the PCU and the Sub-Director and Administrative Officer of the hospital, and the Chief of Nursing as permanent members. Other temporary members will be designated as needed. During the first phase of the project, a training workshop will be conducted for the Working Group and other key hospital personnel, modernization plans will be designed, and (first year) action plans for initiation of implementation will be developed.

3.28 Each hospital modernization program will consist of four stages: (i) ratification of a modernization plan specifying specific objectives to be achieved over the life of the project and during the first year; (ii) technical assistance and training to hospital personnel based on action plans for hospital modernization; (iii) additional equipment rehabilitation and procurement; and (iv) implementation of reorganization, and organizational, financial, and management modernization plans.

3.29 First, the hospital and MSPAS (through the PCU) will subscribe to a performance agreement specifying the relative responsibilities of each party, activities to be carried out (action plans), and expected results.

3.30 Second, with technical assistance and training, the Hospital Working Group will revise the modernization plan and will initiate management, clinical, and financial modernization.

3.31 Eligibility for the third step (equipment rehabilitation and purchase with project resources) will be based on the successful completion of agreed performance targets to be evaluated by the PCU and the Bank. It is expected that this third step will not occur until at least the second year of the project.

3.32 Fourth, the project will introduce a results-based payment system for financial management of selected diagnostic related procedures.

3.33 Integration and coordination of organizational modernization within the network of providers will be implemented in seven stages that represent a rolling agenda and not a specific chronology for all participants at one given time. Network coordination entails (i) creation of a registry of the beneficiary population of the pilot area; (ii) mapping of potential beneficiaries to be served by health unit according to criteria of coverage and utilization; (iii)) maintenance of and strengthening of the system of providers that results from primary health unit selection under subcomponent Ia; (iv) expansion of the competitive offer of service providers to include non-public providers, especially in areas of low and medium coverage; (v) signing of performance agreements between MSPAS and providers for service delivery; (vi) introduction of referral systems and capitation procedures for the health network; and (vii) establishment of criteria and systems for monitoring and evaluation of the health network and system.

2. Execution of Component II: Modernization of Key Functions at the Central Level

a. Execution of Subcomponent IIa. Reorganization of Key Administrative Subsystems in MSPAS

3.34 Modernization of the MSPAS requires the integral participation of personnel from the Ministry in operational activities. The ED and division chiefs for each of the key functions will form the **Committee for Internal Reorganization** (CIR) to coordinate and oversee implementation. In accordance with qualifications established in the Operations Manual, the ED and the respective functional area division chiefs will name MSPAS personnel in each of the functional areas to implement the project under the coordination of the TS for Component II. In the case of the medical and pharmaceutical supplies system, a Working Group for Supplies (WGS) with participation from the pilot hospitals and Departmental Directorates, will be created to facilitate implementation. This Working Group will revise and implement the procedures for bidding based upon the therapeutic protocols, local management of supplies, quality control, and procedures for the distribution of medical supplies to establishments participating in the pilots.

b. Execution of Subcomponent IIb. Redefinition and Strengthening of Regulatory, Normative and Coordinating Functions of MSPAS

3.35 A **Committee for Intra Sectoral Coordination (CIS)** will be established with membership from MSPAS and key institutional actors in the sector. The ED of the PCU will serve as liaison between this Committee and the Committee on Modernization within the ministry, and will contract any and all activities required under the project for the fulfillment of the mandate of this subcomponent. This will include, in particular, contracting of studies necessary for the development of a white paper on sectoral reform, the institutional accreditation system, the establishment and codification of additional regulatory mechanisms, the establishment of short and medium term communications strategies.

3.36 The project contemplates some activities related to strengthening the regulatory capacity of the MSPAS and some modifications in the regulatory framework for the health sector as these are related to the specific component activities of the project (eg.accreditation system). However, broader regulatory reform is seen as part of the larger context of sector reform for which this project simply provides an initial step. Thus, the strengthening of the regulatory framework under this project will be introduced gradually (by year 3) and in accord with the building of broader sector consensus.

D. External Audit Requirements

3.37 The Borrower, through the Executing Agency, will present financial statements for the project certified through formal external audits by an independent firm acceptable to the Bank. These audits will be financed through resources from the loan.

E. Supervision and Evaluation System

1. Semi-Annual Reports

3.38 During project execution the PCU will present semi-annual progress and financial reports, including but not limited to: status of fulfillment of contractual obligations; progress in each of the subcomponents in accordance with measurable impact indicators in action plans and the Logical Framework (see Table 6); and disbursements by subcomponent. These reports should also address activities programmed for the subsequent review period, and include draft terms of reference for all studies and consultants.

2. Project Supervision

3.39 The Bank will conduct periodic supervisory missions to review progress and issues of project implementation. These will include:

1. **Annual Reviews.** Within 30 days of the submission of alternating semi-annual reports, the Government and the Bank will conduct an annual evaluation of the project, which will entail meetings with personnel from the PCU, with key personnel from the MSPAS, Hospital and Department Directors in the pilot exercises, and others involved in project implementation. These evaluations will cover the general progress of the project, annual work plans, the expenditure and disbursement plans for the following year, and subcomponent specific action plans and disbursement profiles;

2. **Mid-term Project Evaluation.** At the end of the second year of project execution, the Government and the Bank will initiate a mid-term project evaluation which will focus particular attention on the general advances of the project toward stated objectives; process and impact indicators agreed upon between the Borrower and the Bank; advances in overall and component-specific modernization activities in accordance with action plans, measurable targets, and country and sector conditions. Based upon this evaluation, and where necessary and appropriate, mid-course revisions and corrective actions in project design and implementation will be taken. If, as a result of this evaluation, it is determined that appropriate progress in project implementation has not occurred, the Bank may cancel portions of uncommitted funds.

Table 6. Summary Benchmarks for Components as Indicators of Effective Progress and Platform for Sector Reform
El Salvador Modernization of MSPAS Project ES-0053

Component	Benchmark	Timing
Primary Care Model	Capitation system in place in pilot units as the mechanism for financing provision of service.	End of Year 3
	Registry and Referral systems in place for identifying and channeling beneficiaries to appropriate health care providers (hospitals and primary care units)and initial network established.	End of Year 2
	Health units have budget system in place and linked to program planning (POAs)	End of Year 3
Hospital Management	Hospitals have effective integrated financial management system in place (from planning through audit functions)	End of Year 3.
	Hospital management has effective capacity to select, hire, train, promote, and replace personnel, within discretionary limits and exceptions achieved under the Civil Service Law.	End of project
Reorganization of MSPAS	MSPAS executes 100% of its budget within integrated financial management system (SAFI).	End of Year 2
	SIRH in place and functioning with widened discretion in MSPAS over personnel practices within framework of Civil Service Law.	End of Year 3
	Revised Cuadro Básico and Therapeutic Protocols utilized	End of Year 4
	National Evaluation System in place and integrated with Accreditation System for Hospitals and Primary Health Care Providers.	End of Project for Hospitals, with invitation of application for health units.
Strengthening of MSPAS Normative, Regulatory, and Coordinating Leadership Role	User Satisfaction Surveys show positive image for MSPAS reform efforts.	End of Year 3
	White Paper on Health Sector Reform Strategy produced and subject to discussion among key sector actors through Intrasectoral Committee.	Beginning of Year 4
	Intersectoral Committee functioning effectively as precursor to Government-sponsored representative Health Sector Reform Commission.	Year 4

IV. BENEFITS AND RISKS

A. Social and Economic Impact Analysis

4.1 The principal beneficiaries of the project are the poor who rely on government-provided health services or who pay out-of-pocket costs for private providers. Through the establishment and financing of basic services (largely maternal-child health) for targeted unserved populations in the pilot Departments of San Miguel and Santa Ana, the project directly benefits the poor in these regions. Through the introduction of modern management techniques, the project will improve the efficiency and quality of services in the two target hospitals. Through the initiation of restructuring and reorganization of MSPAS at the central level, the introduction of results-oriented incentives, and through a redefinition of the basic health care package, the project will improve the efficiency and equity of government resource allocation and will reduce the financial burden for improved quality health care for the poor.

B. Benefits

4.2 The project will result in five categories of benefits:

1. Equity

4.3 The beneficiaries of the project are the poor who rely on the government health services or pay out-of-pocket for private services (23 percent of the poor pay for private health care). Through financing a package of basic services for the targeted unserved and underserved population, the project will contribute to the improvement of their health. The new model of health care delivery is expected to be replicated by the Government in the rest of the country, and thus will benefit all of the poor, currently estimated at 58 percent of the population.

4.4 By financing the strengthening, reorganization and expansion of the cost-recovery system in the pilot hospitals, it is estimated that approximately 35 percent of hospital costs and 10 percent of primary care costs can be recovered from third-party insurers and thus dedicated to improvement and expansion of services to the poor.

2. Benefits for Women

4.5 In the pilot projects in Santa Ana and San Miguel approximately 287,500 women (16 percent of the total female population of El Salvador) will benefit directly from the basic package of services. The types of services included in the basic health package will benefit reproductive-age women who currently experience high rates of morbidity and mortality related to childbearing. Moreover, the primary users of the MSPAS health services are women and their children.

3. Quality

4.6 Quality will be improved through (i) creation of an accreditation system that will apply minimum standards to institutions providing health care; (ii) establishment of standardized therapeutic norms and protocols; and (iii) introduction of incentives for health care providers to improve quality.

4. Efficiency and Cost-Effectiveness

4.7 The project will improve the efficiency and equity of GOES resource allocation, raise the cost-effectiveness of service provision, and reduce the financial burden of health care on the poor by introducing a gradual process of (i) restructuring and modernizing the Ministry, pilot hospitals and primary health units; (ii) streamlining administrative processes; (iii) reorienting financial flows toward primary health care; (iv) introducing results-oriented incentives; (v) defining a basic package of cost-effective services; (vi) establishing a referral and counter-referral system; (vii) and redesigning and streamlining the medical supply system using a standardized products list and therapeutic protocols.

4.8 The interventions provided in the basic health package are derived from the international literature on cost-effectiveness and efficacy and provide the greatest value for the money in terms of reducing the frequency of death and disease in the target population. Targeting beneficiaries with a basic health package and paying providers on a per capita basis considerably changes the organization and the structure of finance and provision of MSPAS health services. This new method of doing business creates incentives for service providers to deliver cost-effective quality services efficiently, and is superior to possible alternatives that work within existing structures. As noted in Chapter I, the current system is not structured to foster positive incentives, use targeting, or define service provision and provider payment systems in a cost-effective and efficient manner.

5. Health Status of the Population

4.9 For the target population, it is expected that infant mortality will be reduced 15 percent (from 61 to 52/live births in San Miguel and 45 to 38/1000 live births in Santa Ana); intrahospital maternal mortality reduced by 20 percent from 9.5 to 7.6/10,000 live births in San Miguel and from 6.8 to 5.4/10,000 live births in Santa Ana; and that effective coverage with the basic health services package will increase by 60 percent by the end of the project.

C. Environmental Impact

4.10 The Project Report was reviewed by the Committee on Environmental and Social Impact (CESI/TRG) on December 15, 1997. No Environmental and Social Impact Report (ESIR) was requested or prepared. The environmental impact is expected to be negligible as

there is no infrastructure investment. Medical wastes will be addressed by ES-0074, with which this project is closely coordinating. The environmental impact of this project is expected to be negligible because the project is primarily one of institutional and administrative change. There is no infrastructure investment and the equipment to be purchased and installed primarily replaces existing equipment. Equipment installation may require some modification of existing infrastructure, but that will be minimal. Finally, a 1998-project, Decontamination of Critical Areas (ES-0074), addresses the problem of hospital wastes on a national scale and will provide regulatory measures, training, guides and manuals, mechanisms for contracting the private sector for safe and regulated solid waste collection and disposition, technical assistance, and limited investments in hospital incinerators. Moreover, training will be provided to MSPAS trainers for the proper handling of medical wastes from primary health units. The two pilot hospitals for ES-0053 will be among the first scheduled for the implementation of ES-0074. The project teams for ES-0053 and ES-0074 will closely coordinate their work to assure project integration as well as compliance with environmental impact regulations.

D. Financial Viability

4.11 Because of the small size of the loan and the pilot nature of the primary care model to be implemented, the direct and longer term financial impact of the proposed project is minimal, amounting to an increase of 1.6 percent in GOES recurrent health expenditures. An analysis of the direct impact of the project on recurrent budget of the MSPAS and the debt burden of GOES is revealed in pars. 4.12 to 4.15.

4.12 The new recurrent costs of provision of the subsidy for the two pilot Departments is equal to 53 million colones (US$6.0 million). The (1997) recurrent budget for MSPAS is equal to 1,382 million colones (US$159 million). The increased recurrent costs to MSPAS of the pilot areas under the life of the project is equal to 13.78 million colones per year (US$1.6 million) or approximately 0.99 percent of this year's recurrent budget. The additional costs of extending the basic services package to the remaining poor population of the Departments is equal to 34.1 million colones (US$3.9 million), or 2.6 percent of this year's recurrent budget.

4.13 Historically, public expenditures for health have been low relative to other Central American countries and to El Salvador's own budget (approximately 8.9 percent of GOES expenditures) for the 1990-1996 period and remain lower than the pre-1980 period (9.0 percent). Projected expenditures for the 1998-2002 period are approximately 8.6 percent of recurrent expenditures, and increase from 1,598 million colones (1998) to 2,412 million colones (2002). It is the stated goal of the GOES, and in accordance with the Peace Accords, to increase social sector expenditures as a percent of total expenditures.

4.14 If the primary care model were to be extended to the entire population of the poor (3.3 million, or 58 percent of the total population of 5.7 million), then the total cost of the model for the universe of the poor would be equal to approximately 369 million colones (US$42.2 million). However, more realistically, if the MSPAS reached 40% of the total poor by 2002, the cost would be 148 million colones (US$16.9 million), representing a 6.1 percent increase in the projected budget for that year. 9/

4.15 The (1996) budget as a percentage of the PIB is 15.0 percent, and the health budget as a percentage of the PIB is equal to 1.4 percent. The increase represented by this project is less than 0.1 percent. In terms of debt burden, estimates are that the overall impact of this project (US$20.7 million) on debt burden, debt payments, or interest beyond the grace period would be equal to less than 0.1 percent as well. The 1996 public debt of El Salvador was US$2,523.7 million (30.5 percent of PIB), which is an increase of US$355.3 million over 1995. Ninety two percent of the Non-Financial Public Debt (NFPD) is with international organizations. While this overall debt burden is significant in total terms, this project represents virtually no increase in that burden.

E. Risks

4.16 The March 1999 elections may result in changes in the Government's project team that could delay project implementation. Attempts to mitigate the situation by gaining and consolidating support for project objectives and activities include discussions with the Medical Association, an internal communications strategy for Ministry staff, and an external strategy for the general population. The project also promotes consensus-building through the intrasectoral committees at the national and departmental levels. Moreover, the PCU will be integrated with ongoing ministerial responsibilities.

4.17 Election campaigning has already begun and this may lead to greater volatility in policy-making which could result in the introduction of policies and programs that conflict with or contradict project activities.

9/ For a more complete explanation, see the Project File documents: "Estimating Costs for Pilots of Model of Primary Care"; and Jacir de Lovo, "Impacto Económico y Fiscal del Proyecto-Sector Salud" (9/97) and Viglione, "Analisis Macroeconómico de El Salvador" (9/97).

4.18 The weak institutional capacity of MSPAS both to absorb increased demand and to make managerial change is a risk to successful implementation. The project seeks to mitigate this by establishing an effective referral system to channel demand, and by supporting the reorganization and restructuring of MSPAS at the central level so as to carry out its appropriate institutional roles. Training and technical assistance will be provided to strengthen MSPAS's implementation capacity. Three MSPAS staff attended the November 1997 IDB procurement seminar in El Salvador.

LOGICAL FRAMEWORK
EL SALVADOR
PROGRAM OF MODERNIZATION OF THE MINISTRY OF HEALTH AND SOCIAL ASSISTANCE (ES-0053)

OBJECTIVES	INDICATORS	MEANS FOR VERIFICATION	IMPORTANT CONDITIONS
GOAL: Contribute to the improvement of the health status of the population	1.1 Diminution of infant mortality rate from 45 to 38 (Santa Ana) and 61 to 52 (San Miguel) per 1,000 live births by the fourth year. 1.2 Diminution of intrahospital maternal mortality from 6.8 al 5.4/10,000 (Santa Ana) and 9.5 al 7.6/10,000 (San Miguel) by the fourth year of the project.	1.1 Institutional statistics of MSPAS	1. Socio-political conditions in the country remain stable over the medium term. 2. Project-related activities and the modernization process are continued and strengthened in financial and institutional terms in the short, medium, and long term. 3. Project implementation occurs strategically. 4. Project team and coordinating unit are maintained by authorities sufficient for continuity in implementation.

OBJECTIVES	INDICATORS	MEANS FOR VERIFICATION	IMPORTANT CONDITIONS
PURPOSE: 1. Improved coverage, equity, quality, and efficiency of provision of MSPAS health services.	1.1 Coverage with equity Increased access of the poorest population to health establishments by 25% per year, beginning in Year 2. Increased coverage to health programs in project areas by 60% at the end of the project. 1.2 Quality of Service - User satisfaction in pilot areas increased by 50% in the first year and by 100% in subsequent years in terms of: i) Delay/waiting time ii) Interpersonal treatment iii) Programmed visits and appointments - Diminution of the incidence of intrahospital infection in pilot hospitals by an average of 40% in Year 1, by 70% in Year 2, and by 90% at the end of the project. 1.3 Efficiency - Cost recovery from non-beneficiaries of 40% at the end of Year 1 and 90% at the end of the project. - Cost recovery for costs of medicines in pilot hospitals of 40% at the end of Year 1 and 90% by the end of the project.	1.1 Multi-purpose household surveys. - Sample of pilot establishments and control group for (1) on site supervision and (2) rapid user surveys. 1.2 Monitoring of clinical records - Clinical, administrative and financial audits. - User Satisfaction Survey - Focus groups in pilot areas 1.3 Management Information System (MIS). - Accounting system -On-site supervision -MSPAS Reports - Sample of establishments	1. Existence of political will and commitment for change by maximum authorities of MSPAS. 2. Political support and significant participation of sector stakeholders regarding policy and regulatory framework that will permit redefinition of MSPAS role. 3. Counterpart funds are available in an opportune manner. 4. The epidemiological profile of the country is maintained or improved.
COMPONENT I: Restructuring of Health Care Model	1. MSPAS programmatic activities are prioritized by beginning of Year 2. 2. Services offered in project areas are efficient, efficacious, and equitable. 3. Cost recovery of 70% in establishments in pilot areas by end of Year 3.	1. On-site supervision with sample of establishments. 2. Evaluation report for pilots and control group. 3. MSPAS. Reports.	

OBJECTIVES	INDICATORS	MEANS FOR VERIFICATION	IMPORTANT CONDITIONS
1.1 Establishment of Primary Health Care Model and Modernization of Primary Care Units.	1. Six performance agreements with health care units (30% of pilot) agreed at end of Year 1. 2. Training for 3000 persons (MSPAS, hospitals, primary care units) per year in new health care model for first two years. 3. Twenty primary health care establishments participating in model and reorganized by end of Year 3.	1. Action Plans 2. Project Reports 3. On-site supervision 4. Technical audits	1. Optimization of use of project resources for proposed management innovations and availability of technical resources for cost-effective service provision in model.
1.2 Modernization and Institutional Strengthening in Pilot Hospitals and Innovations in Organization of Health Care System/service network.	1. Modernization Plans agreed by end of Year 1. 2. Referral and Counter-referral system implemented by Year 4. 3. Information system with beneficiary Registry implemented by end of Year 3. 4. Purchase and Installation of bio-medical equipment for pilot hospitals is 60% by end of Year 3.	1. On-site supervision 2. Project Monitoring and Evaluation Reports.	1. Stability in prices of medical supplies and drugs and equipment.
COMPONENT II: Reorganization of key functional Administrative Subsystems at Central Level and Strengthening Policy Functions of MSPAS	1. Increase in decision-making by MSPAS establishments in terms of financial management, human resource management, and supplies management. 2. MSPAS evaluation system implemented and linked to management decision-making. 3. Greater transparency in budget decisions and allocations in response to specified programmatic priorities of MSPAS at central and local level.. 4. Cuadro Basico and Therapeutic Protocols implemented by end of Year 2. 5. Favorable opinion of modernization expressed by MSPAS personnel, stakeholders and public.	Annually: 1. Sample of establishments and control group. 2. Project Reports and interviews with management personnel. 3. Reports from SAFI and SIRH, Project Reports, MSPAS Reports, and Reports from Intersectoral Committees 4. Project Reports 5. Opinion Surveys and Focus Group exercises.	
2.1 Key Administrative Subsystems Reorganized:			

OBJECTIVES	INDICATORS	MEANS FOR VERIFICATION	IMPORTANT CONDITIONS
- Financial Subsytem	Finance: 1. Budget allocations linked to outputs, per capita payments and activities by end of Year 2. 2. Sistema de Administración Financiera Integrado (SAFI) implemented by end of Year 3. 3. 100% of budget executed by end of Year 2.	1. MSPAS budget 2. On-site verification of SAFI functioning. 3. Annual Reports of Ministry of Finance and of MSPAS Department of Finance.	1. SAFI is operational at the level of the Ministry of Finance.
- Human Resource Subsystem	Human Resources: 1. Greater flexibility and responsiveness of autonomous human resource management decisions at the level of primary health care establishments in project areas. 2. Human resource management procedures fully implemented in pilot establishments by end of Year 4, including automation of SIRH (and as first step toward generalization of model in future phases of reform). 3. Human Resource Development Plan consistent with Ministry's Plan de Oferta de Salud implemented in Year 2. 4. Contracting time for personnel reduced from 4 months to 1 month in Year 2.	1. On-site supervision and Project Reports. 2. Operations Manual and Procedures and SIRH. 3. Evaluation of Plans. 4. Sample of pilot establishments and MSPAS evaluation	2. Reduction of internal bureaucratic resistance to changes in organizational culture is achieved.
- Supply Subsystem	Supplies: 1. Distribution of quantity and quality of medical supplies and drugs to establishments in accordance with their supply calendars. 2. Cuadro Básico and Therapeutic Protocol distributed and utilized in establishments by end of Year 4.	1. On-site supervision 2. Sample of Cuadro Básico y Therapeutic Protocol in use	3. Medical unions accept organizational changes and new forms of service provision.

OBJECTIVES	INDICATORS	MEANS FOR VERIFICATION	IMPORTANT CONDITIONS
- Evaluation and Supervision Subsystem	Evaluation and Supervision: 1. National System of Health Indicators for use in pilot areas designed at end of Year 1. 2. New Evaluation System in use by mid-project. 3. Evaluation System integrated with supervision and self-management systems by end of project.	 1. New Evaluation System Monitoring Reports.	
2.2 Normative, Regulatory, and Coordination Functions of MSPAS strengthened.	1. Accreditation system implemented: - Accreditation policy established in Year 1; - Accreditation criteria established in Year 2; - 50% of hospitals accredited by end of Year 3; - 100% of hospitals accredited by end of project. 2. Intersectoral Committee for Health established and functioning by end of Year 1. 3. Local Technical Committees established and functioning by end of Year 2. 4. Corporate and Social Communication Strategy designed by end of Year 1. 5. Positive opinion polls on sector reform.	1. Project Reports and Accreditation System Files. 2. Committee Reports. 3. Committee Reports. 4. Project Reports. 5. User and public opinion surveys.	1. Existence of commitment of other sector stakeholers in participation in Intersectoral Committee. 2. Legislative branch approves regulatory and legal reforms in a timely manner.

EL SALVADOR
SUPPORT OF THE MODERNIZATION OF THE MINISTRY OF PUBLIC HEALTH AND SOCIAL ASSISTANCE (ES-0053)
PROCUREMENT PLAN

Main Procurement	Financing	Procurement Method	Prequali-fication	Expected SPN Publication Date (semester) if Required by Bank
1. Program Administration				
Individual Consultants US$1,720,000	100% IDB	NCB from $100,000 to $199,999 PCB less than $100,000	No	N/A
Equipment and Maintenance US$995,000	100% IDB	ICB from $250,000 NCB from $150,000 to $249,999 PB less than $150,000	No	II/98
2. Program Execution				
Medical Equipment US$1,400,000	100% IDB	ICB from $250,000 NCB from $150,000 to $249,999 PB less than $150,000	No	I/99
Equipment and Material US$2,630,000	100% IDB	ICB from $250,000 NCB from $150,000 to $249,999 PB less than $150,000	No	II/98
Studies, workshops, training US$1,390	100% IDB	ICB from $200,000 NCB from $100,000 to $199,999 PCB less than $100,000	Yes	II/98
Specialized Consultancies US$3,750,000 Average: US$50,000	100% IDB	ICB from $200,000 NCB from $100,000 to $199,999 PCB less than $100,000	Yes	II/98

ICB International Competitive Bidding
NCB National Competitive Bidding
PCB Private Competitive Bidding
SPN Specific Procurement Notice

RE2-ES109P
ES-0053
Original: English
Appendix I

PROPOSED RESOLUTION

EL SALVADOR. LOAN ___/OC-ES TO THE REPUBLICA DE EL SALVADOR
(Project to Support Modernization of the Ministry of Public Health and Social Assistance)

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 El Salvador, as Borrower, for the purpose of granting it a financing to cooperate in the execution of a Project to Support Modernization of the Ministry of Public Health and Social Assistance. Such financing will be for the amount of up to US$20,700,000, from the resources of the Single Currency Facility of the Bank's Ordinary Capital, and will be subject to the "Terms and Financial Conditions" and to the "Special Contractual Conditions" of the Executive Summary of the Loan Proposal.