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UNITED STATES INTERNATIONAL DEVELOPMENT COOPERATION AGENCY
AGENCY FOR INTERNATIONAL DEVELOPMENT
Washington, D. C. 20523

COSTA RICA

PROJECT PAPER

HEALTH SERVICES SUPPORT

AID/LAC/P-159

Project Number: 515-0203
Loan Number: 515-U-042

UNCLASSIFIED

AGENCY FOR INTERNATIONAL DEVELOPMENT PROJECT DATA SHEET		1. TRANSACTION CODE <input type="checkbox"/> A = Add <input type="checkbox"/> C = Change <input type="checkbox"/> D = Delete <input checked="" type="checkbox"/> A	Amendment Number _____	DOCUMENT CODE 3
2. COUNTRY/ENTITY COSTA RICA		3. PROJECT NUMBER 515-0203		
4. BUREAU/OFFICE LAC 05		5. PROJECT TITLE (maximum 40 characters) Health Services Support		
6. PROJECT ASSISTANCE COMPLETION DATE (PACD) MM DD YY 1 2 3 1 8 6		7. ESTIMATED DATE OF OBLIGATION (Under 'B.' below, enter 1, 2, 3, or 4) A. Initial FY 8 3 B. Quarter 4 C. Final FY 8 4		

8. COSTS (\$000 OR EQUIVALENT \$1 =)						
A. FUNDING SOURCE	FIRST FY 1983			LIFE OF PROJECT		
	B. FX	C. L/C	D. Total	E. FX	F. L/C	G. Total
AID Appropriated Total						
(Grant)	(180)	(70)	(250)	(230)	(70)	(300)
(Loan)	(5,600)	(100)	(5,700)	(9,750)	(250)	(10,000)
Other U.S.	1.					
	2.					
Host Country	5,150	1,850	7,000	15,000	5,000	20,000
Other Donor(s)						
TOTALS	10,930	2,020	12,950	24,980	5,320	30,000

9. SCHEDULE OF AID FUNDING (\$000)									
A. APPROPRIATION	B. PRIMARY PURPOSE CODE	C. PRIMARY TECH. CODE		D. OBLIGATIONS TO DATE		E. AMOUNT APPROVED THIS ACTION		F. LIFE OF PROJECT	
		1. Grant	2. Loan	1. Grant	2. Loan	1. Grant	2. Loan	1. Grant	2. Loan
(1)	580	530		0		0,250		0,300	
(2)	580		570		0		5,700		10,000
(3)									
(4)									
TOTALS						0,250	5,700	0,300	10,000

10. SECONDARY TECHNICAL CODES (maximum 6 codes of 3 positions each) 510 930						11. SECONDARY PURPOSE CODE			
12. SPECIAL CONCERNS CODES (maximum 7 codes of 4 positions each) A. Code BU BR									
B. Amount 4,500 5,500									

13. PROJECT PURPOSE (maximum 480 characters)

To provide pharmaceuticals and medical supplies to Costa Rica's health care system, and to help stabilize the financial position of the Caja Costarricense de Seguro Social.

14. SCHEDULED EVALUATIONS Interim MM YY MM YY Final MM YY 0 3 8 5 0 9 8 6				15. SOURCE/ORIGIN OF GOODS AND SERVICES <input type="checkbox"/> 000 <input checked="" type="checkbox"/> 941 <input checked="" type="checkbox"/> Local <input type="checkbox"/> Other (Specify) CACM			
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16. AMENDMENTS/NATURE OF CHANGE PROPOSED (This is page 1 of a _____ page PP Amendment.)

17. APPROVED BY	Signature <i>Bastian B. Schout</i>		18. DATE DOCUMENT RECEIVED IN AID/W, OR FOR AID/W DOCUMENTS, DATE OF DISTRIBUTION			
	Title <i>Acting Mission Director</i>		Date Signed MM DD YY 0 7 3 0 8 3		MM DD YY	

PROJECT AUTHORIZATION

Name of Country : Costa Rica
Name of Project : Health Services Support
Number of Project : 515-0203
Number of Loan : 515-U-042

1. Pursuant to Section 104(c) of the Foreign Assistance Act of 1961, as amended, I hereby authorize the Health Services Support project for Costa Rica involving planned obligations of not to exceed Ten Million United States Dollars (\$10,000,000) in loan funds ("Loan") and Three Hundred Thousand United States Dollars (\$300,000) in grant funds ("Grant") over a two year period from date of authorization, subject to the availability of funds in accordance with the A.I.D. OYB/allotment process, to help in financing foreign exchange and local currency costs for the project. The planned life of the project is three years and four months from the date of initial obligation.

2. The purpose of the project ("Project") is to provide pharmaceuticals and medical supplies to Costa Rica's health care system, and to help stabilize the financial position of the Caja Costarricense de Seguro Social ("CCSS").

3. The Project Agreement(s) which may be negotiated and executed by the officer to whom such authority is delegated in accordance with A.I.D. regulations and Delegations of Authority shall be subject to the following essential terms and covenants and major conditions, together with such other terms and conditions as A.I.D. may deem appropriate.

4. a. Interest Rate and Terms of Repayment

The Government of Costa Rica ("GOCR") shall repay the Loan to A.I.D. in U.S. dollars within twenty (20) years from the date of first disbursement of the Loan, including a grace period of not to exceed ten (10) years. The GOCR shall pay to A.I.D. in U.S. dollars interest from the date of first disbursement of the Loan at the rate of (a) two percent (2%) per annum during the first ten (10) years, and (b) three percent (3%) per annum thereafter, on the outstanding disbursed balance of the Loan and on any due and unpaid interest accrued thereon.

b. Source and Origin of Commodities, Nationality of Services (Loan)

Commodities financed by A.I.D. under the Loan shall have their source and origin in countries which are members of the Central American Common Market or in countries included in A.I.D. Geographic Code 941, except as A.I.D. may otherwise agree in writing. Except for ocean shipping, the suppliers of commodities or services shall have countries which are members of the Central American Common Market or countries included in A.I.D. Geographic Code 941 as their place of nationality, except as A.I.D. may otherwise agree in writing. Ocean shipping financed by A.I.D. under the Loan shall be financed only on flag vessels of countries which are members of the Central American Common Market or countries included in A.I.D. Geographic Code 941, except as A.I.D. may otherwise agree in writing.

c. Source and Origin of Commodities, Nationality of Services (Grant)

Commodities financed by A.I.D. under the Grant shall have their source and origin in countries which are members of the Central American Common Market or in the United States, except as A.I.D. may otherwise agree in writing. Except for ocean shipping, the suppliers of commodities or services shall have countries which are members of the Central American Common Market or the United States as their place of nationality, except as A.I.D. may otherwise agree in writing. Ocean shipping financed by A.I.D. under the Grant shall be financed only on flag vessels of the United States, except as A.I.D. may otherwise agree in writing.

d. Conditions Precedent to Disbursement

(i) Prior to any disbursement, or the issuance of any commitment documents under the Project Agreement, the GOCR shall, except as A.I.D. may otherwise agree in writing, furnish to A.I.D., in form and substance satisfactory to A.I.D., evidence that the CCSS has a system in place for Loan funded procurement which is consistent with A.I.D. procurement regulations, including those specific to pharmaceuticals.

(ii) Prior to any disbursement, or the issuance of any commitment documents under the Project Agreement, in excess of \$5,000,000, the GOCR shall, except as A.I.D. may otherwise agree in writing, furnish to A.I.D., in form and substance

satisfactory to A.I.D., evidence of the progress made on the CCSS procurement system as a result of technical assistance furnished under A.I.D.'s PPAI project.

e. Covenants

The GOCR shall covenant that, unless A.I.D. otherwise agrees in writing, it will:

(i) Pay to the CCSS, in a timely manner, its employer's contribution for the years 1984 and 1985.

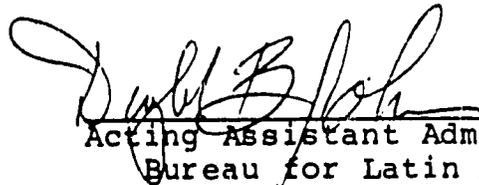
(ii) Pay to the CCSS the remainder of its employer's quota in arrears by June 30, 1985.

(iii) Cause the CCSS to provide sufficient funds in its 1984 and 1985 pharmaceuticals budget to cover the purchase of required items not covered by the Loan.

(iv) Cause the CCSS to pay off the rest of its debt to foreign suppliers by the end of 1985.

f. Waivers, Approvals

The requirement that a notice of availability of an IFB be publicized in the Commerce Business Daily or an A.I.D. Publication is hereby waived for procurements of pharmaceuticals and medical supplies financed under the Project in an amount not to exceed \$10,000,000 in the aggregate.



Acting Assistant Administrator
Bureau for Latin America
and the Caribbean

Aug 16, 1983
Date

^{PM}
GC/LAC:GWinter:gjw 0058A/8/17/83:X23272

LAC/CEN:MSchwartz MS

LAC/DR:ABisset AB

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- B. Logical Framework
- C. Statutory Checklist
- D. Request for Assistance
- E. Request for Waiver of U.S. Advertising Requirements
- F. Illustrative Procurement Lists for Pharmaceuticals and Disposable Medical Supplies
- G. Consultants' Technical Reports ^{1/}
 - (1) Dieter K. Zschock, Financial and Economic Analysis for the Health Services Support Project Paper
 - (2) Dr. Aida Leroy and Dr. Ronald O'Connor, Health Services Support Project Analyses
- H. Project Development Team Members
- I. Environmental Examination

^{1/} Available in USAID and AID/W Project files.

I. SUMMARY

It is well documented that Costa Rica is experiencing an economic crisis. The figures show (see FY'84 and FY'85 CDSSes for example) that in the last three years real GDP declined, unemployment rose, inflation became a serious problem and real wages declined significantly. When the Monge Administration took office in May of 1982, it was faced with a national economic crisis. It has since made it clear that it intends to stabilize the economy, re-establish economic growth and preserve Costa Rica's political and social stability. At the same time the GOCR is committed to preserving its social sector institutions, and it realizes that improved efficiency in the public sector is needed.

USAID/Costa Rica's strategic goals in the social sector complement the GOCR's goals. This project will help address Costa Rica's health care system's immediate financial problems in the next few years while improvements are being made in the system's efficiency. The procurement of pharmaceuticals and medical supplies will help keep the CCSS and MOH health care system operating so that improvements in policy and management can take hold.

Costa Rica's health care system's achievements are impressive. Thanks to its efforts, the major causes of death common to developing countries such as infections and parasitic and gastrointestinal diseases, have been generally overcome. The Costa Rican health care system is proof to Latin America that democratic government can provide effective social support systems.

This project will directly assist Costa Rica's social support system. Availability of pharmaceuticals and supplies is crucial for the CCSS and the MOH. Without drugs and supplies the health care system will suffer. Crisis management of the system will take its toll on public confidence in Costa Rica's democratic institutions, the delivery of health care, and the fiscal soundness of the system. This project will contribute to stabilizing the level of health services and the CCSS's financial situation, and to promoting operational improvements by the CCSS in how it finances its programs.

It is the goal of this project to support the continued availability to all Costa Ricans of an adequate level of health care services. The health care system is a focal point of Costa Rican society and a visible manifestation of the democratic principles on which it is founded. By supporting the system now, this project will help Costa Rica avoid the destabilizing effects of any real or perceived major breakdowns in the health care system. The project's purpose is to provide pharmaceuticals and medical supplies to Costa Rica's health care system and to help stabilize the CCSS's financial position. As a result of the project, drugs and medicines from the U.S. will help maintain the Costa Rican health care system. Also because of the project, the CCSS will be able to take steps to repair some of the fiscal damage done to it in recent

years. Under a complementary administrative reform project the operational efficiency of the CCSS will be improved.

The CCSS procurement system works now and in order to strengthen it further, USAID/CR is proposing that for the most part it be used for this \$10,000,000 procurement. A.I.D. will provide \$150,000 of technical assistance funds to help administer this procurement. A.I.D. funded drugs and supplies will be procured as part of the CCSS's routine weekly orders over two years. One or several large drug orders under the loan aren't feasible. There is no need, no capacity to process the paper and no place to store the drugs. In order to use and therefore strengthen the CCSS's procurement system, a waiver of A.I.D. advertising requirements for each specific order is requested.

II. BACKGROUND

A. Overview

The Government of Costa Rica has had a long-standing commitment to provide preventative and curative health services to its population, increasing coverage until it is now almost universal. The result of this commitment is an admirable achievement in health care. The major causes of death that are common in developing countries such as infections and parasitic diseases in adults, and gastrointestinal diseases in children, were diminished or overcome during the 1970's. With the exception of measles, more than 80% of children under one year are immunized against the major preventable childhood diseases, and more than 80% of the population has access to potable water. Between 1970 and 1980, infant mortality decreased from 61.5/1000 to 19.1/1000; woman's death as a result of childbirth decreased from 1/100 to .4/100 as a result of maternity care; life expectancy rose from 68.1 years to 73.2 years.

Just how impressive Costa Rica's health achievements have been was pointed out in a recent comparison of Social Security systems in Cuba, Chile and Costa Rica^{1/}. The Costa Rican system has out-performed those of Cuba and Chile in health care. The study shows that in 1960, Costa Rica was behind Cuba in the major health facilities and health standards indicators. By 1980, Costa Rica, with fewer physicians and hospital beds per inhabitant, had better general and infant mortality rates, and better life expectancy. Costa Rica is proof that an effective health care system can operate in Latin America without following the Cuban model. Unfortunately, the effects of the national economic crisis are beginning to show. Although no confirmed data is

^{1/} From the study titled "Alternative Strategies to the Social Security Crisis: Socialist, Market and Mixed Approaches" by Carmelo Mesa-Lago, Director Center for Latin American Studies, University of Pittsburgh, June, 1983.

available yet, malnutrition appears to be on the rise, which could effect infant mortality.

A profile of health status in Costa Rica is contained in the Social Analysis for this project.

B. Organization and Responsibilities of The Costa Rican National Health System

The Costa Rican National Health Service System has two principal actors: the Caja Costarricense de Seguro Social (CCSS) and the Ministry of Health (MOH).

The CCSS is the largest of the two with approximately 21,000 employees and an average 72% of the national health budget. It is an autonomous GOCR institution which operates the national pension fund known as Invalidez, Vejez y Muerte (IVM), and the Seguro de Enfermedad y Maternidad (SEM) which is a national health care program.

The CCSS is responsible for medical care which encompasses certain preventative health measures and primary health care, as well as specialized medical and surgical care. Currently, approximately 80% of the population of Costa Rica is officially covered by the SEM - 63% has either direct worker's insurance or worker's family coverage; 10% is insured by the GOCR, including the indigent, handicapped and elderly; the remainder are covered through voluntary insurance plans. Real coverage of the SEM is actually more than 80%, as non-insured patients can receive ambulatory and inpatient care in CCSS facilities for a relatively small fee, and buy medicines in CCSS pharmacies at low cost. In Latin America, only Brazil and Argentina match Costa Rica in medical coverage provided and financed through social security programs.

The Ministry of Health provides primary health care (including immunizations, maternal child health, family planning, nutrition and dental care) for approximately 20% of the urban and 30% of the rural population not fully covered by the SEM. In addition, the Ministry of Health (MOH) is responsible for disease control (vector borne diseases, tuberculosis and sexually transmitted diseases), community health education, food and drug control, and environmental health. In recent years it has had an average of 7,000 employees and received 16% of the health care budget; the remaining 12% of the health care budget goes to other agencies for water (10%) and the National Insurance Agency (2%).

The CCSS and MOH health systems are coordinated by the National Health Council, which is made up of representatives of the CCSS, MOH, University of Costa Rica, the Ministry of Planning and the College of Physicians and Surgeons.

C. Current Status and Problems of the CCSS and the MOH

When the Monge Administration took office in May of 1982, it was, and continues to be, faced with a national economic crisis. One of the institutions threatened by this crisis, and by past circumstances, is the CCSS, which is currently confronted by severe financial problems. The Monge Administration has made it clear that it intends to stabilize the economy, and that it will also continue the long-standing GOCR commitment to quality health services for the population at large. One step in this process is to address the CCSS' financial problems.

The SEM has been operating with a budget deficit for more than a decade. However, the magnitude and the character of this deficit and the requirements for ameliorating it have changed since 1978.

The SEM is financed primarily from payroll taxes, including payments from the GOCR which is the country's largest single employer. In 1982, such payroll taxes amounted to 78% of total revenue for the SEM program. Additional sources of revenue include earmarked lottery and sales tax receipts, and a small subsidy from the GOCR general revenues to support hospital and clinic services.

Prior to 1978, SEM operating budget deficits were primarily the result of the GOCR's failure to make its contributions as an employer, and to finance health services for the indigent. Had the Government paid its full annual quotas, the operating budget would have been in surplus every year between 1970 and 1977. Beginning in 1978, the SEM operating budget deficit exceeded the GOCR quota, and from 1979 through 1981, by a very substantial amount. This increase in the deficit after 1977 derives from several sources in addition to the failure of the GOCR to pay its quota, although this remains a key factor. The GOCR's accumulated debt to the SEM for the period 1975-1981 was 878 million colones (\$22 million at 40/\$1), and 984 million colones (\$24.8 million) when debts remaining from earlier years were included.

In order to finance the deficits of the SEM resulting from failure of the GOCR to fulfill its quota obligations, the CCSS withheld amounts from other funds, also financed by payroll taxes for which the CCSS serves as fiscal agent. Such funds included, among others, the national pension fund (IVM), and the Asignaciones Familiares - a social welfare program. The amount of the GOCR debt to the SEM program has now been reduced to some 600 million colones (approximately \$15 million at 40/\$1) by payment of a portion of the arrearages. The amount the SEM still owes to other programs, is approximately equal to the GOCR's unpaid 600 million colones debt to the SEM.

There is an additional SEM debt of one billion colones (\$25 million) that is not due to GOCR non-payment of its employees contributions. Rather, this represents the funds acquired through formal loans from the IVM pension fund over the period 1972-1981, and chiefly during the period 1978-1981. These loans were taken to finance the

investment budget and in particular, to finance expenditures that exceeded annual revenues by an average of over 20% during 1979-1981. This source of deficit financing has now been stopped, but the CCSS will have to service the debt.

The SEM fell into these deficits partly because of the progressive expansion of its system without sufficient funding, plus the country's general economic crisis. Over its forty year history, the SEM program has progressively absorbed most of Costa Rica's health care facilities. The last major transfer began in the early 1970's, after the National Assembly passed a law in 1971 aimed at integration of a National Health System. As a result, some 22 clinics and hospitals were transferred to CCSS management from other auspices between 1975 and 1978. This transfer included redirecting some of the sources of funds that had supported these facilities to the CCSS, However, these funds have proved insufficient.

Also in the 1970's the GOCR put through measures to include indigent Costa Ricans under SEM coverage, but as mentioned above, the GOCR routinely failed to cover the cost of this coverage with timely payments.

An additional factor which contributed to the sudden and sharp increase in the SEM's deficits were the financial policies of the previous GOCR Administration.

Unfortunately, the above described problems coincided with a general economic crisis in Costa Rica. The crisis has limited the government transfers of general revenue to support the SEM's greatly increased budgetary requirements. In addition to the budget deficits, it has also created problems with foreign exchange availability for purchases of imported medicines.

There are two aspects of the foreign exchange problem. One is that the CCSS was unable, for a period of time, to obtain the foreign exchange required to pay its debts to foreign suppliers of pharmaceutical products. As a result of failure to pay suppliers, credit was cut back, forcing the CCSS to procure from a more limited number of sources and at higher cost. The debt to suppliers accumulated since 1981 reached \$22 million; it has now been reduced to approximately \$10 million. It appears that the foreign exchange will be available to pay off this balance by 1985.

A second aspect of the foreign exchange situation is that the Government has ended the exchange rate subsidy on medicines purchased by the CCSS. On all purchases prior to February 24, 1983, the official exchange rate, which is currently 20/\$1, was applied. Purchases must now be made at the interbank rate which is currently around 41/\$1, thus more than doubling the cost of such items. Even though the volume of pharmaceutical purchases remains level, the total colones cost of pharmaceuticals has been drastically increased since some 75% are

procured from overseas. To the extent such costs of the foreign exchange rate revision are not provided for, then either purchases must decrease or proportionate reductions must be made in other categories of SEM expenditures. The GOCR decision to no longer allow the CCSS to buy dollars at the subsidized rate makes macro-economic sense, but it does cause problems for the CCSS and the SEM program.

Although the MOH's direct role in providing health care continues to decline, it still has a role to play in preventative health care. In the last few years the MOH budget has been hard hit by the same economic types of problems as the CCSS. As a central government Ministry, the MOH's budget is sensitive to the GOCR's budgetary situation. Like the CCSS, the MOH has had difficulties obtaining funds to pay for the vaccines, immunizations, etc. that it routinely administers for disease control.

D. AID and Costa Rican Response

Given the problems and the needs described, the question is, what must be done for the CCSS to enable it to sustain the current level of services and coverage. This will require maintaining the level of health services in the short-run, while simultaneously undertaking the financial and institutional improvements required to enable the CCSS to continue operating over the long-term on a self-sufficient basis - that is, without resorting to deficit financing.

A.I.D. proposes to help address these problems in the context of the Health Services Support Project, the description and rationale for which are presented in the following section. Complementary assistance under A.I.D.'s Policy, Planning, and Administrative Improvement Project (PPAI) is also described.

On the Costa Rican side, the GOCR and the CCSS have recently taken a number of positive steps which are both critical to resolving CCSS/SEM problems, and indicative of Costa Rica's commitment to do so. These include the following:

- o The Central Government has paid all of its 1982 quota to SEM, and one-third of its arrears; it has agreed to pay two-thirds of the remaining debt with proceeds of the AID Loan, plus it will covenant to pay the balance from its own resources;
- o The Central Bank has made foreign exchange available, with which the CCSS has paid \$12 million of the \$22 million that it owed to foreign suppliers;
- o The National Assembly has passed a law forbidding the CCSS to borrow from funds, such as the IVM, in order to finance the SEM;

- o The CCSS has significantly increased payroll tax contributions from 10.75% to 14.75% of the wage base in both the public and the private sectors;
- o The CCSS has, in the past year, taken a number of steps to increase its efficiency. It has frozen new employee hiring; reduced its personnel rolls from approximately 23,000 to 21,300 by a retirement incentive program and the laying off of temporary employees hired by the previous administration; developed and installed a new drug formulary reducing the number of drugs from over 1,000 down to approximately 540; frozen new equipment purchases; and in conjunction with other A.I.D. assistance described in Section III. B. below, installed new budget control mechanisms.

In addition, a special CCSS Commission is presently studying how other countries are dealing with the economics of maintaining social security health services systems.

III. PROJECT DESCRIPTION, RATIONALE, AND RELATIONSHIP TO A.I.D. STRATEGY

A. Project Description

The Health Services Support project will provide \$10.15 million to the CCSS to enable it to purchase pharmaceuticals and disposable medical supplies over the next two years.

This assistance will be in the form of a \$10 million loan to the GOCR, which will transfer this amount to the CCSS, plus a \$150,000 grant to the CCSS for technical assistance in the procurement process. Up to \$2.0 million dollars worth of preventative care pharmaceuticals will be purchased by the CCSS for the MOH.

The Mission intends to add \$150,000 in FY 1983 grant funds to the Policy, Planning and Administrative Improvement Project (PPAI) for complementary technical assistance activities described in Section III. B. below.

The Goal to which the Health Services Support project will contribute is:

Continued availability to all Costa Ricans, of an adequate level of health services.

From an institutional standpoint, this goal requires that the CCSS and other organizations that provide health care to Costa Ricans, continue to be relatively effective. It also assumes economic recovery, such that Costa Rica's level of employment and GDP is sufficient to support the system.

The project purpose is:

To provide pharmaceuticals and medical supplies to Costa Rica's Health Care System, and to help stabilize the CCSS' financial position.

The Health Services Support project will help to maintain services by supporting the flow of medicines and medical supplies in the face of a "cash crunch", and will also help the SEM to recover from its current budget deficit.

This purpose complements the purpose of the CCSS component of the Policy, Planning, and Administrative Improvement (PPAI) project. The PPAI/CCSS administrative improvement activity aims to improve operational efficiency of the CCSS. As described more fully below, the PPAI project provides technical assistance to help the CCSS to reduce the cost of providing health care, and thus to reduce and to eventually eliminate its deficits.

Achievement of the project purpose also assumes that the GOCR and the CCSS will continue to support the recovery effort with reforms, and that the GOCR will continue to provide the financial contribution required of it as an employer, which it will covenant to do in the Project Agreement for the period of the project.

Achievement of the project purpose also depends on the functioning of the CCSS and MOH networks for distributing health supplies and administering treatment. Medicines must continue to be moved through their distribution systems to clinics and hospitals, and must be provided to clients along with other medical services, in an appropriate manner.

Outputs, which are specific to the project, are as follow:

Adequate quantities of required pharmaceuticals and disposable medical supplies will be procured and delivered to the CCSS and the MOH.

The GOCR will, during the life of the project pay off its outstanding debt to the CCSS.

The GOCR will pay its 1984 and 1985 employer's quota to the CCSS.

study, development, and implementation of treatment norms for the most common complaints at SEM facilities; and

improvement of client compliance with instructions for use of pharmaceutical products.

Inputs:

A.I.D. inputs will include a \$10 million loan for commodities (pharmaceuticals and other essential medical supplies), and a \$300,000 grant for technical assistance. This will consist of a full-time technical assistant to help with the weekly procurements and the TDY services of a pharmacist on a regular basis.

Short-term assistance will be for repeated visits by a pharmaceutical supply specialist familiar with AID procurement mechanisms; the specialist will assist the CCSS with specific technical decisions regarding drug and supply choices that arise during the course of the project. The specialist will spend two months at the beginning of the project, and two weeks every three months during the two-year course of the project. The project will finance four and a half months of short-term technical assistance at an estimated cost of \$45,000.

Long-term assistance will be provided to the CCSS for the Offices of Therapeutic Qualifications and of Materials Management, in order to help their staff cope with the extra workload of acquiring pharmaceuticals and medical supplies under the terms of this loan. This person will serve as liason between the CCSS and the General Development Division of USAID/CR. A total of two person years at \$30,000 a year for a total of \$60,000 is projected.

Some \$45,000 is budgeted for evaluation and contingency costs. This will cover other technical assistance and evaluation/management needs for the procurement process.

The CCSS will contribute counterpart funds in the following manner:

Approximately \$20,000,000 for the purchase of supplies and pharmaceuticals during the 1984 and 1985 life of the project.

In addition to these direct project inputs, the CCSS will also pay off its remaining debt to its foreign suppliers, which now stands at \$10,000,000.

B. Complementary A.I.D. Activities Planned or Underway

In order to promote the kind of efficiencies in management and treatment that will contribute to lowering the SEM's costs and to balancing its budget over the longer term, A.I.D. is also providing selected, complementary assistance to the CCSS under the Policy, Planning, and Administrative Improvement Project (PPAI); the CCSS component is currently funded at \$1.0 million. The activities being carried out with the CCSS under PPAI include:

Assistance in improving accounting and financial management functions with emphasis on helping the CCSS to establish control of expenditures and investments, and establishing the budgeting process as a basis for planning and management;

Assistance in improving procurement procedures and materials management for medical supplies, with the intention of establishing effective controls and reducing expenditures;

Assistance to redesign the CCSS' budgetary system and make it capable of analyzing, planning and controlling expenditures more efficiently;

Assistance to establish an integrated accounting system, compatible with the new budget system, which will enable CCSS management to keep close control of the CCSS' day to day financial situation, and thus better control expenditures;

Assistance to improve effectiveness of the CCSS payment collection system for payroll deductions and specific fees, thus directly increasing revenues;

Assistance to update the system through which costs are determined by the CCSS, and where necessary, adjust the system for greater efficiency;

Assistance to the CCSS to review and modify its credit and investment system so as to allow it to fulfill its social requirements but optimize returns on investments;

Assistance to strengthen CCSS procurement procedures and materials management, and specifically, to cut costs and strengthen controls by:

- developing a revised supplies catalog with fewer, more standardized items available for purchase;
- developing and implementing a supplies planning system more closely linked to the annual budgetary system;
- optimizing use of available CCSS warehouse space;
- reviewing and updating the system used to decide how and to what level supplies are distributed;
- developing and implementing an information/evaluation system to continuously feed back information and thus better control the flow of supplies.

In addition to these activities which are now starting up, several other areas which would improve both the efficiency and the effectiveness of primary health services have been identified.

C. Complementary Activities by Other Donors

Other donors are also contributing to the effort to sustain and revitalize the health system. The IDB is now preparing a \$600,000 two year equipment maintenance project with the CCSS and the MOH. PAHO is also collaborating in this effort. The project, which is scheduled to begin late this year, will provide funds to organize and initiate the work of a joint CCSS/MOH equipment maintenance unit. Short and long-term training will be provided to this unit's employees and to CCSS/MOH employees responsible for equipment from health posts on up to the largest hospitals. The purpose of this activity is to keep CCSS/MOH existing equipment working as long as possible, and to thus contribute to greater efficiency.

The Pan American Health Organization (PAHO) has traditionally worked with the Ministry of Health, but not the CCSS. However, PAHO began to work seriously with the CCSS in 1980. PAHO's initial assistance was in the form of a one year, in-depth analysis of the CCSS. The study described the current status of the CCSS and specified areas where corrective action was needed. This joint CCSS/PAHO analysis laid the foundation for the PPAI-funded CCSS administrative improvement activities. PAHO now plays a major, continuing role in policy dialogue and administrative improvement activities with the CCSS. The CCSS component of the PPAI project is being jointly implemented by the CCSS, AID, and PAHO. In the future, PAHO expects to continue its efforts to strengthen CCSS management and to improve its efficiency through short and long-term technical advisors. USAID/CR works closely with PAHO and has been pleased with the good results of this collaboration.

A recent but important arrival on the donor scene for the CCSS is the World Bank. As part of its upcoming \$75 million Structural Adjustment Loan, the World Bank is developing a program to assist the CCSS. Early indications are that the World Bank will, as part of the Structural Adjustment Loan and related technical assistance funding, be working with the CCSS on long-term revenue and financial concerns of both the SEM, and the IVM pension programs. The World Bank is in contact with USAID and is planning its activities to complement and strengthen the efforts undertaken in both the Health Services Support Project and the PPAI Project.

D. Rationale

1. Impact of the Project on Costa Rica's Health Care System

The proposed assistance under the Health Services Support Project would help to ameliorate the health care system's problems in the following ways:

first, the assistance will help to assure an adequate supply of the imported medicines and medical supplies required for preventative and curative health care during the years 1984 and 1985, while financial and institutional steps are being taken to help the system adjust to the financial shocks of the past few years;

second, in accepting the obligation to repay the loan the Central Government will pay off a major portion of its remaining debt to the CCSS, and will covenant to pay the balance;

third, the assistance will help to offset the loss, during a period of readjustment, of the foreign exchange subsidy for pharmaceuticals.

Over the next few years, availability of pharmaceuticals and supplies is crucial, for both the CCSS and the MOH. Without them the years of effort to develop Costa Rica's health care system will suffer a serious blow. Obviously, neither the preventative nor the curative systems can work without a reliable supply of good quality drugs. Crisis management of the health care sector would take its toll both in terms of the health care people receive, and the fiscal stability and soundness of the system.

In the long run, a financially weak health care system would mean declining health services. The proposed assistance can make a significant contribution to stabilizing the level of health services by reenforcing and promoting reforms in GOCR and CCSS policies with respect to financing of CCSS programs. The Project alone cannot, however, resolve all of the CCSS's financial problems. What it will do is provide financial and policy support for the complementary activities under the PPAI Project and those of other donors in the area of administrative improvement.

2. Impact of Health Care Problems on Political/Social Stability in Costa Rica

As described in more detail in the Social Soundness Analysis, the pension and health benefits of the CCSS are a focal point of Costa Rican society, and a highly visible manifestation of the Government and the democratic principles on which it is founded. Any significant deterioration in the CCSS's health services, and those of the

MOH, could be viewed by the general public as a signal that Costa Rica's government is failing in its ability to maintain its effectiveness and/or its principles. The effect of such a perception in a time of crisis could be destabilizing.

E. Relationship to Mission Strategy and A.I.D. Policy

The Mission's strategic goals as outlined in the FY 1984 CDSS, the FY 1985 CDSS Supplement, and the FY 1984 ABS consist of both a short-term focus on bringing about political, economic, and social stability, and a long term focus on helping Costa Rica re-orient its economy and re-establish dynamic growth in a manner intended to preserve the basic tenets of its democratic structures. To this end, the strategy includes, among other emphases, taking measures to bring about stabilization and recovery in the near-term, and to improve both economic policy making and public administration in order to achieve an enduring development impact.

This project is consistent with the Mission strategy in that it helps to meet both short-term stabilization needs, and long-term needs to improve efficiency in the public sector. USAID/CR's approach is to help the Costa Ricans keep the effective health service system they have, but to make it more cost effective.

The project is also consistent with the Agency's stated policy for activities in the health sector. A.I.D.'s recently published Health Policy Paper confirms the Agency's support for health programs that assist in developing broadly-based and cost-effective preventative and curative health services. With respect to pharmaceuticals and expendable medical supplies, the Health Policy Paper advocates the provision of such items as needed to support cost-effective health services. It also states that A.I.D. will support, through technical assistance and training, the improvement of pharmaceuticals supply systems to reduce costs and to improve effectiveness of health services.

While the procurement of pharmaceuticals and medical supplies is an important component of the project, it should be kept in mind that the objective of doing so is to keep the health care system operating, so that improvements in policy and management can take hold, and so that health services continue to be available.

IV. SUMMARIES OF ANALYSES AND RECOMMENDATIONS

A. Technical and Administrative Analyses

The feasibility of the project from the standpoint of implementation, and its ability to contribute to the project purpose and goal, were the subjects of intensive review, both by a team of technical consultants, and by Mission staff. Since several of the key technical

issues pertain also to questions of administrative systems and capability, the administrative and technical questions were treated together both in the analysis and in this presentation.

1. Selection and Availability of Appropriate
Pharmaceuticals and Disposable Medical Supplies

The primary question to be addressed was whether a significant part of Costa Rica's drug needs could be met with the \$10 million loan, given A.I.D. pharmaceutical procurement restrictions on the one hand, and on the other hand, CCSS and MOH requirements for pharmaceuticals - plus the cost of these medicines. The technical consultants have concluded that this is feasible, and have recommended an approach for accomplishing this.

A list of 215 drugs for possible purchase using funds from this loan was chosen from those requested by the CCSS and the MOH, in consultation with the CCSS's Oficina de Calificaciones Terapéuticas (Office of Therapeutic Qualifications). Briefly, these drugs fall into three priority categories: first, those which are used for primary health care, first aid, and preventive services; second, those used for maintenance of chronic diseases, thus allowing ambulatory treatment; and third, specialized drugs, and those of secondary therapeutic importance. In addition, they must meet A.I.D. procurement guidelines as follow:

- Source and origin must be United States;
- Pharmaceuticals must comply with the U.S. Food and Drug Administration's safety and efficacy standards (FDA approved);
- Any drugs procured from outside the United States may not infringe on a U.S. patent (not waivable);
- Certain categories of prohibited drugs may not be procured (e.g. blood derivatives, amphetamines, androgenic hormones)(not waivable).

The actual list of 215 priority drugs is attached as Annex F. Further information on the selection rationale is available in Annex G. In addition to the illustrative drug list, an illustrative list of disposable medical supplies was obtained (See Annex F). These are high-volume supplies that the CCSS currently purchases in the U.S.

A further question was whether, if the CCSS's worldwide procurement system were used, U.S. pharmaceutical manufacturers were sufficiently competitive to win \$10 million worth of procurement over a two year period for those items on the eligible list. Based on the consultants' review of past CCSS procurements, plus a survey of drug manufacturers for price quotes, it was concluded that it is feasible to disburse the loan over a two-year period as proposed. Disposable medical supplies also pose no problem, as the CCSS currently procures most of these from the U.S. Based on this information and the priority

categories, it is estimated that the following amounts of drugs and supplies will be purchased during this project's life:

- a. Priority 1 drugs, \$5,000,000
- b. Priority 2 drugs, \$2,500,000
- c. Priority 3 drugs, \$1,500,000
- d. Disposable Medical Supplies, \$1,000,000

2. Quality Control for Pharmaceuticals

The technical consultants reviewed the CCSS' quality control laboratory which analyzes samples of all products bid, and samples of shipments arriving. They observed that, "It is headed by an extremely competent pharmacist who has instituted standard policies and procedures of operation". Their assessment was that despite some problems with lack of replacement parts and maintenance for existing equipment, plus a shortage of trained personnel, it is a good quality control facility.

3. Procurement Process

The objective of the technical/administrative analysis with respect to procurement was to identify those procurement options which would support the project objectives and also be feasible from an implementation standpoint. The conclusions of the analysis are as follow.

- o The CCSS procurement process is lengthy and cumbersome, but it is effective in procuring the required supplies, and at historically excellent prices;
- o To strengthen the CCSS procurement system - an objective of the PPAI Project - it should be utilized under this loan, not circumvented;
- o Massive drug orders under the loan are inappropriate: there is no need, no capacity to process the paper, and no place to store the drugs;
- o None of the alternative procurement mechanisms offer substantial advantages over operating within the CCSS existing system, plus relying on PAHO for selected other purchases.

a. The CCSS and PAHO Procurement Systems

The CCSS operates under the Financial Administration Law of the Republic of Costa Rica; it is subject to the oversight of the Controller General with respect to its financial proceedings, including procurement.

The CCSS has an institutionalized procurement process for medicines and supplies. The Materials Management Office, the Unit of Therapeutic Qualifications and the Finance Department are the specific CCSS offices involved. These offices routinely handle annual drug and supply procurement several times the loan amount. The Materials Management Office heads the units which specialize in procurement, warehousing and distribution of all materials purchased by the CCSS. The procurement division publishes tenders for pharmaceuticals and supplies in the official newspaper, La Gaceta, as a result of the needs cued by a computerized inventory; these needs are analyzed for technical and administrative criteria, in conjunction with the Unit for Therapeutic Qualifications. In limited cases, private bidding and emergency direct purchases are also used. The Procurement Division has adequate, experienced personnel to effectively carry out their procurement functions. The manual processing of the paper flow is being improved and will be mechanized under the PPAI grant.

Only companies with registered representatives in Costa Rica are allowed to present offers, in order to assure that the Government has recourse against a supplier. Once the best offer is selected from a technical standpoint, that decision must be approved by the Assistant Manager for Medical Services (Subgerente Médico) if the purchase is under 500 thousand colones, or by the Board of Directors if it is over that amount. The supplier is notified by official publication and if no appeals are presented, the purchase order is processed and consigned to the CCSS or a bank intermediary. A quality control check is performed and any claims are processed shortly thereafter. Once the medicines are accepted they are stored until needed. Warehousing is one of the first areas to be dealt with by industrial engineers, under the PPAI grant. Present facilities are not ideal, but are adequate and could be better utilized.

The Finance Department controls the budget and authorizes expenditures. The Finance Department will deal with the Ministry of Finance for the repayment of the debt the GOCR still owes to CCSS, and for the disbursement of the loan for which the GOCR has responsibility.

The CCSS procurement process is a long one, and one which involves a large number of procurements. Experience, custom, administrative rulings and legal procedures have evolved into a process where 12-15 month lead times for ordering are expected and employed. Therefore, with the possible exception of a few items that have run low during the recent period of financial constraint where suppliers withheld orders due to unpaid bills, the existing procurement process has proved adequate to meet most needs. CCSS regular bid/ordering/procurement process involves issuing a weekly request for bids. Each RFQ (Requests for Quotation) solicits annual quantities of 10-12 items from the CCSS own list of 540.

The materials procurement staff and CCSS leadership readily acknowledge that the procedures are not maximally efficient and

sometimes produce errors that decrease procurement efficiency. However, the system of procurement does work, and will be the subject of further analysis and potential modifications to increase its efficiency and cost effectiveness with the assistance of the PPAI project.

PAHO has a good medical procurement system that specializes in obtaining preventative care pharmaceuticals. The CCSS and the MOH have had positive experiences using PAHO's procurement services, as has USAID/Costa Rica. PAHO procures vaccines of excellent quality at very reasonable prices by combining many country's needs into one order. Discussions with the Chief of PAHO's Procurement Division indicate that there will be no problem in Costa Rica's continuing to procure its vaccines through PAHO, and either USAID paying PAHO directly for the vaccines, or reimbursing the CCSS for their purchase. Because PAHO's lowest-cost bidding/contract system rarely results in contracts with U.S. firms, a waiver for procurement by PAHO from Code 899 (Free World) countries will form part of the Project Authorization. It is expected that not more than \$500,000 total of the loan funds will be so spent.

b. Other Procurement Options

Several other options were explored including A.I.D. direct procurement, and establishment by the CCSS of a bidding process in the U.S. for U.S. suppliers, separate from their world-wide system.

A.I.D. direct procurement was the first option considered. It was thought initially that with SER/COM's help as a contracting agent and the GSA's as a purchasing agent, drugs might be purchased from the Federal Supply Schedule. Further study revealed, however, that this is not feasible. SER/COM does not have sufficient personnel to act as contracting agent, and the Federal Supply Schedule is not a list of readily available products; tenders for drugs would still have to be made. Also, GSA drug supplies don't meet Costa Rican language and packaging requirements.

Even if it were possible, A.I.D. direct procurement suffers from several problems. First, some drugs would have to be selected for U.S. only competition. There is no mechanism for selecting which of the drugs that the CCSS requires are most likely to be cheapest in the U.S. This would require the costly effort of obtaining world wide price quotes on a weekly basis, with no guarantee that drugs ultimately pre-selected for procurement from the U.S. could not have been obtained for a better price elsewhere. If after having received U.S. bids, the CCSS found them to be too high, it would have to rebid on a world wide basis adding 6 months or more to its procurement time. If on the other hand, it decided to accept the U.S. bids, it would be diminishing its limited drug procurement buying power. The GOCR and the CCSS are naturally very reluctant to use loan funds in a way that may diminish their buying power.

The CCSS also cannot afford to set up a bid process for the U.S. only, or a whole new procurement operation to run side by side with the existing one. Except for a few special cases, procurement outside of the CCSS' normal process is not recommended - nor is a separate procurement operation. To place such additional bureaucratic requirements on the CCSS would go counter to the very objectives of this Project and

the objectives of the PPAI Project for improving the efficiency and cost-effectiveness of the CCSS.

Use of a procurement agent was also considered, but this would do nothing to solve the fundamental problems identified. Moreover, purchasing service agents are expensive. For example, for this \$10,000,000 procurement the price would probably be \$500,000. Also, four to six extra months would be needed to bid the contract through an RFP, and then to select an agent.

c. Recommendations and Requirements

It is for such reasons as given above, that the consultants and the Mission concluded that the procurement of pharmaceuticals and disposable medical supplies under this project, other than those drugs obtained through PAHO, must be carried out under the CCSS's own system of international bidding. To do so requires a blanket waiver by AA/LAC of U.S. advertising requirements for all individual procurements of pharmaceuticals and supplies, the request for which is contained in Annex E. A.I.D. will, however, notify U.S. suppliers through the Commerce Business Daily at the beginning of the project, that the procurements will be taking place.

Since the CCSS issues RFQs to suppliers on an international basis, it cannot tailor them to the requirements pertaining to U.S. suppliers alone. Moreover, with a minimum of 50 RFQs per year, there may be problems in getting material published in the Commerce Business Daily on a timely basis, and in getting closing dates to correspond to those published in Costa Rica.

No negative effects on U.S. business would result from a waiver of U.S. advertising, as procurement of pharmaceuticals under the project would, nonetheless, be restricted to the U.S. The use of the CCSS procurement system has the added long-term advantage of increasing participation by U.S. firms after AID funds are used up. More U.S. firms will become accustomed to doing business in Costa Rica under the CCSS' bidding and award system. Moreover, CCSS procurement history shows that some 25% of the value of prior year drug procurements have been obtained from the U.S. - about \$5 million worth of drugs annually - plus about a million dollars worth of disposable medical supplies. At least \$4 million of the total annual pharmaceutical procurement from the U.S. has been for items which are on the list of U.S. drugs approved by A.I.D. for this project.

Given a waiver of U.S. advertising requirements, A.I.D. would pay for eligible drugs and supplies from U.S. sources which were selected through the CCSS's world-wide, competitive bidding process. Some steps would have to be taken to assure that the CCSS's procurement process conforms to A.I.D. requirements, but these would not affect its basic integrity.

4. The CCSS Distribution Process

Once in country, drugs and supplies must be distributed to service points; about 1235 such sites now exist for the CCSS and the MOH. CCSS distribution is adequate for project purposes, but could be made more efficient. It currently operates based on pull from the central warehouse by the regional offices, and in turn from service sites. Distribution will improve as activities to improve the procurement and supplies system are carried out under the PPAI Project. An example of a deficiency which will be addressed is the lack of information at a central point regarding inventory at lower levels in the system.

5. Delivery of Health Services

In order for pharmaceuticals and supplies to be used efficiently and to have the desired effect on health, such items must be correctly prescribed/used by doctors and other medical personnel and, in the case of medicines which are self-administered, the items must be correctly used by clients.

Costa Rica's health statistics show that the CCSS and the MOH are effective in delivering services to the population. Nevertheless, use of drugs is an area in which improvements are possible. Development and implementation of treatment norms, and improved client compliance with instructions for pharmaceutical use were areas recommended by the consultants for further attention, and which the Mission proposes to address in the context of the PPAI Project.

6. Procurement for the Ministry of Health Requirements

The Ministry of Health's project function is important, but it is not directly involved in the procurement of the drugs/supplies. The CCSS will purchase up to \$2 million worth of drugs and supplies for the MOH under the Project. Once the CCSS has obtained the drugs/supplies earmarked for the Ministry, it will deliver them to the MOH for use in its health care facilities. The CCSS routinely procures for the MOH because the CCSS has a better procurement process and gets lower prices via bulk purchases. USAID/CR experience under the Nutrition Loan showed that the MOH had problems handling procurement, and since the CCSS/MOH procurement relationship already exists and works, it was decided to use it.

7. A.I.D. Management Capacity

Given the lack of specialized procurement expertise in the Mission, USAID found it necessary to call in outside experts from the private sector and AID/W to help design the project. Given not only this lack of expertise, but the general problem of understaffing, the Mission has built what it believes to be an adequate level of TDY technical assistance and implementation management into the project. The magnitude and frequency of procurements, plus the need to determine which items selected can be paid for under the Loan, have resulted in the decision to

hire a full-time implementation advisor.

It is anticipated that some advice and assistance may be required of SER/COM, LAC/GC, and LAC/DR in finalizing details of implementation arrangements, and during the course of the Project.

While the Mission is overburdened, it can provide responsible management of the Project if it is approved as proposed.

B. Financial Analysis

1. Financial History

The GOCR's failure, prior to 1982, to pay its full obligations to the SEM were the major cause of annual deficits in the operating budget until 1978. Deficits in the SEM's operating budget were approximately equal to the GOCR's unpaid obligation in every year between 1970 and 1977. The budget for the period 1975-78 shows the following balances (in millions of current colones):

	<u>1975</u>	<u>1976</u>	<u>1977</u>	<u>1978</u>
Revenues	510.5	716.9	952.0	1,265.1
Expenditures	<u>513.5</u>	<u>709.8</u>	<u>1,024.1</u>	<u>1,383.0</u>
Deficit (-) or Surplus(+)	(-)3.0	(+)7.1	(-)72.1	(-)117.9
Deficit as Proportion of Expenditures	0.6%	1.0	7.0%	8.5%
GOCR Debt	50.7	86.0	105.4	98.0

Beginning in 1979, however, and through 1981, the SEM operating budget deficit substantially exceeded the Government's debt. These deficits were due in part to the structural changes in the responsibilities for health care as Costa Rica took a major step toward the integration of a National Health System under the CCSS. In the process, the composition of total public sector health care expenditures shifted toward the CCSS which now accounts for about 72% of expenditures, while the MOH, the Water and Sewage Institute and the National Insurance Institute account for the other 28%. The shift of functions to the CCSS was not accompanied by a sufficient re-allocation of the corresponding revenues required to support these activities. The sharp increase in annual deficits between 1979 and 1981 can also be attributed to financial policies of the previous GOCR administration.

The following Table shows the magnitude of the SEM's annual operating deficits since 1979.

	<u>1979</u>	<u>1980</u>	<u>1981</u>	<u>1982</u>
Revenues	1,490.6	1,788.8	2,166.6	4,034.5
Expenditures	<u>1,804.7</u>	<u>2,273.9</u>	<u>2,782.4</u>	<u>3,934.9</u>
Deficit (-) or Surplus (+)	(-)314.1	(-)485.1	(-)615.8	(+)99.6
Deficit as Proportion of Expenditures	17.4%	21.3%	22.1%	no deficit
GOCR Debt	156.1	79.8	438.7	no GOCR debt

The GOCR's unpaid contributions accumulated to a level of ₡984 million (\$24.6 million at ₡40/\$1) before the Government began to reduce the debt in 1982. It now stands at some ₡600 million. This shortfall in contributions was financed by the CCSS' withholding roughly the equivalent amount from other funds for which it serves as fiscal agent. These funds include the national pension fund (IVM), Asignaciones Familiares, plus several other social programs.

In addition to the amount which the CCSS has withheld from other funds to finance the shortfall due to the failure of the GOCR to meet its quotas to the SEM, the SEM has accumulated a further ₡1 billion debt resulting from deficits in its investment budget, and from its higher operating expenditures during 1979-1981. These additional deficits were financed by the CCSS borrowing formally from the IVM pension fund, but at rates which are clearly negative, and thus at the expense of the IVM.

The consultant's financial analysis notes that it is typical of medical care funds under social insurance programs in developing countries not to budget for investment expenditures from ordinary revenue, but rather to finance them by borrowing from their pension funds. Inter-fund transfers of the types used to finance SEM deficits were outlawed in May 1981 by Law 6577. However, the CCSS continued withholding funds from other programs until the GOCR began to pay its quota in 1982.

Unfortunately, the SEM's financial problems coincided with the country's national economic crisis. As a result of balance-of-payments problems, the CCSS was unable to obtain the necessary foreign exchange in 1981 and 1982 to pay its foreign suppliers of pharmaceuticals. The debt owed to foreign suppliers accumulated to \$22 million. As a result, suppliers cut off credit, and many ceased to bid on CCSS procurements, forcing the CCSS to pay higher prices than it would otherwise have done. This debt to foreign suppliers has not been due to the Government's failure to pay its obligations to SEM, since this deficit was covered by the SEM borrowing from other funds. Foreign exchange limitations seem to have been largely overcome in recent months. The debt to foreign suppliers has been reduced to approximately U.S. \$10 million as of this date, and the remainder is likely to be paid off in

1984 according to CCSS budget authorities. About half of the remaining debt is for products already received and the other half is for products awaiting payment before they will be released from customs storage.

For the Monge administration, the Government's accumulated debt to the CCSS has been a major concern. In spite of the Government's financial problems, the GOGR paid in full its 1982 payroll tax quota, as well as one third of its accumulated debt, making evident its firm commitment to the CCSS. In 1982 the SEM had an operating surplus of ₡99.6 million.

In December 1982, the GOGR arrived at a Standby Agreement with the IMF. Among several policy changes accepted in the agreement, the GOGR increased the employee-employer payroll tax for the SEM effective January, 1983. The combined employer-employee payroll tax was increased by 4% from 10.75% to 14.75. The combined total wage levy in support of SEM, which took effect January 1, 1983, is equal to 16% of the country's wage base ^{1/}. Revenues from the payroll tax in 1982, when the GOGR also paid its full share as employer, totalled 3 billion colones, equivalent to 78% of SEM's total revenues. The CCSS estimates that payroll taxes will yield additional revenues of 1.1 billion colones in 1983. This would represent about one fourth of total projected revenues from wage-based contributions this year. The CCSS projection may be overly optimistic considering that the nominal wage base this year probably will be only slightly larger than last year.

In addition to the higher payroll tax which increases the CCSS's revenues, the GOGR also accepted, as part of the IMF Agreement, the elimination of the exchange rate subsidies that had benefitted several public sector institutions, including the CCSS. This move increased the CCSS's costs. The subsidy had allowed the CCSS to obtain foreign exchange for the purpose of purchasing imported medicines, at the official rate. This rate was ₡20.5:\$1 when the subsidy was removed on February 24, 1983. While the pre-1983 debt to foreign suppliers is being paid off at the official exchange rate, new imports ordered since February 24, 1983 have to be paid for at in the inter-bank rate, which is more than twice the official rate.

2. Financial Projections and Impact of A.I.D. Assistance

In 1983, expenditures for pharmaceutical purchases are projected to rise to 7.1% of total expenditures as the back-log of orders is paid for and new orders are again being accepted by suppliers. In 1984, the earlier level of purchasing equal to around 10% of expenditures, which is the average for most countries, is expected to be reached once more. During 1984 and 1985 the procurement level will be maintained with the aid of the \$10,000,000 AID loan. The AID loan will help to facilitate pharmaceutical imports over a period of adjustment to the higher exchange rate, and while the CCSS is working to improve the overall financial soundness of the SEM. To reinforce such efforts, the loan's covenants will also require that the GOGR

^{1/} Of the 16%, an amount equal to 1.25% of the wage base is paid by the GOGR and goes to the SEM for indigent coverage.

continue to pay its contribution to the SEM during the project lifetime, and require that the CCSS pay off the remaining debt to foreign suppliers, thus reestablishing its credit-worthiness and access to the best prices for medicines and supplies. The AID loan cannot by itself however, be expected to balance the SEM's budget.

Due to higher costs of goods and services, the SEM's total expenditures are projected to increase by close to 45% in 1983 over 1982, and a significant amount of funds will go towards sharply increased domestic and foreign debt service obligation (from 3% to 8% of total expenditures). The budget projections made by the CCSS, which include both the \$10,000,000 loan and the higher cost of pharmaceuticals, show a substantially better financial position for the SEM starting in 1985. For 1985 and 1986, surpluses of ₡454 and ₡396 million respectively have been calculated. However, these projections were considered as overly optimistic by the financial consultant, who estimates a continuing budgetary imbalance during the next few years. On the expenditure side, he projects that the CCSS is underestimating personnel costs on the order of 10-20% annually. On the revenue side, the CCSS's projections are considered to be overly optimistic because they assume that private sector contributions will increase substantially despite the country's severe recession, and that lottery and sales tax revenue projections will increase substantially; the CCSS's projections also assume that the government will be able to continue paying its full quotas.

If our consultant's less optimistic forecast is correct, the CCSS will be forced to drastically reduce expenditures, and as a consequence health services provided by the CCSS could be also curtailed if other measures are not taken. In the long run CCSS administration must face the probability of seriously curtailing operating expenditures. Hopefully, this can be accomplished through greatly increased operating efficiencies rather than reduction in essential services.

The PPAI project aims to improve the efficiency and cost effectiveness of the CCSS. PPAI will help the CCSS to establish efficient and effective management control mechanisms for its accounting and financial operations, and for the procurement and management of supplies. In order to evaluate the combined impact of the Health Services Support Project, the PPAI project and other donor activities on the CCSS financial situation, regular estimates and projections of revenues and expenditures will be made as part of the Mission's project monitoring and evaluation activities. For its part, if assumptions do not prove as optimistic as the CCSS hopes, the CCSS will need to think about additional ways of reducing expenses, or conversely, increasing revenues. Since personnel costs constitute approximately 75% of expenditures, this is an obvious area for reduction once economic and political stability have been restored to the country. In the meantime the CCSS has already taken steps by freezing hirings, cutting temporary employment and increasing voluntary retirements. Such measures are appropriately part of the policy dialogue that A.I.D. and other concerned donors have established with the CCSS. USAID/CR is looking to PAHO and the World Bank to help the CCSS address these long-term, macro economic and financial problems.

C. Economic Analysis

1. Relationship to the GOCR-IMF Agreement - The IMF Agreement calls upon the GOCR to limit further foreign exchange indebtedness within negotiated limits, and domestically, to reduce the public sector deficit. Also, salary increments in the public sector are to be limited to offsetting price increases of essentials such as food, transportation, water, and electricity. IMF and monetary targets will not be jeopardized by this loan as few expenditures are expected to occur in this calendar year, and the loan will be taken into account in fixing the parameters of next year's expected Standby Agreement.

The payment of the CCSS debt to foreign pharmaceutical suppliers is in keeping with the spirit of the IMF Agreement, which furthermore stipulates that there should be no new accumulation of external payments arrearages in the future. Finally, the GOCR has lived up to the IMF Agreement by having increased quotas for combined employer-employee contributions by 4 percentage points. This was envisioned as an important element of the GOCR fiscal program under the IMF Agreement.

2. Relationship of the SEM and CCSS to GOCR Economic Policy - Costa Rica has a long-standing commitment to a major governmental role in providing social welfare services for its population. In macro-economic terms, this has resulted in a relatively large SEM which accounts for approximately 5% of GDP. In comparison with other Latin American countries with comparable levels of development, such as Brazil, Mexico, and Venezuela this is a relatively high proportion. However, Costa Rica has a higher percentage of coverage than comparable programs in these other countries.

3. SEM Costs and Cost-Effectiveness - The SEM is regarded, both within Costa Rica and by outside observers, as a capital-intensive, not highly efficient, and largely curative medical care program. By comparative Latin American standards, however, its average cost per capita for the covered population is about the same as in most of the other 15 countries which offer medical services under social insurance programs. For 1977, the per capita cost of SEM financed services was estimated at U.S. \$51 (in 1975 dollars). In 1982, the estimated per capita cost (in current dollars) is \$100. However, this estimate is based on the 20:1 official exchange rate in 1982. If one uses an exchange rate conversion of 41.5:1, which is closer to the equilibrium rate, the per capita cost estimate drops to U.S. \$50. In spite of the potential for improving efficiency of the CCSS/SEM, this level of per capita expenditure is not exorbitant, nor is the per capita cost of pharmaceuticals, estimated at about U.S. \$5. In terms of comparable cost-effectiveness, Costa Rica compares favorably with other middle-level developing countries, particularly because of its more effective population coverage.

As stated previously, in the past year the CCSS has taken the following measures to decrease costs: frozen new employee hiring; reduced its personnel rolls from approximately 23,000 to 21,300 by a retirement incentive program and the laying off of temporary employees hired by the previous administration; developed and installed a new drug formulary reducing the

number of drugs from over 1,000 down to approximately 500; frozen new equipment purchases; and in conjunction with PPAI installed new budget control mechanisms.

4. Economic Impact of the Project - The impact of the \$10 million loan per se is relatively small and limited time-wise in terms of the CCSS, the GOOCR, and the economy in general. However, it must be considered in the context of the administrative improvements and policy dialogue which are linked to it through the PPAI project and other donor activities. In this context, it has the potential to contribute to a much wider and longer term impact through helping the CCSS become more efficient in providing health services.

With respect to the cost-effectiveness of the proposed project, the economic analysis concluded that to assure an uninterrupted flow of pharmaceuticals would be the most cost-effective means of assisting the SEM at this time. While pharmaceuticals and medical supplies represent only about one-tenth of total SEM expenditures, as is the norm in most other countries, their impact on the effectiveness of overall delivery of health services is a disproportionate one.

D. SOCIAL SOUNDNESS ANALYSIS

1. Beneficiaries

In this relatively small country of less than two and a half million people, the concept of responsibility for each other's well-being has been institutionalized into a health and social security system that is notable for its breadth and its successes. The development of the health system over the past forty years has been marked by a steady increase in coverage, both of classifications of people insured and of geographic areas served.

Few Costa Ricans lack access to public health assistance. Clinics and hospitals cover Costa Rica, except for an inaccessible riverine area in the north and a national park in the south. A previously unassisted Indian reserve in the remote southeast will eventually be served by a clinic that is being built with assistance from Canada. In addition to the broader coverage, the type of health assistance offered by the CCSS has grown from maternal/child care and the treatment of disease to include preventive medicine, treatment for occupational injuries, and the most complex medical care.

Briefly, the history of the national health system began when the CCSS was formed by law in 1941 as an insurance plan to assist salaried lower-income workers in urban areas. Through the 1940s, coverage was gradually extended to the rural salaried workers of the Central Valley. In 1961, an amendment to the constitution obligated the health system to extend coverage to the entire population, including the self-employed and agricultural workers where location and conditions permitted. In the following years, coverage was broadened to include all Costa Ricans, including

indigents. No one is excluded, but users who are not enrolled are charged for services. In the most remote areas where the CCSS facilities will not be constructed, Costa Ricans are provided with primary health care by Ministry of Health workers.

The constitutionally mandated "universalization" required the expansion of the health system infrastructure and the construction of hospitals, clinics, warehouses, and laboratories. In 1973 a program of accelerated infrastructure development was begun in previously uncovered rural areas and in urban fringe settlements. From 1973 to 1982 the number of people employed by the CCSS grew from 5000 to 22,000, making it one of the largest employers in Costa Rica. By 1978, 81 percent of the population was covered effectively by accessible clinics and hospitals. The proposed assistance will directly benefit this population, plus those receiving medicines dispensed through the MOH.

2. The Policy of Cultural Appropriateness in Health Care

The health system responds to regional differences in the demand for health care, and the administration of it has been decentralized into 5 regions: Central, Pacifico Seco, Pacifico Sur, Atlantica, and Norte. In providing services, the system considers the demand for these in terms of the desire for health care based on local traditions and practices, and the need for health care based on pathological phenomena. For example, the difference in the demands of each region may be urban versus rural hazards, ethnic preferences, or simple versus sophisticated expectations.

An alternative to the public health system is to pay for increasingly costly private medical care. Costa Ricans who can afford it have often chosen to combine private medical consultation at their own expense, with the treatment or surgery that may be required, at the CCSS's expense. The recent economic crisis has diminished this as a possibility for many, and the future may place further burdens on the CCSS' consultation services.

3. Accomplishments of the National Health System

The Costa Rican philosophy of social responsibility has resulted in a commitment to public health care that has produced the impressive statistics given on page No. 1. Access to potable water, sewage disposal, immunizations and medicines has become all but universal throughout the more densely populated urban areas, and are widely available in rural areas. In general, Costa Ricans no longer die from typical LDC maladies. The incidence of dysentery has declined by 98 percent from 1970 to 1982. Rheumatic fever has decreased from 94 cases in 1970 to 12 cases in 1980. Malaria has decreased from 4500 cases in 1967 to 168 cases in 1981. By contrast, in 1981, Guatemala suffered 67,994 cases of malaria; El Salvador, 93,385 cases; Honduras, 49,377 cases; and Nicaragua, 17,434.

A summary profile of health facilities and indicators as of 1980, for Costa Rica versus Chile and Cuba is attached as Table 1.

Health Facilities and Standards: 1960-1980

Country	Years	Physicians per 1,000 inh.	Hospital beds per 10,000 inh.	Mortality Rates		Life expectancy ^b
				General (per 1,000)	Infant ^a	
<u>Chile</u> ^c	1960	6.0	3.7	12.3	120.3	56.1
	1965	5.7	4.2	10.6	107.0	57.6
	1970	5.1	3.8	8.9	86.5	60.6
	1975	4.3	3.8	7.2	55.6	64.2
	1980	8.8	3.1	6.7	33.0	67.0
<u>Costa Rica</u> ^c	1960	3.7	4.5	8.0	68.6	60.2
	1965	4.5	4.2	8.1	69.3	63.0
	1970	5.1	4.0	6.7	61.5	65.6
	1975	6.7	3.8	4.9	37.9	68.1
	1980	12.2	3.4 ^d	4.1	19.1	73.2 ^e
<u>Cuba</u>	1960	8.9	4.3	6.1	35.9	64.0
	1965	7.9	4.6	6.4	37.8	65.1
	1970	7.1	4.6	6.3	38.7	68.5
	1975	9.9	4.5	5.4	27.3	70.9
	1980	15.6	4.5	5.7	19.6	71.8 ^f

a Death of infants less than one year per 1,000 live births.

b In five year periods unless specified; 1970-75 and 1975-80 are projections.

c Only facilities of social security, excludes private and other public facilities (except for physicians in Chile in 1980).

d 1979.

e 1976-80 actual.

f 1980 projected estimate.

1/ From study titled Alternative Strategies to the Social Security Crisis: Socialist, Market and Mixed Approaches by Carmelo Mesa-Lago, Director Center for Latin American Studies, University of Pittsburgh, June, 1983

Sources: Author's computations. Basic source for all are ECLA, Statistical Yearbook for Latin America 1979, 1980; and UCLA, Statistical Abstract of Latin America 1965 to 1980. Also Chile from Instituto Nacional de Estadística. Compendio Estadístico 1982. Also Costa Rica from U.N. Demographic Yearbook 1980; World Health Statistical Annual 1981 PAHO, Health Conditions in the Americas 1977-1980; and Ministerio de Salud, Memoria 1982. Also Cuba from Mesa-Lago, The Economy of Socialist Cuba; Anuario Estadístico Estadístico de Cuba 1980; and Sergio Díaz-Briquets, The Health Revolution in Cuba (Austin: University of New Mexico Press, 1983).

4. Health Challenge of the Future

Unfortunately, as Costa Ricans solve their old problems, new problems appear. There are as yet unconfirmed indications that since the outset of the economic crisis in 1980 malnutrition has been on the rise. Refugees and immigrants from the countries to the north bring malaria and infectious diseases and also add to the numbers of people seeking health services.

Furthermore, Costa Ricans are increasingly susceptible to the health risks of the more developed countries. CCSS officials are concerned about the apparent rise in circulatory problems such as heart attack and stroke, alcoholism, venereal diseases, and cancer. Even as the Costa Rican national health system registers more successes in eradicating traditional health concerns, the demands on it are growing and the solutions will be complex.

V. COST ESTIMATES AND FINANCIAL PLAN

A. Funding Level and Sources

Total life of project cost will be \$ 30,150,000, of which AID will provide \$10 million in loan funds and \$150,000 in grant funds, and the host country \$20 million. The actual amount of the counterpart contribution required will vary with the exchange rate and the actual cost of pharmaceutical purchases during the life of the project. The CCSS will spend sufficient counterpart to cover procurement of the 540 pharmaceuticals it normally buys, less the value of those that are purchased with AID funds. These funds will be drawn from the CCSS medical procurement budget. The grant and the loan will be funded from Section 104c of the FAA-Assistance for Health and Disease Prevention.

The Mission plans to add an additional \$150,000 in FY 1983 grant funds, also under Section 104c of the FAA, to the PPAI Project. These funds would support the complementary TA activities described earlier.

B. Financial Plan

Actual drugs and supplies to be procured, and quantities, are not known at this time; neither are final costs per unit. The list of drugs and supplies to be procured is included in this PP along with the last price paid. These figures for drugs and supplies purchased show that in recent years, approximately twenty-five percent of the total CCSS annual medical procurement of approximately \$20 million for pharmaceuticals and medical supplies was from the U.S. Of \$5,000,000 in goods procured from the U.S., approximately \$4 million are on the list of eligible commodities for the project. AID's commitment to this project is for the purchase of up to \$ 9,000,000 drugs and \$1,000,000 in disposable supplies over a two year period. Specific types and quantities of drugs and supplies cannot be specified in advance, but must be selected from the list of eligible drugs and supplies as the needs are identified.

During intensive review, the procurement consultant did a survey of the 215 drugs on the eligible list to get an estimation of total cost of the drugs and how U.S. prices compared with previous CCSS prices. 180 priority 1, 2 and 3 drugs were studied. It will cost approximately \$10.4 million annually to buy these drugs and approximately 7.2 million of them were judged to be candidates for U.S. procurement. This \$7.2 million was judged either to be competitive cost-wise or because U.S. source was preferred irrespective of cost for reasons of drug quality such as bio-availability. These calculations show that the \$9,000,000 available for drugs will be committed in 18-24 months and that potential demand exceeds AID funding available.

Composition of the proposed technical assistance is detailed in the inputs section of the Project Description.

TABLE 2

Summary Cost Estimates and Financial Plan
(thousands of U.S. dollars) 1/

<u>Project Components</u>	<u>AID</u>		<u>HOST COUNTRY</u>		<u>TOTAL</u>
	FX	LC	FX	LC	
<u>1. Pharmaceuticals and medical supplies</u>					
a. Priority 1 drugs ^{2/}	5,000	-	UND ^{3/}	UND	UND
b. Priority 2 drugs	2,500	-	UND	UND	UND
c. Priority 3 drugs	1,500	-	UND	UND	UND
d. Medical supplies	750	250			
e. Other drugs	--	-	UND	UND	UND
Subtotal	<u>9,750</u>	<u>250</u>	<u>15,000</u>	<u>5,000</u>	<u>30,000</u>
<u>2. Technical Assistance</u> ^{4/}					
a. Technical assistance for procurement	<u>80</u>	<u>70</u>	<u>-</u>	<u>-</u>	<u>-</u>
Subtotal	<u>80</u>	<u>70</u>	<u>-</u>	<u>-</u>	<u>-</u>
TOTAL	9,830	320	15,000	5,000	30,150

1/ Exchange rate used for calculating host country contributions: 41.5/\$1

2/ Priority categories are defined in Section IV.A.1.

3/ UND - stands for undetermined at this time

4/ Note that an additional \$150,000 of Technical Assistance funding will be added to the PPAI project along with GOCR counterpart.

TABLE 3

A.I.D. Obligations by Fiscal Year

(thousands of U.S. dollars)

	<u>Loan</u>	<u>Grant</u>	<u>Total</u>
FY 1983	6,000	150	6,150
FY 1984	4,000		4,000

TABLE 4

Expenditures by Fiscal Year

(thousands of U.S. dollars)

<u>Fiscal Year</u>	<u>Loan</u>	<u>Grant</u>	<u>Total</u>	<u>Host Country</u>	<u>Total</u>
1984	6,000	70	6,070	7,000	13,070
1985	4,000	60	4,060	13,000	17,060
1986		<u>20</u>	<u>20</u>	<u> </u>	<u>20</u>
	10,000	150	10,150	20,000	30,150

C. Disbursement Procedures

Standard A.I.D. disbursement procedures will be used. For the pharmaceuticals and medical supplies it is anticipated that A.I.D. direct letters of credit will be used. Both dollars and colones will be used for technical assistance procurement.

VI. IMPLEMENTATION ARRANGEMENTS

A. Roles and Responsibilities

A.I.D. will sign a Loan Agreement with the GOCR for \$10.0 million. The Agreement, which will be co-signed by the CCSS and the Ministry of Health, will specify the terms under which the GOCR will, transfer the full amount of the Loan to the CCSS. In accepting repayment responsibility for the loan, the GOCR will cancel the colon equivalent of \$10 million (presently ₡415,000,000) of the ₡600 million it owes in back payments to the SEM minus an estimated one to two million dollars for drugs allotted to the MOH.

A.I.D. will in addition, sign a Grant Agreement in the amount of \$150,000 with the CCSS; this agreement will cover the technical assistance required to facilitate the procurement under the Loan.

The procedures for and the timing of the accounting transactions which cancel the Government's debt to the SEM are being worked out between the Ministry of Finance and the CCSS, and will be specified in the Loan Agreement. The method proposed is that with each disbursement of the Loan funds, CCSS will credit the Ministry of Finance, thus incrementally reducing the GOCR debt.

The Loan Agreement will also provide for the CCSS to procure certain preventative care drugs for the MOH with loan funds. The items to be procured and their end use will be specified in the Loan Agreement. Further, the Loan Agreement will stipulate that the Executive President of the CCSS will be the designated authorized representative of the borrower for purposes of implementing Project activities, and that the CCSS may communicate directly with A.I.D. for such purposes.

USAID/Costa Rica's General Development Division will be primarily responsible for providing assistance to the CCSS in implementing and monitoring the project. The Materials Management Office of the CCSS will be the day-to-day counterpart to USAID for this project. Decision-making concerning eligible products and ordering will be facilitated by regular technical assistance to that office during the eighteen to twenty-four month period that loan-funded orders will be placed. (See Project Description, Inputs).

AID/Washington - LAC/DR, GC, or SER/COM - may be requested to

provide advice or assistance on occasion with respect to questions which may arise concerning procurement procedures in general, or procurement of pharmaceuticals in particular.

B. Procurement Procedures

There will be two types of procurement under the project, technical assistance and commodities, the latter consisting of pharmaceuticals and disposable medical supplies. The Loan Agreement will limit procurement of pharmaceuticals and supplies to those items on the list in Annex F. This list may be changed, by mutual agreement, during the life of the project in order to accommodate changing needs.

It is anticipated that all pharmaceuticals, and most if not all medical supplies will be U.S. source and origin, with the exception of those which are procured under the PAHO agreement.

Pharmaceuticals will be procured by two routes. A small amount, estimated to be in the range of \$500,000, and representing the cost of vaccines for use by the MOH, will be procured by PAHO. The balance of the pharmaceuticals and medical supplies will be obtained through a competitive bidding process.

Procurement of pharmaceuticals and disposable medical supplies will be based on recommendations resulting from the Technical/Administrative Analysis detailed in Sections IV.A.1. and 2. Standard A.I.D. procurement procedures will be used, with the following exception: a waiver of the requirement for U.S. advertising is hereby requested. As recommended in the Technical/Administrative Analyses, Section IV.A.3., this waiver is required to permit host country procurement via the CCSS' international bidding process. This is the alternative to relying upon A.I.D. direct procurement which SER/COM advises is not feasible, or to forcing the CCSS to set up a parallel procurement system for purposes of implementing this project. The latter would only serve to compound the type of administrative inefficiencies that the PPAI project is attempting to address. Working through the CCSS' existing structure to the extent possible also assures that the CCSS obtains goods for the lowest price, and it avoids both severe implementation delays and the burden on A.I.D. staff that would result from having to advertise in the Commerce Business Daily and assist with at least 50 separate procurements per year.

A.I.D. will pay for drugs and supplies which the CCSS selects through the international bidding process, which are on the list of approved items for the Project, and which AID determines are eligible under its procurement regulations as they apply to the Project.

C. Implementation Schedule

The following is an estimated schedule of major project events:

- Authorized by A.I.D. in August 1983.
- Approved by GOCR and sent to Asamblea in September 1983.
- Technical Assistance contracted in October 1983.
- First IFB's for pharmaceuticals and supplies which meet A.I.D. requirements issued in December 1983.
- Ratified by the Asamblea in December 1983.
- Conditions Precedents met in February 1984.
- Pharmaceuticals/Supplies begin arriving in July 1984.
- Last Bids out in July 1985.
- Last Pharmaceutical/Supply deliveries in September 1986.
- PACD December 1986.

D. Evaluation Plan

Evaluation efforts will be management oriented. In addition to the day-to-day monitoring that the project will require, quarterly progress reviews will be held between the Mission and the CCSS. Given the short-term objectives of the project, however, no impact evaluation or base line studies are planned. Evaluation efforts will be focused on improving procurement management and on the CCSS's efforts to achieve financial equilibrium of the SEM. An internal mid-term evaluation with possible AID/W assistance is planned. The evaluation effort will be coordinated with evaluation of the PPAI project.

VII. Conditions and Covenants

A. Conditions

In addition to the standard conditions precedent, the following conditions will be included in the Agreement signed by the Ministry of Finance, and co-signed by the CCSS and the MOH:

Prior to any disbursements of loan funds, the cooperating Country will submit evidence, satisfactory to AID, that the CCSS has a system for loan funded procurement in place which is consistent with A.I.D. procurement regulations, including those specific to pharmaceuticals.

Prior to making disbursements for more than \$5,000,000 in loan funds, the cooperating country will submit evidence satisfactory to USAID/Costa Rica that efforts to strengthen the CCSS procurement system, under the PPAI project, are making satisfactory progress.

B. Covenants

1. The Cooperating Country covenants to pay to the CCSS, in a timely manner its contribution for the years 1984 and 1985;

2. The Cooperating Country covenants to pay to the CCSS, the remainder of its employer's quota in arrears by 1985;

3. The Cooperating Country covenants that the CCSS will provide sufficient funds in its 1984 and 1985 pharmaceuticals budget to cover the purchase of required items not covered by the AID Loan;

4. The Cooperating Country covenants that the CCSS will pay off the rest of the SEM's debt to foreign suppliers by the end of 1985.

ACTION AID-7 INFO AMB DCM ECON /10

ACTION

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TAGS:

SUBJECT: COSTA RICA HEALTH SERVICES SUPPORT (515-0203)

THE PID FOR THE HEALTH SERVICES SUPPORT PROJECT WAS REVIEWED AND APPROVED BY THE LAC BUREAU ON MAY 5, 1973. THE BUREAU RECOGNIZED THAT THE DUAL PURPOSES OF THE PROJECT, FIRST TO MAINTAIN AN ADEQUATE LEVEL OF PROCUREMENT OF URGENTLY NEEDED MEDICAL SUPPLIES AND EQUIPMENT, AND SECOND, TO HELP STABILIZE THE FINANCIAL POSITION OF THE CCSS, ARE EQUALLY IMPORTANT. THE FOLLOWING COMMENTS AND GUIDANCE ARE PROVIDED BY THE DAE TO ASSIST THE MISSION IN ITS INTENSIVE REVIEW AND IN THE SUBSEQUENT PREPARATION OF THE PROJECT PAPER. THE PROJECT WILL BE AUTHORIZED BY AID/W.

A- FINANCIAL PLAN OF THE PROJECT

A.1 - THE BUREAU UNDERSTANDS THAT THE MISSION INTENDS TO USE THE DOLS 10 MILLION AID LOAN FUNDS THROUGH STANDARD DA PROCEDURES, E.G., THE BORROWER WILL BE THE GOCR, WHICH WILL PASS THE FUNDS THROUGH TO THE CCSS FOR THE

PROCUREMENT OF PHARMACEUTICALS AND MEDICAL EQUIPMENT FOLLOWING PROCUREMENT PLANS TO BE DEVELOPED IN CONSULTATION WITH SER/COM.

A.2 - THE MISSION SHOULD EXAMINE AND CLARIFY THAT THE GOCR COUNTERPART CONTRIBUTION, THE COLON EQUIVALENT OF DOLS 12 MILLION, WILL REDUCE THE GOCR'S ACCUMULATED DEBT TO THE CCSS (FOR THE INSURANCE OF THEIR OWN EMPLOYEES). THE MISSION SHOULD VERIFY THAT THIS PUBLIC SECTOR EXPENDITURE DOES NOT COMPROMISE THE FISCAL AND MONETARY TARGETS OF THE IMF AGREEMENT.

A.3 - THE MISSION WILL CLARIFY THE SPECIFIC STEPS THE CCSS PLANS TO TAKE TO REPAY OR REFINANCE ITS DEBT TO PHARMACEUTICAL SUPPLIERS, AND HOW THIS PROJECT WILL HELP RESTORE THE CREDITWORTHINESS OF THE CCSS WITH ITS U.S. SUPPLIERS.

B- INSTITUTIONAL ANALYSIS AND DEVELOPMENTAL IMPACT

B.1 - THE MISSION IS REQUESTED TO PREPARE A FINANCIAL

USAD	Costa Rica
Route To	Act/Info
MDIR	/
DDIR	/
MO	
LO	
GDD	/
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TO	
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CONT	/
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AND ECONOMIC ANALYSIS OF THE CCSS THAT WILL ALSO IDENTIFY ALTERNATIVES FOR CUTTING COSTS AND INCREASING REVENUE. PROJECTIONS SHOULD BE MADE REGARDING REVENUES AND EXPENDITURES, AND THE IMPACT ON THE CCSS INCOME EXPECTED FROM THE RECENT CHANGE IN THE PAYROLL TAX FROM 10.5 PERCENT TO 14.5 PERCENT.

B.2 - THROUGHOUT THE INTENSIVE REVIEW AND PROJECT DEVELOPMENT, THE MISSION SHOULD TRY TO RELATE THE COMPLEMENTARY ACTIVITIES OF THE SUBJECT PROJECT AND THE PPAI PROJECT. THE MISSION ANALYSIS SHOULD SHOW, FOR EXAMPLE, HOW THE TECHNICAL ASSISTANCE PROVIDED IN THE PPAI PROJECT WILL HELP THE GOCR FIND WAYS TO ELIMINATE THE UNDER-REPORTING OF PAYROLL DEDUCTIONS AND IDENTIFY OTHER MEASURES THAT WOULD MAXIMIZE CCSS REVENUES. IN ADDITION, THE FEASIBILITY AND DESIRABILITY OF GREATER USER FEES, AND THE REALISTIC POSSIBILITY OF FAVORABLE LEGISLATIVE ACTION, IF USER FEES ARE WARRANTED, SHOULD BE EXPLORED.

2. OTHER CONCERNS RELATED TO THE CCSS WHICH THE PPAI PROJECT MAY ADDRESS (SUCH AS THE CCSS'S BUDGET, CREDIT AND INVESTMENT, ACCOUNTING, AND HOSPITAL/INDUSTRIAL COST ACCOUNTING SYSTEMS) WILL BE FURTHER RELATED TO THE HEALTH SERVICE SUPPORT PROJECT IN ORDER TO RESPOND TO THE DAEC CONCERN ABOUT WHERE THE CCSS WILL BE, AS AN

INSTITUTION, AFTER THE PROJECT HAS BEEN COMPLETED. THE MISSION SHOULD IDENTIFY THOSE REFORMS OR CHANGES NEEDED WHICH TOGETHER WITH THE FINANCIAL SUPPORT PROVIDED IN THIS PROJECT WILL MAKE THE CCSS FINANCIALLY HEALTHY.

3. IF THE PROJECT PREPARATION ANALYSES UNCOVER THE NEED FOR FURTHER STUDIES, THE MISSION SHOULD REQUEST ADDITIONAL GRANT FUNDS FOR THE PPAI PROJECT RATHER THAN FOR THE SUBJECT PROJECT.

C- PROCUREMENT

C.1 - DURING THE INTENSIVE REVIEW THE MISSION SHOULD EXAMINE CAREFULLY ADVANTAGES AND DISADVANTAGES OF THE LOCAL PROCUREMENT OF FINISHED PHARMACEUTICALS AND/OR THE OFFSHORE PROCUREMENT OF RAW MATERIALS FOR PROCESSING BY THE CCSS. THE MISSION IS TO BE GUIDED BY AID HANDBOOK 1B, CHAPTER 4, WHICH CONTAIN SPECIAL RULES FOR PHARMACEUTICAL PROCUREMENT. THE NORMAL REQUIREMENT IS FOR PROCUREMENT IN THE U.S. THE PROCUREMENT PLAN MUST MEET THE HANDBOOK CRITERIA IF LOCAL PROCUREMENT IS TO BE PERMITTED, AND MUST INCLUDE JUSTIFICATION FOR ANY SPECIFIC WAIVER.

D- ASSISTANCE TO THE MISSION IN DEVELOPING THE PROJECT

THE DAEC RECOMMENDED THAT THE SERVICES OF TWO PROCUREMENT SPECIALISTS AND AN ECONOMIST-FINANCIAL ANALYST WILL BE NEEDED TO RESPOND TO THE ISSUES RAISED HERE AND TO ASSIST THE MISSION IN PP PREPARATION. THE TECHNICAL ASSISTANCE MAY BE PROVIDED USING AGENCY IQCS, AND THE MISSION HAS IDENTIFIED ITS HEALTH ACCOUNT PD&S ACCOUNT AS A POSSIBLE SOURCE OF FUNDS FOR THESE SERVICES. AID/W HAS PREPARED PIO/TS AND IQC TASK ORDERS, AND IS AWAITING MISSION FISCAL DATA TO PROCEED WITH CONTRACTING. PROJECT DEVELOPMENT ASSISTANCE FROM AID/W WILL ALSO REQUIRE THAT MISSION OPERATING EXPENSES BE USED FOR TRAVEL. MISSION SHOULD REQUEST AN INCREASE IN THEIR OE BUDGET ASAP, IF NECESSARY, TO FUND THESE TDYS.

4. THE QUESTION OF ASSISTANCE FROM SER/COM REGARDING RECOMMENDED PROCUREMENT PROCEDURES WILL BE HANDLED IN LARGE PART BY CORRESPONDENCE WITH THE MISSION. THE MISSION IS REQUESTED TO CABLE ASAP THE LIST OF DRUGS CURRENTLY PROCURED BY THE CCSS. IN ORDER THAT

USAID/CR AND THE PROPOSED PROCUREMENT SPECIALIST RECEIVE EARLY GUIDANCE REGARDING THE ADVISABILITY AND ACCEPTABILITY OF SPECIFIC ITEMS, AS WELL AS RELATIVE COSTS EARLY IN THE DEVELOPMENT OF THE PP, THE BUY LIST SHOULD BE CABLED TO MR. KWYN ABRAHAMS, SER/COM, ROOM 535, SA-14, AID, WASHINGTON D.C. 20523.

AID/GC/LAC:RMEIGHAN AID/LAC/DR:ILEVY
 AID/LAC/DR:DBJOENSON AID/DAA/LAC:MDBROWN

SHULTZ

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ROCAF	

PROJECT DESIGN SUMMARY
LOGICAL FRAMEWORK

Life of Project:
From FY 83 to FY 86
Total U.S. Funding \$10,150,000
Date Prepared: 7-6-83

(INSTRUCTION: THIS IS AN OPTIONAL FORM WHICH CAN BE USED AS AN AID TO ORGANIZING DATA FOR THE PAR REPORT. IT NEED NOT BE RETAINED OR SUBMITTED.)

AND (OPTIONAL) SUPPLEMENT 1

Project Title & Number: Health Services Support (515-203)

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
<p>Program or Sector Goal: The broader objective to which this project contributes: (A-1)</p> <p>o Continued availability to all Costa Ricans of an adequate level of preventative and curative health services, after the project has terminated.</p>	<p>Measures of Goal Achievement: (A-2)</p> <p>o No significant deterioration of health status in Costa Rica.</p> <p>o SEM and MOH services continue to reach all Costa Rican's desiring these.</p> <p>o Adequacy of health services available versus needs does not deteriorate.</p>	<p>(A-3)</p> <p>o GOCR and international organization health statistics</p> <p>o SEM and GOCR statistics and reports on number and location of delivery sites; % and nature of population covered versus number and location of clients.</p> <p>o SEM and MOH records & reports on types of services offered; availability by area; health needs.</p>	<p>Assumptions for achieving goal targets: (A-4)</p> <p>o All health related organization in Costa Rica function effectively and maintain coverage in the long run.</p> <p>o CR economy recovers sufficiently to support its health system.</p>

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PROJECT DESIGN SUMMARY
LOGICAL FRAMEWORK

Life of Project: 83 - 86
From FY 83 to FY 86
Total U.S. Funding: \$10,150,000
Date Prepared: 7-6-83

Health Services Support (515-203)

Project Title & Number

PAGE 2

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
<p>Project Purpose: (B-1)</p> <p>o To provide pharmaceuticals and medical supplies to Costa Rica's health care system and to help stabilize the financial position of the CCSS.</p>	<p>Conditions that will indicate purpose has been achieved: End-of-Project status. (B-2)</p> <p>o Pharmaceuticals and/or medical supplies are available as required in 95% or more of cases.</p> <p>o SEM and MOH services continue to reach population during project lifetime.</p> <p>o Adequacy of SEM and MOH services available versus needs does not deteriorate.</p> <p>o Annual expenses decline as a percentage of annual budget.</p> <p>o Accumulated debt declines (without passing inequitable burden to IVM pension fund).</p>	<p>(B-3)</p> <p>o SEM and MOH records; AID evaluation/survey.</p> <p>o SEM records and reports. o MOH records and reports.</p> <p>o SEM records and reports; MOH records and reports; AID evaluation.</p> <p>o CCSS/SEM financial records and reports</p>	<p>Assumptions for achieving purpose: (B-4)</p> <p>o CCSS procurement process continues to operate effectively during project life time.</p> <p>o MOH and CCSS distribution networks operate effectively during project lifetime.</p> <p>o SEM and MOH networks for administering treatment function at current level or better.</p> <p>o CCSS, AID (PPAI) and GOCR efforts to increase efficiency and financial responsibility are successful.</p> <p>o Issue of repayment for SEM debt to IVM is equitably resolved.</p>

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PROJECT DESIGN SUMMARY
LOGICAL FRAMEWORK

Life of Project:
From FY 83 to FY 86
Total U.S. Funding \$10,150,000
Date Prepared: 7-6-83

Project Title & Number: Health Services Support (515-203)

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
<p>Project Outputs: (C-1)</p> <p>Adequate quantity of pharmaceuticals and medical supplies are procured and delivered to the SEM and the MOH.</p> <p>o GOCR pays off remainder of quota-generated debt during project lifetime</p> <p>o GOCR pays 1984 and 1985 employer's quota to CCSS.</p>	<p>Magnitude of Outputs: (C-2)</p> <p>ø600 million</p> <p>To be determined based on formula</p>	<p>(C-3)</p> <p>o CCSS records</p> <p>o CCSS records</p> <p>o CCSS records</p>	<p>Assumptions for achieving outputs: (C-4)</p> <p>o CCSS procurement system continues to function effectively</p> <p>o CCSS is able to budget for SEM pharmaceutical and supplies needs not covered by AID loan.</p> <p>o CCSS and GOCR adhere to covenants of Assistance Agreement.</p> <p>o</p>

B-3

U.S. HEALTH ASSISTANCE
SUPPLEMENT 1

PROJECT DESIGN SUMMARY
LOGICAL FRAMEWORK

Life of Project: 83 to FY 86
From FY 83 to FY 86
Total U.S. Funding: \$10,150,000
Date Prepared: 7-6-83

Project Title & Number: Health Services Support (515-203)

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
<p>Project inputs: (D-1)</p> <ul style="list-style-type: none"> o Funds to procure commodities : <ul style="list-style-type: none"> - Pharmaceuticals - Medical supplies 	<p>Implementation Target (Type and Quantity) (D-2)</p> <ul style="list-style-type: none"> \$ 9,000,000 in 18-24 mo \$ 1,000,000 in 18-24 mo 	<p>(D-3)</p> <ul style="list-style-type: none"> o USAID records 	<p>Assumptions for providing inputs: (D-4)</p>
<ul style="list-style-type: none"> o Technical assistance: <ul style="list-style-type: none"> - Pharmacist consultant - Project implementation assistant 	<ul style="list-style-type: none"> o 4,5 months (TDY) o up to 2 years (full time) 		<ul style="list-style-type: none"> o Qualified persons located

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PAGE NO. SM-10	EFFECTIVE DATE September 30, 1982	TRANS. MEMO NO. 3:43	AID HANDBOOK S, App 5M
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ANNEX C

page 1 of 8

5C(2) PROJECT CHECKLIST

Listed below are statutory criteria applicable to projects. This section is divided into two parts. Part A. includes criteria applicable to all projects. Part B. applies to projects funded from specific sources only: B.1. applies to all projects funded with Development Assistance Funds, B.2. applies to projects funded with Development Assistance loans, and B.3. applies to projects funded from ESF.

CROSS REFERENCES: IS COUNTRY CHECKLIST UP TO DATE? HAS STANDARD ITEM CHECKLIST BEEN REVIEWED FOR THIS PROJECT?

Except as noted below Country checklist is up to date**. Yes.

A. GENERAL CRITERIA FOR PROJECT

1. FY 1982 Appropriation Act Sec. 523; FAA Sec. 634A; Sec. 633(b).

Congressional Notification FY 1983

(a) Describe how authorizing and appropriations committees of Senate and House have been or will be notified concerning the project;
 (b) is assistance within (Operational Year Budget) country or international organization allocation reported to Congress (or not more than \$1 million over that amount)?

2. FAA Sec. 611(a)(1). Prior to obligation in excess of \$100,00, will there be

Yes.

**as of Mar.18,1983, Costa Rica was in violation of 620Q of the FAA: the Secretary of State has made an exception for FY 1983

(a) engineering, financial or other plans necessary to carry out the assistance and (b) a reasonably firm estimate of the cost to the U.S. of the assistance?

3. FAA Sec. 611(a)(2). If further legislative action is required within recipient country, what is basis for reasonable expectation that such action will be completed in time to permit orderly accomplishment of purpose of the assistance?

N/A

4. FAA Sec. 611(b); FY 1982 Appropriation Act Sec. 501. If for water or water-related land resource construction, has project met the standards and criteria as set forth in the Principles and Standards for Planning Water and Related Land Resources, dated October 25, 1973? (See AID Handbook 3 for new guidelines.)

N/A

5. FAA Sec. 611(e). If project is capital assistance (e.g., construction), and all U.S. assistance for it will exceed \$1 million, has Mission Director certified and Regional Assistant Administrator taken into consideration the country's capability effectively to maintain and utilize the project?

N/A

6. FAA Sec. 209. Is project susceptible to execution as part of regional or multilateral project? If so, why is project not so executed? Information and conclusion whether assistance will encourage regional development programs. N/A
7. FAA Sec. 601(a). Information and conclusions whether project will encourage efforts of the country to: (a) increase the flow of international trade; (b) foster private initiative and competition; and (c) encourage development and use of cooperatives, and credit unions, and savings and loan associations; (d) discourage monopolistic practices; (e) improve technical efficiency of industry, agriculture and commerce; and (f) strengthen free labor unions. a) Yes, by increasing the use of US pharmaceuticals
b) bids will be competitive
c) N/A
d) yes, competitive bids
e) N/A
f) N/A
8. FAA Sec. 601(b). Information and conclusions on how project will encourage U.S. private trade and investment abroad and encourage private U.S. participation in foreign assistance programs (including use of private trade channels and the services of U.S. private enterprise). Project will support US pharmaceutical production and sales.

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9. FAA Sec. 612(b), 636(h);
FY 1982 Appropriation
Act Sec. 507. Describe
steps taken to assure
that, to the maximum
extent possible, the
country is contributing
local currencies to meet
the cost of contractual
and other services, and
foreign currencies owned
by the U.S. are utilized
in lieu of dollars.
- Costa Rica is providing
a substantial contribution
to the project in local
currency. The US owns no local
currency.
10. FAA Sec. 612(d). Does
the U.S. own excess
foreign currency of the
country and, if so, what
arrangements have been
made for its release?
- N/A
11. FAA Sec. 601(e). Will
the project utilize
competitive selection
procedures for the
awarding of contracts,
except where applicable
procurement rules allow
otherwise?
- Yes.
12. FY 1982 Appropriation Act
Sec. 521. If assistance
is for the production of
any commodity for export,
is the commodity likely
to be in surplus on world
markets at the time the
resulting productive
capacity becomes
operative, and is such
assistance likely to
cause substantial injury
to U.S. producers of the
same, similar or
competing commodity?
- N/A
13. FAA 118(c) and (d).
Does the project comply
with the environmental
procedures set forth in
AID Regulation 16? Does
- Yes

the project or program take into consideration the problem of the destruction of tropical forests?

N/A

14. FAA 121(d). If a Sabel project, has a determination been made that the host government has an adequate system for accounting for and controlling receipt and expenditure of project funds (dollars or local currency generated therefrom)?

N/A

B. FUNDING CRITERIA FOR PROJECT

1. Development Assistance Project Criteria

a. FAA Sec. 102(b), 111, 113, 281(a). Extent to which activity will (a) effectively involve the poor in development, by extending access to economy at local level, increasing labor-intensive production and the use of appropriate technology, spreading investment out from cities to small towns and rural areas, and insuring wide participation of the poor in the benefits of development on a sustained basis, using the appropriate U.S. institutions; (b) help develop cooperatives, especially by technical assistance, to assist rural and urban poor to help themselves toward better life, and

a) The Costa Rican Health System is available to the entire population, and is heavily used by the poorest of the poor. This project will enable the health sector to continue to offer its services within the context of a deteriorating economy, without severe setbacks in the overall health situation.

otherwise encourage democratic private and local governmental institutions; (c) support the self-help efforts of developing countries; (d) promote the participation of women in the national economies of developing countries and the improvement of women's status; and (e) utilize and encourage regional cooperation by developing countries?

b. FAA Sec. 103, 103A, 104, 105, 106. Does the project fit the criteria for the type of funds (functional account) being used?

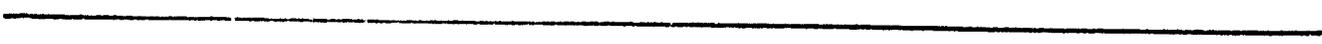
Yes.

c. FAA Sec. 107. Is emphasis on use of appropriate technology (relatively smaller, cost-saving, labor-using technologies that are generally most appropriate for the small farms, small businesses, and small incomes of the poor)?

N/A

d. FAA Sec. 110(a). Will the recipient country provide at least 25% of the costs of the program, project, or activity with respect to which the assistance is to be furnished (or is the latter cost-sharing requirement being waived for a "relatively least developed" country)?

Yes.



e. FAA Sec. 110(b).
Will grant capital assistance be disbursed for project over more than 3 years? If so, is justification satisfactory to Congress been made, and efforts for other financing, or is the recipient country "relatively least developed"? (M.O. 1232 defined a capital project as "the construction, expansion, equipping or alteration of a physical facility or facilities financed by AID dollar assistance of not less than \$100,000, including related advisory, managerial and training services, and not undertaken as part of a project of a predominantly technical assistance character.

N/A

f. FAA Sec. 122(b). Does the activity give reasonable promise of contributing to the development of economic resources, or to the increase of productive capacities and self-sustaining economic growth?

Yes, by maintaining a healthy population.
The institutions will be helped during a crisis period, and will be practicing cost-cutting and efficiency measures.

g. FAA Sec. 281(b). Describe extent to which program recognizes the particular needs, desires, and capacities of the people of the country; utilizes the country's intellectual resources to encourage

The project recognizes the needs and desires of the population for an adequate health care system, which is dependent upon a constant flow of medicines.

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institutional development;
and supports civil
education and training in
skills required for
effective participation in
governmental processes
essential to self-government.

2. Development Assistance Project
Criteria (Loans Only)

- a. FAA Sec. 122(b).
Information and conclusion
on capacity of the country
to repay the loan, at a
reasonable rate of interest.

The country is under
going severe economic problems
nevertheless, it appears
quite capable of repaying
the loan.

- b. FAA Sec. 620(d). If
assistance is for any
productive enterprise which
will compete with U.S.
enterprises, is there an
agreement by the recipient
country to prevent export
to the U.S. of more than
20% of the enterprise's
annual production during
the life of the loan?

N/A

- c. ISDCA of 1981, Sec. 724
(c) and (d). If for
Nicaragua, does the loan
agreement require that the
funds be used to the
maximum extent possible for
the private sector? Does
the project provide for
monitoring under FAA Sec.
624(g)?

N/A

3. Economic Support Fund
Project Criteria

- a. FAA Sec. 531(a). Will
this assistance promote
economic or political



REPUBLICA DE COSTA RICA
MINISTRO DE HACIENDA

San José, 27 de julio de 1983

Señor
Daniel Chaij
Director
Agencia para el Desarrollo Internacional
Presente

Estimado señor:

En representación del Gobierno de Costa Rica, por este medio solicito un préstamo de la Agencia para el Desarrollo Internacional, por un monto de U.S.\$10 millones para abonar la deuda que éste tiene con la Caja Costarricense de Seguro Social, ésta por su parte lo usará para financiar la compra de medicamentos y materias primas, rubros en los que actualmente tiene un déficit importante.

El préstamo financiará la compra de medicamentos y materias primas para la fabricación de éstos en los laboratorios de la citada Institución, lo que ayudará a solucionar el déficit actual y a mejorar los servicios médico asistenciales que brinda la Caja, los cuales se han visto afectados por la crisis económica y el debilitamiento de la situación financiera de la C.C.S.S., causada entre otros aspectos por la deuda del Estado acumulada en años anteriores.

En virtud de la crisis económica que atraviesa Costa Rica, quisiera solicitarle que el préstamo se nos otorgue dentro de las mejores condiciones posibles.

En espera de que la presente propuesta reciba una consideración favorable por parte de la A.I.D., suscribe de usted,

... /



REPUBLICA DE COSTA RICA
MINISTRO DE HACIENDA

- 2 -

Atentamente,

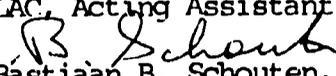

DR. FEDERICO VARGAS PERALTA
MINISTRO DE HACIENDA



mdccs.*

C.C: Ing. Claudio A. Volio./ MINISTRO DE PLANIFICACION
Presidencia Ejecutiva./ C.C.S.S.
Archivo.*

ANNEX E

TO : LAC, Acting Assistant Administrator, Marshall D. Brown
FROM:  Bastiaan B. Schouten, Acting Mission Director, USAID/Costa Rica
SUBJECT: Request for a Waiver of U.S. Advertising Requirements - Health Services Support Project (515-0203)

PROBLEM:

Under the Project cited, \$9 million in pharmaceuticals and \$1 million in disposable medical supplies will be procured for Costa Rica. The Caja Costarricense de Seguro Social (CCSS), the Cooperating Country implementing agency, procures all of its pharmaceuticals and supplies through an established, competitive procurement process in which all tenders are made on an international basis. Moreover, one or two IFB's are issued per week. If A.I.D.'s advertising requirements are applied to procurements made under the project, the problems of separating out U.S. procurements from the CCSS' international bidding process, plus the sheer volume of advertisements given the frequency of procurements, will make the implementation of the Project extremely difficult, if not impossible.

DISCUSSION:

Irrespective of whether host country or A.I.D. direct procurement is used, to procure in the U.S. separate from the CCSS' international tenders creates an unviable situation. It involves identifying selected items from CCSS lists in order to advertise in the Commerce Business Daily, and to issue IFB's to U.S. bidders only. This entails a process of deciding which drugs are likely to be obtained more cheaply in the U.S., and requires the costly and unmanageable effort of obtaining informal price quotes once or twice a week. If host country procurement is used, the CCSS would also be required to set up a separate bidding process for the U.S. only. Both of these scenarios create inefficiencies and costs in an institution where A.I.D.'s objective is to reduce these, and are clearly at odds with the purpose of this Project and the related Policy, Planning, and Administrative Improvement Project.

Aside from the inefficiencies involved in making separate U.S. procurements under the loan, the sheer volume of procurements is such that to place one to two advertisements per week would also be unmanageable.

Waiver of the U.S. advertising requirement will make implementation of the project feasible, and will have no negative effect on U.S. suppliers of goods. The CCSS will select the low bidder on the basis of its international bidding process; if the low bidder is an eligible supplier, the loan will finance the procurement. With respect to pharmaceuticals, the loan requires code 000 procurement, thus protecting U.S. sources. Historical data establishes that the CCSS bidding system is effective in reaching U.S. suppliers. The CCSS currently purchases about 25% of its pharmaceuticals from the U.S. per year (about \$5 million worth); of the drugs which are on the list of those eligible for purchase with A.I.D. funds, U.S. suppliers could expect to be the low bidders on at least \$4 million worth per year. With respect to disposable supplies, the CCSS currently purchases annually from the U.S., an amount equal to the \$1,000,000 that the loan will provide.

CCSS procurements tend to be frequent and small in size; the average procurement by the CCSS is approximately \$50,000, thus offering U.S. firms many opportunities to bid - which it is clear that they already do, and do with success. Moreover, inasmuch as A.I.D. policy is to exempt procurements estimated to come in at less than \$100,000 from the U.S. advertising requirement, the blanket waiver will be consistent with what would be allowable in any case for many of the individual procurements. Nevertheless, in order to assure that the maximum number of U.S. firms are aware of the opportunity to supply goods to Costa Rica under this A.I.D. loan, the Mission proposes to publish a one-time notice in the Commerce Business Daily when procurement is ready to begin. The notice will advise suppliers that a series of IFB's will be issued by the CCSE, and inform them as to where they can obtain full information on the publication of the IFB's, and the GOCR and A.I.D. eligibility requirements.

The authority to waive the requirement for U.S. advertising is within your authority per A.I.D. Handbook 1B.12C4b.

RECOMMENDATION:

That you approve the request for a waiver of U.S. advertising requirements for loan-funded procurement under the Health Services Support Project (515-203).

Yes _____

No _____

Date _____

(Subsequent pages of Annex F are oversized. They are available in IAC/DR project bulk files)

2020 CONSOLIDATED LIST OF MEDICAL SUPPLIES

CONSUMO DE MATERIALES MEDICOS
LISTA PRECUAL

ARTICULO	UM	CONSUMO ANUAL ESTIMADO	VALOR UNITARIO ESTIMADO	MONTO ANUAL ESTIMADO COLONES	MONTO ANUAL ESTIMADO DOLARES
PLACAS RADIOGRAFICAS 14x17"	CJ	3500	2000	7000000	168675
PLACAS RADIOGRAFICAS 14x14"	CJ	1000	1500	1500000	43373
PLACAS RADIOGRAFICAS 11x14"	CJ	1500	1100	2400000	57531
PLACAS RADIOGRAFICAS 10x12"	CJ	3000	1500	4500000	107434
PLACAS RADIOGRAFICAS 8x10"	CJ	3000	1200	3600000	86747
PLACAS RADIOGRAFICAS 6 1/2 x 8 1/2"	CJ	200	1000	200000	4819
FIXADOR RADIOLOGICO - AUTOM.	ST	400	650	260000	6265
FIXADOR RADIOLOGICO - MANUAL	ST	1200	250	300000	7229
REVELADOR RADIOLOGICO - AUTOM. MANUAL	ST	1200	120	144000	3470
BOLSAS INTERNAS P/SUEROS - 300 ML.	UN	275000	2,60	687500	16506
BOLSAS INTERNAS P/SUEROS - 600 ML.	UN	150000	3,-	1950000	46958
BOLSAS PARA COLESTEROL	UN	125000	5,-	1250000	15060
BOLSAS PARA ORINA	UN	15000	5,50	82500	1958
JERINGAS 5 C.C.	UN	25000	7,50	187500	4518
JERINGAS 10 C.C.	UN	20000	8,25	165000	3976
JERINGAS 20 C.C.	UN	8000	30,00	240000	5783
JERINGAS ASEPTO 2 OZ.	UN	3000	65,00	195000	4699
JERINGAS P/INSULINA	UN	10000	7,50	75000	1807
VENDA GASA SIMPLE	RL	50000	6,50	325000	7831
VENDA GASA 2" x 10 YD.	RL	25000	6,50	162500	3916
VENDA GASA 4" x 10 YD.	RL	25000	7,-	175000	4217
VENDA GASA KLING 4"	UN	20000	30,-	400000	9639
VENDA ELASTICA 3"	RL	150000	15,-	2250000	4217
VENDA ENYESADA 7,62 CMS.	UN	25000	5,25	131250	3163
VENDA ENYESADA 12,70 CMS.	UN	30000	8,60	258000	6145
CATGUT CRÓMICO #0 CON AGUJA	DC	1800	85,00	153000	3687
CATGUT CRÓMICO #0 SIN AGUJA	DC	1000	100,00	100000	2410
CATGUT CRÓMICO #1 CON AGUJA	DC	1000	125,00	125000	3012
CATGUT CRÓMICO #1 SIN AGUJA	DC	3000	125,00	375000	9036
CATGUT CRÓMICO #2-0 CON AGUJA	DC	2500	165,00	412500	9940
CATGUT SIMPLE #2-0 CON AGUJA	DC	1500	105,00	157500	3795
CATGUT SIMPLE #3-0 CON AGUJA	DC	1500	225,00	337500	8133
NYLON NEGRO #3-0 CON AGUJA	DC	3000	135,00	405000	9759
CATER INTRAVENOSO #20	UN	125000	4,30	537500	13554
TERMOMETRO ORAL	UN	40000	13,30	532000	13012
LIMPIADURA AMALGAMA	PC	2000	200,-	400000	9639
PH-4740 SONDAS PARA ALIMENTACION #K-32	UN	20000	7,-	140000	3373
APLICADORES CON ALGODON	ML	5000	24,-	120000	2892
PH-4750 SONDAS URETRALES #14, PUNTA OBLIC.	UN	2000	20,-	40000	964
GASO QUIRURGICO	PZ	25000	320	8000000	192530
ALGODON	PQ	35000	50,-	1750000	42167
EQUIPOS XRAY - LAMPA	UN	45000	7,-	315000	7540
COMP. FILTRO P/ RAYOS X	ST	2500	320	800000	19277
GUANTES PARA QUIRURGIA N° 6 1/2	PR	30000	5,30	159000	3976
GUANTES PARA QUIRURGIA N° 7	PR	90000	5,30	477000	11428
GUANTES PARA QUIRURGIA N° 7 1/2	PR	140000	5,30	742000	19277
GUANTES PARA QUIRURGIA N° 8	PR	25000	5,30	132500	3213

NOTA: EL TIPO DE CAMBIO SE HA ESTIMADO A TASA DE U.S. \$ 1,00 = \$ 41,50

ANNEX G

**FINANCIAL AND ECONOMIC ANALYSIS
FOR THE HEALTH SERVICES SUPPORT PROJECT PAPER (515-0203)**

**Prepared for USAID, San Jose, Costa Rica
by Dieter K. Zschock, Consultant**

June 22, 1983

INTRODUCTION

The purposes of the project - as spelled out in the PID - are, first, to maintain an adequate level of procurement of medical supplies and equipment for the Seguro de Enfermedad y Maternidad (SEM) of the Caja Costarricense de Seguro Social (CCSS), and second, to help stabilize the financial position of the CCSS. The PID identified the causes of current problems in procurement and financial stability as stemming from the country's large balance of payments deficit, leading to foreign exchange restrictions which prevented the CCSS during 1980-82 from paying its debts to foreign suppliers of pharmaceutical products, from the government's elimination of a foreign exchange subsidy to the CCSS, and from the Government's failure in recent years to pay its full contributions to the CCSS, thus causing the latter to incur large operating budget deficits.

The proposed solution is to provide a U.S. \$10,000,000.00 loan for purchases of medical supplies and equipment (pharmaceuticals) in 1984, this would help liberate ordinary revenues to pay off an accumulated debt to foreign suppliers and thus reestablish SEM's credit worthiness. The Government, in turn, would obligate itself to pay its full contributions to the CCSS in 1984. Moreover, the GOCR would be the borrower and thereby in part liquidate its accumulated debt to the CCSS.

The following financial and economic analysis has been prepared, in keeping with the terms of reference spelled out for this task in the PID, a draft Scope of Work and guidelines spelled out in AID Handbook 3. It is important to note at the outset that - in part - conditions have improved since the preparation of the PID. This could be interpreted as lessening the urgency of the project. On the other hand, the present financial analysis identifies deficit financing practices by the CCSS which are fiscally unsound. Corrections in these practices have also to some extent already been implemented. The unsound financing practices refer to technically illegal debts incurred by the CCSS with other social programs for which it serves as fiscal agent. The proposed loan represents a timely opportunity for the GOCR to reduce its debts to the CCSS, and for the latter to settle its illegal debts to these other entities. The loan would thus help reestablish the fiscal stability not only of the SEM but also of the other entities. At the same time, the loan would enable SEM to maintain an adequate level of pharmaceuticals procurement during 1984 by compensating for its loss of a favorable exchange rate privilege that will double the cost of its foreign procurement. The financial and economic analysis provides the parameters and rationale for the stabilization effort and reestablishment of an adequate flow of pharmaceuticals.

FINANCIAL ANALYSIS

The financial analysis first reviews revenues, expenditures, and deficits of the SEM for the periods 1975-1978 and 1979-82. ^{1/} Although, the earlier of these two periods was one of relative fiscal stability, it was also the time during which some 22 hospitals and clinics were transferred to the SEM from semi-autonomous community organizations and private sector enterprises. This transfer included redirecting some of the sources of funds that had supported these facilities to the CCSS, but these have proved to be insufficient to support these facilities under SEM management. The impact of this intra-sectoral transfer of facilities and funds, however, was not fully felt until the 1979-82 period when it unfortunately coincided with the country's general economic crisis.

The second part of the financial analysis focuses on the financial impact of the proposed USAID loan over the period 1984-85. The third section evaluates the overall financial viability of SEM with particular reference to its projected revenues and expenditures for the period 1983-86, with and without the proposed loan. The financial analysis concludes with recommendation for the loan agreement.

^{1/} Financial data cited below for the period 1975-82 are taken from a study by Jorge E. Brenes C., Chief of the CCSS Dirección Técnica Actuarial y de Planificación Institucional, Estudio Integral de la Situación Financiera del Seguro de Enfermedad y Maternidad, Octubre, 1982, including 1982 supplement. This study, shows all revenue and expenditure transactions after they have cleared the CCSS accounting process. Data for the period 1979-83 shown in Table 1, below, are interim working estimates prepared by the CCSS finance division

1. Revenues, expenditures and deficits, 1975-82 - For reasons not entirely clear, the GOCR in no year prior to 1982 paid its full obligations to the SEM. These unpaid obligations were the major cause of annual deficits in the SEM operating budget until 1978. Had the Government paid its full annual quotas, the operating budget would have been in surplus every year between 1970 and 1977. In summary, the budget for the period 1975-78 shows the following balances (in millions of current colones):

	<u>1975</u>	<u>1976</u>	<u>1977</u>	<u>1978</u>
Revenues	510.5	716.9	952.0	1,265.1
Expenditures	<u>513.5</u>	<u>709.8</u>	<u>1,024.1</u>	<u>1,383.0</u>
Deficit (-) or Surplus(+)	(-)3.0	(+)7.1	(-)72.1	(-)117.9
Deficit as Proportion of Expenditures	0.6%	1.0%	7.8%	8.5%
GOCR Debt	50.7	86.0	105.4	98.0

Between 1970 and 1974, annual deficits had also ranged between 1-10%, due largely to non-payment by the Government of its obligations. Thus, the period 1975-78 shows no departure from previous years. Beginning in 1979, however, and through 1981, the SEM operating budget deficit substantially exceeded the Government's debt, as the

following budget summary shows:

	<u>197^a</u>	<u>1980</u>	<u>1981</u>	<u>1982</u>
Revenues	1,490.6	1,788.8	2,166.6	4,034.5
Expenditures	<u>1,804.7</u>	<u>2,273.9</u>	<u>2,782.4</u>	<u>3,934.9</u>
Deficit (-) or Surplus (+)	(-)314.1	(-)485.0	(-)15.7	(+)99.6
Deficit as Proportion of Expenditures	29.0%	21.3%	22.1%	no deficit
GOCR Debt	156.1	79.8	438.7	no GOCR debt

The total GOCR debt to the SEM for the period 1975-81 is 878 million colones (or 984 million colones including debts remaining from earlier years). The CCSS has financed this Government debt by withholding roughly the equivalent amount from the Invalidez, Vejez y Muerte (IVM) pension fund which it also administers (328 million colones), as well as from the Asignaciones Familiares, a social welfare program (348 colones) and from several other social programs, all financed by wage levies for which the CCSS serves as fiscal agent. ^{2/}

^{2/} See Brenes, *ibid.*, pp.3-13, and summary on p.92

It is noteworthy that about half of this "debt financing" through withholding of transfer, occurred after the passage by the National Assembly in May 1981 of Law 6577 which explicitly prohibits inter-fund borrowing. Thus, while the legislative branch meant to stop deficit financing by the CCSS, the latter discontinued the practice only once the executive branch of the GOCR paid its 1982 contributions in full in 1982. The GOCR has also paid about one third of its accumulated debt to SEM, leaving a remaining government debt of approximately 600 million colones. This (not coincidentally) is about the same amount the CCSS is still withholding from its IVM fund and the Asignaciones Familiares program after having paid off several small debts to other entities.

³ These withholdings, one should note, do not represent formal loans to the SEM which makes this form of "deficit financing" highly questionable from a fiscal point of view.

The major debt carried by the SEM, however, is a total of 1 billion colones accumulated in annual formal loans from the IVM fund over the period 1972-81. ⁴ This debt is not due to GOCR non-payment of its contributions. This, instead, is the accumulated operating and investment budget deficit, most of which was incurred by expenditures that exceeded annual revenues by an average of over 20% during 1979-81.

³ Estimates of loans paid off according to Lic. Jorge Arturo Hernandez, Chief, CCSS Finance Division.

⁴ See Brenes, *opcit.*, p.7, sum of loans 1972-81, not including C328.4 million that constitute withholding of transfers rather than formal loans.

Even in earlier years when payment of the GOCR contribution would have put the operating budget of the SEM into a surplus position, the SEM fund borrowed from the IVM fund. The reason, most probably, was to cover not only operating deficits but also investment expenditures; no detailed investment accounts are available from the CCSS. However, it is typical of medical care funds under social insurance programs in developing countries not to budget for investment expenditures from ordinary revenue, but rather to finance them on an ad hoc basis by borrowing from their pension funds. This is an unsound fiscal practice unless there are clearly budgeted loan repayment provisions.

In 1970, the CCSS "solved" this repayment problem by issuing non-negotiable 30-year bonds bearing 2% annual interest and thereby cancelled its prior debts with the IVM. The loans contracted with the IVM between 1972-81 bear 6% interest through 1980 and 8% for 1981, these have not yet been converted into bonds. The nominal interest rates are clearly negative in real terms, considering the recent high rates of inflation in Costa Rica. Starting in 1979, operating budget expenditures include debt service entries of 20.5 million colones in 1979, rising to 66.7 million colones in 1982 (1.7% of total expenditures), but no breakdown for external and internal debt service is provided (see Table 1). The treatment of SEM's 1 billion colones debt to the IVM, which - to repeat - was not the result of GOCR non-payment of its obligations to SEM, remains unresolved. The 1981 law outlining such loans has been technically observed since no formal loans have been made by IVM since then.

2. Loan Impact - The "borrowing" by SEM of funds from other entities has been in the form of withholding wage levy collections for other institutions by the CCSS as fiscal agent, as noted above. The "justification" has been the non-payment by the GOCR of its obligations as employer and source of funds for coverage of the medically indigent (see below). While technically illegal since 1981, this ploy seems to have succeeded in getting to the GOCR to pay its full obligations in 1982 and to begin repayment of its accumulated debts of prior years. A loan of U.S. \$10 million would enable the GOCR to repay the remaining half of its debt to SEM, after having repaid the first half during 1983 (as it seems to be doing).

The loan, in the form of a line of credit, would also free the GOCR from having to allocate an equivalent amount of scarce foreign exchange for conversion of colones from SEM revenue for the importation of pharmaceutical products during 1984-85. The debt to foreign suppliers of U.S. \$22 million which SEM has incurred since 1981 has been due to the GOCR's inability or unwillingness in 1981-82 to grant SEM the necessary foreign exchange conversion of its pharmaceutical budget allocation. It has not been due, as suggested in the PID, to the Government's failure to pay its obligations to SEM since this deficit was covered by SEM through internal deficit financing, as explained above. SEM's foreign exchange limitations seem to have been largely overcome in recent months. The debt to foreign suppliers has been reduced to approximately U.S. \$10 million as of this date, and the remainder is likely to be paid off by

early 1984 according to CCSS budget authorities (i.e., Jorge Arturo HERNANDEZ) (Table 3). About half of the remaining debt is for products already received and the other half is for products awaiting payment before they will be released from customs storage.

Payment of the U.S. \$22 million debt, however, will not entirely solve SEM's problems of pharmaceutical supplies from international sources in 1984/85. While the debt is being paid off at the exchange rate of 20:1, all new imports ordered since February 24, 1983 have to be paid for in colones at an exchange rate of 44:1. This reduces by over half the purchasing power of SEM budgetary allocations for pharmaceutical products that have to be imported. Thus, a major justification for the loan - as foreseen in the PID - is SEM's loss of the favored exchange rate privilege due to conformance by the GOCR with IMF guidelines that call for a uniform foreign exchange rate for all imports. Medical supplies are no longer excluded.

Based on a projection of operating expenditures for the period 1983-86, prepared by the CCSS, the share of medicines will rise from the low of 5.9% it had reached in 1982 to almost 15% by 1986 (Table 4). The share of medicines in total SEM operating costs had been about 10% during the period of relative fiscal stability, 1975-1978. It then declined sharply in the 1979-82 period, largely due to the GOCR's restrictions of drug imports which have usually accounted for 50-75% of total pharmaceuticals consumption by SEM. This trend and projection is summarized in Table 5.

In 1983, pharmaceuticals purchases are projected to rise to 7.1% of total expenditures as the back-log of orders is paid for and new orders are again being accepted by leading providers. In 1984, the earlier level of purchasing of around 10% is expected to be reached once more, in part with the aid of the anticipated U.S. AID loan. Since SEM will not have to use its own revenues for foreign exchange conversion for about half of its total imports that it expects to finance under the loan, the overall budgetary allocation can still be contained at about 10%. Thereafter, however, as the last third of the loan is used in 1985 and as SEM once again becomes self-reliant in pharmaceutical imports, it expects to allocate close to 15% of total expenditures to such purchases. This proportional increase, of course, will be necessary to compensate for the higher foreign exchange costs. It will not signify a greater quantity of imports.

SEM has thus already factored in the new reality of higher imported pharmaceuticals costs for its projected expenditures in 1985 and 1986. In the short run, the U.S. AID loan will smooth the transition toward this new reality. As a result, SEM expects to operate with a balanced budget as early as 1984 rather than having to cope with deficits for two more years, deficits which it is no longer permitted to finance through borrowing. The alternative of proportionately reducing expenditures in other categories could thus be avoided. The following section will discuss SEM's financial viability as well as the feasibility of the unofficial projections of revenues and expenditures in Table 4.

3. Financial viability - SEM went through a period of highly unstable budgeting in the period 1979-81, following many years of a relatively stable relationship between income and expenditures. Its budget deficit increased from 8.5% in 1978 to 29% in 1979 and deficits continued at the relatively high levels of about 22% in 1980 and 1981.^{5/} The explanation probably lies largely in the major reorganization of curative medical care, with the transfer of almost all health care facilities from the community boards operating under Ministry of Health (MOH) auspices to SEM, Costa Rica took a major step toward the integration of a National Health System. In the process, the composition of total public sector health care expenditures has shifted toward SEM which now accounts for about 75%, while the MOH and Water and Sewage Institute jointly account for the other 25%. As a proportion of GDP, SEM expenditures have increased from about 3% to 5%, but total health sector expenditures have only risen from about 6% to 6.5%.^{6/}

The major deficits of SEM in 1978-81 thus reflected a structural transition problem rather than a basic flaw in the program's budgetary equilibrium. It was an unfortunate coincidence that the major impact of the sectoral transition coincided with Costa Rica's serious general economic crisis. Rather than receiving government transfers of general revenue equivalent to its greatly increased budgetary require-

^{5/} Calculated from data in Brenes, opcit, Cuadro No.11, p.85.

^{6/} Based on Luis Asis Beirute, Financiación Pluralista de las Prestaciones Médicas en la Seguridad Social Costarricense, VII Congreso Americano de Medicina de la Seguridad Social, Quito, Ecuador, June 1981, and Dieter K. Zchock, "Review of Medical Care Under Social Insurance in Latin America", mimeo, March 1982.

ments, CCSS solved its budgetary imbalance by massive borrowing from the IVM fund. This practice, however, was outlawed in 1981, as explained above. Instead, CCSS was able to enact major increases in public and private sector wage levies and in the Government's support for SEM coverage of the medically indigent. Those increases took effect January 1, 1983.

The combined employer and employee quotas were increased by four percentage points, from 10.75% to 14.75% of the wage base, in both, the private and the public sector. Previously, the Government's quota to support the indigent had been raised from 0.25% of the country's total wage base to 3.25% in 1982, but it has now been reduced to 1.25% as the employer/employee contributions were raised. Thus, the combined total wage levy in support of SEM is 16% of the country's wage base in 1983, a net increase of only two percentage points over 1982. Also, all wage ceilings for assessment purposes have been eliminated, only a C1,000/month earned income minimum remains below which workers do not contribute.

Revenues from the 14% total assessment in 1982 (i.e., 10.75 employers/employees and 3.25% Government coverage of the indigent), when the GOCR also paid its full share as employer, totalled C3 billion, equivalent to 78% of SEM's total revenues. ^{7/} Additional revenues

^{7/} Based on data in Table 1.

came from earmarked lottery and sales tax revenues that are paid to SEM in partial support for the hospitals it took over from the community boards. These represented 11% of total revenue. An additional general revenue subsidy in support of hospital services is provided for in the law under which the hospital facilities were transferred to SEM. The annual amount is to be negotiated between the CCSS and the MOH, but this subsidy has never amounted to more than 5% of total revenues, in 1982, it amounted to only 1%.

In 1983, the net increase in wage quotas is expected to yield additional revenues of 1.1 billion colones which would represent about one fourth of total projected revenues from wage-based contributions this year. This may be an overly optimistic projection, considering that the net increase in the combined quotas is only about 9%. Also, while salaries have increased in nominal terms over the past year, unemployment has increased from 10% to about 15% and total output of the economy is expected to decrease by an estimated 9% this year. Thus, the nominal wage base this year probably is not significantly greater than it was last year. However, due to significantly higher costs of goods and services, SEM's total expenditures are projected to increase by close to 50% in 1983 over 1982, which is a realistic projection. A significant part of the increase in expenditures will in 1983 also be accounted for by a sharply increased debt service obligation. Domestic debts are mostly those to the 1 billion colones IVM loans on which interest payments must be made (i.e. 60 million). Payments on the U.S. \$20 million loan from the IDB do not begin until

next year, but other foreign debts require payments (on loans totalling \$1.5 million from the GE Co. and U.S. \$3.2 million equivalent from two W. German sources). SEM's debt service, which until 1982 had never been more than 2-3% of total expenditures, will be a significantly larger share in the future (over 8% in 1984).

On balance, SEM's fiscal stability remains uncertain. The US AID loan would facilitate pharmaceuticals imports over a period of adjustment to a higher exchange rate, but it should not be expected to play a major role in balancing SEM's budget. Projected increases in revenues for the period 1983-86 (Table 4) are likely to be overly optimistic due to the worsening economic situation of the country. While the GOCR paid its full quota as employer and provided coverage for the indigent in 1982, it is unlikely that it will be able to do so this year and in the near term. Last year, SEM's total expenditures increased less than the rise in its revenues, despite substantial wage increases for SEM's medical doctors and other categories of employees. The full impact of these wage increases, however, will only be felt this year since they were negotiated in the second half of last year. Indeed, expenditures in 1983 are projected to be 45% higher than last year, while revenues are projected to increase by only 33%. Accordingly, the 1983 budget deficit is anticipated to be 15.8% of total estimated expenditures.

Projections of essentially balanced revenues and expenditures, provided by the CCSS for the period 1984-86, must therefore be regarded with considerable scepticism. The attainment of a balanced

budget with the help of the USAID loan in 1984 is unrealistic. The CCSS is probably being realistic in its expenditure projection for 1984-86, except for its personnel costs which are likely to rise more rapidly if for no other reason than that salaries are indexed to the consumer price index (CPI). The underestimate in the personnel cost projection may be on the order of 20-10% annually. On the revenue side, the projection is far less realistic. It assumes that the government will pay its full quotas, both as employer and to provide coverage for the indigent. It also assumes that private sector contributions will increase substantially, despite the country's severe recession. Lottery and sales tax revenue projections also seem optimistically high, and so does a significant increase projected in the income from sales of medical services. Since no fees for services are being contemplated, there seems to be no basis for the indicated six-fold increase in this revenue category from 1983 to 1984.

4. Recommendation

The financial analysis supports making the proposed loan on the grounds that it will help SEM adjust to a doubling in the cost of pharmaceutical imports. The loan is expected to finance about half of total import requirements in 1984 and 14% in 1985 if loan disbursements are scheduled for US \$6.67 million in 1984 and US \$3.33 million in 1985. The GOCR would have to authorize 290 million colones to be converted into foreign exchange for the other half of total import requirements in 1984, and for 616 million colones to be converted into foreign exchange in 1985 to finance 86% of the total import requirements. Should the exchange

rate decline, correspondingly higher amount of colones would have to be allocated by SEM and authorized for foreign exchange conversion by the government.

With GOCR acceptance of all debt service obligations on the proposed loan, the equivalent amount in colones at the exchange rate prevailing at the time of loan disbursement should be deducted by SEM from the government's remaining debt, currently estimated at between 600-800 million colones. As counterpart obligations in the loan agreement, SEM/CCSS should commit itself to financing the projected colones expenditures for pharmaceutical import (about 50% of total import requirements in 1984 and 86% in 1985), subject to GOCR authorization of foreign exchange conversion; furthermore, the government should commit itself to pay off any remaining debt to SEM beyond the loan equivalent in colones, and it should also commit itself to full payment of its employer and employee quotas, as well as 1.25% of the country's total wage base to provide SEM coverage for the medical indigent.

It is also recommended that the MOH transfer the full amounts of earmarked revenues from the lottery, sales tax, and hospital stamp tax to SEM as provided for in Law 5349 of 1971 under which 22 hospitals were transferred to SEM. (Some of these revenues, according to the executive Director of CCSS, have been withheld by the MOH for its own operating expenditures in recent years). Furthermore, the MOH and CCSS should negotiate whether annual hospital subsidies, as called for in the above law, are needed and arrive at a formula for consistently determining the amount of such subsidy if it is required.

These recommendations do not address the large issues raised by the financial analysis, namely that the SEM appears likely to face new deficits, starting with 15% this year and possibly rising further in the next three years. With deficit financing from IVM or other entities served by the CCSS as fiscal agent no longer allowed, SEM must face the alternative of seriously curtailing operating expenditures. Hopefully, this can be accomplished through greatly increased operating efficiencies rather than reduction in essential services. The accompanying pharmaceuticals analysis and recommendations for cost reductions through greater efficiency in purchasing procedures and utilization practices show how such reforms could be achieved in at least one major area of SEM operations.

ECONOMIC ANALYSIS

The economic analysis will be relatively brief inasmuch as the potential impact of the loan within the macro-economic context of the CCSS, the Government and the economy in general is relatively small and strictly limited time-wise. It was important, nevertheless, to determine that the loan impact would not violate guidelines of the GOCR-IMF agreement. Assurances to that effect have been obtained, as briefly summarized below. It was also important to evaluate the relative importance of the SEM/CCSS within the larger context of the Government's social policy. And finally, some assessment of costs and cost-effectiveness of the SEM/CCSS was called for, including consideration of possible alternative approaches to the proposed loan project (although none were explicitly foreseen in the PID). These three topics will be discussed below.

GOCR-IMF Agreement Guidelines - The Agreement calls upon the GOCR to limit further foreign exchange indebtedness within negotiated limits, and domestically to avoid Government deficit spending and increasing the size of the consolidated public sector. Also, salary increments in the public sector are to be limited to offset price increases of essentials such as foods, transportation, water, and electricity. With specific reference to the CCSS, the Agreement states:

"...the deficit of the Social Security Institute will be limited, both in 1982 and 1983, to the amount of foreign exchange losses that the Central Bank will have to incur in selling foreign exchange to the Institute, at the official rate, for the importation of medicines and medical equipment. To ensure this outcome, the Institute has recently increased social security contributions by 4 percentage points..." 7/

A technical point is worth noting here. The Agreement explicitly specifies that the official rate of 20:1 applies to 5% of export proceeds and to payments for imports of medicine and medical equipment made by CCSS. 8/ The official exchange rate of 20:1 was enacted into law by the Legislative Assembly in accordance with the country's Constitution. This law has not yet been changed. Yet, the GOCR has since February 24, 1983 ceased authorizing the Institute to exchange its payments for imports at the official rate, instead forcing it to make payment at the banking rate of 40:1. CCSS is contesting this decision in the courts with every submission of an import bill to the Banco Central for payment in foreign currency.

7/ IMF, "Costa Rica - Request for Stand-By Arrangement," mimeo, Nov. 23, 1982, p. 17. Note: this is a CONFIDENTIAL document.

8/ Ibid., p. 14

The GOCR-IMF Agreement envisions that net capital inflows would increase substantially, mainly because of extraordinary assistance by the U.S. Government, the IBRD, the IDB and commercial debt relief. It notes specifically that,

"The authorities consider the normalization of relations with foreign creditors of great importance. The authorities also intend to reduce significantly, and if possible eliminate completely, existing external payments arrears in 1983." 9/

The payment of SEM's \$22 million debt to foreign pharmaceuticals suppliers is clearly in keeping with the Agreement, which furthermore stipulates that there should be no new accumulation of external payments arrears in the future.

In discussions with U.S. AID officials in Washington and San Jose (i.e. Clarence Zuvekas and Bastiaan Schouten, respectively) and with a representative of the GOCR Ministry of Finance, it was made clear that the proposed loan is part of an agreed-upon total of \$28 million in DA allocation to Costa Rica, and that it would in no way violate the GOCR-IMF Agreement. Finally, the CCSS on its part has lived up to the Agreement by having increased quotas for combined employer-employee contributions by 4 percentage points. This was envisioned as one of the main elements of the GOCR fiscal program under the Agreement. 10/

9/ Ibid, p.22

10/ Ibid, p. 32

2. SEM/CCSS with the large context - Costa Rica's commitment to a major Government role in providing social welfare services for its population is of long standing. In macro-economic terms, this has resulted in a relatively large SEM which accounts for approximately 20% of total consolidated central Government expenditures. This, in turn, is equivalent to 5% of GDP. In comparison with other Latin American countries, such as Brazil, Mexico, and Venezuela with comparable levels of development, this is a relatively high proportion. However, Costa Rica can justifiably claim to have attained 85% effective coverage of the population with health services provided through SEM. This is a higher percentage than is effectively served by comparable programs in these other countries.

Moreover, within the overall context of social policy, the SEM accounts for half of total expenditures. Other entities, for which the CCSS serves as fiscal agent as noted above, account for the remaining half of the Government's total social welfare program. The combined social welfare program is financed by a total wage base tax of 31.50%, this is equivalent to 40% of consolidated central Government expenditures. The latter, however, represent only about 21% of GDP in Costa Rica (roughly the same as the U.S.) which does not qualify Costa Rica for the label "welfare state," except by very conservative standards.

3. SEM Costs and Cost-Effectiveness - SEM is regarded, both within Costa Rica and by outside observers, as a capital-intensive, not highly efficient, and largely curative medical care program. By comparative Latin American standards, however, its average cost per capita of the

covered population is about the same as in most of the other 15 countries with medical programs under social insurance programs. 11/ For 1977, the per capita cost of SEM services was estimated at U.S. \$51 (in 1975 dollars). In 1982, the estimated per capita cost (in current dollars) is \$100. However, this estimate is based on the 20:1 official exchange rate in 1982. If one uses an exchange rate conversion of 40:1, which was closer to the equilibrium rate, the per capita cost estimate drops to U.S. \$50. Despite SEM's capital intensity and inefficiency, this level of per capita (is not exorbitant, nor is the per capita) cost of pharmaceuticals, estimated at about U.S. \$5. In terms of comparable cost-effectiveness, Costa Rica thus compares favorably with other middle-level developing countries, particularly because of its more effective population coverage.

Even though pharmaceuticals represent only about one-tenth of total medical expenditures (in Costa Rica as in most other countries), interruptions and/or other inefficiencies in the supply and utilization of medicines have a disproportionate effect on the overall quality and quantity of medical services actually delivered. This is a serious current problem in Costa Rica, as originally identified in the PID. Breaking the bottleneck of an interrupted flow of pharmaceuticals due to foreign exchange constraints over the past two years is probably the most cost-effective alternative of providing foreign aid to SEM at this time.

11/ Zechock, *opcit.*, Table 10

The transfer and renovation of physical facilities and equipment has been accomplished, in part with the aid of a \$20 million loan by the BID and lines of credit for equipment from U.S. and German suppliers. Moreover, the BID is currently negotiating a grant with the CCS/GOCR to help improve facilities maintenance procedures. The SEM has imposed a hiring freeze and hopefully has satisfied labor demands with recent wage settlements. The World Food Program is negotiating a \$1.5 million nutritional supplement grant to the MOH, and UNICEF plans to provide support for further improvements in rural water and sanitation systems. The proposed U.S. AID loan would include replenishing MOH stocks of vaccines for its PHC program in rural areas.

Taking all these activities into account, including technical assistance under the U.S. AID PPAI grant component allocated for drug procurement and financial administration improvements in the SEM, the proposed loan indeed appears to be the most cost-effective alternative. It will help SEM overcome the negative effects of having to import pharmaceuticals at twice the cost in colones as last year. Moreover, by paying off its current debt to foreign suppliers, cost-effective procurement procedures will be reestablished and possibly improved upon through complementary technical assistance under an expanded PPAI allocation.

TABLE V
Actual Purchases of Medicines as Proportion of
Total Expenditures, 1975-80
and CCSS Projections to 1983-86 Including USAID Loan

(in million of current colones)

Year	Purchases of Medicines	Total Operating Expenditures	Medicines Total Expenditures	
1975	44.5	513.5	8.7%	
1976	70.9	709.8	10.0	
1977	114.8	1,024.1	11.2	
1978	150.0	1,383.0	10.8	
1979	171.2	1,804.8	9.5%	
1980	183.9	2,273.9	8.1	
1981	230.3	2,782.4	8.2	
1982	231.9	3,934.9	5.9	
<u>Projected Expenditures</u>				
1983	434.3	6,123.4	7.1%	
1984	780.0	7,200.0	10.8	
a)	195.0 (25%)			
b)	295.0 (38%)	(295.0)	(4.1)	
c)	290.0 (37%)			
1985	1,014.0	7,711.0	13.2	USAID loan shares
a)	253.0 (25%)			
b)	145.0 (14%)	(145.0)	(1.9)	
c)	616.0 (61%)			
1986	1,318	9,055.0	14.6	

a) Domestic purchases

b) U.S. AID loan allocations for imports (U.S.\$0.67 mill in 1984,
U.S.\$ 3.33 in 1985)

c) CCSS/SEM budget allocations for imports

Note: CCSS projections are for total foreign purchases only; the breakdown of U.S. AID loan disbursements is my own, based on internal staff and consultant advice that the full \$10 million probably cannot be spent in 1984.

Data from Tables 2 and 4.

PROYECCION INGRESOS Y EGRESOS

SEGURO DE ENFERMEDAD Y MATERNIDAD

1984-1986

- MILLONES DE COLONES -

<u>Ingresos</u>	<u>1984</u>	<u>1985</u>	<u>1986</u>
<u>Financiación por cargas sociales</u>			
Estado como Patrono	643	748	855
Otras Cuotas Pat. del Estado	99	143	164
Estado como Tal	492	573	654
Cuotas Pat. Particulares	2.207	2.587	2.955
Cuotas Trabajadores	<u>1.967</u>	<u>2.301</u>	<u>2.662</u>
Sub Total	<u>5.408</u>	<u>6.352</u>	<u>7.290</u>
<u>Donación A.I.D.</u>	403		
<u>Rentas Específicas</u>			
Rentas Ley N° 5349	479	670	848
Subvención Estatal Sistema Hosp.	<u>116</u>	<u>132</u>	<u>200</u>
Sub- Total	<u>595</u>	<u>802</u>	<u>1.048</u>
<u>Venta Bienes Servicios y otros</u>			
Servicio Méd. Asist.	433	510	594
Venta Bienes y Servicios	12	15	19
Servic. Recaudac.	200	250	325
Otros Ingresos	<u>59</u>	<u>100</u>	<u>175</u>
Sub- Total	<u>704</u>	<u>875</u>	<u>1.113</u>
TOTAL INGRESOS	7.110	8.029	9.451
<u>EGRESOS</u>			
Servicios Personales	3.580	3.954	4.530
Servicios No Personales	<u>237</u>	<u>261</u>	<u>328</u>
<u>Materiales y Suministros</u>			
<u>Medicamentos :</u>			
Compra Local	195	253	329
Compra Exterior	<u>585</u>	<u>761</u>	<u>989</u>
TOTAL MEDICAMENTOS	780	1.014	1.318
Materia Prima	94	122	159
Otros	<u>840</u>	<u>1.092</u>	<u>1.245</u>
Pendiente Pago Proved Ext.	415		
Sub-Total	<u>2.129</u>	<u>2.228</u>	<u>2.722</u>
Maquinaria y Equipo	76	91	118
Desembolsos Financieros	20	20	30
Construcciones Adiclon. y Mejoras	110	130	169
Transferencias Corrientes	<u>879</u>	<u>945</u>	<u>1.096</u>
Servicio de la Deuda	<u>160</u>	<u>82</u>	<u>62</u>
Total Egresos	7.200	7.711	9.055
Déficit o Superavit (90)		318	396
Déficit Acumulado Sin Donac. A.I.D. (493)		(176)	221

TABLE 2

TOTAL DEUDA EXTERIOR AL 6-6-83		US\$ 13.096.648.95
Menos pendiente giro Tesorería	US\$ 3.876.625.77	
Menos pendiente de autorizar Banco Central	US\$ <u>669.239.99</u>	
	US\$ 4.545.865.76	
SALDO DEUDA EXTERIOR		US\$ 13.550.783.20
VALOR MERCADERIA CONSIGNADA ABANCO, EN ADUANA		US\$ 6.672.266.62
Desglose:		
Medicamentos- Materias primas- Reactivos	US\$ 2.334.798,64	
Equipos	918.682.50	
Materiales e Implementos Médicos	US\$ 2.438.885,77	
Repuestos	580.814.66	
Otros- Varios	<u>399.085.05</u>	
	US\$ 6.672.266,62	
VALOR MERCADERIA CONSIGNADA A CAJA, DESALMACENAJE		US\$ 6.878.516.53
Desglose:		
Medicamentos- Materias primas- Reactivos	US\$ 5.502.813,27	
Equipos	US\$ 24.839,84	
Materiales e Implementos Médicos	US\$ 865,033,58	
Repuesto	US\$ 167.904,08	
Otros- Varios	US\$ <u>317.925,81</u>	
	6.878.516,58	

SEGURO DE FERTILIDAD Y MATERNIDAD
CUADRO COMPARATIVO DEL SUPUESTO DE EFECTIVO 1979-1983
 (MILLONES DE COLONES)

*Actual 7 Decem
 civil Expenditur
 (compare w. bu
 geted data, T.*

	1979	1980	1981	1982	1983*
INGRESOS					
<u>Financiación por Cargas Sociales</u>					
Estado como Patrono	77,792	142,110	30,200	368,516	108,334
Costas Patronales	---	---	117,664	99,906	---
Estado como Patrono	---	(1)	---	---	(1)
Costas Patronales	---	132,600	---	516,992	358,311
Estado como Patrono	---	---	---	---	---
Costas Patronales	413,531	469,598	599,929	922,616	1,867,967
Costas Patronales Particulares	191,571	511,832	127,578	1,141,937	1,709,376
CB-TOTAL	682,900	1,336,440	1,455,371	3,082,999	4,431,341
<u>ENTAS ESPECIFICAS</u>					
Costas Ley	78	333,695	256,799	417,447	374,477
Convención Estatal Sist. Hoop	81,114	85,661	36,419	30,690	116,000
CB-TOTAL	81,192	419,356	353,209	448,137	490,477
<u>Costas Bienes y Servicios</u>					
Servicio Médico Asistencial	257,470	52,510	83,880	111,348	66,812
Costas Bienes y Servicios	3,310	3,975	7,271	11,126	9,005
Servicio de Evaluación	98,657	15,945	94,764	117,067	121,732
Gros Ingresos	29,624	29,267	37,509	41,453	24,814
CB-TOTAL	389,061	95,697	222,424	283,004	327,363
<u>Gros Ingresos (2)</u>	<u>402,636</u>	<u>320,350</u>	<u>460,849</u>	<u>366,806</u>	<u>---</u>
TOTAL INGRESOS	C 1,463,811	C 2,161,986	C 2,491,853	C 3,852,306	C 5,152,181
EGRESOS					
Servicios Personales	1,041,767	1,283,052	1,723,636	2,386,572	3,211,317
Servicios No Personales	94,151	102,015	147,405	198,979	262,875
Materiales y Suministros	182,616	163,426	156,011	346,940	434,271
Medicamentos	20,118	25,685	47,607	128,408	58,622
Gros Productos Químicos	211,513	261,300	323,789	718,885	982,609
CB-TOTAL	429,411	450,111	528,237	1,224,233	1,475,502
Equinaria y Equipo	37,685	69,278	89,210	64,710	66,667
Empleos y Contratos	3,069	31,932	196,710 (3)	9,430	4,395
Construcciones, Adquisición y Mejoras	22,546	91,655	53,769	31,127	81,667
Transferencias Corrientes	111,320	110,001	166,633	268,621	496,192
Servicio de la Deuda	61,854	109,901	78,711	17,579	481,501
TOTAL EGRESOS	C 1,909,849	C 2,276,975	C 2,918,921	C 4,201,651	C 6,123,110
PERAVI O DEFICIT	C (446,038)	C (114,989)	C (427,068)	C (349,345)	C (970,929)

* 1983 incluye las modificaciones presupuestarias hasta la fecha; los egresos están calculados por todo el año.

1) La partida Costas Patronales Estado está incluida dentro de la partida Estado como Patrono.

2) Gros Ingresos Incluye: Transferencias Corrientes, Venta de Activos, Recuperación de Préstamos y Colocaciones, e Ingresos por Endeudamiento.

3) Incluye C 133 millones de colocaciones bono 0045 a plazos.

ANNEX G

HEALTH SERVICES SUPPORT

PROJECT ANALYSES

**PREPARED FOR USAID/CR
BY**

**DR. AIDA LEROY AND
DR RONALD O'CONNOR**

June23, 1983

TASK 1

METHODOLOGY FOR DEVELOPMENT OF THE ILLUSTRATIVE LJST

Prior to travelling to Costa Rica various preparatory steps were conducted. Orientation meetings were held with Mr. Ted La France of SER/COM with the objective of becoming familiar with AID procurement guidelines. Specifically, those most applicable to this project are:

1. The source of AID-financed procurement is limited to the United States.
2. Procurement outside the United States of those pharmaceuticals which infringe on U.S. patents is prohibited.
3. All pharmaceuticals must comply with the U.S. Food and Drug Administration's safety and efficacy standards (FDA approved).
4. Certain categories of drugs may not be procured with AID funds (e.g. derivatives of blood, amphetamines, androgenic hormones).

If guidelines 2-4 are adhered to, a waiver may be obtained to purchase from a non-U.S. source, if the price is 50% of the U.S. price and the supplier is from an approved nation (i.e. from the free world).

With the SER/COM orientation and a preliminary list of drug products submitted to AID from the CCSS Oficina de Calificaciones Terapéuticas a data collection sheet was created See Fig. 1. All products requested were listed on these sheets by generic name, strength, and dosage form. These sheets have columns indicating FDA approval status, CCSS drug code, priority designation (priority 1 through 4 to be defined below in more detail), prior annual consumption or quantity dispatched from the central warehouse, last cost per 100 units of drug or per other pertinent unit, projected quantity to be purchased, and comments.

A preliminary priority designation was assigned based on the following definitions:

Priority 1 - Drugs used for primary health care, first aid treatment, and preventive health services. (e.g. Antibiotics, antiparasitic drugs, aspirin, adrenalin, vaccines, and oral electrolytes).

Priority 2 - Drugs used for maintenance of chronic diseases thus allowing ambulatory treatment (e.g. digoxin, diuretics, anti-asmatic agents, etc.) and frequently used parenteral drugs used in general hospitals (e.g. heparin, parenteral aminophylline).

Priority 3 - Drugs of a specialized nature (e.g. antineoplastic agents, antipsychotic agents, etc.) and drugs of secondary therapeutic importance (e.g. antispasmodic agents, anti-anxiety agents, etc.).

Priority 4 - Drugs with relatively lower frequency of use, of extremely high cost, requiring careful monitoring (e.g. certain antineoplastic agents, diaminodlarginine vasopressin), drugs that should be used after other treatment has failed (nifedipine, piroxicam) or drugs of extremely limited therapeutic importance (e.g. anti-hemorroidal cream).

The priority definitions were created specifically to meet the objectives of the loan. Those objectives are to assure an adequate supply of pharmaceuticals and vaccines for preventive health services, primary health care programs and disease control activities carried out by the CCSS and the Ministry of Health. Secondly, to partially support the purchase of pharmaceuticals to meet the current high priority needs of the CCSS client population. Thus, these designations are not the traditional vital, essential, non-essential (VEN) classifications.

It must be emphasized that there is some overlap between priority categories defined above and final determinations were based on certain subjective judgements and negotiations between the consultant team and the CCSS representative.

The designated representative for the CCSS was Dr. Enrique FALCON, Director of the Unidad de Calificaciones Terapeúticas. The illustrative drug list was developed in Costa Rica with Dr. Falcon. Each drug product proposed on the initial list submitted to the AID was discussed as well

as other pertinent drugs previously not considered. A priority designation was negotiated for each product.

Once a priority designation was assigned for each product, prior quantities dispatched from the central warehouse and prior price paid for each item was noted on the data collection sheets. The majority of prices paid were for purchases in 1982 and 1983. About 30% were prices paid before 1982. In several instances, prices were studied for a given product in 1981, 1982 and 1983. Remarkably, prices have remained relatively constant over the past few years.

Additionally, Dr. Falcon supplied projected annual quantity estimates for the procurement. These estimates were based on prior quantities used, recent monthly quantities dispatched, and adjustments for stock-outages and elimination of products from the Basic Drug List.

In order to determine the reasonableness of the projected quantities, for some maintenance drugs with potentially high utilization rates, the average annual person year of therapy was estimated. For example, the average daily dose of methyldopa (levo-alfa metildopa) 250 mg is eight tablets per day or 2,920 (8x365 days) a year. The annual projected quantity for this drug is 10,500,000 units. Therefore, by dividing 10,500,000 by 2,920 one determines that that quantity will treat 3,595 people for one year or 0.1% of the population.

When possible, the last supplier of a given product was noted on the data collection sheets. This information will serve to identify products that are already being obtained from U.S. sources.

Preliminary Results

The illustrative list contains 215 pharmaceutical products. These products are distributed across the four priority groups as follows:

	<u>No. of Products</u>
Priority 1	50
Priority 2	56
Priority 3	74
Priority 4	<u>35</u>
Total	<u>215</u>

The Ministry of Health submitted a list of products which are included within the illustrative list. Twenty-three of the Ministry's requested products were designated Priority 1. Three were designated Priority 2.

Preliminary calculations using recent dollar prices (inflated by 20%)

obtained by the CCSS indicator:

	<u>Cost</u>
Priority 1 drugs	4,224,174
Priority 1 & 2 drugs	7,530,943
Priority 1, 2, & 3 drugs	10,309,718

From these preliminary calculations it appears that basic drug needs can be met with the 10 million dollar loan, subject to clarification of current prices and AID prices for shelf drugs. Further refinements in the list can be made by adjusting quantities to be purchased (i.e. increasing quantity projections to fulfill drug needs for 18 months).

Characteristics of Priority Classifications

<u>Priority</u>	<u>Characteristics</u>
1	Primary Health Care First Aid Treatment Preventive Health Services
2	Maintenance Therapy for Chronic Diseases Frequently Used Parenteral Drugs (in general hospitals)
3	Specialized Drugs Secondary Therapeutic Importance
4	Expensive, Infrequently Used Requires Careful Monitoring Treatment of Conditions Not Responding to Drugs of Choice Extremely Limited Therapeutic Importance

TASK 6QUALITY CONTROL

The CCSS quality control laboratory, appears that it is functioning relatively effectively. It is headed by an extremely competent pharmacist who has instituted standard policies and procedures of operation. All samples of products offered for bid to the CAJA are analyzed for purity, concentration, dissolution, physical characteristics, etc. Additionally, arriving shipments are analyzed since samples offered during the bidding process are usually from a different manufacturing lot. Currently, the rejection rate of products analyzed is 2%. The reasons for rejection range from discoloration and physical decomposition to unacceptable variations in concentration of the active ingredient.

The major problem facing the laboratory at this time is lack of replacement parts and maintenance for existing equipment, and more trained personnel. However, in spite of these limitations, it is a good quality control facility.

IDENTIFICATION OF PROCUREMENT MECHANISMS AND
PREPARATION OF IMPLEMENTATION PLANS

BACKGROUND

Four significant facts should be considered in identifying the procurement mechanisms.

1. CCSS procurement works - It is cumbersome, but long experience has built in 18 month lead times which they plan for.
2. There is little or no need for emergency procurement under the loan - In general stocks are adequate for current consumption, and the explanations for most stock out items will neither require loan-related procurement nor in fact be affected by it.
3. The ProAg for the loan, as a legal agreement between governments can serve, for the loan itself, to supersede some cumbersome procurement procedures, and act as a potent experiment to document some administrative reforms while the CCSS would like to institute.

4. None of the alternative procurement mechanisms offer substantial advantages over a relatively simple process with responsibilities divided between the CCSS, AID and PAHO.

SUGGESTED PROCUREMENT PROCESS

To strengthen the CCSS procurement process, it should be used by the loan, not circumvented. One way to use it effectively is outlined in the attach 1 Figure (Suggested AID/CCSS Procurement Process), a scheme which recognizes that the CCSS routinely orders estimated annual requirements for about 10-12 drugs per week, accounting for the 500 items on the list per year. A massive drug order under the loan, attempting to procure all drugs at once, is inappropriate: there is no need, no capacity to process the paper, and no place to store the drugs.

In brief, when the usual order time occurs, items on the list that meet USAID purchase criteria are considered. Vaccines are ordered through PAHO, funded by the USAID loan. Other items are reviewed by CCSS in light of the priority criteria and component to USAID shelf prices and recent bid prices. Items on the "USAID shelf list" (readily available via government procurement) with lower or comparable prices should be bought with the loan. Items not on the list or not competitively priced are issued for bids by CCSS in the normal way, including potential U.S. suppliers.

If the U.S. bid is low, or if reputable foreign suppliers offer at less than 50% of U.S. bid, then CCSS can buy using USAID loan funds.

The major decision point facing CCSS will be, and should appropriately be, the financial choices to be made throughout the loan period on whether to buy U.S. goods with loan funds at a higher price than they can get from foreign suppliers with Costa Rican funds. It is unlikely that CCSS will be able to specify that decision in advance; it will likely be different over time, depending on relative prices and the balance of loan funds available.

TASK 4I. INSTITUTIONAL ANALYSIS OF MATERIALS MANAGEMENT OFFICE/CCSSA. Organization and Staffing

The Materials Management Office is responsible, once bids are selected, for the monitoring and acquisition of goods from essentially all vendors for CCSS, accounting for perhaps 9-10,000 items, 8,000 of which are routinely stocked in several warehouses. Medicines represent a small fraction of this total, and are concentrated in one facility.

The office has long been headed by a senior CCSS employee with 30+ years of service and experience. His deputy, also an experienced staff member, is preparing to take over next year when mandatory retirement will relieve the incumbent. The organization and its leaders therefore have long and generally successful acquaintance with medical procurement for CCSS. In fact, Costa Rica is easily one of the most experienced countries in effective (if not efficient) medical procurement, ranking with the very best in the developing world.

B. Procedures

The CCSS procurement process is long and convoluted, but it works, particularly when the financial constraints (which are beyond the control of the materials management office) are dealt with. Expeditious procurement is difficult except in emergent conditions, but long experience, custom, administrative rulings and legal procedures have evolved into a process where

12-15 month lead times for ordering are expected and employed. Therefore, with the possible exception of a few items that have run low during the recent period of financial constraint (where suppliers withhold orders due to unpaid bills), the existing procurement process is adequate to meet most needs. That is, despite increasing financial constraints, CCSS continues its regular bid/ordering/procurement process with 10-12 items (of the 500 + list) being solicited in annual order quantities weekly.

The materials procurement staff and CCSS leadership readily acknowledge that the procedures are antiquated and result in delays and errors that decrease procurement efficiency. A major drawback is the lack of an order trading system to monitor the status of priority goods. However, the system of procurement does work, and is expected to be the subject of further analysis and potential modification with the assistance of the PPAI project. A major role in the procurement of medicines under this project is reasonable and appropriate for the materials management office.

TASK 5

II. TECHNICAL ASSISTANCE

A. Background

Costa Rica, with its widespread CCSS health system and MOH preventive services program, is far advanced in the procurement of medicines by any standard. The size, organization and priority of social development makes Costa Rica a world leader in this field. However, even in Costa Rica

there are many areas in the drug supply process which are deficient, deserve attention, and can make major improvements in the quality and cost of health care. In this environment, where enlightened social policy is implemented through reasonable systems by competent and experienced administrators, attention to improving the drug supply process can have great impact if the Caja chooses to act.

B. Current Status

At the moment, attention is focused on procurement, largely as a result of the (hopefully) temporary financial crisis which has resulted in supplier skepticism and some pipeline disruption. However, in general the procurement process works, though all concerned agree that it is long, cumbersome and inefficient.

A more useful frame of references, however, is to consider project activities in context of the major goal: effective and affordable medicines, appropriately used, in the hands of the Costa Ricans who need them. This project, and related activities such as PAHO-assisted components of the PPAI project, should be viewed in context of the drug logistics process which they are designed to improve. Given the high degree of interdependence of the parts of the logistics cycle, we must analyze which parts of the process are likely to be the most serious constraints in approaching the goal, and then apply the resources appropriately.

Figure 1 - The Logistics Cycle - illustrates the overall process of drug logistics, with its four major steps: selection, procurement, distribution,

and use. A preliminary impression suggests that three of the four major steps-selection, procurement and distribution have and continue to receive attention in Costa Rica, but that the fourth, drug use, has not.

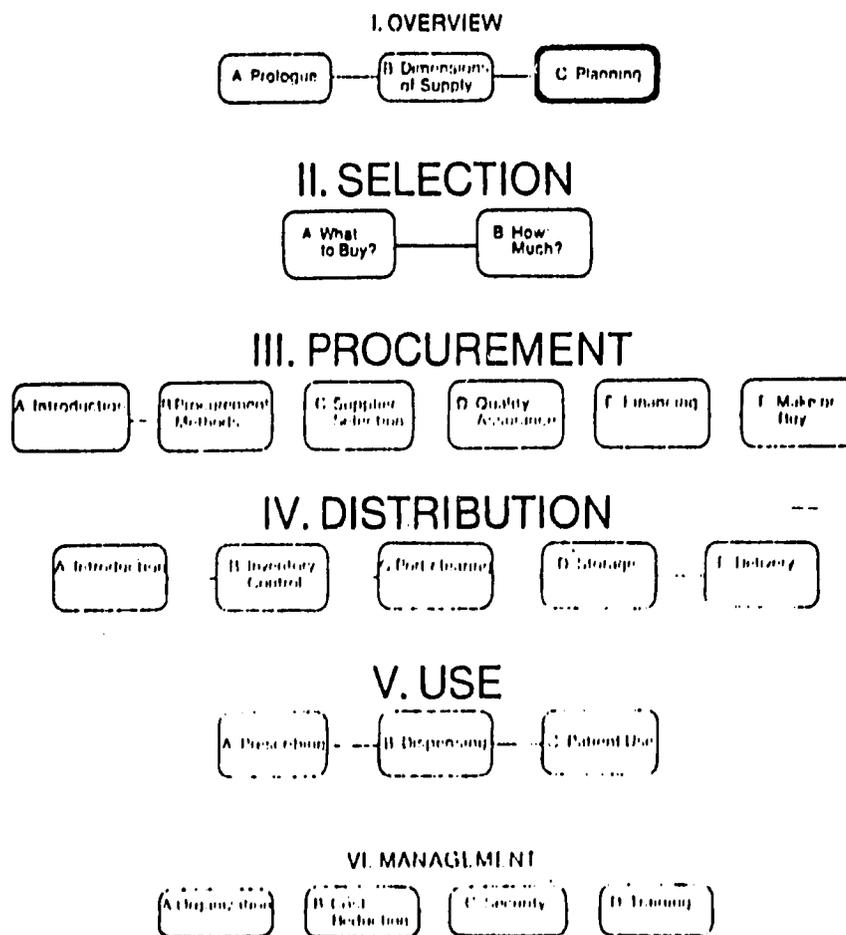
Figure 2 - Illustrates the elements which make up each step. It also provides a quick review mechanism for current activities, and therefore a basis for considering additional activities in neglected areas to strengthen existing CCSS initiatives and complement anticipated work under PPAI.

Selection: What to buy and how much? Important initial steps in formulary limitation (what to buy) have occurred over the last year, and this consultancy is assisting Dr. Falcon and the Office of Therapeutic Qualifications in planning current purchase quantities (though more attention is appropriate as discussed below under use). Dr. Falcon represents the strongest focus of technical competence in the drug procurement process.

Procurement: While cumbersome, the current procurement process works (with stimulation the Office of Therapeutic Qualifications) under the administration of the Materials Management Office. They are aware of, and interested in, the need for procedural reform and improved information processing, both apparently contemplated with PAMO assistance under PPAI. From the drug standpoint, the major current frustrations are the lack of an order status monitoring system (nobody keeps track of what's bogging down in the order pipeline), and cumbersome procedures which add several months to the pipeline.

FIGURE 2

Planning for Drug Supply



Best Available Document

Distribution: The centralized aspects of storage and delivery are competently administered as part of a system-wide distribution service. Increased efficiency can probably be anticipated by reconsideration of safety stock levels of the central warehouses. Little attention has yet been paid to inventory control practices at the 100+ pharmacies in hospitals and health centers where overstocks and "defensive ordering" are expected to exist widely. Again, PAHO assistance under PPAI is anticipated to address the control aspects of warehousing and information processing.

Use: As with many countries, the elements of drugs use have been largely avoided to date. However, in contrast to most countries, drug use - prescribing practices, dispensing practices and patient use - is probably the most important single area for management attention in Costa Rica. There are two reasons for this: a) Costa Rica is well advanced in the areas of selection, procurement and distribution, so deficiencies in use become more obvious constraints; b) the high priority traditionally accorded to health has accustomed doctors to ask for almost anything without responsibility for considering cost, and in general, what they ask for has been ordered and paid for.

C. Suggested Strategy for Technical Assistance

The strategy builds on three factors:

- i) The sophistication of the existing CCSS system, and its relative strengths in selection, procurement and distribution. Additional progress may be made rapidly in some of these areas given the current experience and momentum.

- ii) The anticipated support for administrative and procedural improvements with PAHO assistance under the PPAI project. An ambitious number of activities to improve procedures are contemplated. All will not be feasible given the resources available, but useful activities to improve accountability and speed of expenditure are likely. It is unlikely, however, that a new centralized computer system, with multiple input/output sources will be operational within the two-year time frame contemplated. The planning and expectations observed on this point are highly, unrealistic and may lead to major disillusionment.

- iii) The potential impact of concentrated attention on aspects of drug use, with supplemental attention to limited elements of selection, procurement and distribution. The notes below present a summary rationale for attention to drug use:

To a large extent, demand from practitioners (in terms of requests for drugs) drives the CCSS drug management system. The standards of health service are high, large amounts of money have been available, few control mechanisms limit requests, and one pharmaceutical representative for every four physicians all combine to drive up drug consumption.

In practice, only two kinds of response are likely to be effective in balancing practitioner and user demand: economic/financial constraints, and educational/motivational strategies for providers, dispensers and consumers.

Economic/financial constraints: Budgetary limits for medicines at each institution can play important roles, particularly when combined with drug selection and drug use planning as outlined below. User fees, (even in advanced social insurance programs) are also often employed to constrain indiscriminate drug consumption. If some form of prescription fee is found to be unacceptable politically given the high level of current taxation, then educational/motivational strategies emerge as the only reasonable alternatives .

Educational/motivational strategies: Once practitioners and dispensers are out of school (which is a long time ago for most), the predominant sources of drug use information are detail men - drug company representatives - whose motivation and reward systems are strongly focused on selling drugs - nothing else. Their natural bias can only be balanced by strong, objective sources of information on managing medicine provided by disinterested parties such as government agencies and academic or non-profit organizations.

Figure 3 summarizes a number of activities in the drug use area that could readily be incorporated in a collaborative technical assistance

plan with CCSS. Each is briefly described in the following section, along with several other activities which would complement existing initiatives in distribution, procurement and selection. Dr. Miranda, Head of CCSS and Dr. Falcon, head of the Therapeutics Office is extremely interested in issues of drug use, and has been limited so far in his own initiatives largely by the procurement bottleneck which has preoccupied his time. The Office of Therapeutics under Dr. Falcon is the appropriate focus of responsibility for the activities described in figure 3 and the text that follows.

FIGURE 3

ILLUSTRATIVE TECHNICAL ASSISTANCE

ACTIVITIES WHICH WILL IMPROVE DRUG USE BY PHYSICIANS,
PHARMACISTS AND PATIENTS IN COSTA RICA

<u>ACTIVITY</u>	<u>PRESCRIBER</u>	<u>DISPENSER</u>	<u>PATIENT USE</u>
1. Diagnosis/Treatment			
Analysis	X	X	
2. Treatment Norms	X	X	
3. Procurement Planning		X	
Training			
4. Utilization Review	X	X	
5. Patient Instruction/ Compliance Analysis	X	X	X
6. Course of Treatment Packaging	X	X	X
7. Drug newsletter/ Therapeutics Guide	X	X	

D. Suggested Activity Summary for Potential Project Technical Assistance

The activities below are described with the assumption that they may be of mutual interest to the CCSS decision-makers with program responsibility. None can or should be undertaken without their involvement and commitment, which implies their interest in potentially using the results for program improvement. A summary figure follows which outlines the range of level of effort envisioned for these activities. Should some of the activities take hold, then effort might be reallocated accordingly.

Drug Use-Related Activities

- 1) Diagnosis/treatment patterns analysis - Currently we do not know how practitioners treat specific problems, we only know in total that so much medicine is consumed. As a basis for continuing education, and for establishing appropriate treatment norms, a sample study of practitioner activity in different health service setting could be conducted. A very useful and practical study could be conducted and completed with CCSS leadership and 3-4 months technical assistance over a 6-8 month period, and would help set priorities for the development of treatment norms and practitioner education (see 2).
- 2) Treatment Norms - For many common health problems, there are specific treatment patterns, including use of medicines, that

can be established by groups of respected health authorities, applying internationally recognized scientific experience in the Costa Rican environment. A committee, perhaps composed of MOH, CCSS and academic authorities, could undertake the process of establishing norms of good practices for many health problems. These norms could form an important base for continuing education, and contribute to the success of (activities 4-7) other drug use actions noted below. Perhaps 3 months of technical assistance for 2 years, six months total would be useful for staff support and consultation to the committee.

- 3) Procurement Planning Training - At the current time, pharmacies order medicines without ready means to keep track of related medicines, consumption rates or cost. PPAI is expected to give more rapid access to expenditures, and a very useful training program for pharmacy. Level procurement planning could be added, using a small computer for simulating procurement and drug use. Once training is underway, the small computer could be used for individual CCSS pharmacies - at least the larger and more interested ones - to plan and update their ordering and procurement choices on a regular basis. Leadership from the CCSS office of Therapeutic Qualifications, 5-6 months of technical consultation over two years and access to a microcomputer would accomplish both design, programming and initial training. A microcomputer, compatible with the larger system anticipated, could expedite both the necessary

familiarization by CCSS staff as well as specific problem solution without waiting the two year it will take to get the larger system into use.

- 4) utilization Review - What has happened with drugs - looking at drug use to alleviate major specific problems actually occurring in Costa Rica, such as inappropriate prescription of dangerous drugs or over - and underprescribing as well. Busy practitioners will often respond to carefully presented material or new information about patient problems they are dealing with, through they may ignore more general educational messages. A utilization review process could be tested using sample data from a few pilot institutions, with 2-4 months of technical assistance over two years.

5. Patient Instruction/Compliance Analysis - The entire economic and health investment in services often comes down to whether a patient actually knows how to take medicine correctly and does so, that is, whether they comply with treatment. Even in the most developed countries compliance can be as low as 25 to 30%, which can virtually eliminate the effect of therapy, or increase problems of drug resistance. A sample study, focusing on several specific health problems as treated in different settings, would give useful information on current prescriber and dispenser capacity to communicate clearly to patients, and suggest ways to improve patient compliance. Approximately 3-5 months of technical assistance and analysis could be required, and could be tied to course of treatment packaging (activity 6).

6. Course of Treatment Packaging - A common problem in drug use is that patients receive an inadequate amount of medicine (a few antibiotic tablets, for example), in an inadequate package (a twist of paper or an unmarked container), with inadequate instructions (in unfamiliar language). For many common health problems where treatment norms have been established, and which are seen frequently, a standard package with clear, attractive labelling and sufficient medicine for an adequate course of treatment can be an effective approach to improving drug use. (oral contraceptives, or a 10 day's supply of penicillin tablets for pneumonia are examples). A pilot study of the potential impact in Costa Rica could be conducted with 4-6 months consultation and perhaps \$30,000 at packaging and medicines over a 18 month period.
7. Drug Newsletter/Therapeutics Guide - At the current time most practitioners rely on drug company representatives as their primary source of medical information, despite their obvious self-interest. The MOH and CCSS could offer a very valuable continuing education services to all physicians and dispensers by sponsoring a regular newsletter on practical aspects of drug use. In looseleaf form and regularly updated in practical language, such a newsletter could be guided by an eminent panel of practitioners and pharmacists, and might be assisted in its early stages by 2-4 months of technical assistance over two years.

Drug Distribution-Related Activities

1. Pharmacy Inventory Control and Stock Management - While some order levels are apparently set for some medicines at some faculties, there appears to be little inventory control beyond the central warehouse. Large stocks of drugs may well be accumulating at some points, with substantial wastage at others. A brief management analysis of the range of stock management practices and problems in the field could serve as the basis of a stock management training program for pharmacy staff. Intermittent follow-up workshops or consultations could substantially improve stock management and house drug distribution efficiency. Four months of technical assistance (including workshop development) would be reasonable over two years.

Drug Procurement-Related Activities

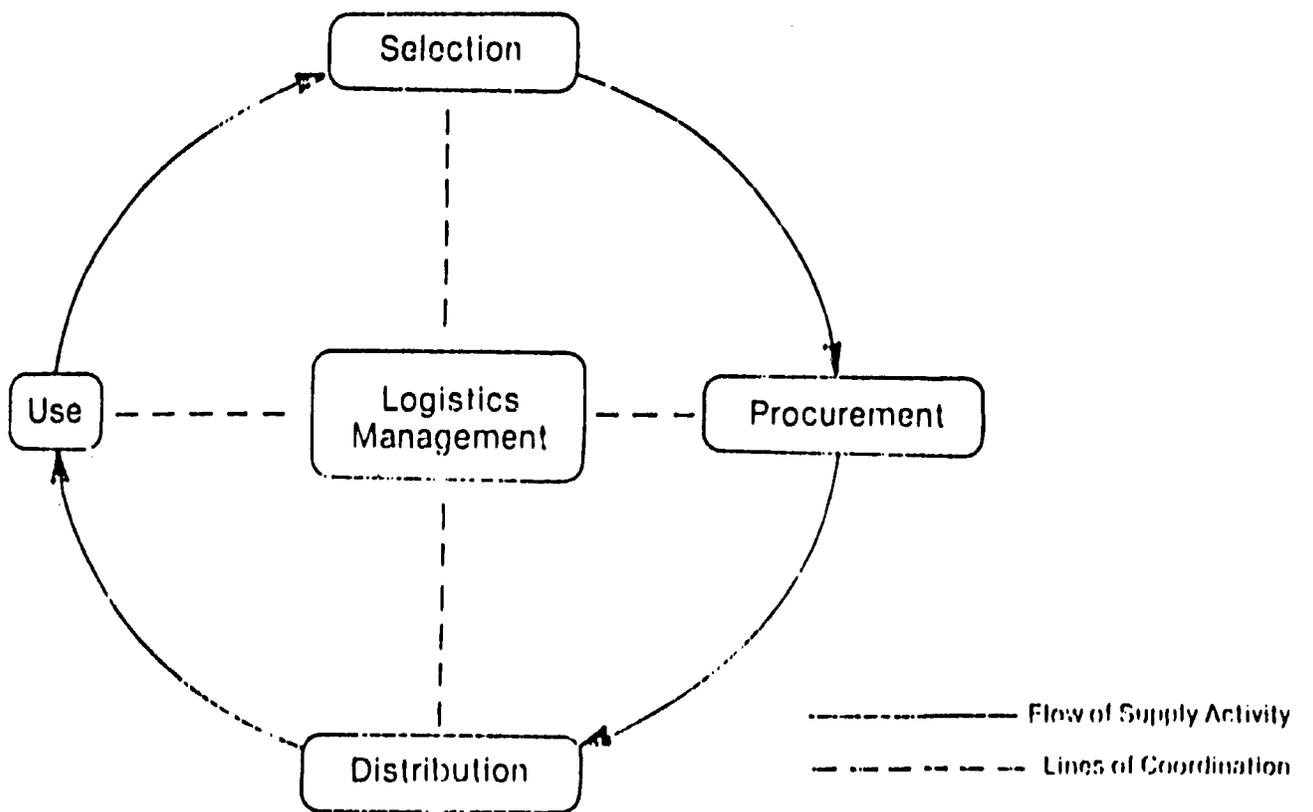
1. Procurement Monitoring Assistance Given the long but workable procurement process at CCSS, the anticipated assistance from PAHO under PPAI, and the built-in 18 month lead times currently employed, no large blocks of procurement technical assistance are required. Three activities would be valuable:
 - a) Using the loan leverage and the legal effect of the ProAg to supersede some of the procurement steps (as already proposed by Dr. Falcon) on a pilot basis for loan commodities. Successful experience might encourage the Government to enact permanent changes.

- b) Establish an order status monitoring system, to keep track of changes on order (& other priority supplies) prior to the institution of the reforms and computer system envisioned by FAHO under the PPAI project. A manual system, if necessary, would suffice to keep track of important shipments that are now neglected in the general mass of procurement.
- c) Establish a supplier performance analysis system - Currently there is no system for consolidating information on suppliers who deliver inadequate goods or who fail to meet contract schedules. A reliable index of these activities could be readily organized in a manual (or preferably in a system as complex as this on a small, inexpensive microcomputer. 4-6 months of assistance over a two year period would be reasonable, covering both procurement monitoring and supplier performance.
2. Procurement Planning - The microcomputer based procurement planning approach (described above under drug use for training pharmacists and those in major institutions who drive the procurement process with their orders) could readily be adapted for use by the CCSS Office of Therapeutics which is responsible for control procurement decisions. A relatively simple program to allow simulation of various drug procurement decisions, of cost alternatives, and of alternative treatment modes could assist CCSS decision-makers in digesting and using the mass of data available to them. As a separate activity, 2-4 months of assistance over two years could be needed, or perhaps 2 months if combined with other work.

Technical Assistance Summary

<u>Activity</u>	<u>Level of Effort (person-months)</u>
<u>Drug Use-Related</u>	
Diagnosis/Treatment Analysis	3-4
Treatment Norms	3-6
Procurement Planning Training	5-6
Utilization Review	2-4
Patient Instruction/Compliance	
Analysis	3-5
Course of Treatment Packaging	4-6
Drug Newsletter/Therapeutics	
Guide	2-4
<u>Drug Distribution Related</u>	
Pharmacy Inventory Control	4
<u>Drug Procurement Related</u>	
Procurement Monitoring/	
Supplier Performance	4-6
Procurement Planning	<u>2-4</u>
Total - Range	32-49

Figure 1
The Logistics Cycle



Project Preparation Team

Thomas A. McKee	General Development Officer	USAID/CR
Carlos Poza	General Development Division	USAID/CR
David Kitson	General Development Division	USAID/CR
Betsy Murray	General Development Division	USAID/CR
Joan Silver	Capital Development Office	USAID/CR
Virginia Ramírez	Capital Development Office	USAID/CR
Priscilla del Bosque	Program Office	USAID/CR
Minor Sagot	Program Office	USAID/CR
Carlos Ferro	Management Office	USAID/CR
William Schrider	Controller (Acting)	USAID/CR
Carol Dabbs	LAC/DR	AID/W
Joanne Connolly	LAC/DR	AID/W
Robert Perkins	GC	AID/W
Dr. Guido Miranda	CCSS	
Dr. Enrique Falcón	CCSS	
Víctor Bolaños	CCSS	
Jorge Arturo Hernández	CCSS	
Aida LeRoy	Management Services for Health	
Dieter K. Zschock	Management Services for health	
Ronald O'Connor	Management Services for Health	

ENVIRONMENTAL EXAMINATION

PROJECT LOCATION: Costa Rica
PROJECT TITLE: Health Services Support Loan
FUNDING: FY 1983 & 1984
\$10,000,000.00 Loan
\$ 150,000.00 Grant
LIFE OF PROJECT Three (3) Years

PROJECT DESCRIPTION

This project will provide for the procurement of Health Service commodities - pharmaceuticals and related goods, which will enable the CCSS to maintain an adequate level of services during a period of financial crisis that affects both the institution and Costa Rica.

The project implementation plan will follow both AID and FDA guidelines.

ACTION

This project contemplates the procurement of pharmaceuticals, raw materials, and health care commodities which in agreement with Environmental Procedures, Regulation 16, Sections 216.2(c) (2) (VIII), 216.2(c) (2) (IX), and 216.3(a) does not require an Initial Environmental Examination.

EE PREPARED BY:



Heriberto Rodríguez
USAID/General Engineer

4/8/83

CONCURRENCE:



Bastiaan Schouten
Acting Mission Director
USAID/Costa Rica

DATE: April 8, 1983

JCM HESTER IEE TEL

UNITED STATES INTERNATIONAL DEVELOPMENT COOPERATION AGENCY
AGENCY FOR INTERNATIONAL DEVELOPMENT
WASHINGTON, D C 20523

LAC/DR-IEE-83-40

ENVIRONMENTAL THRESHOLD DECISION

Project Location : Costa Rica

Project Title and Number : Health Services Support Loan
515-0203

Funding : \$10,000,000 (L), 300,000 (G)

Life of Project : one years

IEE Prepared by : Heriberto Rodriguez
USAID/San Jose

Recommended Threshold Decision : Negative Determination

Bureau Threshold Decision : Concur with Recommendation

Copy to : Bastiaan Schouten
Acting Director, USAID/San Jose

Copy to : Heriberto Rodriguez
USAID/San Jose

Copy to : Joanne Connoly, LAC/DR

Copy to : IEE File

James S. Hester Date 26 July 1983

James S. Hester
Chief Environmental Officer
Bureau for Latin America
and the Caribbean