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HONDURAS

PROGRAM TO SUPPORT HEALTH SECTOR REFORM

(HO-L1182)

LOAN PROPOSAL

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ABBREVIATIONS

ADESSs	Administradoras de Servicios de Salud [Health Services Administrators]
CGSS	Conjunto Garantizado de Prestaciones y Servicios de Salud [Guaranteed Package of Health Benefits and Services]
ENC	Estrategia Nacional de Calidad [National Quality Strategy]
ENDESA	Encuesta Nacional de Demografía y Salud [National Demographic and Health Survey]
ESFAMs	Equipos de Salud Familiar [Family Health Teams]
IHSS	Instituto Hondureño de Seguridad Social [Honduran Social Security Institute]
IMF	International Monetary Fund
LMPS	Ley Marco de Protección Social [Framework Social Protection Law]
LRF	Ley de Responsabilidad Fiscal [Fiscal Responsibility Law]
MARCOPORE	Marco Conceptual Político y Estratégico de la Reforma [Health Sector Reform Policy and Strategy Conceptual Framework]
MGD	Modelo de Gestión Descentralizada [Decentralized Management Model]
MNS	Modelo Nacional de Salud [National Health Model]
NGO	Nongovernmental organization
PSNC	Política y Sistema Nacional de Calidad [National Quality Policy and System]
RBF	Results-based financing
RISSs	Redes Integradas de Servicios de Salud [integrated health services networks]
SAS	Seguro de Atención en Salud [Health Care Insurance]
SEFIN	Ministry of Finance
SESAL	Ministry of Health
SNS	Sistema Nacional de Salud [National Health System]
UGD	Unidad de Gestión Descentralizada [Decentralized Management Unit]
UPEG	Unidad de Planificación y Evaluación de la Gestión [Management Planning and Evaluation Unit]
USAID	United States Agency for International Development

PROJECT SUMMARY

HONDURAS
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Financial Terms and Conditions			
Borrower:	**Source**	**%**	**Amount (US$)**
Republic of Honduras	**IDB (Regular OC):**	60	30,000,000
Executing agency:	**IDB (Concessional OC):**	40	20,000,000
Ministry of Finance (SEFIN)	**IDB:**	100	50,000,000

	Regular OC (FFF) [a]	**Concessional OC**
Amortization period:	20 years	40 years
Disbursement period:	1 year	
Grace period:	5.5 years	40 years
Interest rate:	LIBOR-based	0.25%
Credit fee:	[b]	N/A
Inspection and supervision fee:	[b]	N/A
Weighted average life (WAL):	12.75 years	N/A
Approval currency:	United States dollars	

Project at a Glance

Project objective/description: The objective of the programmatic series is to enhance the coverage, efficiency, and quality of the National Health System in the delivery of services to improve the health of the population throughout the country. The first operation will support the preparation and adoption of tools to strengthen the Decentralized Management Model, as well as a legal and regulatory framework for implementing health reform and changing the service delivery and organization model. It will also support the formulation of the National Quality Strategy, the restructuring of the Ministry of Health budget, and the development of a human resources management and control system.

This is the first operation in a programmatic policy-based series (PBP), to be comprised of two contractually independent and technically linked loans.

Special contractual conditions precedent to the single disbursement of financing: The single disbursement of loan proceeds will be contingent upon fulfillment of the policy reform conditions, pursuant to the Policy Matrix (Annex II) and Policy Letter provisions, and of the contractual conditions established in the loan contract (see paragraph 3.3).

Exceptions to Bank policies: None

Strategic Alignment

Challenges:[c]	SI	☑	PI	☐	EI ☐
Crosscutting issues:[d]	GD	☑	CC	☐	IC ☐

[a] Under the Flexible Financing Facility (document FN-655-1), the borrower has the option of requesting changes to the amortization schedule, as well as currency and interest rate conversions. When reviewing such requests, the Bank will take into account operational and risk management considerations and prevailing market conditions, as well as the loan's level of concessionality, in accordance with the Bank's applicable policies.

[b] The credit fee and inspection and supervision fee will be established periodically by the Board of Executive Directors as part of its review of the Bank's lending charges, in accordance with applicable policies.

[c] SI (Social Inclusion and Equality); PI (Productivity and Innovation); and EI (Economic Integration).

[d] GD (Gender Equality and Diversity); CC (Climate Change and Environmental Sustainability); and IC (Institutional Capacity and the Rule of Law).

I. PROJECT DESCRIPTION AND RESULTS MONITORING

A. Background, problems, and rationale

1. Recent economic performance

1.1 Honduras ended 2016 with real GDP growth of 3.6%, similar to the 2015 figure and higher than the -0.5% estimated for Latin America and the Caribbean. This expansion was sustained by strong performance in the financial, communications, and maquila sectors (25% of GDP). On the spending side, private final consumption (74% of GDP) and private gross investment (19% of GDP) were the primary drivers of economic activity. International Monetary Fund (IMF) projections anticipate average growth of 3.7% for the 2017-2018 period, supported by higher levels of private investment and exports.

1.2 The external sector shows favorable development characterized by a reduction in the current account deficit and maintenance of the capital and financial account surplus. In December 2016, net international reserves amounted to US$3.89 billion, equivalent to 4.6 months of imports. For the same month, the exchange rate showed year-on-year depreciation of 5.2%, higher than the 3.8% recorded in December 2015.

1.3 In 2016, inflation reached 3.3%, below the range established by the Central Bank (3.5% to 5.5%). The decline in international oil prices and its impact on domestic prices was reflected in rapid deceleration of the inflation rate (a reduction of 2.5 points since December 2014).

1.4 The 2016 nonfinancial public sector (NFPS) deficit is estimated at 1.4% of GDP, similar to the 2015 figure. In 2016, the authorities moved ahead with implementation of the fiscal consolidation program agreed upon with the IMF in 2014.[1] Notable fiscal measures implemented include: (i) financial restoration of the National Electricity Company (50% reduction in payroll, 20% increase in the average rate since 2014); (ii) consolidation of spending control measures and increased tax collection (yield of 4.7% of GDP since 2014); and (iii) reform of the institutional framework for sustainable management of fiscal policy, emphasizing the adoption of the medium-term fiscal framework incorporated in the budget since 2015 and approval of the Fiscal Responsibility Law (LRF) in 2016.[2] These actions have had an impact on stabilizing total public debt at around 48% of GDP.

1.5 The country's fiscal position is expected to strengthen over the short and medium term in accordance with the provisions of the LRF and the program with the IMF. Based on fiscal performance in 2013, the program establishes an increase in tax revenues of 2.5 points of GDP, until reaching 17.6% of GDP in 2017, as well as a reduction in current expenditure from 19.8% to 17.6% of GDP. On the spending side,

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1 The Stand-by Arrangement ends in December 2017. The IMF Board approved the third and fourth reviews of the arrangement on 26 October 2016.

2 The LRF, approved in April 2016, establishes the need to ensure the consistency of budgetary policy over time, as well as to guarantee fiscal consolidation, debt sustainability, and poverty reduction with fiscal transparency, responsibility, and prudence. The LRF is based on three macrofiscal rules: (i) an annual ceiling for the deficit in the overall balance of the NFPS equal to 1.0% of GDP, which will be applied gradually between 2016 and 2018; (ii) the central government's nominal current expenditure may not exceed the annual average real GDP growth in the last 10 years plus projected average inflation for the upcoming year; and (iii) new floating debt as of the close of the fiscal year may not exceed 0.5% of nominal GDP.

a reduction in the wage bill is anticipated, amounting to 1.4 points of GDP (estimated at 8.4% of GDP for 2017).

2. The health system in Honduras

1.6 The Honduran health system is made up of the public sector, consisting of the Ministry of Health (SESAL) and the Honduran Social Security Institute (IHSS);[3] and the private for-profit and nonprofit sector.

1.7 The public delivery of health services, provided by the IHSS, serves the working population and their beneficiaries enrolled in the social security system. SESAL, which is the entire health system's apex agency, also provides services to the population not enrolled in social security and those with more limited economic resources. It is estimated that the SESAL services network covers 60% of the population, the IHSS covers 17%, the private sector covers 5%, and the remaining 18%—or 1,300,000 inhabitants—still have problems accessing health services.[4]

1.8 Eighty-four percent of SESAL services are centrally managed, including the contracting of human resources and the purchase of medications and inputs, and services are organized from the central level. The remaining 16% are managed through the Decentralized Management Model (MGD), which consists of the administration and delivery of health services through nonprofit management entities with their own legal status independent of SESAL. In addition, the IHSS manages its own services and also purchases services from the private sector in several of the country's municipios (subrogated model).

1.9 With regard to financing, the entire SESAL budget comes from government transfers made on an historical basis. For its part, the IHSS collects and administers the funds from mandatory contributions from employees and employers in the formal productive sector that are intended to finance health insurance and temporary disability, permanent disability, old-age, and death benefits. Although by law the government is supposed to contribute 0.5% of the salary of those contributing to the IHSS, these payments have been made irregularly and, when payment is not made, the debt is documented and paid under other administrations either through transfers from SEFIN or government bonds. Health expenditure in Honduras amounts to 8.7% of GDP, which is close to the average for the countries of Central America (where the average is 8.5%). However, per capita expenditure (US$212) is well below the regional average for Latin America and the Caribbean (US$695.57). Public spending on health represents 48.1% of health spending (98% of public spending comes from SESAL and the IHSS) and out-of-pocket spending represents 92% of private spending.[5]

3. The health services decentralized management model

1.10 In 2004, SESAL began to use the MGD in health services, through a results-based financing (RBF) model. Under this model, management entities[6] are contracted to

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[3] There are also the armed forces health services, but these cover a very small percentage of the population, including members of the army.

[4] National Demographic and Health Survey. 2011-2012.

[5] World Development Indicators. World Bank 2016. Private spending on health is all spending not made through public institutions like SESAL, IHSS, the Armed Forces, municipalities, etc. It includes spending by companies, private insurers, and out-of-pocket spending by households.

[6] The managers are organizations such as municipalities, associations of municipalities, community associations, and nongovernmental organizations (NGOs).

deliver primary care services.[7] The managers receive per capita payment for the covered population, including payment for meeting quality, performance, and efficiency indicators. In addition, they are paid for every child born in a clinical setting,[8] as an incentive to increase the number of such deliveries.

1.11 As part of RBF, SESAL monitors the managers quarterly by measuring quality and performance indicators. The indicators evaluated include: percentage of pregnant women captured before their 12th week; prenatal, neonatal, postpartum, vaccination and other coverage. If the scores obtained by the manager are lower than those established in the contract, SESAL imposes financial penalties or rescinds the manager's contract, if necessary. Managers are responsible for contracting health personnel, purchasing inputs and medications, and organizing, administering, and delivering the services, under SESAL's control and supervision. In addition, the managers organize family health teams (ESFAMs) made up of a physician, a nursing assistant, and an extension worker. These ESFAMs are responsible for the care of 600 families located in a specific geographic area. The ESFAMs carry out activities to identify and care for priority or at-risk groups and also make home visits and conduct prevention and promotion actions in the community.

1.12 In 2009, the primary care MGD was covering 693,584 people, located in 45% of the country's poorest municipios.[9] In that year, studies[10] comparing this model with centrally managed health services indicated that the MGD had improved the coverage, quality, and efficiency of health services in the municipios where it had been implemented, as shown in the following paragraphs.

1.13 It was apparent that prenatal care coverage was 72.5% under the MGD compared to 45.3% in the centralized model; childbirth in a clinical setting was 56.0% under the MGD compared to 21.5% in the centralized model; as for growth and development checkups, 70% of children under the age of two received the respective checkup under the MGD while 50.8% received it under the centralized model; and coverage of postpartum care[11] was 42.9% under the MGD compared to 32.3% under the centralized model.[12]

1.14 In terms of quality, the application of the standards of care was better in cases involving children with diarrhea and pneumonia treated in decentralized services compared to centrally managed services, at 30% and 50%, respectively.[13] In addition, the MGD promoted disease prevention and health promotion activities in the assigned communities, substantially improving the production of home visits. Under the MGD, 20% of families received at least one visit per year, while in the centrally managed units studied there was not even one home visit per family during

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7 The primary level of care includes all services provided in ambulatory units. The secondary level includes hospital services.

8 Maternal and child health clinics that handle uncomplicated deliveries in remote communities.

9 The poorest municipios in the country number 102. In 2009, primary care coverage under the MGD was provided in 46 municipios.

10 *Estudio Comparativo entre el Modelo Descentralizado y Centralizado en la Provisión de Servicios de Salud en Atención Primaria en Honduras*. SESAL. Measure Evaluation; USAID Honduras. March 2009.

11 Puerperium: the period following childbirth.

12 *Estudio Comparativo entre el Modelo Descentralizado y Centralizado en la Provisión de Servicios de Salud en Atención Primaria en Honduras*. SESAL; Measure Evaluation; USAID Honduras. March 2009.

13 Ibid.

the year.[14] In addition, in the areas where MGD was implemented, 100% of deliveries in a clinical setting were attended by physicians, unlike the areas with services provided directly by SESAL, where 50% of deliveries in a clinical setting were attended by a nursing assistant.

1.15 As for efficiency, the MGD showed lower unit costs for all priority health care services and also showed greater accessibility per hours available. For example, in the centralized model, it was found that childbirth care was 12% more expensive, prenatal care was 36% more expensive, and postpartum care was 48% more expensive.[15]

1.16 Subsequently, in 2013, the Government of Honduras, with the support of the Bank,[16] initiated implementation of the MGD in hospitals. In this case, the model consists of signing agreements with nonprofit foundations[17] to administer and deliver hospital services. The funds to be transferred to the foundations are calculated on the basis of estimated hospital discharges produced. Payment to the foundations also includes a variable component linked to the achievement of quality and performance indicators.[18]

1.17 By 2015, the primary care MGD had been extended to a population of 1.3 million, covering 90% of the country's poorest municipios.[19] In these municipios, the coverage of physicians for every 10,000 inhabitants increased from 3.25 to 11.25 and human resources coverage in health quadrupled from 27.5 to 104 for every 10,000 inhabitants.[20] The Fiscal and Financial Sustainability Analysis Study of the MGD in the context of project HO-L1105 (3723/BL-HO) shows that there has been no duplication of expenses or overlapping costs under this model. In addition, 6 of SESAL's 29 hospitals at the national level have been decentralized. This model made it possible for the San Lorenzo hospital,[21] the first hospital to be decentralized, to achieve results such as: (i) reducing in-hospital maternal and neonatal deaths to zero; (ii) reducing hospital stays from 3.5 to 2.5 days; (iii) increasing hospital discharges by 55%; (iv) increasing childbirth care by 15%; and (v) increasing the supply of medications from 22% to 97%.[22]

1.18 Four important elements account for the MGD's good results in comparison to the centralized model: (i) the financing model was changed from supply-driven financing to demand-driven—the requirements of health unit needs (staffing) were financed, while, with the MGD, financing is done based on the population served; (ii) the management and decision-making capacity in the area of inputs, procurement,

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14 Ibid.

15 Ibid.

16 Projects HO-L1072 (2743/BL-HO) and HO-L1090 (2943/BL-HO).

17 The foundations are nonprofit NGOs with legal status created by individuals or civil organizations to provide a specific service to the community. Most of these foundations contracted to manage hospitals have a long history of supporting the hospital in terms of managing resources to pay for staff, equipment, and infrastructure.

18 One of the performance indicators is linked to the minimum number of discharges expected for that hospital. This minimizes the incentive for generating unnecessary discharges.

19 The country's poorest municipios number 102. In 2015, the primary care MGD covered 92 municipios.

20 Decentralized Management Unit (UGD) report based on 2016 management agreements.

21 Since implementation of the MGD in the other hospitals is more recent, sufficient data on their achievements are not yet available.

22 Statistical sources from the San Lorenzo Hospital and SESAL Monitoring Reports.

personnel contracting, and services organization were transferred from the central level to the health services at the local level; (iii) monetary incentives were introduced, such as the link between payment and the attainment of quality, production, coverage, access, and performance indicators; and (iv) accountability and requisition mechanisms were introduced.

4. Health sector reform in Honduras

1.19 Based on the results and experiences learned from the MGD, in 2009 SESAL created the Health Sector Reform Policy and Strategy Conceptual Framework (MARCOPORE), which established the reform program based on the following elements: (i) separation of the governance, financing/insurance, and delivery functions; (ii) strengthening of SESAL's governance role; (iii) implementation of RBF;[23] and (iv) design and implementation of a national quality guarantee policy and system. It also identified the MGD as the strategy to put into operation the separation of functions and RBF.

1.20 In 2011, based on the MARCOPORE and with Bank support, SESAL was organizationally restructured to strengthen its governance role and the Decentralized Management Unit (UGD) was formed as the entity responsible for purchasing and contracting health services. In addition, that same year, the National Quality Policy and System (PSNC), which set the stage for developing the health system's quality guarantee for all levels of care, was approved via a ministerial agreement. This system established the following key components: the licensing[24] of health facilities and the certification[25] and accreditation[26] of services. The guidelines for establishing continuous quality improvement programs in the health services were also defined at that time.

1.21 Continuing the reform process as set out in the MARCOPORE, the Framework Social Protection Law (LMPS) was enacted in July 2015. This law represents an important advance in health sector reform, in that it elevates the reform strategy established in the MARCOPORE to the status of law. Based on experience and lessons learned from the MGD, the LMPS gives new impetus to health care system reform by establishing a model of universal health insurance and picking up on the separation of governance, financing, insurance, and service delivery functions proposed in the MARCOPORE. The LMPS reaffirms that the governance function will be exercised by SESAL, while the IHSS is assigned the role of insurer (i.e., enrollment, risk management, and financing of services through the strategic purchase of those services) and funder of health services.[27] It also establishes that health services will be delivered by public or private health services managers or

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[23] RBF consists of payment to managers based on achievement of quality and performance indicators.

[24] Licensing: under the PSNC, this is the mandatory technical-administrative procedure that verifies compliance with current essential minimum requirements and authorizes a health facility to operate, when it has met the minimum standards.

[25] Certification: under the PSNC, this is the voluntary procedure whereby a third party, called the certifier, issues a written guarantee that a person, facility, or service complies with the requirements established in standards or regulations and attests to the competence thereof.

[26] Accreditation of Health Services and Facilities: under the PSNC, this is the external, voluntary, and periodic evaluation process that guarantees quality by measuring optimum standards previously established and known to the entities being evaluated.

[27] SESAL will continue its role as funder and provider of services through its own network and the MGD network until all financing for all services is transferred to the IHSS.

administrators (ADESSs)[28] with their own legal status independent of SESAL and the IHSS, through an RBF model.

1.22 The LMPS also created the Health Care Insurance program (SAS), which must insure the entire population, including those currently covered by SESAL. The SAS will consist of a subsidized scheme that would cover only those who are poor and unable to make contributions, and a contributory scheme that would cover the working population in the formal and informal sectors as well as domestic workers and the self-employed. Both systems will be administered by the IHSS. In accordance with the law, benefits and services covered by the SAS must be insured, delivered, and administered through the IHSS. Therefore, to implement the SAS, both the funds and the responsibility for guaranteeing the strategic purchase of health services, currently held by SESAL, under the MDG, will have to be gradually and progressively transferred to the IHSS. Meanwhile, SESAL will continue to guarantee health services for the country's poor who are not enrolled in social security.

1.23 To continue with the reform, the LMPS also establishes the need to define a Guaranteed Package of Health Benefits and Services (CGSS), to which the entire population is entitled regardless of their type of enrollment, and which includes promotion, prevention, treatment, rehabilitation, and/or health support measures. The LMPS establishes that the CGSS must be defined by SESAL, according to appropriate technical, financial, and actuarial criteria, based on the system's priorities and operational adequacy, as well as national health objectives. In addition to the above and because the LMPS only defines general aspects of the health system (in that it is a framework law), the LMPS requires the enactment of two complementary laws: the National Health System (SNS) Law, which would expand the responsibilities, functions, and powers of SESAL as the apex agency, as well as the different mechanisms allowing SESAL to exercise its role as system regulator; and a new IHSS law that would define the remaining elements that make up and regulate the operation of the system.

1.24 **Pending challenges in health sector reform.** There are still challenges in overcoming problems of coverage, efficiency, and quality and completing health system reform in Honduras. The actions necessary to overcome these challenges are as follows:

1.25 **Enactment of the SNS Law.** Continuing the reform and moving ahead with the system's reorganization requires the enactment of the SNS Law as a complement to the LMPS.[29] The SNS Law must define the elements that make up and regulate the operation of the system that were not defined in the LMPS, given their nature. The elements the law should contain include: (i) definition of the role, powers, and functions of the institutions that make up the system, complementing those stipulated in the LMPS; (ii) the domains, scopes, and mechanisms of the system's governance and regulatory function; (iii) the mechanisms for coordination and interaction among the institutions that make up the system; and (iv) the criteria and mechanisms for financing services and the criteria for establishing incentives for services supply and demand.

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[28] The LMPS defines the MGD managers and calls them ADESSs.

[29] The IHSS Law is already being discussed in the National Congress.

1.26 In addition to the above and in order to improve the stability and continuity of the services provided by the managers and foundations, within the MGD framework, this law must contain provisions for signing long-term contracts with managers and foundations. As of now, both primary care managers and foundations that administer hospitals must sign annual management contracts or agreements with SESAL, because the Honduran government's procurement law only allows companies or institutions to be contracted for a year. If contracts are signed for a period of more than one year, the contract must be sent to the National Congress for approval.

1.27 **Approval and implementation of the National Health Model (MNS).** Another significant challenge in moving ahead with the reform is changing the current model of care. The current model of care provided through public health services is mostly characterized by a focus on treating injuries and disease, with insufficient prevention and health promotion actions. Services are delivered through a fragmented network with few mechanisms facilitating integration and coordination of the different units. Evidence of this is that less than 20% of the care provided by SESAL was for prevention and health promotion.[30] In addition, from 2007 to 2013, 53% of total public spending on health was for hospitals, while only 24% was for public primary health care services (prevention and promotion) and outpatient services.[31] This far exceeds average spending in hospitals in Central America (49%) and Nicaragua (only 29%).[32]

1.28 The challenge consists of changing the model described above to a comprehensive health care model that prioritizes prevention and health promotion actions and also regulates the networked organization of public health care services under SESAL and the IHSS.

1.29 To address the above, SESAL has proposed approval of the MNS. The MNS incorporates the experience of the MGD and determines that the strategy for implementation of a comprehensive care model focused on the family and community and prioritizing prevention and health promotion should be established through the formation of ESFAMs. In El Salvador,[33] this strategy showed that, for the 88% of the population covered by the Community Health Teams (ECOS), access to services increased: 82% of the beneficiaries expressed satisfaction regarding the response to their health problems and 86% stated that they were supplied with the medications indicated by their health personnel. Currently, SESAL, with the support of the IDB[34] and other organizations such as the Japan International Cooperation Agency (JICA)[35] and the Pan American Health Organization (PAHO), has organized 105 ESFAMS through decentralized managers (representing only 13% of the ESFAMs required to cover SESAL's beneficiary population). Approval of the MNS is intended to standardize the ESFAMs and raise them to the level of public policy so they can be extended to the rest of the network.

1.30 The MNS will also address the formation and implementation of Integrated Health Services Networks (RISSs), including a new categorization of facilities (different from

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30 SESAL Statistical Yearbook. 2014.

31 Honduras: Social expenditures and institutional review. World Bank. June 2015.

32 Ibid.

33 *Evaluación de Medio Término del Programa Equipos Comunitarios de Salud Familiares*-ECOS. MINSA. El Salvador. May 2014.

34 Project HO-L1090 (2943/BL-HO).

35 JICA.

those currently defined: Rural Health Center,[36] Health Center with Physician (CESAMO)[37] and maternal and child health clinics),[38] according to the level of complexity and required treatment capabilities. The RISSs consist of the organization of health services (clinics and supporting entities such as the network of laboratories) at different levels of complexity, which are linked on a complementary basis so that people receive continuous and comprehensive care.[39] This strategy has been shown to improve efficiency in the delivery of services[40] and has had good results in terms of equity, access, and comprehensiveness of care in various countries in the Americas, particularly Brazil, Canada, Chile, and Costa Rica.[41] Various studies suggest that RISSs improve access to the system, reduce the fragmentation of care, improve the system's overall efficiency, strengthen the planning of infrastructure and services, reduce production costs, and better respond to people's needs and expectations.[42] SESAL has 29 hospitals and 1,200 outpatient health units, among which the need to form 69 RISSs in different regions of the country has been identified.

1.31 **Definition of the CGSS.** Another significant challenge to moving ahead with reform of the system, and thus improve the equity, efficiency, and quality of services, is the need to define a health benefits plan or CGSS, as it is referred to in the LMPS. Based on financial resources and needs, the CGSS must define the supply of services that the system must deliver to the population, and regulate the introduction of new health care technologies. As there is no explicit health benefits plan, services in Honduras are rationed implicitly in the form of waiting lists, denial of services, reduction in the delivery of medications, and in other ways. For example, the average waiting list for surgery in public health services is more than 10 months and the supply of medications is less than 45%[43] of what is required on average.

1.32 The LMPS also indicates the need to define the CGSS in order to standardize the benefits of the contributory and subsidized schemes of the SAS so as to guarantee the system's equity. The definition of the CGSS will help to improve resource planning and allocation and the prioritization and rationalization of spending on health. In accordance with the LMPS, the CGSS will define the explicit and enforceable guarantees on access, quality, timeliness, and financial protection for the pathologies covered by both schemes, and will be the basis for defining the obligations of the ADESSs and the MGD managers. Currently, about 63 middle- and low-income countries in all regions of the world, with or without insurance systems, and with or without the participation of private actors, including Mexico, now have health benefits plans.[44] International experiences, including Chile's Explicit Health

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36 Rural Health Centers: services provided by nursing assistants only.

37 CESAMO: health centers with a physician and dentist on staff.

38 Maternal and child health clinics, for deliveries attended by general physicians and nursing degree graduates.

39 Renewing Primary Health Care in the Americas. Integrated Health Service Delivery Networks: Concepts, Policy Options, and a Road Map for Implementation in the Americas. PAHO/WHO, Washington 2010.

40 Health and Nutrition Sector Framework (document GN-2735-7).

41 Renewing Primary Health Care in the Americas. Integrated Health Service Delivery Networks: Concepts, Policy Options, and a Road Map for Implementation in the Americas. PAHO/WHO. 2010.

42 Ibid.

43 SESAL Statistical Yearbook. 2014.

44 Health Benefit Plans in Latin America. Úrsula Giedion, Ricardo Bitrán, and Ignez Tristao. IDB. May 2014.

Guarantees,[45] Colombia's Mandatory Health Plan,[46] and Uruguay's Comprehensive Health Care Plan,[47] demonstrated that defining a package of health benefits has allowed for greater equity and access to care, better coverage of services, and reduced hospitalization and mortality rates for various diseases (diabetes, high blood pressure, myocardial infarction, cervical cancer). In addition, by supplementing other measures, various indicators of health status, out-of-pocket expenses, and waiting times have improved, among others.

1.33 **Approval and implementation of the National Quality Strategy (ENC) in the health sector.** In addition to the challenges mentioned above, there is a need to develop, approve, and implement an ENC for the health sector. With approval of the National Quality Policy and System (PSNC), SESAL took the first step in the structural improvement of service quality. Even so, more efforts are needed for its implementation. For example, only maternal/child health services have some standard or protocol of care; only 7%[48] of the country's public and private health units have a health license authorizing them to operate; and only 31%[49] of SESAL hospitals have continuous improvement teams that are actually in operation. In addition, an external measurement within the framework of the Mesoamerican Health Initiative project (HO-G1003)[50] showed that less than half (46%) of the care for neonatal complications complied with the standards and only 67% did so in the case of care for obstetrical complications,[51] indicating that quite a large gap remains to improve quality.

1.34 Taking up implementation of the PSNC requires the development of a national strategy to put it into operation. Implementation of the PSNC would help proceed with the standardization of care processes,[52] mechanisms and instruments for verification or enforcement of that regulatory framework, guidelines for continuous quality improvement, and mechanisms for the certification[53] and accreditation[54] of care procedures and health facilities, which are necessary elements for guaranteeing and improving the quality of services.

1.35 Within the ENC framework, SESAL must also move ahead with defining and implementing efficient oversight mechanisms and at the same time update the minimum quality standards for the licensing of health units, since the current ones

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45 Bitrán, Escobar, and Gassibe (2010).

46 Health Benefit Plans in Latin America. Úrsula Giedion, Ricardo Bitrán, and Ignez Tristao. IDB. May 2014.

47 Ibid.

48 Data from the Health Regulation Division, SESAL 2015.

49 These are the decentralized hospitals and those targeted under the Mesoamerican Health Project in 2015.

50 The Mesoamerican Health Initiative 2015 (SM2015) is the result of a public/private regional partnership between the Bill & Melinda Gates Foundation (BMGF), the Carlos Slim Health Institute (ICSS), the Spanish Agency for International Development Cooperation (AECID), the IDB, and the countries of the region, to reduce the health gaps of the poorest 20% of the population in Mesoamerica.

51 External measurement of the Mesoamerican Health Project (HO-G1003) May 2016.

52 The standardization of health services is currently limited to maternal/child health care procedures.

53 Certification: voluntary procedure whereby a third party, called the certifier, issues a written guarantee that a person, facility, or service complies with the requirements established in standards or regulations, and attests to the competence thereof.

54 Accreditation of health services and facilities: external, voluntary, and periodic evaluation process that guarantees quality by measuring optimum standards previously established and known to the entities being evaluated.

may not have kept up with the new categorization established by the MNS. This would increase the percentage of health units with licenses to operate.

1.36 **Strengthening and expansion of the health services MGD.** The MGD has shown significant improvements in terms of access, coverage, efficiency, and quality of health services in the country. There are currently 279 primary health care facilities using the MGD, representing 16% of all SESAL units and covering 31% of SESAL's beneficiary population. Although progress has been made in terms of MGD coverage in the country's poorest municipios, implementation of the model must continue in the rest of the country. In addition, as SESAL's services are transferred to the IHSS, it is important that the centrally managed health services move ahead with changing the financing model, incorporating the RBF mechanisms that the MGD has been using, in order to improve the efficiency and quality of those services.

1.37 To achieve the consolidation and expansion of MGD coverage and in order to cover the population without this model,[55] and to incorporate RBF mechanisms in the latter, a strategic plan must be defined that contains, *inter alia*: (i) the chronological order of the network of facilities to be decentralized; (ii) estimated costs and financial requirements for expanding the MGD; (iii) the decentralization method[56] and type of managers; and (iv) the chronology for implementing RBF mechanisms in non-decentralized services. This plan will allow SESAL to allocate the corresponding resources to rapidly move ahead with expansion of the MGD and implementation of the RBF model in those services that are not decentralized. With the expansion of the MGD and based on the results of this model as described in paragraphs 1.13, 1.14, 1.15, and 1.16, the intention is to improve the allocation of human resources in health, coverage, quality, and efficiency in the health services that are decentralized.

1.38 **Approval of regulations for the certification of health services managers.** So that implementation of the MDG in the rest of the country can proceed, and given the various types of managers, there must also be regulations for the certification of health services managers, to regulate and standardize the requirements for the contracting and recontracting of managers. It is important to recognize that managers' capacities vary. For example, the Association of Municipalities (MdM) has the best results, with more than 90% compliance with standards of care for diarrheas and pneumonias in children under five, while the NGOs provide better general coverage, based on their assigned population, with an average of 2.5 visits per inhabitant, followed by the MdM, and then by the Community Based Organization. These regulations are expected to narrow gaps still existing in terms of meeting the managers' performance goals[57] and guarantee that expansion to new areas of the country will have the same level of success as in the implementation of

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55 SESAL estimates that 18% of the population finds it difficult to access services and that the population currently covered by the centralized model amounts to 17% of the country's total population.

56 Decentralization method: whether primary care services and hospital services are incorporated under a single manager in the decentralization process or the primary care network is decentralized separately from the corresponding hospital.

57 For example, SESAL's reports from its monitoring and evaluation of managers have reflected an average of 85% achievement of the targets established in the contracts, an acceptable average in the country. If ratings of less than 60% are obtained, a technical, administrative, and financial intervention of the manager is performed. If the same rating is obtained in the next monitoring, the contract is cancelled and agreements are signed with another manager.

the MGD so far. There are currently 42 managers, including municipalities, associations, community associations, foundations, and NGOs.

1.39 **Restructuring of the SESAL budget.** The SESAL budget is organized into programs, groups, activities, and works. To finance the health service provider units, SESAL assigns them (based on a historical budget) amounts by spending groups, according to production factors such as: salaries, inputs, medications, etc. For a health unit to change an expenditure group or purpose, it must obtain a series of approvals from the SESAL central level and the Ministry of Finance (SEFIN). This budgetary structure limits the implementation and progress of the MGD, in that it is organized based on factors of production (salaries, inputs, etc.) and not based on payment for services or payment per capita based on the covered population. For this reason, SESAL does not have the appropriate budgetary structure for contracting a manager and paying it for the number of people it must serve. In addition to not allowing for per capita payment based on the covered population, that structure makes it difficult to implement RBF, due to constraints on the reallocation of resources from one expenditure group to another, and thus be able to have the necessary flexibility in budgetary management to achieve the health goals agreed upon under the MGD and RBF.

1.40 To move forward with expanding the MGD to the rest of the country and implementing the CGSS, the historical allocation of the budget based on the factors of production must be changed to per capita allocation based on the covered population. An initial step for changing the current allocation and budgeting process would involve revising the catalogues classifying expenditure groups and purposes, so as to enable the creation of expenditure groups and purposes that would appropriately meet the requirements of the MGD and the CGSS.

1.41 **Implementation of a human resources management and control system.** An important element for moving forward with the reform, which has been given limited attention, is to improve SESAL's human resources management and make it more efficient. Studies conducted[58,59] found that 21% of employees within the central level, departmental regions, and health services that have not yet been decentralized[60] receive unjustified payments[61] in SESAL.[62] For the Honduran government, this represents an annual cost of approximately US$23.7 million, without counting accrued pension liabilities,[63] collateral, and various benefits to which SESAL employees are legally entitled.[64] The studies also found cases of personnel who were hired without application of current standards and laws as well as inconsistencies in the payment and functional assignment of personnel. In addition,

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58 Analysis and description of SESAL positions. Deloitte. October 2015.

59 Verification and validation of the payroll of SESAL and the Revenue Division. SEFIN-WB. DLA *Consulting*. 2015.

60 From a sample of almost 8,000 of SESAL's 24,000 employees.

61 Unjustified payments means employees who earn a salary, under any of the following conditions: they are not found in the unit assigned in their contract but are functionally found in other units; they have extended and continuously renewed periods of disability; they have extended absences and/or fail to be present in the assigned unit, or are regularly absent from work; payments to the deceased; and other situations.

62 Verification and validation of the payroll of the Health Ministry and the Revenue Division. Conducted by DLA *Consulting*; in April 2015.

63 It is the debt that companies generate during the years in which an employee works in a company and use to cover benefits under the law.

64 Ibid.

these studies indicated that SESAL has excess numbers of staff not involved in care delivery.

1.42 Recommendations made on the basis of the studies conducted include: (i) improving existing information systems to consolidate figures on total employees by type of contract and to facilitate control and monitoring of payments, positions, and vacancies; (ii) doing a detailed review of the current nomenclature of positions, in order to confirm that they correspond to the nature of the function for which they were contracted, so that they effectively respond to the organization's need; (iii) reordering the assignment of staff with their respective budget line in each of the health units; (iv) defining standardized criteria for each class, delineating responsibilities included within each class, and defining the purpose of the position; (v) creating a system of incentives for high performance, to include salary increases for employees with strong performance; and (vi) reducing the number of employees not directly involved in delivering care and distributing them so that most of the them are engaged in substantive tasks and fewer are engaged in administrative tasks.

1.43 The reason for implementing a human resources management and control system is that such a system will implement the recommendations mentioned and thus reduce the deficiencies found. A firm would be contracted to design the system and SESAL would implement it to resolve the problems found as a result of deficient human resources control and management.

5. Connection to other Bank operations and lessons learned

1.44 The Bank has extensive experience supporting the process of reform and decentralization of health services in Honduras. Since 2011, the Bank has been supporting the financing and expansion of the MGD, through projects under the Program to Strengthen Decentralized Management and Supply of Health Services HO-L1059 (2418/BL-HO) and the Program for Improved Accessibility and Quality of Health Services and Networks HO-L1090 (2943/BL-HO). These projects increased coverage of the MGD from 402,418 to 1,314,432 inhabitants.[65] Under the Mother and Child Hospital Network Strengthening Program HO-L1072 (2743/BL-HO), the country began to implement the MGD in hospitals, having decentralized six hospitals to date.

1.45 Lessons learned through projects supporting the MGD include: (i) the RBF model implemented through the MGD has been effective for improving the coverage, quality, and efficiency of health services; (ii) payment mechanisms are powerful instruments for modulating the behavior of supply; in this regard, linking a portion of capitated payments to the achievement of indicators also contributed to improving the quality, productivity, and coverage of the health services; (iii) contracting foundations to administer hospitals has made it possible to improve hospital quality and efficiency indicators as mentioned in paragraph 1.17; (iv) linking capitated payments to the achievement of quality and coverage indicators in services providing essential obstetrical and neonatal care has promoted significant innovations at the local level, which has helped managers achieve goals agreed upon in the areas of maternal and child health care; (v) implementing the ESFAM pilots in some municipios has made it possible to demonstrate that this strategy facilitates the implementation of a more comprehensive model of care with a focus

[65] Project Completion Report. Program to Strengthen Decentralized Management and Supply of Health Services. Loan contract 2418/BL-HO. 2016.

on the family and the community; (vi) MGD implementation has demonstrated the need to improve the legal framework, specifically in terms of government purchasing and contracting regulations and in the implementation of payment mechanisms; and (vii) while the MGD has been advancing, the need to strengthen SESAL's governance role has been noted, specifically in terms of regulatory capacity, planning, and monitoring and evaluation.

1.46 This operation lends continuity to the support the Bank has provided in the sector and to the lessons learned from the MGD, which will be taken into account for developing the Strategic Plan for Expanding and Extending the MGD, particularly in terms of financing and management modalities, and for preparing and approving the MNS in the case of experiences with the ESFAMs. These lessons learned also reflect the need to strengthen the legal framework in order to improve purchasing and contracting procedures under the MGD and strengthen SESAL's governance role. In addition, this operation generates a synergy with investment operations HO-L1072,[66] HO-L1090, [67] and HO-L1105.[68] On the one hand, the programmatic series seeks to establish a legal-regulatory framework to make reorganization of the system, the separation of system functions, and the MGD viable. On the other, the interventions set out in operations mentioned in this paragraph facilitate the implementation, consolidation, and extension of the MGD both at the primary care level and in hospitals.

1.47 Based on the background, government proposal, and Bank experience supporting the health sector reform process and implementing the MGD, a programmatic series supporting sector reform is proposed to improve the efficiency of the system and quality in the provision of services, under the Policy-based Programmatic Loan (PBP) modality. This instrument makes it possible to monitor compliance with policy measures that are fundamental for system reform and consolidation. To this end, support will be provided for the development of legal regulations (SNS Law) to supplement the LMPS for the reorganization and regulation of the SNS; the approval of a technical-regulatory framework that provides guidelines for changing the model of care, the formation of ESFAMs and RISSs, and the formulation of a national health benefits plan; and the definition of a regulatory instrument that sets standards for the certification of managers.

1.48 In addition to the above, the operation seeks to: establish a regulatory framework to strengthen the quality system, including the definition of standards for authorizing health facilities; and restructure the SESAL budget, to facilitate implementation of the decentralized model and of a new SESAL human resources management and control system, to improve the efficiency of services. In this process, the Bank's contribution stems from its technical knowledge regarding health sector reforms, as well as its experience in the design and implementation of decentralized management models, budgetary allocation mechanisms, and quality systems, among others.

6. Strategic alignment of the program

1.49 The project is consistent with the Update to the Institutional Strategy 2010-2020 (UIS) (document AB-3008) and aligned with the development challenge of social

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66 Mother and Child Hospital Network Strengthening Program HO-L1072 (2743/BL-HO).

67 Program for Improved Accessibility and Quality of Health Services and Networks HO-L1090 (2943/BL-HO).

68 Program to Support the Social Inclusion Network with Priority in Western Honduras HO-L1105 (3723/BL-HO).

inclusion and equality through expansion of the MGD and improved efficiency and rationalization in the use of human and financial resources in health services. It is also aligned with the cross-cutting issue of gender equality and diversity, by increasing access to maternal and women's health services. In addition, the program is aligned with the Corporate Results Framework (CRF) 2016-2019 (document GN-2727-6) through the development outcome indicators of reduced maternal mortality and contributes to the outcome indicator of health services beneficiaries.

1.50 The project is also consistent with the Bank's strategy with Honduras for the 2015-2018 period (document GN-2796-1) with the objectives of: (i) promoting human capital accumulation of minors in households in extreme poverty; and (ii) improving the health indicators of children under five. It also contributes to the strategic lines on human capital of the Alliance for Prosperity Plan in the Northern Triangle (PATN), by promoting maternal-child health in migrant-generating municipios.[69]

1.51 This project is also aligned with the Health and Nutrition Sector Framework (document GN-2735-7), in that it considers actions to increase coverage, primary health care, integration of service networks, continuous quality improvement, and RBF, among others. The program is consistent with the Strategy on Social Policy for Equity and Productivity (document GN-2588-4) and the 2017 Country Programming Document.

B. Objectives, components, and cost

1.52 **Objective and expected outcomes.** The objective of the programmatic series is to enhance the coverage, efficiency, and quality of the National Health System (SNS) in the delivery of services to improve the health of the population throughout the country.

1.53 The first operation will support the preparation and submission to the National Congress of the SNS Law, with provisions defining the roles and responsibilities of the institutions that make up the system. It will also support the definition and approval of the National Health Model (MNS) and the National Quality Strategy (ENC) to implement the National Quality Policy and System (PSNC). Another aspect to be supported by the first operation is the consolidation and expansion of the MGD, including the adoption of a regulatory framework and mechanisms for certifying managers of decentralized services. Lastly, the first operation will support the preparation of a proposed restructuring of the SESAL budget, based on per capita cost of care and the design of a human resources management and control system. The second operation will move forward with implementation of the reform, using as its legal basis the approval of the SNS Law; the definition and approval of the CGSS; the formation of the RISSs and ESFAMs; regulations for licensing health facilities in accordance with the new categorization established in the MNS; expansion of the MGD at the primary care level and in hospitals; the creation of mechanisms for the certification of managers; the implementation of the human resources management and control system; and reforms in SESAL budget formulation.

1.54 **Component 1. Macroeconomic framework.** The objective of this component is to ensure a macroeconomic context consistent with the program objectives as established in the Policy Matrix.

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[69] The decentralized municipios include 57 in the PATN.

1.55 **Component 2. Development of the legal, regulatory, and operational framework of the SNS.** The measures developed under this component seek to improve the efficiency and quality of health services through actions leading to reorganizing the system, strengthening SESAL's governance capacity, changing the model of care and networked organization of health services, and implementing the PSNC—important to reducing maternal and child mortality. Under the first operation, an SNS Law proposal is expected to have been drafted and submitted to the National Congress that covers at a minimum: (i) the functions and mechanisms of the system governance and regulatory role; (ii) mechanisms for coordination and relations among the institutions that make up the system; (iii) the financing sources and mechanisms for the health services; (iv) delivery management modalities; and (v) the arrangement for signing long-term contracts with managers. Support will also be provided for the updating and approval of the MNS, which should contain: (i) a delineation of levels of care; (ii) technical criteria for setting up the RISSs; (iii) the new categorization and characteristics of primary and secondary health care facilities; and (iv) criteria for establishing the ESFAMs. Under this component, approval of the ENC will be sought, in order to proceed with implementation of the PSNC. The ENC will contain the guidelines for moving ahead on the formulation of standards, guides, and protocols of care[70] and the mechanisms and instruments for verification or monitoring of that regulatory framework. The ENC will also include the guidelines for implementing continuous quality improvement programs in hospitals and the mechanisms for certification and accreditation of health care processes and facilities.

1.56 Under the second operation, the SNS Law is expected to be approved so that there is a legal framework in place for reorganizing the system based on the separation of the governance, financing, insurance, and service delivery functions. In addition, the CGSS will be defined and approved, in accordance with the Framework Social Protection Law, applicable to SESAL and the IHSS, as an important element for the planning, prioritization, and allocation of health care resources, seeking equity in the system and improvements in the financial protection of the population.

1.57 Moreover, implementation of the MNS is expected to have begun through the formation of 20 prioritized RISSs among the 69 identified by SESAL, in accordance with the criteria defined in the MNS and the characteristics of the health facilities. Minimum quality standards are expected to have been approved for public and private health facility licensing in accordance with the new categorization, as part of the implementation of the ENC. Moreover, the organization and training of the continuous quality improvement teams should begin in maternal-neonatal services in hospitals that offer these services.

1.58 **Component 3. Decentralized management.** The objective of this component is to increase health services coverage by expanding and strengthening the MGD, which would result in increased coverage for prenatal, delivery, postpartum, and neonatal care. Under the first operation, the strategic plan for strengthening and expanding the decentralized management model should be approved, as a linchpin for the country to proceed with the MGD in primary and secondary care, that includes: (i) the health services networks and population to be covered; (ii) hospitals with a decentralized management model; (iii) decentralized management modality in

[70] Currently, the standardization of health services is limited to health care processes in maternal/child services.

primary and secondary care;[71] (iv) estimated resource requirements and funding gaps for decentralization; (v) identification of the networks in which RBF mechanisms will be implemented;[72] and (vi) measures for strengthening and improving the MGD monitoring and evaluation system. Support will also be provided for approval of regulations for the system to certify managers that deliver decentralized health services at the primary and secondary levels of care, containing the legal, technical, organizational, administrative, accounting, and financial requirements necessary for the process.[73]

1.59 Under the second operation, the continuity and implementation of the policy measures of the first operation will be supported as follows: increasing to 2,000,000 the population covered by decentralized management models for primary health care services and decentralization of at least four additional hospitals. The criteria for prioritizing municipios for expansion of MGD coverage will be as follows: the Human Poverty Index (HPI), the Health Index, and the Human Development Index (HDI). Priority will also be given to those communities in which the *Bono Vida Mejor* conditional cash transfers are provided, to guarantee shared responsibility for health. Support will also be provided for: (i) the definition and implementation of RBF mechanisms in SESAL's centrally managed services; (ii) UGD use of an automated balanced scorecard for monitoring management contracts or agreements, as evidence that the MGD monitoring and evaluation system has been strengthened; and (iii) the certification of at least 10 primary care managers.

1.60 **Component 4. Improvement in the efficiency of public spending in the health care system.** The objective is to improve efficiency in the delivery of services by strengthening the human resources management tools and modifying the budgetary structure to change the process of allocating resources to fund health services.

1.61 In the first operation, SESAL will develop a proposal on criteria for per capita allocation of the budget for the delivery of primary care services. The proposal will contain: (i) territorial allocation criteria based on the assigned population; and (ii) the criteria for calculating the per capita cost of services. In addition and in order to reduce unjustified payments to employees, SESAL is expected to have contracted a firm to design the implementation of a SESAL human resources management and control system,[74] including: (i) measures to improve human resources information systems; (ii) a manual of functions and adjustment of the current nomenclature of SESAL positions; (iii) measures for transition of the labor force approaching retirement age; (iv) strategic measures for raising the level of training of the Health Ministry's labor force, including a human resources development and certification program; (v) human resources control measures to eliminate unjustified payments; (vi) internal work rules; and (vii) manuals of processes and procedures, personnel contracting and control, and others related to the area of human resources.

1.62 With the second operation, SESAL will have formulated the budget using the new allocation criteria (including the funds needed to cover the goal of extending the MGD at the primary care level) and will have submitted it to the Congress.

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[71] The management modality refers to the types of managers to be contracted, whether public or private, and whether primary care will be integrated with secondary care.

[72] Referring to centrally managed services.

[73] This will govern and standardize the requirements for contracting and recontracting managers.

[74] The system's design will be based on recommendations from human resources audits, which are consistent with those listed in this paragraph.

Implementation of the human resources management and control system is expected to have been approved and initiated.

C. Key Results Matrix indicators and economic analysis

1.63 The Results Matrix of the programmatic series identifies the outputs and outcomes that are expected to result from implementation of policy measures aimed at increasing the quality and efficiency of health services delivery. At the impact level of the project matrix, the indicators on maternal and child mortality will be monitored because they adequately reflect the types of improvements that will be achieved with the project. The outcome indicators measure progress made in implementing the reform at the national level, for example: the percentage of health networks that have been formed in the country; the percentage of hospitals offering maternal/child services that have continuous improvement systems in operation; the percentage of certified health managers; the percentage of decentralized hospitals; the coverage of decentralized managers at the primary care level; and unjustified payments to employees at the central level, departmental regions, and health services of SESAL. Outputs notably include the preparation of the SNS Law, the CGSS, revision of the MNS, extension and coverage of primary and secondary care through the MGD; and the design and implementation of the SESAL human resources management and control system.

1.64 An economic analysis was performed of the costs and benefits expected from the reform's most emblematic policy measures. The analysis is based on the social benefits to be generated from increased coverage of decentralized primary health care services and the decentralization of four public hospitals. In both cases, as the base scenario, the present value of savings and benefits generated by the implementation of the policy measures was calculated, using a discount rate of 5%[75] and various scenarios for achieving savings over a period of 10 years. For the analysis of secondary care, the benefits were quantified based on the reduction in unit costs for: childbirths in a clinical setting; reduction in average hospital stay, and increase in outpatient visits.[76] These three phenomena would be the result of improved hospital management. Estimated savings equal a net present value (NPV) of US$26.6 million, a value that does not consider gains due to improvements in service quality. As for the effects of expanding the population covered by decentralized primary health care managers, the benefits are calculated in two ways: based on gains in disability adjusted life years (DALYs) of individuals who previously had no access to health services and based on cost savings by individuals who formerly used centrally managed public health services. In this case, the NPV of the benefits of implementing the reforms in social subsidies is about US$174 million, an amount consisting of US$166.7 million based on DALYs gains and US$7.3 million due to cost savings. With a sensitivity analysis that considers changes in the discount rate and the pace of implementation of the reform, the results range between US$210 million and US$66 million. The overall result in the base scenario—with a discount rate of 5%—is US$200.6 million.

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[75] This value emerges from the suggestion made by Zhuang (2008), who suggests using a discount rate of 3% for countries with moderate growth.

[76] Given that total costs are considered to be constant, this implies a reduction in unit cost.

II. Financing Structure and Main Risks

A. Financing instruments

2.1 This operation was designed as a Policy-based Programmatic Loan (PBP) with two individual loans. Its structure is consistent with the guidelines established in the document "Policy-based Loans: Guidelines for Preparation and Implementation" (document CS-3633-1). This modality is suitable for the dynamic of the policy discussion, in that it makes it possible to monitor and support the health sector reform strategy over the medium term. That reform has technical and coordination elements that justify the selection of the programmatic instrument for monitoring its implementation. The amount of financing under this first operation in the programmatic series is up to US$50 million, US$30 million from regular Ordinary Capital (OC) resources and US$20 million from concessional Ordinary Capital. The amount of financing and the date of the second phase will be defined based on the financial needs of the country and the programming exercise with the Bank.

2.2 **Scaling of the operation.** In accordance with the provisions of paragraph 3.27 (b) of the document "Policy-based Loans: Guidelines for Preparation and Implementation. New version" (document CS-3633-1), the dimensions of the operation were determined based on the country's fiscal resource needs. The external financing needs of the central government are equivalent to 1.9% of GDP, and the amount of the operation is intended to cover 12.3% of such financing needs. According to the analyses done by the Bank and the IMF, the Honduran macroeconomic outlook is positive and debt sustainability analyses indicate that total public debt as a percentage of GDP is trending downward.

B. Environmental and social risks

2.3 According to Directive B.13 of the Environment and Social Safeguards Compliance Policy (document GN-2208-20 and OP-703) the loan does not require classification. The social impact of the program's policy measures is expected to be positive.

C. Other project risks

2.4 There is a favorable context for implementation of the policy measures of this first operation, which fall within the framework of the LMPS approved in July 2015. However, there is a risk of delays in meeting the conditions related to the second operation in the series due to general elections in 2017. To mitigate this risk, the government has already built a consensus with the various actors and different political forces around the LMPS and the IHSS Law. As a result, many aspects that could generate controversy have been addressed and agreed upon in the process of approving the aforementioned laws. In addition, nonreimbursable technical-cooperation resources (HO-T1259) will be provided to support the institutions responsible for implementing the policy measures and discussions will intensify with the new authorities to ensure that the political consensus around the reforms is maintained. Through the technical cooperation operation, technical assistance will be contracted to work together with SESAL and SEFIN on the different conditionalities, so as to have most of them in place prior to the general elections. Other risks identified were that associations of health professionals and workers would oppose measures linked to the management and control of human resources and the reform process in general, particularly in the context of the electoral cycle. To mitigate this risk, a strategy for implementing the human resources management and control strategy will be formulated, beginning with the elements that entail the

least opposition possible, and a social communication campaign will be conducted that emphasizes the benefits of the reform for Honduran citizens.

III. Implementation and Management Plan

A. Summary of implementation arrangements

3.1 The borrower is the Republic of Honduras. The executing agency will be SEFIN, through the Directorate of Public Credit, which will be responsible for coordinating the design and implementation of the reforms, promoting actions to achieve the objectives. SEFIN will also be responsible for delivering reports and evidence that the conditions have been fulfilled. The executing agency will coordinate with SESAL, which will be responsible for fulfilling the policy conditions. The Management Planning and Evaluation Unit (UPEG) will be responsible for monitoring fulfillment of the conditions and the indicators.

3.2 The SNS Law will be administered by SESAL's Office of the Deputy Minister for Networks in coordination with the IHSS Management Board. The UGD, also part of SESAL, in coordination with the UPEG, will be responsible for formulating the Strategic Plan for the Consolidation and Expansion of the MGD and the Regulations for the Certification of Managers. The Primary Care Department will be responsible for developing the MNS. The ENC will be formulated by the Directorate of Services Networks, while preparation of the proposal for the per capita allocation of the budget will be coordinated by SESAL's UPEG and SEFIN's Budget Directorate. Lastly, the Human Resources Management and Control System will be coordinated between SESAL's Human Resources Department and the Civil Service Bureau.

3.3 **Special contractual conditions precedent to loan disbursement.** The single disbursement of the loan proceeds will be contingent upon compliance with the policy reform conditions, in accordance with the provisions of the Policy Matrix (Annex II) and the Policy Letter, and the contractual conditions established in the loan contract.

B. Summary of the results monitoring arrangements

3.4 Program monitoring is defined by verification of the policy measures agreed upon as disbursement conditions and described in the Results Matrix and the Means of Verification Matrix. The results of reforms will also be monitored through the indicators mentioned in the Results Matrix. Achievement of the output indicators will be verified with the detailed information in the Means of Verification Matrix. This matrix contains all the actions to be implemented in the program, the entities responsible for achieving those actions, and specific information that will allow the Bank to verify their achievement. The results of the policy changes promoted will be monitored through information on the achievement of those indicators generated by SESAL institutional reports or administrative systems. As to the impact indicators, in the case of infant mortality the indicator should be calculated using the National Demography and Health Survey (ENDESA). Given that the operation's impact is expected to become effective at least five years after the conditions are fulfilled, the indicators will be taken from the ENDESA survey closest to the year 2022. The indicator of maternal mortality will be calculated from the Ramos study.[77] The

[77] The Reproductive Age Mortality Survey, or RAMOS method, is a type of study covering all deaths among women of reproductive age (ages 10 to 49), in which the causes of each death and the mechanisms that could have prevented it are identified.

project's outcomes will be evaluated as part of project completion report (PCR) prepared for the two operations together, 12 months after completion of the second operation and subsequently through the Honduran ENDESA reports. There are no plans for an ex post evaluation in addition to the operation's PCR. See the Monitoring and Evaluation Plan.

IV. POLICY LETTER

4.1 The Bank agreed with the Government of Honduras that the Policy Letter will be submitted by SEFIN and will describe the policy actions of the government's strategy in the macro and sectoral area that the country is implementing and plans to carry out with this program.

Development Effectiveness Matrix		
Summary		
I. Corporate and Country Priorities		
1. IDB Development Objectives	Yes	
Development Challenges & Cross-cutting Themes	-Social Inclusion and Equality -Gender Equality and Diversity	
Country Development Results Indicators	-Maternal mortality ratio (number of maternal deaths per 100,000 live births) -Beneficiaries receiving health services (#)*	
2. Country Development Objectives	Yes	
Country Strategy Results Matrix	GN-2796-1	(i) Protect minimum levels of consumption among the population in poverty; (ii) Promote the human capital accumulation of minors in households in extreme poverty; (iii) improve the health indicators of children under 5.
Country Program Results Matrix	GN-2884	The intervention is included in the 2017 Operational Program.
Relevance of this project to country development challenges (If not aligned to country strategy or country program)		
II. Development Outcomes - Evaluability	Evaluable	
3. Evidence-based Assessment & Solution	10.0	
3.1 Program Diagnosis	3.0	
3.2 Proposed Interventions or Solutions	4.0	
3.3 Results Matrix Quality	3.0	
4. Ex ante Economic Analysis	10.0	
4.1 The program has an ERR/NPV, a Cost-Effectiveness Analysis or a General Economic Analysis	4.0	
4.2 Identified and Quantified Benefits	1.5	
4.3 Identified and Quantified Costs	1.5	
4.4 Reasonable Assumptions	1.5	
4.5 Sensitivity Analysis	1.5	
5. Monitoring and Evaluation	5.5	
5.1 Monitoring Mechanisms	1.5	
5.2 Evaluation Plan	4.0	
III. Risks & Mitigation Monitoring Matrix		
Overall risks rate = magnitude of risks*likelihood	Medium	
Identified risks have been rated for magnitude and likelihood	Yes	
Mitigation measures have been identified for major risks	Yes	
Mitigation measures have indicators for tracking their implementation	Yes	
Environmental & social risk classification	B.13	
IV. IDB´s Role - Additionality		
The project relies on the use of country systems		
Fiduciary (VPC/FMP Criteria)	Yes	Financial Management: Budget.
Non-Fiduciary	Yes	Strategic Planning National System, Monitoring and Evaluation National System.
The IDB's involvement promotes additional improvements of the intended beneficiaries and/or public sector entity in the following dimensions:		
Gender Equality		
Labor		
Environment		
Additional (to project preparation) technical assistance was provided to the public sector entity prior to approval to increase the likelihood of success of the project		
The ex-post impact evaluation of the project will produce evidence to close knowledge gaps in the sector that were identified in the project document and/or in the evaluation plan		

Note: (*) Indicates contribution to the corresponding CRF's Country Development Results Indicator.

The programmatic series "Program of Support to the Reform of the Health Sector" of Honduras aims to improve the coverage, efficiency, and quality of the National Health System in the provision of services. The first operation will support the preparation and adoption of tools to strengthen the Decentralized Management Model (MGD, for its acronym in Spanish), as well as a legal and regulatory framework to implement the health reform and to change the model of service provision and organization. In addition, it will support the definition of a National Quality Strategy (ENC, for its acronym in Spanish), the restructuring of the budget of Secretary of Health (SESAL, for its Spanish acronym) and the definition of a system of management and control of Human Resources. The program will benefit the population throughout the country.

The vertical logic presented in the POD is consistent, covering inputs, activities, products, results and impacts. The results matrix includes indicators for the main products of this first operation and, also, the results and impacts of the program series. All indicators meet the SMART criteria and include baseline values and targets, as well as the sources and means of verification that will be used to measure them. The final impact indicators will measure maternal mortality ratios and infant mortality rates across the country. The executing agency will be the Secretary of Finance (SEFIN) through the General Directorate of Public Credit, which will be responsible for coordinating the design and implementation of the reforms. The Management Planning and Evaluation Unit (UPEG, for its acronym in Spanish) will be in charge of monitoring compliance with the conditions and monitoring of the indicators.

The project presents a cost-benefit analysis that supports the economic viability of the proposed activities.

Given that the first operation of this program series focuses on the generation of a legal and regulatory framework to advance in the implementation of the reform of the health sector, monitoring mainly consists of following the elaboration, presentation and approval of different norms and laws. In this sense, no additional costs have been allocated for the implementation of the monitoring, since the information needed to follow the indicators of the results matrix will be available as a result of the activities contemplated in the first operation. At the end of the project, a "before-after" evaluation without attribution is planned in the context of the PCR based on the matrix impact indicators.

POLICY MATRIX

Objective: The objective of the programmatic series is to improve the coverage, efficiency, and quality of the National Health System (SNS) in the delivery of services to improve the health of the population throughout the country. The specific objectives are: (i) stability of the general framework of macroeconomic policies; (ii) reorganization of the SNS; (iii) improvement of the model and quality of health services delivery; (iv) expansion and strengthening of the decentralized management model in health care services; and (v) improved efficiency and rationalization in the use of human and financial resources in health care.

Component and specific objective	Policy conditions for Programmatic Loan I (2017)	Trigger mechanisms for Programmatic Loan II
1. Stability of the general framework of macroeconomic policies	1.1 Maintenance of a stable macroeconomic framework conducive to achievement of the program objectives and the guidelines established in the sector Policy Letter.	Maintenance of a stable macroeconomic framework conducive to achievement of the program objectives and the guidelines established in the sector Policy Letter.
2. Development of the legal, regulatory, and operational framework of the SNS (i) Reorganization of the SNS	2.1 A proposal for a National Health System Law has been prepared and submitted to the National Congress, containing: (i) the institutions that make up the system and their functions;[1] (ii) the governance and regulatory role of the system; (iii) the mechanisms governing coordination and relations; (iv) financing sources and mechanisms; (v) delivery management modalities; and (vi) the provisions for signing long-term contracts with managers.	2.1.a The National Congress enacts the law. 2.1.b Definition and approval of the Guaranteed Package of Health Benefits and Services, in accordance with the LMPS, applicable to the Ministry of Health (SESAL) and the Honduran Social Security Institute (IHSS).
(ii) Improvement in the model and quality of health services delivery	2.2 The National Health Model (MNS) has been updated and approved, and contains at least: (i) a definition of the levels of care; (ii) technical criteria for identification and formation of the Integrated Health Services Networks (RISSs); (iii) categorization and characterization of primary and secondary health care facilities; and (iv) criteria for forming Family Health Teams (ESFAMs).	2.2.a. Establishment of at least 20 integrated health services networks (RIISs), in accordance with the criteria set out in the MNS and taking into account the categorization of health facilities.

[1] Consider the understanding and scope of the elements of the law and harmonize it with the Framework Social Protection Law (LMPS). These elements are not necessarily individual titles or chapters of the law.

Component and specific objective	Policy conditions for Programmatic Loan I (2017)	Trigger mechanisms for Programmatic Loan II
	2.3 The National Quality Strategy (ENC) has been approved, including: (i) guidelines for moving forward with formulating standards, guides, and protocols of care; (ii) mechanisms and instruments for verification or monitoring of that policy framework; (iii) guidelines for the implementation of continuous quality improvement programs in hospitals; and (iv) mechanisms for certification and accreditation of health care processes and facilities.	2.3.a. Approval of the regulations containing standards for authorization of public and private health care facilities, based on the new categorization thereof. 2.3.b Initiation of the organization and training of continuous quality improvement teams for maternal-neonatal services in at least 25 hospitals.
3. Decentralized management (i) Expansion and strengthening of the decentralized management model in health care services	3.1 The strategic plan to strengthen and expand the decentralized management model (MGD) in primary and second health care services has been approved and contains: (i) health services networks and the population to be covered; (ii) hospitals with decentralized management models (MDG); (iii) modalities to be decentralized (whether through public or private managers or by integrating hospitals with primary care); (iv) estimated resource requirements and funding gaps for decentralization; (v) definition of networks in which results-based financing (RBF) mechanisms will be implemented; and (vi) measures for strengthening and improving the MGD monitoring and evaluation system.	3.1.a The population covered by decentralized management models in primary care has increased to 2,000,000. 3.1.b At least four additional hospitals have been decentralized. 3.1.c RBF mechanisms have been defined and implemented in SESAL's centrally managed services. 3.1.d The Decentralized Management Unit (UGD) is using an automated balanced scorecard for monitoring management contracts or agreements.

Component and specific objective	Policy conditions for Programmatic Loan I (2017)	Trigger mechanisms for Programmatic Loan II
	3.2 Approval of regulations for the system for certifying managers[2] that provide decentralized primary and secondary care,[3] containing the legal, technical, organizational, administrative, accounting, and financial requirements and guidelines necessary for that process.	3.2 At least 10 primary care level managers have been certified.
4. Improvement in the efficiency of public spending in the health care system (i) Improve efficiency and rationalization in the use of human and financial resources in health services.	4.1 Development by SESAL of proposed criteria for per capita allocation of the budget for the delivery of primary care services, to contain at least: (i) territorial allocation criteria based on the assigned population; and (ii) criteria for calculating per capita costs of services. 4.2 A firm has been contracted to design a SESAL human resources management and control system, including at least the following: (i) measures for improving human resources information systems; (ii) manual of functions and adjustment of current nomenclature of SESAL positions; (iii) measures for transition of labor force approaching retirement age; (iv) strategic measures for raising the training level of SESAL's labor force, including a human resources development and certification program; (v) human resources control measures to eliminate unjustified payments; (vi) internal work rules; and (vii) manuals of processes and procedures, personnel contracting and control, and others related to the area of human resources.	4.1 The SESAL budget formulated using the new allocation criteria, including the funds necessary to cover the goal of extending the decentralized management model, has been submitted to the National Congress. 4.2 Processes and procedures manuals in SESAL's human resources area have been approved.

[2] In accordance with the LMPS, managers will be called *Administradoras de Servicios de Salud* [Health Services Administrators].

[3] Primary care refers to outpatient and low complexity health services; secondary care refers to hospital health services.

DOCUMENT OF THE INTER-AMERICAN DEVELOPMENT BANK

PROPOSED RESOLUTION DE-__/17

Honduras. Loan ____/BL-__ to the Republic of Honduras
Program to Support Health Sector Reform

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 Republic of Honduras, as Borrower, for the purpose of granting it a financing to cooperate in the execution of the Program to Support Health Sector Reform. Such financing will be chargeable to the Bank´s Ordinary Capital (OC) resources in the following manner: (i) up to the amount of US$20,000,000, subject to concessional financial terms and conditions ("Concessional OC"); and (ii) up to the amount of US$30,000,000, subject to financial terms and conditions applicable to loan operations financed from the Bank's regular program of OC resources ("Regular OC"), as indicated in the Project Summary of the Loan Proposal, and subject to the Special Contractual Conditions of said Project Summary.

(Adopted on ____ _____ 2017)

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