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| U.S. only | U.S. \$9,300,000 |
| Limited F.W. | Industrialized Countries |
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| Cash \$9,300,000 | Other |

8. Summary Description
 This program will assist the Government of Chile (GOC) to implement its two-year Program for the Immediate Improvement of Primary Health Care. This program consists of DA Section 104 non-project assistance of \$9.3 million to be provided in two tranches (conditioned upon benchmarks and progress made in achieving outputs as specified in this PAAD) and a technical assistance project component of \$700,000 which will fund program coordination, financial reviews and audits and technical assistance. The non-project dollar funds will be used by the GOC to finance (via reimbursement) public or private sector imports from the U.S. destined for the health sector. Local currency will be generated once dollars are released from the Separate Account and will be deposited into a Special Account. Local currency will help finance short-term costs of restructuring the primary health care system, and will be managed by the Ministry of Health.

"I certify that the methods of payment and audit plan are in compliance with payment verification policy."

[Signature]
LAC/Controller

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| 19. Clearances | Date | 20. Action |
| LAC/DPP:BSchouten <i>B.S.</i> | 11/15/90 | <input checked="" type="checkbox"/> APPROVED <input type="checkbox"/> DISAPPROVED Authorized Signature: <i>[Signature]</i> Date: 12/3/91 Title: |
| GC/LAC:PSullivan <i>PWS</i> | 12/18/90 | |
| LAC/SAM:RNelson <i>R.Nelson</i> | 12/12/90 | |
| LAC/DPP:CADams | 12/13/90 | |
| PPC/PB:TBarker <i>T.Barker</i> | 12/20/90 | |

Chile
Program for Immediate Improvement
of Primary Health Care
(513-0350)

Program Assistance Approval Document

Table of Contents

| | <u>Page</u> |
|--|-------------|
| Summary and Recommendation | i |
| I. Introduction | 1 |
| A. Background and General Overview | 1 |
| B. Importance of Health Sector | 3 |
| II. Description of the Problem | 3 |
| A. Current Health Care System | 3 |
| B. Current Primary Health Care System | 5 |
| C. Problems of the Health Care System | 7 |
| D. Specific Constraints and Bottlenecks of the Primary Health Care System | 11 |
| E. GOC Strategies for Overcoming Identified Constraints and Bottlenecks | 13 |
| III. Other Donors | 15 |
| IV. Program Rationale | 17 |
| V. A.I.D. Sector Assistance Program | 18 |
| A. Goal and Purpose | 18 |
| B. Strategies | 19 |
| C. Structure of the Program | 19 |
| D. Program Outputs | 21 |
| E. Program Inputs and Budget | 23 |
| F. Benchmarks/Conditions Precedent | 25 |
| VI. Program Implementation and Management | 26 |
| A. Implementation of Institutional and Policy Reform | 27 |
| B. Dollar Transfer and Local Currency Procedures and Management | 28 |
| C. Monitoring and Reporting | 31 |
| D. Implementation Plan | 35 |
| E. Audit Plan | 37 |

| | |
|--|----|
| VII. Ministry of Health Monitoring/Evaluation System | 38 |
| A. Monitoring "Performance" of Institutional and Policy Reform Efforts | 40 |
| B. Monitoring "Impact" at the Program Level | 40 |
| VIII. Compliance with Cash Transfer and Local Currency Guidance | 40 |
| IX. Conditions Precedent and Covenants | 43 |

Annexes:

- A. GOC Program for the Immediate Improvement of Primary Health Care
- B. Logical Framework
- C. 611(e) Certification
- D. Statutory Checklist
- E. Initial Environmental Examination
- F. Letter of Request for Assistance
- G. Technical Assistance Project
- H. PID Approval Cable
- I. Program Analyses
- J. Letter to Minister of Health Conveying Financial Procedures and Requirements of Program

Summary and Recommendation

During the 1980s, Chile moved towards an open economy. In line with this goal, the military government began to privatize many of the existing social programs, including health care. It is acknowledged that the structural changes made to the health care system during the 1980s were important and unique in Chile. However, the reforms were incomplete or poorly implemented. Consequently, significant operational problems remain. The GOC recognizes the following constraints to an effectively operating primary health care system: 1) the health financing system gives preference to curative services, distorts the training of health personnel, and discriminates against health education and preventive care; 2) success in decentralization efforts has lagged in many municipalities because of inadequate technical and administrative capacities; 3) there is a lack of social and community participation in the management of primary health care service delivery; 4) the morale of health personnel is very low; 5) access to primary health services is impeded by limited facility hours, inadequate infrastructure, insufficient staff, etc.; 6) the lack of capacity to diagnose and treat health problems at the primary care level gives rise to other problems; 7) primary health services are not sufficiently focussed on the family; 8) serious mental health problems afflict the population and are not being addressed; and 9) PVO primary health care services are not effective due to lack of coordination.

Over the next two years (1991 and 1992), the Government of Chile (GOC), through the Ministry of Health (MOH) is undertaking the Program for the Immediate Improvement of Primary Health Care ("the Program") to address the constraints listed above. The GOC's Program will include five strategies: expansion of core primary level health services to areas not adequately covered; development of improved management, administrative, personnel and resource allocation measures to improve service delivery; improvement of technical problem-solving capacity in primary health care centers through the provision of equipment, training and other resources; improvement of access to primary health care through the use of extended hours, mobile units, and cooperative public/NGO service delivery; and development of innovative primary health care programs to improve quality for underserved groups. The GOC's Program for the Immediate Improvement of Primary Health Care will be an expeditiously implemented, two year effort which will later be subsumed under larger projects backed by the IBRD and the IDB.

The GOC will cover the Program's total value of \$26.7 million with \$16.7 million of its own resources and has asked

the USG to contribute \$10.0 million towards the program: \$9.3 million in local currency (general sector support to the program) and \$700,000 in dollar-funded technical assistance.

Given the maturity of GOC institutions, and the fact that the Program is a GOC initiative which the MOH is certainly capable of implementing, the assistance will be provided through Non-Project Assistance (NPA), with the exception of the technical assistance which will be authorized as a project. Under the NPA, a cash transfer of \$9.3 million will be provided in two tranches to finance health related, private and public imports from the U.S. An equivalent amount of local currency will be placed in a special account and will enter MOH budget accounts to support the Program.

Conditions Precedent to the first disbursement (\$5.8 million cash transfer and \$700,000 Technical Assistance Project), in addition to standard conditions, will include four key benchmarks related to the signing of agreements between the MOH and municipalities, establishment of emergency services, extension of service hours in clinics and hiring of additional medical professionals. Accomplishment of these benchmarks is well in hand and it is expected that the first disbursement will be made shortly after the Program Agreement is signed. The second and final disbursement is planned for one year after the the agreement is signed, i.e. December, 1991. The second tranche will be disbursed subsequent to a determination that the GOC has attained progress in implementing the Program. The determination will be based on a joint review by the MOH and the Office of the A.I.D. Representative, which will examine progress made towards achieving key program outputs in: re-establishment and reinforcement of a functional system of technical supervision of the municipalized primary care system; establishment of a new system for resource allocation for the Primary Health Care system; implementation of a management information system in primary health service areas; and improvement in the morale of Primary Health Care personnel. The outputs are straightforward and the MOH believes that it will easily attain progress in meeting them. Therefore, the final disbursement should occur in one year, as scheduled.

In addition to the program assistance summarized above, the GOC has requested technical assistance to be provided in the form of a project. The Technical Assistance Project, described in detail in Annex G, will deliver the following types of technical assistance: TA to help implement the GOC's program; TA for program management, i.e. a project coordinator within the MOH; and TA for audit and financial reviews. Most of the funding (\$500,000) will be for short term TA to

implement the program. This will be arranged through buy-ins to several ongoing centrally funded projects.

Management of the Program, while consistent with dollar cash transfer and local currency guidance, as well as non-project, sector assistance guidance, will not be burdensome for the A.I.D. Representative. Key management events for the first year will be: review of the report which contains the information indicating that the benchmarks have been satisfied, and other documentation for conditions precedent to initial disbursement; validation of reimbursement documentation for imports from the U.S.; and, review of progress to effect second disbursement, based on program report from the Ministry of Health. During the second year, key events will be: validation of reimbursement documentation for imports from the U.S.; and, review of semi-annual progress reports prepared by the Ministry of Health. For the most part, program monitoring will consist of review of the semi-annual progress reports. As mentioned above, this management/monitoring system is consistent relevant guidance and agency experience in NPA, sector assistance while addressing the need for a "jump-start", i.e. a quickly disbursing program which is not management intensive. To make sure that program management will not be burdensome to the A.I.D. Representative, and to assure effective technical implementation and financial management, a Project Coordinator working in the Ministry of Health will be funded by Technical Assistance funds. One major responsibility of the coordinator will be making logistical arrangements for short term technical assistance.

Based on the description on the GOC's Program for the Immediate Improvement of Primary Health Care and the proposed mechanisms for A.I.D.'s contribution to this program, as contained in the PAAD and summarized above, the A.I.D. Representative recommends that the Assistant Administrator, LAC, authorize program assistance in the amount of \$9.3 million and the Technical Assistance Project in the amount of \$700,000.

I. Introduction

A. Background and General Overview

Although Chile is classified among the lower middle-income economies, with a Gross National Product (GNP) per capita of approximately US\$1,510 in 1988, substantial progress has been made in enhancing the social welfare of its inhabitants during the previous 50 years. From 1923 to 1973, Chile experimented with various economic models, but the general trend was towards increasing state intervention in the economy based on an import substitution economic model. In the early 1970s, this trend became pronounced, and led to macro-economic distortions and social conflict.

After the military government assumed power in 1973, it began introducing a new economic philosophy of open markets. In mid-1975, despite a severe international recession, lower copper prices, and a quadrupling of oil prices, Chile began to seriously implement the free market-oriented policies. During 1974-75, GDP fell by 2.9%, but recuperated in the 1976-81 period, although with high unemployment rates.

Chile's GDP and fiscal spending fluctuated sharply in 1982-83 due to international economic slowdowns in 1981. Total GDP fell by 14.1% in 1982. Fiscal restrictions affected the social reforms. Even though the government attempted to protect per capita social spending relative to other fiscal spending with special regulatory and social safety net relief to help the most needy, social spending was reduced. In 1983, renegotiation of the large foreign debt was undertaken. A two-year International Monetary Fund (IMF) macroeconomic program helped to stabilize the economy.

Chile continued to move towards an open economy. In line with this goal, the military government began to privatize many of the existing social programs, including health care. The popularity of health care, and the concept that it was a social responsibility made changes in the National Health System (SNS) a politically difficult task. The restructuring, although begun in 1979 and nearly completed by 1988, resulted in some negative developments in some areas, especially in primary health care.

The military sought to weaken the political influence of the MOH and the health care delivery system. This agenda was partially accomplished through the expansion of privatized health care, through a total restructuring of the SNS, and through the process of health care decentralization. As discussed in detail below, two negative results of the way in which decentralization occurred were that technical control and supervision were weakened and differences in administrative capacity and health care costs were not addressed.

It is acknowledged that the structural changes made to the health care system during the 1980s were important and unique in Chile. However, the reforms were incomplete or poorly implemented. Consequently, significant operational problems remain. The current democratically elected government of Patricio Aylwin has made a commitment to increasing efficiency and the access of the population to health care, and to addressing the issues of equity in service delivery. The implementation of the primary health care system is expected to play a key role in achieving these objectives.

The extent and speed of Chile's health development have been remarkable. Infant and child mortality and morbidity rates are among the lowest in the developing world; average life expectancy at birth is among the highest. Moreover, the health development process has been relatively rapid, with wide-ranging demographic and health status impact. In a span of twenty years, the demographic structure of the population has changed from that of a typical developing country with 39.1 percent of its population under 15 years and 7.7 percent over 60 years of age (1970) to one more typical of a developed country, with 30.6 percent of the 13.2 million people under 15 years of age and 8.9 percent over 60 years of age (1990).

These demographic changes together with major improvements in the quality of life, which include increases in access to maternal and child health care, improved housing, and potable water and sanitation (especially in the urban areas), and to education have contributed to major shifts in the overall mortality and morbidity patterns.

Unlike most developing countries, Chile has moved steadily from a predominantly infectious and parasitic disease pattern to one of "modern diseases" including cardiovascular illnesses (27.9 percent), cancers (18.0 percent), and accidents/traumas (12.1 percent) which were the major causes of mortality for all age groups in 1988. Additional demands on the health system to address adult and adolescent health problems, such as prevalent chronic diseases (including diabetes, epilepsy, and hypertension) are rapidly increasing. Concurrently, already there are indications of development-related health problems, including those associated with water and air pollutants, and with social illnesses including drug and alcohol addiction problems, psychoses, delinquency and prostitution among adolescents, and both individual and community trauma. These newly emerging health problems are far more complex and require more costly approaches than the maternal and child health interventions which traditionally have been the focus of primary health care programs.

However, it is important to recognize that the epidemiologic transition process is incomplete, with elements of

earlier stages of this process remaining. For example, infectious and parasitic diseases are still prevalent among the urban and rural poor, while the incidence of other infectious diseases, including food-borne illnesses, such as typhoid, are relatively high in the population at large.

B. Importance of the Health Sector

Chile has had a long tradition of health care delivery to its general population. The constitutional right to health care is guaranteed by Section 9 of Article 19 of the current (1980) Constitucion Politica de la Republica de Chile.

Numerous independent systems of delivery evolved early in this century, some within heavy industry and mining, some within civil service systems, others within professional associations, etc. These various forms of health care delivery were subsequently combined into a National Health System (SNS) in 1953. There is also a long history of independent private health care providers. The development of these systems of care reflects a widespread attitude among Chileans that health care is a social responsibility of the government.

The universal health care tax, initially 1% of every employees' salary in 1968, 2% in 1975/76, 4 to 6% in 1980, was raised to 7% by 1981. The employee could decide if this tax would go to the public or private system. The tax reinforced the sense that the provision of health care was a responsibility of the government.

The challenge facing the current government is to attain further health improvements in light of shifting demographic profiles, and changing morbidity and mortality patterns. This requires defining and maintaining the necessary balance between adequate national health resources and other competing national priorities. The government task is to: determine the optimal resource allocation pattern, and the appropriate roles of the public and private sectors in financing and delivering health care; increase the efficiency of the public health system; and encourage private sector involvement in the provision of services as well as community responsibility and participation in health decision-making.

II. Description of the Problem

A. Current Health Care System

Chile's strong social development performance demonstrated by rapid decrease in mortality and morbidity rates beginning in the 1950s, especially among infants and children, was supported by the social reforms instituted in the late 1970s and early

1980s. Despite depressed economic conditions and a decline in per capita income, these improvements were largely maintained in the 1980s.

The reforms of the health care system had two main objectives: 1) to improve the targeting of health services to the at-risk groups; and 2) to increase the efficiency of the public health care system. In order to improve targeting, the government expanded and improved primary health care, emphasizing the most vulnerable groups - mothers and young children in rural areas.

In order to improve efficiency, the government undertook major institutional and financial reforms of the health care system. They included: 1) creating a financial institution for the public health sector (FONASA), charged with collecting all revenue for health services from the national budget and the payroll deductions for health care, and for distributing these funds, including paying the providers of services; 2) continuing the role of the Ministry of Health (MOH) as the policy-making, normative, supervisory, and evaluating agent; 3) decentralizing the National Health Service (SNS) into 27 autonomous Health Service Areas (HSAs) of the National Health Service System (SNSS) capable of providing preventive and curative services in 26 specified geographical areas in addition to an Environmental Care Unit based in Santiago; 4) transferring responsibility for primary health care services and infrastructure to the municipalities; and 5) allowing workers to choose whether to have their payroll deductions for health applied to FONASA or to the private health insurance companies (ISAPRES) which were established in 1981.

As the decade of the 1980s unfolded, it became clear that the theory of how the SNSS and private sectors were to operate was quite different from reality. The decentralization of the MOH and SNS frequently resulted in confusion. The expectation that the private sector could expand rapidly, to absorb many previously covered by the public sector, was not met. Initially, the rate at which the ISAPRES grew in number and membership was much less than hoped. The premiums and fees charged for membership by ISAPRES were too high for the vast majority of the Chilean population, and for those people whose only recourse was the public system, another problem arose. As the military government enacted laws to foster expansion of the private health care sector, it simultaneously reduced funding for the public sector. There was no budget for maintenance and facilities were allowed to deteriorate; salaries of health professionals were reduced, the provision of supplies and technology were insufficient, and operating funds and supervision were crippled. The relatively higher salaries available in the private sector attracted away many physicians and other auxiliary personnel. In short, the public health

care system was allowed to languish while the private sector was encouraged to grow.

The financial mechanism for collection of health revenues, the FONASA, collects 7 percent of the income earned by working Chileans who are not ISAPRE members and distributes these revenues to the public sector. These funds are used to pay for health care services provided within the SNSS to lower middle income families and the working poor. The upper-middle and high income people pay their 7 percent directly to the ISAPRE of their choice. The non-working poor pay nothing for their care, which is provided primarily by the SNSS.

In the final months of the military government, the overall condition of the total combined health care systems of Chile could be described as very uneven in the provision of health care services. The ISAPREs appear to provide ample, high quality curative care to their clients, with the best facilities, equipment, and health care personnel in Chile. However, their services have been limited to the 15% of the population which is well-to-do or fortunate enough to belong to an employment association which has contracted with an ISAPRE. In addition, some ISAPREs have been known to terminate contracts with clients who become afflicted with a costly illness. The ISAPREs have also tended to avoid contracts with elderly Chileans. Furthermore, most ISAPREs do not have their own hospitals, but rather use public facilities on a cost reimbursable basis, a system which carries hidden subsidies from the public to the private sector because of inaccurate or incomplete cost estimates. Preventive care has remained largely the responsibility of the public health system for all Chileans.

B. Current Primary Health Care System

The primary care system that was transferred to the municipalities in a process begun in 1981 consists of four basic types of health facilities: urban and rural clinics (consultorios), rural health posts, and rural medical stations. Urban and rural clinics are responsible for provision of integrated, outpatient/ambulatory care in the basic specialty areas of internal medicine, pediatrics, obstetrics and gynecology, as well as dental care, for which they employ a health team comprised of medical and health professionals and auxiliaries.

Rural clinics are located in communities of between 2,000 and 5,000 inhabitants. However, in reality they provide care to larger geographically defined or catchment areas of approximately 40,000 persons, including both preventive and curative services provided on an outpatient basis for general health problems of limited complexity. In the urban areas the

reality is somewhat different with several consultorios with assigned populations of 100,000 to 175,000 persons.

Rural health posts staffed by resident health auxiliaries provide rudimentary primary care, including curative treatment, and theoretically, health prevention and promotion-oriented activities to catchment areas of approximately 1,000 persons. As an integral part of health promotion, auxiliaries were to be responsible for community outreach activities, including maintenance of a ledger of the health and nutrition status of each family residing within their area of responsibility. However, these outreach and preventive health activities are largely non-functional today.

Rural medical stations (EMR), in contrast, are buildings used only on a temporary basis within given communities to provide a site for periodic visits or "rounds" made by medical teams based in the rural clinics to provide outpatient care to the local populace. They have no permanent medical or health staff in residence.

As an integral component of PHC services, municipalities assumed responsibility for provision of a basic set of pharmaceuticals, as needed, according to a sliding scale defined by socioeconomic levels (ability to pay). The majority of the people served by the system claim to be from the poorest category, skewing the municipalities' pharmacy budgets and resulting in insufficient supplies to meet demand. In delivering all primary services, each municipality agrees to comply with service-specific norms and regulations established by the MOH, and to carry out its responsibilities under the overall technical supervision of, and performance evaluation by, the local HSA to which it corresponds.

Health personnel employed in primary care² facilities and services were transferred from the Ministry of Health payroll with "civil service" status to municipalities as contract employees. They lost their longevity and retirement rights with the public health system and became subject to private sector equivalent labor laws, including what most PHC workers viewed as much more tenuous employment protection, given municipal governments right to hire and fire staff at their own discretion.

The 27 Health Service Areas (HSAs), part of the public health system, are responsible for all secondary and tertiary care services. Cases that the primary health care level cannot adequately handle are to be referred to these higher care levels. The Director of Primary Care (DAP) of the HSA is responsible for technical supervision of all municipal PHC activities within their HSA, which includes assuring that MOH standards and norms are maintained. However, in reality this role is difficult to fulfill because the municipalities do not depend either financially or administratively on the HSA.

The importance of the process of municipalization of health services goes beyond the actual numbers of facilities and staff. Primary care services are the first entry point into the more extensive health care system, and therefore may be the only type of care much of the population receives. Consequently, the quality of the primary health care services strongly influences the health status of the population as well as the system's image. If the public health system, particularly primary health care, is to function efficiently and effectively, financial adequacy must be ensured.

Concomitant with decentralization, and in order to enhance the overall effectiveness of the municipal PHC program in addressing priority health needs, a core set of interventions were identified. This core program includes the following: 1) infant health, 2) maternal health, 3) adult and elderly health, and 4) dental health. In addition to this basic core set of interventions, the municipalities were to develop special PHC programs which were responsive to specific local needs. Some examples of these specific, targeted interventions might have included activities for mental health and adolescents. Unfortunately, these specific, locally relevant interventions were never realized, as has been the case with adult and elderly groups.

C. Problems of the Health Care System

Most public health specialists agree that Chile's extraordinary progress in expanding coverage of basic health services, particularly preventive services for high-risk, low-income populations, has been one of the key elements of the dramatic improvement in health status. Of particular importance from a public health perspective has been the success in expanding maternal and child health services coverage, especially among children under two years of age among all income groups, and maternal access to prenatal, delivery, and postnatal services. Further improvements in traditional health status indicators (i.e., Infant Mortality Rate, Maternal Death Rate, Life Expectancy) are possible if those women and children at highest risk who because of access problems are not receiving adequate care are identified and given preferential treatment.

However, for the vast majority of the population the availability and quality of health care services has deteriorated. In most cases, a visit to a public facility means waiting in long lines, facing the possibility of being rejected for service (especially if you are an adult), possibly going to the emergency room of a hospital because the local clinic is closed and facing a high probability of being treated by a different physician with each visit. If attended at either the consultorio or the hospital, the time spent waiting is usually

several hours, the quality of the facility and equipment is low, the availability of pharmaceuticals and medical supplies is uncertain, and several visits are often required to diagnose and resolve a problem. The information systems that support the public health care system are antiquated, for the most part hard-copy manual systems. The morale of the staff and physicians at such facilities is low and their level of frustration is high. Because of chronic underfunding, conditions in rural health facilities and in some densely populated urban slum neighborhoods are worse than in other areas of the public system; often there is insufficient personnel to fully staff the facility. The shortage of physicians who are willing to work for the SNSS at the primary level is especially acute and most who do work for the SNSS work a half day, as well as maintain a private practice.

Faced with these conditions, it is not surprising that confusion sometimes arises as to the effectiveness of this new, dual health care system and the apparent inconsistency between the problems noted and certain positive indicators of Chilean health status. For example, the low level of infant mortality in Chile is well recognized, as are several other measures of improved infant and maternal health. To put these results in perspective, it should be recognized that early on the military government implemented strong programs which targeted feeding and health care resources to the infant and maternal populations in response to international criticism of a deterioration in infant and child health. The programs were highly successful: the Infant Mortality Rate was 18.5 per 1,000 live births in 1987, dramatically decreasing from 63 per 1,000 in 1974 and 120 per 1,000 in 1960. Likewise, the Maternal Mortality Rate has dropped dramatically from 35 per 10,000 live births in 1961 to 4.6 per 10,000 in 1987.

Unfortunately, the rest of the Chilean population was not targeted for such programs. Partially as a result of new disease distribution patterns as well as cuts in financial resources available to the system, some studies have shown that the working poor and the lower middle class have experienced a deterioration of their health care utilization patterns and health status. The military government was not inclined to reveal these results to the international health care community. The utilization patterns and health status of the upper income groups probably have improved as a result of their coverage under the ISAPRES.

Another complication which must be considered in any discussion of current health care and health status patterns in Chile is the trend towards modern industrial morbidity and mortality patterns. Under the military government, the limited resources that were made available through the SNSS were resources traditionally utilized to fight the bacterial diseases

commonly found in underdeveloped countries. For some time this has not been the significant illness pattern relevant to Chile. As a country in the intermediate range of economic development, Chile has, nevertheless, already joined the advanced industrialized countries in its pattern of illness categories. Chileans, of just about all income groups, suffer from heart disease, hypertension, cancer, and mental health problems. The public health care system passed to the new democratic government is poorly designed to address these modern health care problems. Even the ISAPRES, as currently structured, are not prepared to confront the costs and resource utilization patterns typically associated with these illnesses.

Notwithstanding the substantial achievements that have been made in expanding access to services (especially among the poorest groups), serious gaps in service coverage remain. There is evidence that the overall quantity of health services - particularly primary care provided at the municipal level - is below actual demand. Relatively high rejection rates at the municipal level (estimated at 10-20%) reflect the inability of many clinics to cope with the current demand for care due to both staffing constraints, inadequacy of supplies (including pharmaceuticals), and limited facility hours. Estimates are that at least 2.5 million persons may not be adequately served by either the public health or organized private health system (this may be especially true for the upper low-income and lower middle-income workers).

Further, continuing gaps in access to primary care exist among the poorest groups, for which virtually no alternatives to publicly financed health care exist. The data seem to suggest that certain geographic areas of the country still have not achieved Chile's overall standard level of health development. A major underlying cause of the wide discrepancies in morbidity and mortality both across regions and between municipalities within the same region appears to be highly variable coverage of individual population groups with primary health services, especially with regard to maternal and child health programs. Coverage of other "core" public health programs is still unsatisfactory throughout the system, particularly dental care, and adult and adolescent health services.

Moreover, gaps in health system coverage are not necessarily a phenomenon of isolated rural municipalities. New or poor municipalities in urban areas often have insufficient funds to establish and support a clinic. The GOC has identified 104 rural municipalities and 28 urban ones using health status and poverty indicators where the PHC system needs to be strengthened on a priority basis.

There is a strong curative bias in the health system which is demonstrated by the fact that one of every three (29 percent)

medical consultations provided by the MOH in 1987 was for emergency care. The majority of these consultations were by adults who are rejected from the primary care system often because priority is given to maternal and child health care. Also, this pattern highlights the continuing problem at the municipal level of long waiting periods and the inability to receive non-emergency services (often due to limited facility hours) which forces people to higher level health facilities for emergency care. In addition, the scarcity of health education pertaining to disease prevention and health promotion reinforces curative care.

The gaps in preventive health care are well documented. Data reveal that two out of every three (64.9 percent) of all household members have never had a preventive health visit. This lack of attention is particularly high among households in the lowest income groups.

The present system is essentially an urban-based one which assumes geographic accessibility of the population; the model has limited applicability for the rural areas. It also is a largely "passive" health care approach in which interventions depend on the conscious decision of the patient to seek care. The rural outreach system which existed in the 1970s, and was effective in facilitating the rapid decrease in infant mortality rates during this period, is largely non-existent now.

Widespread deterioration of the public health hospital sector is also believed to adversely affect medical education, as hospitals are the locus of medical school training. Moreover, the increasingly highly specialized orientation of medical education contrasts sharply with the more family-oriented practice required for primary health services.

There is a serious maldistribution of medical professionals throughout the country because of low salaries, poor working conditions (inadequate facilities and equipment), lack of opportunities for advancement or training, and geographical isolation. In addition, shortages of trained rural health manpower are a continuous obstacle to optimal operation of the system. The incentive structure for rural health providers has deteriorated; salaries are low and the ability to obtain additional work is limited.

Based on the evidence provided through recent preparation of an inventory of the present physical status of health facilities within the national health system, observers have indicated that there is need for investment in public sector infrastructure, particularly at the secondary and tertiary levels and in the urban-based primary system. In addition, there seems to be a significant problem with inadequate and inappropriate laboratory and medical equipment in the primary system as well and the inability of the auxiliary staff to

properly utilize equipment. Financial constraints facing municipalities were identified as the primary cause of inadequate maintenance, thus forcing local health administrators to allocate funds to direct more costly service provision.

Pharmaceuticals are an integral part of any health system and serious problems exist with the availability of basic drugs. Throughout the health system, pharmaceuticals are provided according to a sliding socioeconomic scale for payment if prescribed by the health provider. The cost of providing free prescriptions to municipalities, specialized clinics and public hospitals is staggering. Consequently, there are shortages and uneven supplies of basic drugs and medical supplies at all levels.

In summary, the programmatic focus of the public health system no longer responds fully to the priority health needs, particularly not in adult and adolescent care. The strong continuing maternal and child health emphasis does not address many problems that have evolved from the epidemiologic and demographic transition underway. It is not suited to meet the anticipated morbidity and mortality patterns in the future, nor is it efficiently and effectively providing adequate coverage of even maternal and child health services for high risk, low income, and geographically dispersed populations.

D. Specific Constraints and Bottlenecks of the Primary Health System

In order to enable the Primary Health Care system to effectively function in the short term, the following specific constraints and bottlenecks need to be addressed on a priority basis:

1. The uniformly applied "fee-for-service" system (FAPEM) gives preference to curative services, distorts the training of health personnel, discriminates against health education and preventive care, and theoretically establishes a service cost "ceiling" which turns out to be about 50% of the cost of primary health care. It also does not take into consideration differential costs of providing services in the rural versus the urban areas. This has resulted in a chronic shortage of personnel, medicines and other inputs, inadequate maintenance of municipal infrastructure, and failure of outreach mechanisms in rural areas.

2. The ability of municipal health organizations to effectively implement administrative and management decentralization efforts has not been uniformly successful due to variable technical and administrative capacities at the municipal level, lack of administrative flexibility for the use

of funds from the National Health Fund (FONASA), the lack of clear guidelines for monitoring the use of funds in accordance with ministerial norms, and the deterioration of the technical supervisory system for the municipalized system within the Ministry of Health (at the level of the HSA as well).

3. There is a current lack of social and community participation in the management of primary health care service delivery.

4. The poor morale of health personnel, leading to rapid turnover and frequent vacancies particularly in rural areas, is due to low salaries at all levels, the absence of a policy of continuous professional training, the absence of a career civil service or opportunities for professional improvement, the lack of participation in key decision making and programming efforts affecting primary health care, and the poor communication mechanisms within the clinical health team.

5. Access to primary health services is impeded by limited and unfavorable facility hours, inadequate infrastructure in high population density, low income urban areas, inadequate rural outreach mechanisms, and insufficient medical staff to cover demand on a daily basis.

6. The lack of capacity to diagnose and treat health problems at the primary care level gives rise to numerous problems, for example, the excessive use of emergency services, multiple appointments for the same problem, and long delays in diagnosis and treatment while test results are returned from the secondary or tertiary level. This results in the loss of confidence in the municipal health system;

7. The focus of activities at the primary level is solely on the individual and not on the family resulting in multiple visits, little knowledge of the patient or his environment and service provision by multiple practitioners to a single patient.

8. The serious mental health problems which afflict the population, especially in those sectors with few resources, are a result of the past systematic violation of human rights, growing alcohol and drug abuse problems, and psychosomatic illnesses. The Primary Health Care system is clogged with such problems, which it does not have the ability to treat; and

9. A network of parallel PVO health services developed during the last fifteen years in response to gaps in the provision of primary health care and other health services. This network is not coordinated, is sometimes duplicative of the public system and is not being used as effectively as it could be to provide preventive health care.

E. GOC Strategies for Overcoming Identified Constraints and Bottlenecks

In order to overcome these identified constraints and bottlenecks, the MOH has developed strategies keyed to the constraints discussed above:

1. The health fund resource distribution system (FAPEM) will be adapted to a dual system including 1) a "capitation system" with a distribution of resources on a per capita basis, indexed by health status (e.g. standardized mortality ratio), and by the proportion of families in extreme poverty, particularly for preventive services and drugs, and 2) an adjusted "fee-for-service" system which takes into consideration variable service delivery costs in urban and rural areas. To do this, additional funds have been requested for 1991.

Primary Care Resources Solicited
from the Ministry of Hacienda for 1991
(Chilean Pesos)

| | |
|---------------------------------|-----------------------|
| Current fund for primary care | \$ 11,500 mill. |
| Supplemental funds - tax reform | \$ 2,400 mill. |
| Requested budget increase | \$ <u>2,800 mill.</u> |
| Total | \$ 16,700 mill. |

This permits one to establish an average of about C\$1,855 per beneficiary at the municipal primary care level (discounting persons affiliated with the ISAPRES or other private systems). This is equivalent to US\$6.18 per capita, which is an increase of 45% from the present level of about US\$4.25. This increase and more rational use of the funds would permit the health system to begin to resolve the problem of chronic under-funding of the primary health care level.

2. New Agreements between the SNSS and the municipalities currently under negotiation with the mayors, will help assure the adequate use and monitoring of financial resources.

Moreover, a process of training for municipal administrative personnel will be developed. Likewise, the DAPs' supervision and support for local management will be improved. Computerized systems for primary care level management, including incorporation of computerized information systems, should be introduced. The feasibility of doing so will be explored. All these management and training efforts will improve the efficient use of resources in the Municipal Corporations.

3. Social participation will be attained by developing SICOS (community systems). They will be formalized through the establishment of Community Councils (in cooperation with other Government entities, such as the Ministry of the Interior).

4. The municipal health corporations should be improved by the creation of a universal career civil service in the municipal system, with progressive advancement levels which are similar and interchangeable throughout the country. This would help reduce competition between municipalities for health care personnel with the resulting rapid turnover and mobility of providers. The feasibility of this will be explored.

The improved motivation of municipal health personnel will be reestablished in part through a program of training. More than two hundred workshops for stress management and participatory diagnosis of problems in the health system will be held in all of the 26 Health Service Areas. This training will be continued during four years. The feasibility of other personnel incentives will be explored.

5. The municipal health service accessibility problem will be resolved with the gradual extension of service hours until 9:00 p.m. and with the availability of 24 hour Emergency Primary Health Care Centers (SAPU) in the most isolated sectors of the city. In addition, mobile health units will be introduced on a short term basis in high population density, low income urban areas lacking sufficient infrastructure until additional clinics can be built.

6. The capacity to resolve problems at the primary care level will increase with the improvement of coordination with the secondary and tertiary levels through the action of the DAPs and the proposed Commissions for Integrated Health, with adequate financial resources, with standardized norms for basic medicines and supplies, and with the development of basic clinic-based diagnostic laboratories and training of personnel in their use.

7. The change from an individual to a family focus will occur through the development of a Family Medicine Specialization. This experiment will be developed first in test areas where a standardized model will be developed in accordance with the results of efficacy and efficiency analyses for later replication.

8. Mental health services will be established at special clinics in the urban areas in order to address the growing problems of alcohol and drug abuse, human rights violations, and psychosomatic illnesses.

9. NGOs will be incorporated into the primary health care system through joint delivery of primary services with the municipal sector, or through public support for the ongoing service delivery activities of the NGOs. This service delivery model is considered to be particularly applicable to, for example, delivery of preventive education and mental health care services.

III. Other Donors

Approximately \$450 million is currently being proposed by multilateral and bilateral donors in support of the Government of Chile's 1990-1995 National Health Program. Donors include the International Bank for Reconstruction and Development - IBRD (\$170-200 million), the Inter-American Development Bank - IDB (\$200 million), and the Governments of Germany (\$17.5 million), France (\$25 million), Spain (\$12 million), Italy (\$10 million), and the United States (\$10 million).

The IBRD and IDB are currently negotiating with the Government of Chile to determine the "areas of concentration" of possible projects to be financed in parallel by the two Development Banks. The IBRD proposes to address macro issues affecting the health sector including: 1) reform of health care financing; 2) incentives systems for health care personnel; 3) procurement and distribution systems for drug and food supplementation programs; 4) quality control of pharmaceuticals and food products for export; 5) strengthening of health management at the national level; 6) establishment of joint ventures between public/private institutions in health care delivery; and 7) innovative programs for environment-related and women's health problems. Additionally, the IBRD proposes to assist in the development of integrated health care systems and physical investments in the low-income areas of metropolitan Santiago, and the Health Service Areas of Antofagasta and Llanquihue.

The IDB will concentrate on the improvement of health care delivery, management capacity, and information and maintenance systems at the local level starting with a pilot project in selected Health Service Areas (Iquique, San Felipe, Valdivia and Maule) - Stage I. The IBRD/IDB projects are slated to begin in mid-1991. A follow-on IDB project proposed for early 1992 will cover the remaining areas not covered by other donors - Stage II. The IDB's current ongoing National Fund for Regional Development project includes \$70 million for the rehabilitation/reconstruction of health posts, clinics, and Level 3 and 4 hospitals in rural areas.

The Office of International Cooperation of the Ministry of Health (OCI/MOH) currently is negotiating with the Governments of the United States, France, Spain, Italy and Germany for funds totalling US\$74.5 million for the health sector. These funds are to be disbursed in the course of the next three years, and are in the form both of donations (US\$25 million) and soft credits (US\$49.5 million). A more detailed description of these contributions follows:

- The US\$17.5 million in soft credits from Germany are to be applied to the rehabilitation of hospitals in four of the 26 Health Service Areas (Valparaiso/San Antonio - Region V, Concepcion - Region VIII, Araucania - Region IX, and Southeast Metropolitan area of Santiago).
- The Government of Italy is donating US\$10 million to be used for a program of improved comprehensive medical care in areas defined as high risk. Specifically, this donation is to be targeted on the three HSAs of Southeast Santiago, and Vina del Mar/Quillota. This program, complementing that of the Government of Germany, will build primary health care centers linked directly to hospital centers.
- France has offered a US\$5 million donation to be used for the purchase of mobile primary health care units for use in urban areas, and ambulances. In addition, the French government is providing US\$20 million in soft credits to improve the medical equipment in hospitals nationwide.
- Another soft credit of US\$12 million from Spain is intended to complement the French funds, and will be used to buy additional medical equipment and medicine for all of Chile's 26 HSAs.
- The United States is donating US\$10 million to the Immediate Improvement of Primary Health Care Program described in Annex A of this document.

The U.S. assistance is designed to lay the early groundwork for policy and institutional reforms which will be continued and expanded with the extensive and substantial multilateral assistance anticipated during the 1990-1995 period. Projects with the multilateral banks are not expected to have resources flowing until after mid 1991. In the meantime, flexible A.I.D. assistance is critical to generating momentum for diagnosing and addressing the immediate problems facing the Primary Health Care System.

IV. Program Rationale

Public interest polls taken shortly before the new democratically elected administration of President Aylwin took office in March of this year showed that over 40% of those polled considered provision of adequate health services to be the single most urgent issue facing the government and the Chilean population. In response, the incoming administration formulated a short and medium-term strategy and action plan and mobilized bilateral and multilateral donor assistance in order to be able to respond immediately to this political imperative and strongly felt need on the part of the Chilean constituency. As part of this effort, President Aylwin asked the U.S. Congress for help in "jump starting" the primary health care system and in providing support services to victims of human rights abuses. Congress obliged, earmarking \$10 million in supplemental appropriations for this purpose.

The Government of Chile is now working with the World Bank, the IDB and several European Governments as well as USAID to develop external assistance agreements in support of Chile's 1990-1995 National Health Program. Projects with the multilateral banks are not likely to have resources flowing until after January 1991 in the case of IDB and summer of 1991 in the case of the World Bank. In the meantime, the Government of Chile has allocated a small emergency supplemental to this year's budget and hopes to use more flexible bilateral assistance, including U.S. assistance, to provide an immediate response in trying to resolve the most pressing service delivery constraints, particularly at the primary level. In addition, starting in 1991 the GOC expects to be able to augment the normal operating budget of the Health Services System at the primary level with revenues from recently approved tax increases.

Multilateral and bilateral assistance is to be used to assist in completing the reform of the sector and to augment the investment budget which has been virtually non-existent over the past decade. The U.S. assistance is designed to lay the early groundwork for policy and institutional reforms which will be continued and expanded with the substantial multilateral assistance coming on stream over the next year.

A sector program approach to provision of U.S. assistance to the Chile health program makes sense for a number of reasons. The Chilean Government, acting through the Ministry of Health, has a clear plan and is carefully coordinating external assistance. The plan is built on basic, in-depth analyses of the health sector which have been completed over the past two years and the GOC is taking a careful analytical approach to proposed changes. Chile's system of public administration is

sound and, although improvements are needed, the public health services system, in fact, works relatively well in comparison to other systems in the hemisphere and particularly in developing countries throughout the world. Chile has a cadre of very sophisticated human resources in terms of health care planning and service delivery in the MOH, many of whom have recently returned to public service and, in some cases, to the country with the advent of a democratically elected government. There is clearly strong political and technical commitment to this program for immediate improvement of the primary health care system, and the technical and administrative capacity to carry out the proposed reforms. What is needed is additional financial resources for investment in the reform process.

A sector program approach would give the GOC the flexibility it needs to effectively coordinate the A.I.D. resources with national resources and with those coming from other external donors. Furthermore, the types of institutional reforms contemplated would be strongly facilitated by a sector program versus a project approach. The kind of special procedures and detailed end use monitoring and control required in a project tend to set up parallel and artificial mechanisms for program implementation which in this case would interfere with the institutional changes, the policy and planning process, and the development of innovative mechanisms for service delivery which are the program objectives. Generalized subsector support for the primary care level would assure that the innovative pilot service delivery mechanisms and programs are consistent with and can function effectively and efficiently under the normal operations of the public health services. Taking a program approach in a country like Chile where implementation capacity and skills are high also would allow the U.S. Government to support the kind of thoughtful institutional reform process the Chileans want to and need to carry out with A.I.D.'s limited personnel resources in Chile.'

V. A.I.D. Sector Assistance Program

In effect, A.I.D. will be buying into the Government of Chile's Program for the Immediate Improvement of Primary Health Care (PII/PHC) henceforth referred to as "the Program." The goal, purposes, strategies, components, and outputs described below are derived from the Government of Chile's description of the Program contained in Annex A.

A. Goal and Purpose

The Program has, within the goal of improving the quality of life of the Chilean population, the following general purposes:

a) To improve access to primary health care of the Chilean population, especially the poorest sectors, located in dispersed rural areas and marginal urban concentrations; and

b) To improve the quality of and opportunity for health care services through an increase in the capacity for health care problem resolution at the primary level.

B. Strategies

In order to achieve the stated purposes, the implementation of the Government of Chile's Program will involve the use of the following strategies:

1. Expansion of the core primary level health service activities of proven effectiveness to areas, such as isolated rural populations and newer high density, low income urban areas, not now covered by them;
2. Development of improved management, administrative, personnel and resource allocation measures which facilitate the implementation, coordination, technical supervision, and evaluation of the Primary Health Care Program;
3. Improvement of the technical problem-solving capacity in PHC centers through provision of basic laboratory and diagnostic medical equipment, training, increased resource allocation in chronically underfunded municipalities and improved coordination with the secondary and tertiary levels;
4. Improvement of access to primary health care services through the use of extended hours, mobile units, and the introduction and use of cooperative public/NGO health service delivery; and,
5. Development of innovative primary health care programs to improve quality for underserved groups like those with mental health problems, the elderly, adolescents and families, and to increase preventive health care.

C. Structure of the Program

The Government of Chile's Program has the following components to implement the strategies described above:

1. Strengthening Primary Health Care in the Rural Areas -
this program component will include strengthening the supervisory system in the Directorate of Primary Health Care in each Health Service Area, training and motivational workshops, development of educational materials, revised Agreements between the Ministry of Health and the municipalized health system, establishment of community councils and community support systems, and provision of basic equipment.
2. Studies for Improvement of Planning, Administration and Supervision -
this component will include operations research, special studies, and development of an information system at the primary level to assist with design, implementation, monitoring and evaluation of Primary Health Care system interventions in order to improve the effectiveness and efficiency of primary health service delivery. Examples of these studies include the following:
 - Design and implementation of a system to obtain cost information at the primary care level.
 - Diagnosis and monitoring of the efficiency of the health care delivery system at the regional Health Service Area level.
3. Basic Re-equipment at the Primary Health Level -
this component is designed to improve the capacity of the primary health level facilities to diagnose and treat diseases. It includes efforts to provide standardized, basic, and technologically appropriate equipment (including laboratory and medical equipment, and supplies), and to train the auxiliary staff and provide additional staff to adequately and appropriately use it (including basic servicing and maintenance).
4. Incorporation of Non-governmental Organizations (NGOs) into the Primary Care System -
this component is designed to forge a public-private partnership in providing health care services to populations currently served by NGOs through development of a Grants/Cooperative Program. The assistance of NGOs will be sought in order to provide services to isolated or hard-to-reach populations in urban areas with a high concentration of poverty, and in areas where the public system is currently insufficient.

5. Development of Innovative Models of Care -

this component is designed to assist with improvement of the targeting and access of basic or core primary health care services (i.e., maternal and child health activities) to at-risk populations in isolated rural or marginal urban areas. It will also assist with development and implementation of innovative preventive health care programs and the reorientation of curative health care services to be more consistent with the newer epidemiological profile. Examples of additional types of programs to be considered include the following:

- Mental health care with a focus on community centers and treatment for victims of human rights violations.
- Family health care.
- Chronic disease prevention in adults, emphasizing the identification and treatment of specific groups at high risk, i.e. hypertensives.
- Health care for adolescents with emphasis on teenage pregnancy, and alcohol and drug abuse.

6. External Technical Assistance -

this element is designed to support and advise the Ministry regarding the development of suitable program interventions and other monitoring/evaluation and system management activities.

D. Program Outputs

The GOC's Program will achieve the following institutional and policy reforms aimed at improving the efficiency and effectiveness of health care service delivery at the primary care level by the end of December 1992.

1. Strengthening Primary Health Care (PHC) in Priority Rural and Urban Communities Accompanied by the Improvement of Administrative and Supervisory Capacity of PHC

Reestablishment and reinforcement of a functional system of technical supervision of the municipalized primary care system by the Directorates of Primary Health Care (DAPs) in each Health Service Area including:

- DAPs reconstituted and assigned personnel, vehicles, operating expenses and training resources;
- New Agreements signed between the Health Service Areas and the local Mayors which include agreements on specific

Primary Health Care activities and supervisory responsibilities to be carried out; and

- Personnel of DAPs and municipalized Primary Health Care system trained in implementation of supervisory system.

Establishment of a new system for resource allocation for the Primary Health Care system including:

- Studies of actual costs of each type of primary care service completed in a representative sample of Primary Health Care centers in small urban and metropolitan populations.

A Management Information System (MIS) for the Primary Health Care level designed, tested, and implemented in priority Health Service Areas in order to provide accurate and timely data to support planning and management, the new supervisory role of the DAPs, and resource allocation decisions.

Morale of municipalized Primary Health Care personnel improved through:

- Completion of motivational training;
- Completion of feasibility studies on the potential for establishing a career civil service for Primary Health Care workers in the municipalities; and
- Adequate equipment and supplies available so that personnel can perform their duties.

2. Improvement of Technical Problem-Solving Capacity in Primary Health Care (PHC) Centers

Basic diagnostic equipment available and basic diagnostic laboratories established and equipped in priority Primary Health Care areas.

Design, testing, and implementation of technical training for Primary Health Care personnel in the priority areas in the use and maintenance of basic diagnostic equipment.

3. Improved Access to Primary Health Care (PHC)

Compilation of a list of NGOs providing parallel PHC services; development of an instrument to accredit, select, and contract NGOs to provide PHC services in cooperation with both HSAs and the municipalities.

Pilot programs for PHC service delivery by selected NGOs established and tested in priority urban areas.

Thirteen planned 24-Hour Emergency Services (SAPUs) established and pilot tested for effectiveness and efficiency in low-income urban areas; completion of a model for expansion of SAPUs to additional consultorios.

An additional (third) shift established in at least 38 priority PHC centers; evaluation of the model for expansion to additional consultorios.

4. Innovative Programs in Primary Health Care

A pilot mental health program designed, implemented and tested; establishment of a network of community-based mental health centers.

An evaluation completed of the ongoing University affiliated pilot training program for Family Health Practitioners; extension of this training to actual Primary Health Care service delivery.

A pilot service delivery model for caring for the elderly, including chronic disease monitoring, developed and tested; a refined model for elderly care approved for use and replication in the PHC system.

Community Health Councils and community support systems (SICOS) established and operating in at least 80% of the priority municipalities.

E. Program Inputs and Budget

The grant is organized into three parts:
1) dollar disbursement (cash transfer), 2) local currency equivalent to the dollar transfer, and 3) dollar funded technical assistance project including provisions for evaluation, program coordination, and audit and financial reviews.

1. Dollar Disbursement - Cash Transfer

Dollar disbursements to the Grantee will be made in tranches, on satisfaction of conditions precedent. The conditions precedent define a series of policy and institutional reform measures to be undertaken by the Grantee. The performance benchmarks are defined in detail in Section V.F. (Benchmarks) of this document. Procedures for dollar disbursement are described in Section VI.B. U.S. foreign exchange will be used to finance either public or private sector imports from the USA destined for the health sector.

2. Local Currency Program

The Grantee will deposit local currency, equivalent in value to dollar disbursements, in a separate Special Local Currency Account. The fund thus created will help finance additional costs of developing and restructuring of the Primary Health Care system. Recurrent costs for the restructured systems in the Health Service Areas and municipalities would be included in the normal municipal health system budgets after the initial investments are made. The Program local currency will support implementation of the policy and institutional reform objectives of the Program described above. For example, local currency will be used to support development and execution of training activities and materials required to upgrade the supervision, information and financial management systems, and case resolution capability at the primary level of health care delivery services.

3. Dollar Funded Technical Assistance and Evaluation

Technical assistance will be programmed in such areas as operations research, cost analysis, management information systems, health care financing, procurement, and health systems management to assist the Government to carry out the policy reform and institutional strengthening program of the grant. Details of the proposed Technical Assistance Project requirements and management are identified in Annex G.

There will be a final evaluation prior to program termination. The Evaluation component of the program will be managed directly by USAID. All activities under this component will be planned and carried out with full collaboration of the Government of Chile/Ministry of Health, using procedures established with the Government.

The Technical Assistance Project will provide the services of a technical consultant to develop an evaluation methodology and assist with implementation, if necessary. Also, the final evaluation will be a descriptive report based on technical information provided by the MOH in documents submitted to the A.I.D. Representative/Chile for the semi-annual reports. (Refer to Section VI.C. Monitoring and Reporting)

4. Audits and Financial Reviews

Audits and financial reviews will be phased to provide assurance that procedures and controls are effective in their

application during implementation as well as annual compliance verifications. The timing and content of the audits and financial reviews are described in more detail in Section VI.E. (Audit Plan and Financial Review).

| <u>Summary Budget - AID Inputs</u> | | <u>(\$000)</u> |
|--|-------|----------------|
| <u>Cash Transfer and Equivalent Local Currency Program</u> | | 9,300 |
| <u>Dollar Project*</u> | | 700 |
| Technical Assistance | (500) | |
| (including evaluations) | | |
| Program Support (Prog Coord) | (100) | |
| Audits/Financial Reviews | (100) | |
| Total | | <hr/> \$10,000 |

* - Refer to Annex G - Technical Assistance Project - for a complete description of the components.

F. Benchmarks and Conditions Precedent to Disbursement

The following is a list of benchmarks or measures of progress in the implementation of the institutional and policy reforms of the Program for the Immediate Improvement of Primary Health Care. Disbursements are based on two tranches, initial and final, of which the first is expected to be the most significant. Disbursements are to be US\$5.8 million and US\$3.5 million respectively, with the remaining US\$700,000 to be reserved for Technical Assistance, Program Support, and Audits/Financial Review (as described in Annex G).

Initial Disbursement

- New Agreements will be signed between the Health Service Areas (HSAs) and Mayors in at least 85% of the priority 104 rural and 24 urban municipalities. These Agreements will reflect the agreement between these authorities and the Ministry of Health on the goals to be achieved with the increased funding available for Primary Health Care.

- Establishment of at least 11 of the 13 24-Hour Emergency Services planned for selected urban consultorios in the first phase of the Program. Such services will provide previously unavailable emergency health care in underserved areas, reducing congestion both in the consultorios' regular daily hours as well as in the local hospital emergency room.
- Extension of hours in 100% of the 38 consultorios selected to include as third shift during the first phase of the Program. These extended hours will allow greater access to primary health care services by the working public.
- Hiring of at least 50% of the 28 additional medical professionals planned for the first phase of the Program in order to strengthen the technical supervisory capacity of the Directorates of Primary Care (DAPs) of the 18 Health Service Areas (HSAs) which contain the 104 priority rural municipalities.

Final Disbursement

The final disbursement of US\$3.5 million will be made approximately 12 months after the initial disbursement. Prior to release of the final disbursement, a joint review will be held by USAID/Chile and the Ministry of Health to discuss the status of the Program and to determine whether substantial progress has been made towards achievement of the institutional and policy reforms aimed at improving the efficiency and effectiveness of health care delivery at the primary level. The Ministry of Health will prepare a formal descriptive report for USAID/Chile which discusses these achievements and the status of the Program. The Program Outputs or End of Project Status (EOPS), as identified in Section V.D. (Program Outputs) of this document, will serve as guidelines for review of the Program and provide an outline of the descriptive report.

VI. Program Implementation and Management

The Ministry of Health, through its semi-autonomous Health Service Areas, will be the lead Chilean agency responsible for program implementation. Agreements or contracts with other implementing entities including municipalities, universities, NGOs and private for-profit companies will be made through the Ministry of Health. Implementation of the cash transfer foreign exchange component will most likely be through the Central Bank of Chile and the Ministry of Finance, in cooperation with the Ministry of Health. A.I.D. will cooperate with the Ministry of Health in implementing the foreign exchange technical assistance component of the Program.

Management responsibilities for the Program exist at several levels, under three main categories: policy and institutional reform, dollar cash transfer and the local currency program. For the first tranche, U.S. dollars will be disbursed to the GOC upon achievement of agreed upon institutional and policy benchmarks necessary in the reform of the Primary Health Care system. For the second tranche, dollars will be disbursed after a joint review has determined that the MOH has made substantial progress in implementing the Program. U.S. dollars will be applied to finance public or private sector imports from the U.S., destined for the health sector. The local currency equivalent to the U.S. dollar disbursements will be used by the Ministry of Health to effect reforms in the Primary Health Care system.

A. Implementation of Policy and Institutional Reform Program

1. Government of Chile

The Ministry of Health will take the lead for the GOC in coordinating and managing implementation of the institutional and policy reform component of the program. Since many of these reforms will be implemented through the municipalized primary health care system, the MOH will be responsible for coordinating with the Ministry of Interior at all levels: central, regional and municipal.

Within the Ministry of Health, the Department of Primary Care under the Department of Planning and Budget, in coordination with the Office of International Cooperation, will have principal responsibility for overseeing and coordinating the policy and institutional reform components of the program.

The MOH will have the following responsibilities:

- Monitoring and evaluation of the program of institutional and policy reforms;

- Carrying out or ensuring the implementation of the necessary studies, assessments, pilot activities, seminars, workshops and training activities and purchase of commodities and supplies aimed at achieving the intended policy and institutional reforms;

- Ensuring or coordinating the issuance of necessary administrative acts or legal agreements necessary for policy institutional reform implementation from appropriate Ministries or Agencies;

- Coordinating reviews and evaluations of the policy and institutional reform program;

- Identifying required external technical assistance and coordinating with USAID/Chile to obtain the assistance; and
- Reporting to USAID/Chile on program progress and results.

2. USAID

The USAID Representative, with support from his FSN and/or PSC staff and LAC Bureau USDH support staff (specifically LAC/DR/HPN) will be responsible for:

- Monitoring the policy and institutional reform program and preparing report(s) for A.I.D./Washington as required under this program;
- Preparing and reviewing with the GOC any changes or revisions in the Grant Agreement;
- Coordinating and managing requests for external technical assistance to be supplied through buy-ins to Central AID/W or LAC/Regional contracts; and
- Coordinating and carrying out the necessary reviews, evaluations/audits to ensure that the agreed upon institutional and policy reforms have been properly implemented. Assistance from LAC/DR/HPN in the verification of the benchmarks may be required.

B. Dollar Transfer and Local Currency Procedures and Management

The GOC's management of foreign exchange within the financial system is relatively open and "hands-off," compared to other developing countries. Under this system, commercial banks are allowed to hold dollars, but sell dollars exceeding certain established limits to other banks or the Central Bank of Chile. If banks need dollars, they buy from each other or from Central Bank, as long as the amounts which they hold do not exceed the limits established by Central Bank. Thus, Central Bank controls the volume of foreign exchange in the economy. Central Bank can also influence the exchange rate by determining the rate at which it sells dollars. The management and procedures of dollars and local currency takes this foreign exchange management system into account.

As described previously, dollars will be released in two tranches, the first upon satisfaction of conditions precedent to disbursement, including benchmarks of performance, and the

second upon determination that reasonable and substantial progress has been made in the implementation of the Program. Disbursement of the second tranche is expected to take place 12 months after the first disbursement. Dollars will be disbursed into a separate, segregated account at Central Bank or a U.S. bank, which will be an interest bearing account, earning interest until dollars are released from the separate dollar account as described below.

The U.S. dollar funds will be used to finance health related imports from the U.S., with the exception of pharmaceuticals since pharmaceuticals would require advance FDA approval in order to guarantee quality assurance. In order to minimize the A.I.D. Representative's management burden and to simplify procedures for the Government of Chile (GOC), dollars will be used to finance imports on a reimbursable basis. Central Bank will be able to obtain supporting documentation for import transactions such as invoices, bills of lading, etc., from commercial banks to support transactions.

Accordingly, release of funds from the separate dollar account will occur after documentation for imports has been accepted. The dollars will be released from the separate dollar account to an "agent bank", i.e. either the Central Bank or the Banco del Estado (a state-owned entity which holds accounts for government entities and also has commercial bank functions) or other appropriate entity. The agent bank will exchange the released dollars for pesos which will be placed in the special Peso account, at either the Central Bank or the Banco del Estado. The agent bank will, in effect, buy the pesos on the open market, from commercial banks, at the highest rate which is not unlawful.

The special peso account will also be separate, i.e. will contain only Pesos equivalent to the of dollars released from the separate dollar account and the interest earned thereon, since the special peso account will also be interest bearing. As needed and consistent with the budgetary process and GOC funds control, pesos will be released to the MOH's normal accounts for primary health care, and will be commingled with other GOC funds for the Program.

1. Procedures for the Separate Dollar Account

a. The GOC will establish a separate U.S. dollar account in the Central Bank of Chile or in a U.S. bank, containing only dollars disbursed by A.I.D. for this program. This will be an interest bearing account. Dollars will earn interest up to the time that they are released from the separate account.

b. Upon the GOC meeting conditions precedent to disbursement (including benchmarks) for the first tranche, and a determination that substantial progress had been achieved in the program for the second tranche, A.I.D. will disburse dollars into the separate dollar account.

c. Central Bank will be presented with documentation evidencing health imports equal in value to the dollars in the separate dollar account. Imports can be either public or private sector. Lists of individual transactions of health related imports from the U.S. will be backed up by invoices, bills of lading, etc. Imports of pharmaceuticals will not be eligible for reimbursement. Nor will other items prohibited by the U.S. Foreign Assistance Act (military items, abortion equipment, etc.)

d. Once documentation is accepted, dollar funds would be transferred to the agent bank (Central Bank or Banco del Estado). As described below, the MOH agent bank will exchange (sell) the dollars for local currency on the open market with commercial banks, at the highest exchange rate which is not unlawful..

e. The GOC will submit monthly reports to A.I.D. summarizing dollar account transactions.

f. To compensate for import transactions found be ineligible through audit, or any other post-examination, the GOC will either immediately present documentation for other eligible imports or re-deposit into the separate account any amounts, in dollars, equivalent to payments, until acceptable documentation for eligible imports can be presented.

2. Procedures for Special Local Currency (Peso) Account

a. The GOC will establish a segregated, special peso account in the name of the Ministry of Health, which will contain only those pesos equivalent to disbursement of dollar tranches and earned interest, as described above.

b. The special account will be interest bearing and will be at the Central Bank of Chile or the Banco de Estado.

c. As described above, once import transactions are accepted and dollars are released from the separate dollar account, those dollars will be exchanged for pesos in the banking system. The agent bank (Banco del Estado or Central Bank) will do the exchange and

place the pesos in the special peso account.

d. As funds are needed for the Program, they will be disbursed out of the special peso account into the Ministry of Health's normal accounts for the Program. At this point, funds from the special peso account will be commingled with the MOH's normal budgetary resources and possibly resources from other donors.

e. The GOC will provide financial reports to A.I.D. on a monthly basis. Such reports will evidence all transactions in the local currency account and will provide sufficient documentation to demonstrate that funds from the special account have been deposited into the Ministry of Health's accounts for the Program.

f. Such financial reports will be in addition to technical reports demonstrating progress against planned outputs. The financial reports will demonstrate progress in financial indicators which demonstrate that funds provided from the special account have increased the MOH's budget for the Program by certain increments or percentages.

C. Monitoring and Reporting

The monitoring of implementation under this sector assistance program includes: 1) monitoring the institutional and policy reform program, and 2) monitoring the foreign exchange and local currency program.

1. Monitoring of Institutional and Policy Reform

a. Ministry of Health

The Office of International Cooperation (OIC) in the Ministry of Health, in coordination with the Ministry of Planning and the Ministry of Interior, will be responsible for monitoring and reporting on progress (or problems) toward the implementation of the institutional and policy reforms. To accomplish this, the Ministry of Health will contract a project coordinator with funds from the Technical Assistance Project. The coordinator's duties and responsibilities will be agreed upon by the MOH and USAID/Chile. (Refer to Annex G.II. for details).

Semi-annual reports and joint reviews of the Program will be required. The OIC, in collaboration with the Department of Primary Health Care, will have the main tasks of monitoring and evaluating the "performance" and monitoring the "impact" of the

institutional and policy changes (refer to Section VII. MOH Monitoring/Evaluation System). This will be carried out as follows:

- Identify relevant data to be used in the evaluation and determination of progress made in the implementation of the institutional and policy reform program aimed at improving primary health care services;

- Collect the data identified above;

- Assist the Department of Primary Care in the analysis of the data, in the preparation of necessary reports to be used in the review, assessment, and determination of whether the conditions precedent related to institutional and policy reforms have been satisfactorily met;

- Assist the Department of Primary Care to prepare terms of reference of the various studies, assessments, pilot innovative service delivery activities, workshops, training and other activities required to achieve the desired institutional and policy reforms;

- Provide continuing analysis and evaluation of the effects of institutional and policy changes on resource allocation, government finance, organizational and service delivery efficiency and effectiveness, user satisfaction and health status;

- Make recommendations, based on analysis and evaluation, as to the need to modify the institutional and policy reforms to mitigate any unforeseen negative effects of the changes;

- Coordinate and assist other entities involved in the reform program; and

- Prepare required reports for both the Government of Chile and USAID.

b. USAID

The A.I.D. Representative in Chile will carry out A.I.D.'s ongoing monitoring and review responsibilities for the program and will be responsible for reporting to AID/W and other parts of A.I.D. on progress in implementing the primary care institutional and policy reform program.

However, the MOH will assume the major share of the monitoring responsibilities, especially through the Project Coordinator to be hired with Technical Assistance Project funds (refer to Annex G. Section II). Technical assistance

arrangements will provide technical backstopping for USAID and assist with monitoring of the Program's progress.

c. Joint Reviews

Semi-annual reviews between the Government of Chile and the USAID Representative and his staff, with assistance from Washington and the USAID/Peru controller, will be held to discuss the progress made or problems encountered in the Program. The first review will provide the basis for determining subsequent disbursements of funds under this grant. Semi-annual reviews will also provide an opportunity to make necessary adjustments or to correct any errors made during the design or implementation of the program.

The AID Representative, with AID/W assistance mentioned above and the Ministry of Health's Office of International Coordination will make the determination as to whether necessary conditions precedent for subsequent dollar disbursements have been met or whether modifications of institutional and policy reform targets are needed. AID/W will be informed of the decision with necessary documentation to support the decision. Any decision involving substantive modifications of the program will be deferred to the LAC Bureau.

d. Reports

Initial Disbursement -

The Ministry of Health will prepare a formal descriptive report with supporting documentation for USAID which will present the status/achievement of the major benchmarks identified in Section V.F. (Benchmarks and Conditions Precedent) of this document.

Semi-annual -

The Ministry of Health will prepare 4 (four) descriptive reports at six month intervals for presentation to USAID/Chile which discuss the achievements and status of the Program for the Immediate Improvement of Primary Health Care. The Program Outputs/End of Project Status (EOPS) as specified in Section V.D. (Program Outputs) of this document, will serve as a basis for review of the Program and provide the parameters for the descriptive reports. The reports will be reviewed in the semi-annual meetings between MOH and USAID.

The final semi-annual report will serve as the final evaluation document. In addition to presenting an assessment of achievement of the End of Project Status (EOPS) as specified in Section V.D., the MOH will also

present information regarding impact at the program level as described in Section VII (MOH Monitoring/Evaluation System). Technical consultants will assist the MOH with preparation of a simple and quick methodology for "evaluating" the Program and establishing the status of achievements by end of program (December 1992).

Final Disbursement -

The Ministry of Health will prepare a formal descriptive report with supporting documentation for USAID/Chile approximately 12 months after the Initial Disbursement Report. The report will discuss the achievements and the status of the Program based on Program Outputs/EOPS. This Final Disbursement Report may fulfill the requirement for preparation of the first or second semi-annual report.

A joint review between USAID and the MOH will be held to discuss the status of the Program and to determine whether substantial progress has been made towards achievement of the institutional and policy reforms aimed at improving the efficiency and effectiveness of health care delivery at the primary care level.

2. Monitoring of Foreign Exchange and Local Currency

a. Ministry of Health

As described above in Section B. Dollar Transfer and Local Currency Procedures and Management, once conditions are met and dollars are disbursed by the U.S. Treasury to the separate account in the Central Bank of Chile or, possibly a correspondent bank in the U.S., the agent bank will take charge of the process of getting dollars released from the separate dollar account. The Central Bank will request import documentation from the commercial banks review such documentation and pass it to the MOH for its approval, which will pass it to A.I.D. for final validation. After documentation is validated and dollars can be released, the agent bank will buy Pesos from commercial banks and place them in a special account (within the agent bank).

The Agent Bank will prepare monthly reports on the dollar transactions, until such time as the full dollar transfer has been made. Such reports will contain the following: 1) a summary of the current month amounts requested for dollar transfer by eligible Chilean custom codes; 2) a status of transfers to-date by custom code and separated into public and private sector amounts; 3) a reporting of the banking institutions having financed the importation, by custom code, by to-date, and current month; and 4) an itemized accounting of

deposits made to the dollar Special Account as well as withdrawals for the purpose of buying local currency for deposit into the host country owned local currency Special Account.

However, the information will be maintained on a monthly basis and will be available to the MOH and A.I.D., if necessary.

On the local currency side, the peso account will be maintained at the agent bank and the agent bank will receive orders from the MOH on disbursing pesos to MOH current accounts for primary health care. The agent bank will be responsible for providing appropriate documentation to A.I.D. evidencing the withdrawal of funds from the Special Account and the deposit of funds to the MOH's normal account for Primary Health Care. Again, reports will be prepared on a monthly basis, and will contain the following information:

- 1) a summary of the current month host country owned local currency deposits to the Special Account indicating the date of deposit, supported by evidence of the sale of dollars released from the dollar Special Account at the highest rate of exchange legally available from the sale on the commercial money market; and
- 2) a summary of the host country owned local currency withdrawals from the Special Account and evidence of the transfer to the MOH account for the Primary Health Care Program.

b. USAID

The Office of the A.I.D. Representative/ Chile will be responsible for validating the import documentation releasing the dollars from the separate account. The office of the A.I.D. Representative will also review, provide feedback and accept the monthly reports described above.

The import documentation, as well as monthly reports will be subject to post review by the Controller's Office, USAID/Lima as well as independent auditors described under Section VI.E. Audit Plan and Financial Review. The LAC Bureau will not have a role in the review of financial documentation and reports, but will participate in technical reviews, as requested by USAID/Chile.

D. Implementation Plan

1. Institutional and Policy Reform:

The institutional and policy reform implementation schedule

is provided below with the assumption that the sector assistance program will have been authorized in November 1990.

| <u>Action</u> | <u>Date</u> |
|--|--------------------------------|
| Grant Agreement signed | November 1990 |
| Technical Assistance Project authorized | |
| Benchmarks for Initial Tranche submitted | |
| Joint meeting held to discuss achievements | |
| Phase I Technical Assistance visit | December 1990 |
| Program Coordinator identified and hired | |
| Phase I Technical Assistance - | January 1991 |
| Plan of Action presented and reviewed | |
| by MOH and USAID | |
| Phase II Technical Assistance - | January 1991 |
| PIO/Ts prepared by USAID for buy-ins to | |
| central AID/W projects | |
| Phase II Technical Assistance - | February 1991 |
| buy-ins completed by USAID | |
| Semi-annual Report submitted by MOH | June 1991 |
| Joint MOH/USAID review held | |
| Final Tranche prepared, | |
| semi-annual Report submitted by MOH | |
| and joint review held to discuss progress | December 1991 |
| Semi-annual Report submitted by MOH | May 1992 |
| Joint review held to discuss progress | |
| Final Evaluation completed | December 1992 |
| Final Program Report submitted | |
| Joint review held to discuss EOPS | |
| End of Program | December 1992- January 1993 |

2. Dollar and Local Currency Implementation

The dollar and local currency implementation plan is presented below:

| <u>Action</u> | <u>Date</u> |
|--|--------------------|
| First Disbursement of Dollars to Separate Account | early Dec. 1990 |

| | |
|--|-----------------------------|
| Financial Analysis of dollar and local currency management system | Dec. 1990 |
| Conditions Precedent for first tranche met | Dec. 1990 |
| Presentation of import documentation to release dollars | Jan. 1991 |
| Dollars released, converted to Pesos and put into non-commingled special account | Jan./Feb. 1991 |
| Pesos withdrawn from special account and enter MOH account, as needed | begin Feb. 1991, continuing |
| First monthly financial reports presented to A.I.D. | end of Feb. 1991 |
| CPA firm conducts financial review | June 1991 |
| As above, final tranche of dollars disbursed, after joint review of progress | Dec. 1991 |
| Dollars released, converted to Pesos and put into non-commingled special account | Dec/Jan. 1991 |
| Pesos withdrawn from special account and enter MOH account, as needed | begin June 1991, continuing |
| CPA firm does complete audit after first year of program | Jan. 1992 |
| CPA firm conducts financial review | June 1992 |
| CPA firm does complete audit after second year of program | Jan. 1993 |

E. Audit and Financial Review Plan

Audits and financial reviews will be phased to provide assurance that procedures and controls are effective in their application during implementation as well as annual compliance verifications. A financial review will be undertaken at the inception of the program to provide a financial analysis of the entity managing the dollar transactions and the Ministry of Health. A covenant in the grant agreement will assure that any recommendations resulting from the financial analysis will be implemented.

The first Non-Federal Audit will be performed at the end of the first year of operations, which will encompass the dollar transfers. The audit will examine implementation of recommendations of the First Financial Review. A follow-on financial review will be scheduled shortly thereafter to assure the effective application of any necessary remedial actions. Finally, a program close-out, Non-Federal Audit will be performed to coincide with the final program evaluation.

All of the financial reviews and Non-Federal Audits will be contracted by A.I.D. and will be in accordance with established criteria, including General Accounting Office and Generally Accepted Auditing Standards. Funding will be provided by the Grant (refer to Annex G. Section III.); the scopes of work for the financial reviews and Non-Federal Audits will be developed and competed according to standard Regional Inspector General (RIG) procedures.

VII. Ministry of Health Monitoring and Evaluation System

An information system which establishes a monitoring and evaluation process for both the Program for Immediate Improvement of Primary Health Care and the GOC's overall PHC program should have the following characteristics: formative, continuous, adapted to the objectives of the Program, participative, and specially suited to development of local health systems.

As a base, a monitoring and evaluation plan will be introduced which is appropriate for the Program for Immediate Improvement of Primary Health Care. This plan will be established with the following objectives:

General Objectives:

- To design and implement a baseline study that describes the actual conditions of Primary Care and which will permit annual monitoring and evaluation of the sector activities; and
- To develop a ongoing monitoring and evaluation system for Primary Care which will be useful in developing plans of action for the different levels of health care.

Specific Objectives:

- To define related indicators which permit the monitoring of the quality of Primary Care;
- To carry out a diagnosis of the problems of the Primary Care situation;
- To promote the joint participation of the relevant sectors with the purpose of working out a diagnosis of the problems;

- To identify the principal problems which are the obstacles to normal delivery of Primary Care;
- To incorporate monitoring and evaluation as permanent activities in the different levels of Primary Care; and
- To develop a process of formative evaluation.

In connection with the Department of Primary Care, the monitoring and evaluation process will provide useful information relative to the following aspects: coverage, impact, resources, access, and outcome. In addition, it is important to measure the degree of user satisfaction with the Primary Care Services, which may be reflected in the degree of community participation in health.

Some of the indicators that may be used to monitor and evaluate the actual status of the Program are as follows:

- Resources -

total health expenditures of the population; pharmaceutical expenditures per inhabitant; annual doctor hours per inhabitant; annual patient hours per inhabitant; auxiliary personnel hours per inhabitant (these indicators will be analyzed at the community level).

- Coverage -

hypertension, diabetes, alcoholism and epilepsy program coverage; immunization program coverage; screening for uterine cancer coverage; percentage of pregnant women who attend prenatal care during pregnancy (these indicators will be analyzed at the community level).

- Impact -

infant mortality and general mortality rates; principal causes of death; principal causes of morbidity; incidence of infectious diseases; annual number of medical consultations per inhabitant (indicators at the health service level).

- Access -

the number of persons denied service in relation to the number of persons seeking service; number of emergency service consultations versus the total number of consultations at the primary level; the number of emergency service consultations for non-emergency care versus total number of emergency service consultations (indicators at the health service level).

- Outcome -

number of referrals per 100 consultations; number of laboratory examinations per 100 consultations; waiting time for referrals and counter-referrals; waiting time for major laboratory tests (indicators at the community level).

- Satisfaction -

as a baseline, changes in user satisfaction with the services at the primary care facilities.

Developing an ongoing monitoring and evaluation process will allow regular semi-annual review and analysis of the Program. At the same time, this process will be useful for developing a standard "before and after" study model. This will facilitate decision-making and problem resolution processes and permit the timely incorporation of required programmatic changes.

A. Monitoring "Performance" of Institutional and Policy Reform Efforts

The indicators of performance criteria to which the semi-annual reports and final disbursement are tied are given in Section IV.D. These indicators are intended as targets toward which the institutional and policy reform program will move. The concept of "program performance" includes three successive levels of objectives - policy adoption, policy implementation, and direct effects of implementing the policy changes.

B. Monitoring "Impact" at the Program Level

All institutional and policy reform measures can be expected to have their ultimate impact in terms of changes of health status or institutional changes (e.g. the impact on the efficiency and effectiveness of health services). The monitoring and evaluation system described above will provide data sets on these indicators and on the most common intermediate indicators. Examples might include resources, coverage, access, outcome, and/or satisfaction indicators as identified on the previous page. These indicators will provide the information for the Final Evaluation/Reporting required by USAID.

VIII. Compliance with Cash Transfer and Local Currency Guidance

The Program was designed with close attention to existing cash transfer and local currency guidance, and with the draft

local currency guidance expected to be released before December, 1990. Essential dollar transfer guidance is contained in State 050845 (Oct. 1987-incorporated in HB 1 Part IV) and State 194322 issued June, 1990. Local currency guidance is contained in State 327494, Supplemental Guidance on Programming Local Currency (Oct. 1987 also incorporated in HB 1 Part IV) and State 313159, LAC Supplemental Host Country Owned Local Currency Guidance.

A. Compliance with Dollar Guidance

On the dollar side, the Program is consistent with the guidance in the following ways (according to the requirements in State 194322, Financial Management Guidance on Dollar Separate Accounts for ESF Cash Transfers and ESF, DA and DFA-funded Non Project Sector Assistance Cash Disbursements):

-The specific uses of the dollars is identified: the dollars will be used for financing health imports, using reimbursement.

-Dollars will be deposited into a interest bearing, separate account, within 48 hours of disbursement by U.S. Treasury.

-Interest earned will be programmed as principal.

-A financial assessment of the host country managing the separate dollar account will be completed, but not until after obligation of program funds. This assessment will be funded by the Technical Assistance Project under the Program, since the program is the only possible source to fund the assessment. It is also assumed that this is acceptable in an ADC which has sophisticated financial management practices.

-The GOC will implement any recommendations resulting from the financial assessment.

-The GOC will provide monthly reports on the dollar account.

-Audits will be conducted once a year, with interim financial reviews every six months.

B. Compliance with Local Currency Guidance

Local currency procedures are consistent with the Local Currency Guidance cited above, as follows (following State 313159, LAC Supplemental Guidance):

-Local currency will deposited into a interest bearing separate account.

-Local currency will be programmed according to agreement with the GOC-the program will be described in the grant agreement.

-A.I.D. is satisfied that GOC programming and budgeting systems provide assurance that primary health care objectives of the program will be achieved.

-Programming for primary health care is consistent with the FAA.

-Monitoring procedures have been reviewed with the GOC. A.I.D. will monitor local currency account transactions on a monthly basis, and technical progress, formally on a semi-annual basis.

-As with dollar transactions, A.I.D. will receive monthly reports on local currency account transactions, in addition to semi-annual technical reports.

C. Compliance with Draft Guidance

The draft local currency guidance is similar to the existing guidance, with the exception that the draft guidance requires that the following assessments be performed prior to or during the design stage: 1) general assessment of host country financial management and contracting capabilities and 2) a financial assessment of the institution receiving the local currency. The program, as designed, conforms to the draft guidance: i.e. local currency will be for general sector support, there will be a separate account, reporting and auditing requirements are met, etc.

However, it will not be possible to conduct a general assessment of the Government of Chile's financial management and contracting capabilities prior to the completion of the PAAD. The same is true of the financial assessment of the institution managing/receiving the local currency (presumably the Ministry of Health). In the case of the former, guidance on the content of the general assessment remains to be issued. Such guidance seems to be appropriate for full missions. Clarification may be needed on how to apply general assessments to Advanced Developing Countries such as Chile and Colombia where A.I.D. has small AID Representative Offices and financial and contracting systems of the host countries are presumably sophisticated and very sound.

The financial assessment of the Ministry of Health and any other entity involved in managing/receiving the local currency will have to be done after funds are obligated. This is principally for funding reasons-the AID Representative does not have PD&S to pay for a CPA firm to conduct the assessment. Also, it is presumed ADC institutional capabilities are sophisticated. Strictly speaking, the current local currency guidance, which does not require a financial assessment of the institution receiving local currency, applies to the design of this PAAD. However, the assessment will be conducted and the

draft guidance will be adhered to, but after signing of the grant agreement.

D. Other Considerations

Neither the dollar nor the local currency guidance stipulate that local currency must be deposited simultaneously with the disbursement of dollars to the separate dollar account. The GOC has been advised that this is AID's preference, but has expressed some doubt on whether this is possible from a Treasury/budgetary standpoint. At any rate, the government has agreed that local currency will be deposited into the special account at the time dollars are released from the dollar account.

AID's concern is that dollars disbursed from the U.S. Treasury are expeditiously used for their intended purposes. The probability of this occurring is very good since imports for the health sector total some \$200 million per annum and the GOC must present documentation for reimbursement for less than \$10 million worth of imports. The documentation should be presented quickly after each disbursement to the separate dollar account. Similarly, local currency drawdown from the special account should also be expeditious since the program is short term and the GOC expects to expend approximately \$27 million on the program over two years. However, drawdowns from the special peso account will not be made as quickly as from the separate dollar account, since local currency drawdowns will depend on implementation of the program.

IX. Conditions and Covenants

A. Conditions

1. First Tranche: U.S. 5.8 Million

Prior to the disbursement of the first tranche (expected to be effected in December, 1990), the GOC will comply with the standard conditions precedent (legal opinion and authorized representatives), as well as with the conditions described below for the cash transfer portion of the grant. The technical assistance project will have only the standard conditions listed above in order to facilitate expeditious technical assistance, project coordination and auditing services.

- Establishment of a separate account and a special account for the deposit of the U.S. dollar and Chilean Peso proceeds of the grant, respectively;
- Provision to A.I.D. of the procedures governing how the dollars and pesos will be handled;

- Documentation (i.e. a report) evidencing that the following benchmarks have been achieved:
 - New Agreements will be signed between the Health Service Areas (HSAs) and Mayors in at least 85% of the priority 104 rural and 24 urban municipalities. These Agreements would reflect the agreement between these authorities and the Ministry of Health on the goals to be achieved with the increased funding available for Primary Health Care.
 - Establishment of at least 11 of the 13 24-Hour Emergency Services planned for selected urban consultorios in the first phase of the PII/PHC Program. Such services will provide previously unavailable emergency health care in underserved areas, reducing congestion both in the consultorios' regular daily hours as well as in the local hospital emergency room.
 - Extension of hours in 100% of the 38 consultorios selected to include as third shift (during the first phase of the PII/PHC Program). These extended hours will allow greater access to primary health care services by the working public.
 - Hiring of at least 50% of the 28 additional medical professionals planned for the first phase of the PII/PHC Program in order to strengthen the technical supervisory capacity of the Directorates of Primary Care (DAPs) of the 18 Health Service Areas (HSAs) which contain the 104 priority rural municipalities

2. Second Tranche: U.S. 3.5 Million

Prior to the disbursement of the second tranche, tentatively scheduled to be effected by Dec., 1991, the GOC will have attained progress, based on joint review by GOC and AID, in implementing the Program for the Immediate Improvement of Primary Health Care. The joint review will measure progress attained in achieving the outputs described in Section V.D. Program Outputs.

B. Covenants

The Government of Chile will covenant to implement recommendations identified in the Non-Federal Audits and Financial Reviews.

The Government of Chile will covenant to implement any recommendations identified and mutually agreed upon in the institutional and policy reform semi-annual reviews.

10/11/90:CHILE

REPUBLICA DE CHILE.
MINISTERIO DE SALUD.
DEPTO DE ATENCION PRIMARIA.

PROGRAMA DE ATENCION PRIMARIA - 1991.

I - MARCO CONCEPTUAL :

El marco conceptual del Programa de Atención Primaria (APS) está definido en el documento base " Principios generales y tareas específicas del Primer Año de Atención Primaria ". Sin embargo parece importante hacer énfasis en los siguientes aspectos :

1 - La APS es tarea-objetivo prioritaria del Sistema de Salud dentro de las acciones tendientes al "pago de la deuda social" tal como ha sido definido en los documentos programáticos de la Concertación y en innumerables intervenciones públicas del Presidente Aylwin.

2 - La APS está orientada a toda la población para favorecer una mejor calidad de vida, donde este asegurada la satisfacción de las necesidades de salud de los sectores mas pobres (tradicionalmente postergados).

3 - La APS promueve la programación, gestión y evaluación fundamentalmente en el nivel local, apoyando de esta manera el proceso de descentralización progresiva del sector Salud.

4 - La APS promueve la participación social a través de la creación de los Consejos Comunales en un intento por reforzar el enfoque intersectorial.

5 - La APS recoge la problemática de salud mas sentida por la comunidad y orienta sus acciones en la perspectiva de ofrecer soluciones coherentes y realistas.

El problema fundamental de APS para 1991 radica en la desproporción que existe aún, a pesar de los recursos asignados durante el 2o semestre de 1990, entre, por un lado, las necesidades sentidas o expresadas por la población, que traducen el considerable daño en salud incluido el medio ambiente y, por otro lado, la disponibilidad de recursos humanos y financieros. Es por ello que nos parece esencial lograr :

- Una expansión del aporte global al Programa de Atención Primaria para 1991 que permita el cumplimiento de los objetivos que se indican mas adelante ;

- Una asignación eficiente, basada en los diagnósticos locales de la situación de salud y de los recursos disponibles.

La APS se constituye entonces en una estrategia global (bio-psico-social) que se propone resolver el problema de salud de las poblaciones mediante la reorientación y reorganización de todos los recursos (los disponibles mas los necesarios) para satisfacer las aspiraciones de toda la sociedad, en función de los requisitos de la Salud Para Todos en el Año 2.000.

II - OBJETIVOS.

1) OBJETIVOS GENERALES:

1.1. Desarrollar en forma integral el programa de Atención Primaria de Salud (APS) a nivel de todo el país, con énfasis en la extensión de cobertura y en la diversificación de los programas, integrando aquellos incluidos en el programa de Salud de la Concertación y que no han sido cubiertos hasta ahora.

1.2. Lograr un desarrollo armónico de la APS urbana y rural en el contexto de servicios y regiones, con el objeto de eliminar las distorsiones que se han observado hasta ahora.

2) OBJETIVOS ESPECÍFICOS:

2.1. Implementar las medidas tendientes a mejorar la calidad de la atención en el nivel primario, haciendo que ésta sea más sectorizada y con mayor capacidad resolutoria.

2.2. Consolidar un diagnóstico acabado a nivel comunal de las necesidades y de la situación del sector salud, con énfasis en los grupos prioritarios: niño menor de 5 años, adolescente, mujer, trabajadores y medio ambiente.

2.3. Dar un fuerte impulso a la participación en salud a través de la creación y consolidación de instancias tales como los Consejos Comunales de Salud en las 330 comunas del país u otras instancias de participación existentes o que se generen.

2.4. Dar un fuerte impulso a la Coordinación Intersectorial, con énfasis en el nivel comunal, poniendo en marcha proyectos integrados de desarrollo, particularmente en las 104 comunas rurales más postergadas.

2.5. Reforzar considerablemente la Educación para la Salud/ Comunicación Social en términos de APS y de los programas prioritarios, con énfasis en el nivel local y utilizando una metodología adaptada a las necesidades locales.

2.6. Preparar e implementar el reemplazo legal del FAPEM por una medida de asignación de recursos financieros en APS per cápita que tienda a asegurar la satisfacción de las necesidades de la APS.

2.7. Implementar con el personal de APS las medidas que el Ministerio de Salud elabore en cuanto a nueva Carrera funcionaria de los profesionales médicos y paramédicos.

2.8. Reforzar las actividades iniciadas en las áreas de validación en las comunas de La Florida y Conchalí en la perspectiva de concretizar la experiencia de Sistemas Locales de Salud.

2.9. Continuar reforzando la Capacitación del Personal de Atención Primaria, con énfasis en el nivel local y utilizando la estrategia participativa.

III) ESTRATEGIA :

1.) Definición de incremento de cobertura:

a) Consolidación en 1991 de la cobertura lograda en el 2o semestre de 1990 en las 24 comunas urbanas y las 104 comunas rurales (Ver Lista en Anexos No 1 y 1 A).

b) Aumento de la cobertura a 32 comunas intermedias en el sector urbano y peri-urbano (Ver Lista en Anexo No 2).

2.) Definición de los Programas y de las actividades que se van a implementar:

a) Extensión de la APS básica: Salud Materno-Infantil, Medicina General, Programa de crónicos, Enfermería, etc.

b) Implementación de Programas nuevos orientados a grupos prioritarios, tradicionalmente postergados:

- Salud Mental
- Salud laboral
- Medio Ambiente
- Mujer Trabajadora
- Adolescente embarazada.
- Adulto mayor.

3.) Coordinación con el Departamento de Programación para la implementación de los diferentes programas, especialmente los de Educación para la Salud/Comunicación Social y Salud Mental.

4.) Coordinación con los diferentes Ministerios a nivel regional (Seremis) para la implementación de los proyectos de desarrollo a nivel local, especialmente en las 104 comunas prioritarias.

5.) Realización de algunas Jornadas movilizadoras de APS en algunos temas específicos : se sugiere realizar en 1991 una Jornada Nacional por el Medio Ambiente que incluya la realización de tareas tales como plantación de árboles, enterrar basuras en barrios periféricos, desratizaciones, etc.

Igualmente se pudiera discutir con el Departamento de Programación la realización de Jornadas Regionales o Comunales de Vacunación contra el Sarampión en 1991 en aquellas comunas que presentan bajas coberturas de vacunación en 1989. (Planteamientos hechos por el Pdte Aylwin en su Mensaje del 21/05/1990).

6.) Las actividades propuestas en este documento se enmarcan dentro de lo que ha sido el planteamiento inicial del Depto de Atención Primaria en cuanto a ampliar de manera urgente este nivel de atención para hacer frente a las necesidades mas importantes y mas sentidas por la población y dentro de las limitaciones

presupuestarias planteadas por el Ministerio de Hacienda para 1991; igualmente están hechas dentro del marco actual de elaboración del presupuesto del Ministerio, en la perspectiva de sólo ampliar los techos del FAPEM y los convenios actuales con las Municipalidades, procedimientos que deseáramos ver modificados en el curso de 1991.

7.) Implementación progresiva en 1991 en el personal de Atención Primaria de las proposiciones de Carrera Funcionaria elaboradas por el Departamento de Recursos Humanos, una vez que hayan sido legalmente aprobados por el Ministerio.

8.) Implementación legal en 1991 de un texto que incentive la creación de Consejos Comunales de Salud u otros mecanismos que den cauce a la participación en salud, de acuerdo a los cánones legales vigentes.

9.) El Plan de Acción de APS en 1991 continuará apoyándose en las Direcciones de Atención Primaria (DAP) de cada Servicio como elemento fundamental para la implementación del Programa y continuará apoyando la creación y el reforzamiento de éstos en aquellos Servicios donde aún están débiles o no constituidos.

ANEXO No 1.

PROGRAMA DE REFORZAMIENTO DE ATENCION PRIMARIA EN
COMUNAS DE MAYOR RIESGO EN 1990.

SERVICIOS DE SALUD.

- 1) Metrop. Oriente
- 2) Metrop. Sur-Oriente
- 3) Metrop. Sur
- 4) Metrop. Central
- 5) Metrop. Occidente
- 6) Metrop. Norte
- 7) Valparaíso
- 8) Viña del Mar
- 9) Concepción
- 10) Temuco

COMUNAS PRIORITARIAS.

- Barnechea
Peñalolén.
- Florida
Pintana
Puente Alto
San Ramón.
- Cisterna
El Bosque
Lo Espejo
San Joaquín
Pedro Aguirre Cerda
San Bernardo
- Estación Central
Maipú
- Cerro Navia
Pudahuel
Renca
Lo Prado
- Conchalí
Huechuraba
- Valparaíso
- Viña del Mar
- Concepción
- Temuco

LISTADO DE CONSULTORIOS POR SERVICIO, COMUNA
Y ACTIVIDADES.

| <u>SERVICIO.</u> | <u>CONS C/IMPLEMENTAC.</u> <u>DE PERSONAL.</u> | <u>TERCER TURNO</u> | <u>SAPU.</u> |
|-----------------------|---|---|----------------------------------|
| 1) METROP. SUR. | La Feria Joao Goulart Cóndores de Chile San Bernardo Conbrat Carol Urzúa San Joaquín (7) | Dávila Sor Teresa Valledor 3 Cisterna Sur Santa Anselma Julio Acuña P. (6) | Santa Anselma |
| 2) METROP. SUR-OP. | La Granja La Bandera Pablo de Rokha San Rafael Stgo del Nvo Extremo Bellavista Villa O'Higgins Los Castaños Los Quillayes Alep. del Río San Gregorio. (11) | La Granja La Bandera Los Castaños Villa O'Higgins San Rafael (Doble turno) (5) | Los Quillayes. |
| 3) METROP. ORIENTE | La Faena Rosita Renard (2) | San Luis de Peñal. Sta Julia. (2) | Lo Barnechea (*) Aristía (*) |
| 4) METROP. NORTE. | Lucas Sierra Quinta Buin Pincoya Eneas Gonell A. Scroggie J. Symon Valdivieso (6) | Lucas Sierra Quinta Buin Pincoya Scroggie (4) | Lucas Sierra |
| 5) METROP. OCCID. | Sta Anita R. Yazigi C. Avendaño A. Steeger C. Albertz Pudahuel. La Estrella. Renca. Huamachuco. (9) | R. Yazigi C. Avendaño A. Steeger C. Albertz Pudah. Poniente Huamachuco (6) | Renca Pudahuel Cerro Navia |

* = ya en funcionamiento.

| | | | |
|--------------------|---|---|------------------------|
| 6) METROP. CENTRAL | Maipú Los Nogales Lo Valledor (3) | Maipú Los Nogales Cerrillos (3) | San José Chuchunco. |
| 7) VALPA-RAISO | Mena Quebrada Verde Reina Isabel Los Placeres Plaza Justicia Rodelillo Puertas Negras. (7) | Reina Isabel Los Placeres (2) | Quebrada Verde |
| 8) RIVIRA DEL MAR | Nueva Aurora Miraflores Gómez Carreño Lusitania (4) | Nueva Aurora Canal Beagle Miraflores Forestal (4) | Concón(*) |
| 9) CONCEP. | O'Higgins Tucapel Costanera San Pedro Lorenzo Arenas Chiguayante (6) | San Pedro Tucapel (2) | Chiguayante |
| 10) TEMUCO | Pueblo Nuevo Padre Las Casas Las Quilas Villa Alegre Santa Rosa Miraflores (6) | Pueblo Nuevo Padre Las Casas (2) | Miraflores |

TOTALES.

- 1 - CONSULTORIOS CON AUMENTO DE PERSONAL : 61.
- 2 - CONSULTORIOS CON TERCER TURNO : 36.
- 3 - CONSULTORIOS CON SAPU : 13 (de los cuales 3 están ya en funcionamiento).

(*)= ya en funcionamiento.

ANEXO No 2.

22 COMUNAS PROPUESTAS PAR BENEFICIAR DE APOYO APS EN 1991.

| <u>COMUNAS.</u> | <u>POBLACION (30/06/1990).</u> |
|-------------------|--------------------------------|
| 1) ARICA | 191.803 |
| 2) IQUIQUE | 149.482 |
| 3) ANTOFAGASTA | 219.291 |
| 4) CALAMA | 116.709 |
| 5) COPIAPO | 80.241 |
| 6) OVALLE | 84.562 |
| 7) COQUIMBO | 115.158 |
| 8) LA SERENA | 116.738 |
| 9) SAN FELIPE | 50.572 |
| 10) LOS ANDES | 50.669 |
| 11) CHILLIOTA | 64.400 |
| 12) QUILPUE | 108.289 |
| 13) RANCAGUA | 195.305 |
| 14) SAN FERNANDO | 49.245 |
| 15) TIERRAS | 106.091 |
| 16) TALCA | 177.952 |
| 17) DAVOGENES | 40.796 |
| 18) LINARES | 70.528 |
| 19) PHILLAN | 159.665 |
| 20) TALCAHUANO | 247.312 |
| 21) LOTA | 44.416 |
| 22) PORCNEI | 76.309 |
| 23) LOS ANGELES | 134.522 |
| 24) LEBU | 25.553 |
| 25) ANCOH | 44.072 |
| 26) VALDIVIA | 101.911 |
| 27) BIFORME | 133.156 |
| 28) FUERTE MONTE | 122.413 |
| 29) ANQUE | 33.434 |
| 30) CASTRO | 29.858 |
| 31) COYHAIQUE | 49.818 |
| 32) PUNTA ARENAS | 123.373 |
| TOTAL POBLACION : | 3.333.543 |

65

GOVERNMENT OF CHILE
 PRIMARY HEALTH CARE PROGRAM
 IMPLEMENTATION PLAN
 (1990 - 1992)

| USES | 90 | | | | 91 | | | | 92 | | | | |
|---|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|
| | OCT | JAN | APR | JUL | OCT | JAN | APR | JUL | OCT | JAN | APR | JUL | OCT |
| I. IMPROVED ADMIN. & SUPERVIS. CAP. OF FHC | | | | | | | | | | | | | |
| 1.1 ASSIGNMENT OF PERSONNEL | X | X | | | | | | | | | | | |
| 1.2 SIGMO (MIS) STUDY | X | X | X | | | | | | | | | | |
| 1.3 SIGMO (MIS) IMPLM. | | | | X | X | X | X | X | X | X | X | X | X |
| 1.4 STUDY OF ADMIN. AND SUPPLY. AT REG. LEVEL | | X | X | | | | | | | | | | |
| 1.5 FHC COST STUDY | | X | X | | | | | | | | | | |
| II. IMPROVED FHC RESOLUTION CAPACITY | | | | | | | | | | | | | |
| 2.1 PHARMACEUTICALS DELIV. | X | X | X | X | X | X | X | X | X | X | X | X | X |
| 2.2 BASIC EQUIPMENT DELIV. | X | X | X | X | X | X | X | X | X | X | X | X | X |
| III. IMPROVED ACCESS TO PRIMARY HEALTH CARE | | | | | | | | | | | | | |
| 3.1 FREE FHC SERVICES | X | | | | | | | | | | | | |
| 3.2 HEALTH PROMOTION IN RURAL SECTORS | X | X | X | X | X | X | X | X | X | X | X | X | X |
| 3.3 BAPL INCLUDING AMBULL. | X | X | X | X | X | X | X | X | X | X | X | X | X |
| 3.4 THIRD SHIFTS | X | X | X | X | X | X | X | X | X | X | X | X | X |
| 3.5 MOBILE UNIT S | X | X | X | X | X | X | X | X | X | X | X | X | X |
| 3.6 AMBULANCES AND RADIO | X | | | | | | | | | | | | |
| 3.7 NGOs | | X | X | X | X | X | X | X | X | X | X | X | X |
| IV. INNOVATIVE PROGRAMS | | | | | | | | | | | | | |
| 4.1 MENTAL HEALTH - Pilot | | X | X | X | X | X | X | X | X | X | X | X | X |
| 4.1 MENTAL HEALTH - Impl. | | | | | | | X | X | X | X | X | X | X |
| 4.2 HUMAN RIGHTS | | X | X | X | X | X | X | X | X | X | X | X | X |
| 4.3 FAMILY HEALTH - Pilot | | X | X | X | X | X | X | X | X | X | X | X | X |
| 4.3 FAMILY HEALTH - Impl. | | | | | | | X | X | X | X | X | X | X |
| 4.4 HEAL. HEAL. - SERVICE | | X | X | X | X | X | X | X | X | X | X | X | X |
| 4.5 AGED HEALTH SERV. - Pil. | | X | X | X | X | X | X | X | X | X | X | X | X |
| 4.5 AGED HEALTH SERV. - Impl. | | | | | | | X | X | X | X | X | X | X |
| 4.6 HEALTH EDUCATION - Pil. | | X | X | X | X | X | X | X | X | X | X | X | X |
| 4.6 HEALTH EDUCATION - Impl. | | | | | | | X | X | X | X | X | X | X |
| 4.7 CHRONIC ILLNESSES - Pil. | | X | X | X | X | X | X | X | X | X | X | X | X |
| 4.7 CHRONIC ILLNESSES - Impl. | | | | | | | X | X | X | X | X | X | X |
| 4.8 YOUTH AND ADUL. - Pil. | | X | X | X | X | X | X | X | X | X | X | X | X |
| 4.8 YOUTH AND ADUL. - Impl. | | | | | | | X | X | X | X | X | X | X |
| 4.9 OTHER INNOV. PROGRAMS | | | | | | | X | X | X | X | X | X | X |
| V. MONITORING AND EVALUATION SYSTEM | X | X | X | X | X | X | X | X | X | X | X | X | X |
| VI. TECHNICAL ASSISTANCE | | X | X | X | X | X | X | X | X | X | X | X | X |

96

PRIMARY HEALTH CARE PROGRAMS
 SOUTH AFRICA 1990-1992
 (US\$000)

| USES | 1990 | | | 1991 | | | 1992 | | | TOTAL | | |
|---|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|
| | GOC | AID | OTHER |
| I. IMPROVED ADMIN. & SUPERVIS. CAP. OF FHC | | | | | | | | | | | | |
| 1.1 ASSIGNMENT OF PERSONNEL | 0.80 | | | 0.28 | | | 0.88 | | | 2.07 | | |
| 1.2 STAFF | | | | | 10.09 | | | | | | 10.09 | |
| 1.3 STUDY OF ADMIN. AND SUPERV. AT REG. LEVEL | | | | | 10.07 | | | 10.08 | | | 10.15 | |
| II. IMPROVED FHC RESOLUTION CAPACITY | | | | | | | | | | | | |
| 2.1 PHARMACEUTICALS | 2.20 | | | 2.22 | | | 2.22 | | | 6.64 | | |
| 2.2 BASIC EQUIPMENT | | 1.00 | | | 10.50 | | | | | | 1.50 | |
| 2.3 RESOURCE ALLOCATION | | | | | 10.05 | | | 10.05 | | | 10.10 | |
| III. IMPROVED ACCESS TO PRIMARY HEALTH CARE | | | | | | | | | | | | |
| 3.1 FREE FHC SERVICES | 2.00 | | | 2.20 | | | 2.20 | | | 6.40 | | |
| 3.2 HEALTH PROMOTION IN RURAL SECTORS | | | | | 10.67 | | | 10.67 | | | 1.30 | |
| 3.3 SAHO INCLUDING AMBUL. | 1.00 | 0.40 | | | | | | | | 1.00 | 0.40 | |
| 3.4 THIRD SHIFTS | 0.70 | | | 0.22 | | | 0.22 | | | 0.98 | | |
| 3.5 MOBILE UNITS | 0.00 | | 1.90 | 1.20 | | | 1.20 | | | 2.70 | | 1.80 |
| 3.6 AMBULANCES AND RADIOS | | | 0.20 | | | | | | | | 2.00 | |
| 3.7 NROs | | | | | 10.80 | | | 11.20 | | | | 0.50 |
| IV. INNOVATIVE PROGRAMS | | | | | | | | | | | | |
| 4.1 MENTAL HEALTH | | | | | 10.57 | | | 10.19 | | | 0.92 | |
| 4.2 HUMAN RIGHTS | | | | | 10.25 | | | 10.27 | | | 0.55 | |
| 4.3 FAMILY HEALTH | | | | | 10.12 | | | 10.12 | | | 0.24 | |
| 4.4 WEST. HEALTH SERVICE | | | | 0.01 | 10.25 | | 0.01 | 10.25 | | 0.02 | 0.50 | |
| 4.5 AGED HEALTH SERVICES | | | | 0.20 | 10.48 | | 0.20 | 10.12 | | 0.40 | 0.61 | |
| 4.6 HEALTH EDUCATION | | | | | 10.05 | | | | | | 0.05 | |
| 4.7 CHRONIC ILLNESSES | | | | | 10.15 | | | 10.15 | | | 0.20 | |
| 4.8 YOUTH AND ADOLESCENTS | | | | | 10.15 | | | 10.15 | | | 0.20 | |
| 4.9 OTHER INNOV. PROGRAMS | | | | | 10.20 | | | 10.19 | | | 0.29 | |
| V. MONITORING & EVAL. OF FHC PROG. | | | | | | | | | | | 0.1 | |
| VI. TECHNICAL ASSISTANCE | | | | | 10.25 | | | 10.25 | | | 0.50 | |
| TOTALS | 16.80 | 11.40 | 2.20 | 17.04 | 14.67 | 0.00 | 17.04 | 17.91 | 0.00 | 20.68 | 10.00 | 2.70 |

| Narrative Summary | Objectively Verifiable Indicators | Means of Verification | Assumptions |
|---|--|--|---|
| <p><u>Program or Sector Goal:</u> To improve the quality of life of the Chilean population.</p> | <p><u>Measures of Goal Achievement:</u> Continued reduction/maintenance of infant and child morbidity and mortality rates.</p> | <p>GOC statistics and reports, other organizations reports (IBRD, BID), and independent evaluations; data collected through MOH management information system.</p> | <p>GOC continues to promote strategies o improved health status through primar and preventive care.</p> <p>Economic, political and social conditions do not detrimentally affect target groups.</p> |
| <p><u>Program Purposes (Specific Objectives):</u></p> | <p><u>End of Project Status (EOPS):</u></p> | <p>GOC reports, records, evaluations, and special studies.</p> <p>Review of GOC semi-annual reports; joint review meetings.</p> | <p>GOC commitment to institutional and policy reforms continues.</p> <p>GOC supports studies and operations research which would help to formulate health financing policies and improved delivery of PHC services</p> <p>Host country institutions have adequate funding and absorptive capacity to fund and manage PHC programs.</p> <p>Adequate funding is available for programs and models which will utilize information provided by these activities.</p> <p>Local currency component from this program used to finance activities and purchase equipment/medical supplies which contribute to improved health status.</p> |
| <p>1. To improve access to primary health care of the Chilean population, especially the poorest sectors, located in dispersed rural areas and marginal urban concentrations.</p> | <p>Application of technology and information are reflected in increased access to PHC of the poorest sectors.</p> | <p>GOC reports, records, evaluations, and special studies.</p> | <p>GOC commitment to institutional and policy reforms continues.</p> <p>GOC supports studies and operations research which would help to formulate health financing policies and improved delivery of PHC services</p> |
| <p>2. To improve the quality of and opportunity for health care services through an increase in the capacity for health care problem resolution at the primary care level.</p> | <p>Application of technology and information are reflected in improved quality of and opportunity for health services.</p> | <p>Review of GOC semi-annual reports; joint review meetings.</p> | <p>Host country institutions have adequate funding and absorptive capacity to fund and manage PHC programs.</p> <p>Adequate funding is available for programs and models which will utilize information provided by these activities.</p> <p>Local currency component from this program used to finance activities and purchase equipment/medical supplies which contribute to improved health status.</p> |

| Narrative Summary | Objectively Verifiable Indicators | Means of Verification | Assumptions |
|--|--|---|---|
| <u>Outputs:</u> | <u>Conditions Indicating Outputs Have Been Achieved:</u> | | |
| <u>Institutional and Policy Reforms-</u> | | | |
| 1. <u>Strengthening Primary Health Care in Rural and Urban Communities Accompanied by Improvement of Administrative and Supervisory Capacity of PHC.</u> | <p>Reestablishment and reinforcement of a functional system of technical supervision of the municipalized primary care system by the Directorates of Primary Health Care (DAPs) in each Health Service Area including:</p> <ul style="list-style-type: none"> - DAPs reconstituted and assigned personnel, vehicles, operating expenses and training resources; - New Agreements signed between the Health Service Areas and the local Mayors which include agreements on specific PHC activities and supervisory responsibilities; and - Personnel of DAPs and municipalized PHC system trained in implementation of supervisory system. | <p>Review of GOC semi-annual reports; joint review meetings.</p> <p>Data collection from MOH management information system.</p> | <p>GOC commitment to institutional and policy reforms continues.</p> <p>GOC supports studies and operations research which will help to formulate health financing and management policies and improved delivery of PHC services.</p> <p>Required technical services are available.</p> |

| Narrative Summary | Objectively Verifiable Indicators | Means of Verification | Assumptions |
|-------------------|--|-----------------------|-------------|
| | <p>Establishment of a new system for resource allocation for the PHC system including:</p> <ul style="list-style-type: none"> - Studies of actual costs of each type of primary care service completed in a representative sample of PHC centers in small urban and metropolitan populations. <p>A management information system (MIS) for the PHC level designed, tested and implemented in priority Health Service Areas in order to provide accurate and timely data to support planning and management, the new supervisory role of the DAPs, and resource allocation decisions.</p> <p>Morale of municipalized PHC personnel improved through:</p> <ul style="list-style-type: none"> - Motivational training completed; - Feasibility studies completed on potential for establishing a career civil service for PHC workers in the municipalities; and | | |

| Narrative Summary | Objectively Verifiable Indicators | Means of Verification | Assumptions |
|--|--|---|---|
| | - Adequate equipment and supplies available so that personnel can perform their duties. | | |
| 2. <u>Improvement of Technical Problem-Solving Capacity in PHC Centers</u> | Basic diagnostic equipment available and basic diagnostic laboratories established and equipped in priority PHC areas. | Review of GOC semi-annual reports; joint review meetings. | GOC commitment to institutional and policy reforms continues. |
| | Design, testing, and implementation of technical training programs for PHC personnel in priority areas in the use and maintenance of basic diagnostic equipment. | Data collection from MOH management information system. | Required technical services are available. |
| | | | GOC supports studies and operations research which will help to formulate health financing and management policies and improved delivery of PHC services. |
| 3. <u>Improved Access to PHC</u> | A list of NGOs providing parallel PHC services compiled; development of an instrument to accredit, select, and contract NGOs to provide PHC services in cooperation with both HSAs and the municipalities. | Review of GOC semi-annual reports; joint review meetings. | GOC commitment to institutional and policy reforms continues. |
| | Pilot programs for PHC service delivery by selected NGOs established and tested in priority urban areas. | Data collection from the MOH management information system. | GOC supports studies and operations research which will help to formulate health financing and management policies and improved delivery of PHC services. |
| | | | Required technical services are available. |

| Narrative Summary | Objectively Verifiable Indicators | Means of Verification | Assumptions |
|--|--|---|---|
| 4. <u>Innovative Programs in Primary Health Care</u> | <p>Thirteen planned 24-Hour Emergency Services (SAPUs) established and pilot tested for effectiveness and efficiency in low-income urban areas; completion of a model for expansion of SAPUs to additional consultorios.</p> <p>An additional (third) shift established in at least 38 priority PHC centers; evaluation of the model for expansion to additional consultorios.</p> | <p>Review of GOC semi-annual reports; joint review meetings.</p> <p>Data collection from the MOH management information system.</p> | <p>GOC commitment to institutional and policy reforms continues.</p> <p>GOC supports studies and operations research which will help to formulate health financing and management policies and improved delivery of PHC services.</p> <p>Required technical services are available.</p> |
| | <p>An evaluation completed of the ongoing University affiliated pilot training program for Family Health Practitioners; extension of this training to actual PHC service delivery.</p> | | |
| | <p>A pilot service delivery model for caring for the elderly, including chronic disease monitoring, developed and tested; a refined model for elderly care approved for use and replication in the PHC system.</p> | | |

| Narrative Summary | Objectively Verifiable Indicators | Means of Verification | Assumptions |
|-------------------|---|-----------------------|-------------|
| | Community Health Councils and community support systems (SICOS) established and functioning in at least 80% of the priority municipalities. | | |

Inputs:

| | <u>(\$000)</u> |
|--|---------------------|
| <u>Cash Transfer and Equivalent Local Currency Program</u> | 9,300 |
| <u>Dollar Project</u> | 700 |
| 1. Technical Assistance (500) (including evaluation) | |
| 2. Program Support (FSN/PSC) (100) | |
| 3. Audit/Financial Review (100) | |
| Total | <u>\$10,000</u> |

Annex C

CERTIFICATION PURSUANT TO SECTION 611 (e) OF
THE FOREIGN ASSISTANCE ACT OF 1961, AS AMENDED

I, Paul Fritz, the Principal Officer of the Agency for International Development in Chile, having taken into account, inter alia, the maintenance and utilization of Projects in Chile previously financed or assisted by the United States, do hereby certify that, in my judgement, Chile has both the financial capability and the human resources capability to effectively implement and execute the proposed Program for the Immediate Improvement of Primary Health Care.

This judgement is based upon the Program Assistance Approval Document and is subject to the conditions imposed therein.

Paul Fritz
A.I.D. Representative, Chile

11.01.61
Date

64

AGENCY FOR INTERNATIONAL DEVELOPMENT

WASHINGTON D C 20523

LAC-IEE-91-06

ENVIRONMENTAL THRESHOLD DECISION

Project Location : Chile

Project Title : Program for the Immediate
Improvement of Primary Health Care

Project Number : 513-0350

Funding : \$10 Million (G)

Life of Project : 2 years

IEE Prepared by : Jeffrey J. Brokaw
LAC/DR/E

Recommended Threshold Decision : Categorical Exclusion

Bureau Threshold Decision : Concur with Recommendation

Comments : None

Copy to : Paul Fritz, Director
USAID/Santiago

Copy to : Howard Clark, USAID/Quito

Copy to : Peter Lopera, LAC/DR

Copy to : Thomas Park, LAC/HPN

Copy to : IEE File

John O Wilson Date OCT 22 1991

John O. Wilson
Deputy Chief Environmental Officer
Bureau for Latin America
and the Caribbean

67

Drafted:T. Hourigan:th:6513E:10/22/90

ANNEX E

Initial Environmental Examination

Project Location : Chile

Project Title : Program for the Immediate Improvement of Primary Health Care

Project Number : 513-0350

Funding : \$10 million (G)

Life of Project : 2 years

IEE Prepared by : Jeffrey J. Brokaw
LAC/DR/E

Recommended Threshold Decision : Categorical Exclusion

Project Description: The purpose of the Government of Chile's Program for the Immediate Improvement of Primary Health Care is to improve the quality and access of primary health care for the Chilean population, especially the population's poorest sectors. The Program's six components are:

1. Strengthening Primary Health Care in Rural Areas -- The supervisory system of the Directorate of Primary Health Care for each Health Service Area will be strengthened. This will be done through training and motivational workshops, management appraisals in each Service Area, adjustments in the resource allocation system, development of educational materials, revised Agreements between the Ministry of Health and the municipal health system, and establishment of community councils and community support systems.

2. Studies for Improvement of Planning, Administration and Supervision - Operations research, special studies, and development of an information system at the primary level will be done for design, implementation, monitoring and evaluation of Primary Health Care system interventions.

3. Basic Reequipment at the Primary-Health Level -- The capacity of the primary-level health facilities to diagnose and treat disease will be improved. Standardized, basic, and technologically appropriate equipment will be provided. Staff will be increased and trained in the equipment's use.

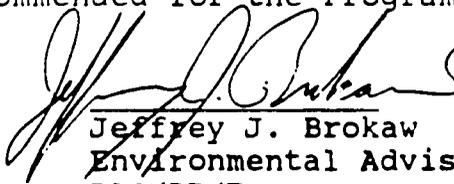
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4. Incorporation of Non-governmental Organizations (NGOs) into the Primary Care System -- A public-private partnership will be forged to provide basic health care as well as specific services, such as mental health or health education, to populations where no public system is currently operating.

5. Development of Innovative Models of Care -- Innovative preventative and curative health care services will be developed and implemented that are oriented toward current epidemiological profiles, especially those diseases affecting adolescents and the elderly. Improvement in targeting and access of basic primary health services will also be made.

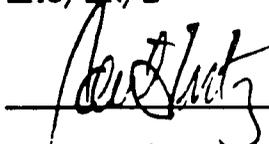
6. External Technical Assistance -- The Ministry of Health will be supported and advised in the development of suitable program interventions and other monitoring/evaluation and system management activities.

Environmental Impacts and Recommendation: Under 22 CFR Part 216.2(c)(2)(viii), programs involving nutrition, health care or population and family planning services qualify for a Categorical Exclusion except to the extent that such activities include those directly affecting the environment (such as construction of facilities, water supplies systems, waste water treatment, etc.). The Immediate Improvement of Primary Health Care Program involves institution building, technical assistance, studies, training, and the provision of some medical equipment. It does not include activities that will directly affect the environment. Therefore, a Categorical Exclusion is Recommended for the Program.


Jeffrey J. Brokaw
Environmental Advisor
LAC/DR/E

Date October 3, 1990

Concurrence:


Paul Fritz
Representative
USAID/Santiago

Date Oct. 10, 1990

República de Chile
Ministerio de Salud

SANTIAGO, 10 de Octubre de 1990

Señor
Paul Fritze
Representante S.A.I.D.
Consulado de los Estados Unidos de América
P R E S E N T E

Señor Fritze :

El Gobierno de Chile está efectuando un Programa de Corto Plazo para el Mejoramiento de la Atención Primaria de Salud, con el objeto de superar una de las principales deficiencias que existe actualmente en el Sector Salud. Este Programa es importante, porque la Atención Primaria, desde el punto de vista de la Población, representa la puerta de entrada al Sistema de Salud, que ve en ella una imagen global del sistema estatal destinado a este tema.

El Programa contempla acciones para cumplir los siguientes objetivos :

- 1.- Mejorar la oportunidad y calidad del acceso al sistema estatal de Atención Primaria de la Salud por parte de los pobres de las zonas rurales y aquellos ubicados en las áreas urbanas.
- 2.- Desarrollar modelos apropiados de Atención Primaria para enfrentar el nuevo perfil epidemiológico, incluyendo acciones de prevención y educación con énfasis en la atención de adultos y adolescentes.
- 3.- Diseño e implementación de sistemas eficientes de administración de la Atención Primaria de la Salud, mejorando los sistemas de información y gestión.

Para realizar todo este programa, se ha estimado un presupuesto de US\$ 27 millones en el período 1990 - 1992.

Para estos efectos, me permito solicitar sus gestiones en orden a obtener la participación del Gobierno de Estados Unidos de América a través de A.I.D., colaborando con el financiamiento del Programa citado en un monto de US\$ 10 millones. De esta cantidad, US\$ 9.3 millones serán destinados a programas locales y el resto, US\$ 0.7 millón para asistencia técnica y la administración y seguimiento del programa de A.I.D.

Saluda atentamente a Ud.



JORGE JIMENEZ DE LA JARA
MINISTRO DE SALUD

ANNEX G

TECHNICAL ASSISTANCE PROJECT

Additional support to the Government of Chile's Program for the Immediate Improvement of Primary Health Care (PII/PHC) includes a 2 year US\$700,000 Technical Assistance Project. It is designed to support and advise the Ministry of Health regarding development of suitable program interventions, and other monitoring/evaluation and system management activities.

This Technical Assistance Project contains the following components: 1) Technical Assistance for the Program for the Immediate Improvement of Primary Health Care, 2) Program Support (Program Coordinator), and 3) Audit and Financial Reviews.

I. Technical Assistance for PII/PHC

A. Identify Technical Assistance Needs

The Technical Assistance Project of the Chile Program for the Immediate Improvement of Primary Health Care will provide selected appropriate technical assistance to the Ministry of Health. A major part of this is assistance in addressing informational or technical needs on a short term basis in the areas of health care management, health care financing, and studies/research.

The services required may include operations research, systems analyses, special studies, and development of an information system at the primary level to assist with design, implementation, monitoring, and evaluation of Primary Health Care interventions in order to improve the efficiency and effectiveness of primary health service delivery. Examples of current studies underway include the following:

- Design and implementation of a system to obtain cost information at the primary care level.
- Diagnosis and monitoring of the efficiency of the health delivery system at the regional Health Service Area.

12

PHASE I:

In order to support and advise the Ministry of Health regarding development of suitable program interventions and other monitoring/evaluation and system management activities, the A.I.D. Latin America and Caribbean Bureau will provide the technical services of a senior U.S. technical consultant (at no cost to the MOH or USAID). This consultant will be funded through the new LAC Regional Health and Nutrition Technical Services Support Project (598-9657).

Scope of Work:

The consultant will work with the MOH to carry out the following tasks:

1. Review and gain familiarity with the Government of Chile's Program for Immediate Improvement of Primary Health Care (PII/PHC);
2. Review both administrative/managerial and technical constraints of the PII/PHC especially those which impede the institutional and policy reform efforts of the MOH;
3. Assist the MOH with the systematic identification and preliminary development of operations research, special studies, monitoring and information systems, and other appropriate research efforts to define and address these constraints;
4. Identify the types of technical assistance required to support and advise the MOH in design, implementation, and analyses of health financing and health management, operations research, special studies, monitoring and information systems, and other appropriate research efforts as defined in #2 and #3 above;
5. Prepare a 2 year Plan of Action for Technical Assistance to the MOH for the PII/PHC Program which includes identification of specific A.I.D. central S&T/Health and/or LAC Regional contracts that are able to provide the required short term technical assistance; and
6. Provide additional technical assistance to the MOH as appropriate.

77

Qualifications of technical consultant:

1. PhD in social science/DrPh in Public Health;
2. Strong working knowledge and technical skills in health research (particularly operations research, data bases, information systems, evaluation);
3. Fluency in Spanish required (S-3/R-3);
4. Familiarity with A.I.D. procedures and programs, especially with potential "buy-ins" to S&T/Health and LAC Regional Technical Assistance Projects; and
5. Overseas experience in project design and implementation in the LAC Region.

Time: two (2) weeks beginning o/a December 3, 1990.

Responsibilities: The technical advisor will report to Paul Fritz, AID/Representative, and work with Mr. Carlos Adriquez (Chief) and James Sitrick, Office of International Cooperation, Ministry of Health and other Ministry of Health officials identified by the OIC.

Reporting: The technical advisor will debrief the MOH and USAID, and submit a draft report to them for review prior to departure from country. A final report (which will include identification of operations research and other special studies/research and monitoring information systems to be implemented by the MOH, the plans for design and implementation of research/studies, and scopes of work for the necessary A.I.D. supported technical assistance) will be sent to USAID/Chile not later than January 14, 1991 for presentation to the MOH.

PHASE II:

Based on USAID/Chile and MOH review and concurrence with this proposed 2 year Plan of Action for Technical Assistance, USAID will prepare the required PIO/Ts for "buy-ins" to the centrally funded AID/W projects.

Due to the need for timeliness and a quick response for the provision of technical assistance, additional support from LAC/DR/HPN will be required in order to complete document preparation and contracting for the "buy-ins" as well as to facilitate timely provision of appropriate short term technical assistance throughout the two year period of this Program.

B. Management

This component will be managed by USAID/Chile. The technical services required will be procured, in most cases, by using Program funds (approximately US\$500,000 will be reserved for foreign exchange costs of technical assistance) to "buy-in" to centrally-funded A.I.D. projects (including S&T and LAC Regional Projects) as required for the specific technical advisory tasks.

USAID/Chile will coordinate the requests for technical assistance through these contracts with the Ministry of Health. The Ministry of Health, through the Program Coordinator (refer to Section II. of this Annex) will submit written requests to USAID (at least 1 month prior to the requested arrival date of the technical consultant) for all short term technical assistance and include specific scopes of work, dates, duration of assignment, identification of responsible MOH officials, and the technical advisor's qualifications and name(s), if known.

C. Relationship to Other A.I.D. Projects

1. The Science and Technology Bureau (S&T) works with the Latin America and Caribbean Bureau to ensure that the most appropriate applications of science and technology are used to complement and support development programs. The S&T offices carry out their responsibilities through technical assistance to LAC field programs and implementation of assistance projects which respond to needs that extend beyond bi-lateral or regional interests or capabilities. To this end there exist specific S&T projects which are relevant to the components identified in this Program. An illustration of an appropriate S&T Project which could provide appropriate technical assistance support to the GOC PII/PHC Program is as follows:

Project Title: APPLIED RESEARCH IN CHILD SURVIVAL SERVICES
(ARCSS)

Project #: 639-5992 Coop Agreement #: DPE-5992-A-00-0050-00

Purpose/Description: Methodologies developed under PRICOR-II revealed widespread shortcomings in the way primary health care (child survival) services are actually delivered in large scale programs. The ARCSS project will continue and refine the innovative strategies developed under PRICOR-II as well as address new technical areas. Major issues and new areas for the ARCSS project include the following activities:

1. Refinement of data collection methodologies;
2. Generation of systems analyses/operations research data base;
3. Further simplification of operations research studies;
4. Adaptation of systems analysis for routine use as a management information system;
5. Application of research to policy and management issues;
6. Correlation of process and effectiveness measures;
7. Examination of cost issues; and
8. Training.

Services: Limited short term technical assistance and training in addressing quality-of-care and related topics identified above. Selected technical services can be carried out through mission "buy-ins".

Implementing Agency: University Research Corporation (URC)
Center for Human Services
7200 Wisconsin Ave.
Bethesda, Maryland 20814-4204
Contact: David Nicholas, M.D.
Phone: 301/654-8338

Subcontractors: Johns Hopkins Institute for International Programs
Academy for Educational Development (AED)

2. In addition, the Latin America and Caribbean Bureau has authorized an LAC Regional project to assist missions in developing regional and bilateral programs and activities in the health and nutrition sectors of LAC. The project is as follows:

Project Title: HEALTH AND NUTRITION TECHNICAL SERVICES
SUPPORT PROJECT (HNTSS)

Project #: 598-9657

Purpose/Description: The purpose of this project is to improve the effectiveness of strategies, programs, and projects in the areas of health management, health financing, and nutrition in the LAC Region by facilitating the exchange and application of technology and information among LAC Missions and LAC host country institutions with respect to activities in these areas.

Services: To achieve these purposes, the project will fund the following services, utilizing regional LAC funds and also, Mission funds through the "buy-in" mechanism.

a. A "Core Contract" with the University Research Corporation (URC) will provide advisors in the areas of health management and health finance (of relevance for the PII/PHC Program). The advisors will assist the LAC Missions, as requested, in such activities as the preparation of strategies, analyses, and assessments; the performance of evaluations; the preparation of analyses required for PIDs and PPs; development of tracking and monitoring systems; carrying out operations research, special studies, and cross cutting evaluations; and information

Implementing Agencies: a. University Research Corporation (URC)
7200 Wisconsin Ave.
Bethesda, Maryland 20814-4204
Contact: Lani Marquez
Phone: 301/654-8338

Subcontractors: Community Systems Foundation (CSF)
International Science and Technology
Institute (ISTI)
Development Group (DG)

6. Prepare and review with the Ministry of Health and USAID/Chile any changes or revisions in the Grant Agreement;

7. Coordinate and carry out the necessary reviews and evaluations to ensure that the agreed upon institutional and policy reforms have been properly implemented; and

8. Provide additional program coordination and program support to the Ministry of Health and USAID/Chile as appropriate.

III. Audit and Financial Reviews

A. Scope of Work and Plan

Audits and financial reviews will be phased to provide assurance that procedures and controls are effective in their application during implementation as well as annual compliance verifications. A financial review will be undertaken at the inception of the Program to provide a financial analysis of the entity managing the dollar transactions and the Ministry of Health. A covenant in the Grant Agreement will assure that any recommendations resulting from the financial analysis will be implemented.

The first Non-Federal Audit will be performed at the end of the first year of operations, which will encompass the dollar transfers. The audit will examine implementation of recommendations of the First Financial Review. A follow-on financial review will be scheduled shortly thereafter to assure the effective application of any necessary remedial actions. Finally, a program close-out, Non-Federal Audit will be performed to coincide with the final Program evaluation.

B. Management

All of the Financial reviews and Non-Federal Audits will be contracted by A.I.D. and will be in accordance with established criteria, including General Accounting Office and Generally Accepted Auditing Standards. Funding will be provided by the Grant (approximately US\$100,000 will be reserved for costs). The scopes of work for the financial reviews and Non-Federal Audits will be developed and competed according to standard Regional Inspector General (RIG) procedures.

ACTION: AID-2 INFO: AMB DCM ECON USIS AGR COML\9

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 INFO RUEHPE\AMEMBASSY LIMA IMMEDIATE 5422
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LOC: 410 497
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 CN: 07256
 CHRG: AID
 DIST: AID

AIDAC AID/REP., PAUL FRITZ, CONTROLLER USAID/LIMA

E.O. 12356: N\A

TAGS:

SUBJECT: PROGRAM FOR IMMEDIATE IMPROVEMENT OF PRIMARY HEALTH CARE (513-0350) PID REVIEW

CHRON COPY

1. INTRODUCTION. THE ISSUES MEETING FOR SUBJECT PROGRAM WAS HELD ON THURSDAY, SEPT. 13. THE ISSUES MEETING WAS CHAIRED BY LAC/DR DIRECTOR PETER BLOOM AND INCLUDED REPRESENTATIVES FROM LAC/GC, LAC/DR, LAC/SAM, LAC/DP AND PPC/PB. DUE TO THE UNIQUE NATURE OF THE PROPOSED PROGRAM, IT WAS DECIDED THAT, IN LIEU OF A FULL DAEC, A SMALLER MEETING WOULD BE HELD WITH DAA FREDERICK SCHIECK. THE MEETING WAS HELD ON MONDAY, SEPTEMBER 17, AND WAS BASED ON A SUMMARY OF THE PROPOSED PROGRAM, QUOTED IN PARA. 2.

2. SUMMARY OF PROPOSED PROGRAM. QUOTE. ACTION REQUESTED: THAT YOU APPROVE THE DEVELOPMENT OF A DOLS 10.0 MILLION SECTOR PROGRAM (NON-PROJECT ASSISTANCE) FOR PROVISION OF U.S. ASSISTANCE TO THE CHILE HEALTH PROGRAM. THIS APPROACH WAS DISCUSSED AND RECOMMENDED BASED ON THE RESULTS OF THE SEPTEMBER 13TH ISSUES MEETING FOR THE CHILE PROGRAM FOR THE IMMEDIATE IMPROVEMENT OF PRIMARY HEALTH CARE (513-0350).

BACKGROUND: PUBLIC INTEREST POLLS TAKEN SHORTLY BEFORE THE NEW DEMOCRATICALLY ELECTED ADMINISTRATION OF PRESIDENT AYLWIN TOOK OFFICE IN MARCH OF 1990 SHOWED THAT PROVISION OF ADEQUATE HEALTH SERVICES WAS THE SINGLE MOST URGENT ISSUE FACING THE GOVERNMENT AND THE CHILEAN POPULATION. IN RESPONSE, THE GOC BOTH FORMULATED A STRATEGY AND ACTION PLAN, AND MOBILIZED DONOR ASSISTANCE IN ORDER TO ADDRESS THIS PROBLEM. IN RESPONSE, THE U.S. CONGRESS EARMARKED DOLS 10 MILLION FOR HELP IN QUOTE JUMP STARTING UNQUOTE THE PRIMARY HEALTH CARE SYSTEM.

MULTILATERAL AND BILATERAL ASSISTANCE (APPROXIMATELY DOLS 450 MILLION FOR THE PERIOD 1990-1995) IS TO BE USED TO ASSIST IN COMPLETING THE REFORM OF THE HEALTH SECTOR AND TO AUGMENT THE INVESTMENT BUDGET WHICH HAS BEEN VIRTUALLY NON-EXISTENT OVER THE PAST DECADE. THE U.S.

ASSISTANCE IS DESIGNED TO LAY THE EARLY GROUNDWORK FOR POLICY AND INSTITUTIONAL REFORMS WHICH WILL BE CONTINUED AND EXPANDED WITH THE SUBSTANTIAL DONOR ASSISTANCE.

DISCUSSION: THE NPA SECTOR PROGRAM APPROACH WOULD GIVE THE GOC THE FLEXIBILITY IT NEEDS TO EFFECTIVELY COORDINATE THE A.I.D. RESOURCES WITH NATIONAL RESOURCES AND WITH THOSE OF OTHER EXTERNAL DONORS. FURTHERMORE, THE TYPES OF INSTITUTIONAL REFORMS CONTEMPLATED WOULD BE STRONGLY FACILITATED BY A SECTOR PROGRAM VERSUS A PROJECT APPROACH. THE SPECIAL PROCEDURES AND DETAILED END USE MONITORING AND CONTROL REQUIRED IN A PROJECT DEFEAT THE INTENT OF THE U.S. CONGRESS ASSISTANCE TO BE FLEXIBLE, QUICK DISBURSING, AND SIMPLE. GENERALIZED SUBSECTOR SUPPORT FOR THE PRIMARY HEALTH CARE PROGRAM WOULD ASSURE THAT THE RESTRUCTURED SERVICE DELIVERY MECHANISMS AND PROGRAMS DEVELOPED BY THE MOH ARE CONSISTENT WITH AND CAN FUNCTION EFFECTIVELY AND EFFICIENTLY UNDER THE NORMAL OPERATIONS OF THE PUBLIC HEALTH SERVICES. A PROGRAM APPROACH IN A COUNTRY LIKE CHILE WHERE IMPLEMENTATION CAPACITY AND SKILLS ARE HIGH ALSO WOULD ALLOW THE U.S. GOVERNMENT TO SUPPORT THE KIND OF THOUGHTFUL INSTITUTIONAL REFORM PROCESS THE CHILEANS WANT TO AND NEED TO CARRY OUT WITH A.I.D.'S LIMITED PERSONNEL RESOURCES IN CHILE.

PROGRAM CHARACTERISTICS: THE ASSISTANCE WILL CONSIST OF THREE PROCESSES: 1) CONDITIONAL DOLLAR DISBURSEMENT, 2) LOCAL CURRENCY EQUIVALENT TO THE DOLLAR TRANSFER, AND 3) TECHNICAL ASSISTANCE AND EVALUATION/AUDIT IN SUPPORT OF PROGRAM OBJECTIVES.

THE DOLLAR DISBURSEMENTS WILL BE MADE IN TRANCHEES (ONE OR TWO), ON SATISFACTION OF CONDITIONS PRECEDENT (BENCHMARKS WHICH WILL ESTABLISH THE BASIS FOR THE INSTITUTIONAL AND POLICY REFORMS OF THE IMMEDIATE IMPROVEMENT OF PRIMARY HEALTH CARE PROGRAM). U.S. FOREIGN EXCHANGE WILL BE USED TO FINANCE U.S. IMPORTS DESTINED FOR THE HEALTH SECTOR (USING THE REIMBURSEMENT METHOD.)

EITHER PRIOR TO OR AT THE TIME OF EACH DOLLAR DISBURSEMENT, THE GOC WILL DEPOSIT THE LOCAL CURRENCY EQUIVALENT INTO A SPECIAL LOCAL CURRENCY ACCOUNT. FUNDS WILL THEN BE TRANSFERRED TO THE PRIMARY HEALTH CARE SUB-SECTOR OF MOH'S BUDGET AND WILL BE USED TO FINANCE APPROXIMATELY ONE-HALF OF THE GOC'S IMMEDIATE IMPROVEMENT OF PRIMARY HEALTH CARE PROGRAM (TOTAL SUB-BUDGET IS DOLS 23 MILLION). THE LOCAL CURRENCY WILL BE A CONTRIBUTION TOWARDS IMPLEMENTATION OF THE POLICY AND INSTITUTIONAL REFORM OBJECTIVES OF THE PROGRAM.

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MONITORING ARRANGEMENTS: LAC/DR AND LAC/CONT. HAVE REVIEWED THE FINANCIAL AND TECHNICAL MONITORING REQUIREMENTS ACCORDING TO BOTH CURRENT AND NEW, DRAFT GUIDANCE ON LOCAL CURRENCY. LOCAL CURRENCY WILL BE JOINTLY PROGRAMMED FOR GENERAL SECTOR SUPPORT, BY CONTRIBUTING TOWARDS THE GOC'S IMMEDIATE IMPROVEMENT OF THE PHC PROGRAM. AID WILL BE REQUIRED TO VERIFY THAT LOCAL CURRENCY HAS REACHED THE PRIMARY HEALTH CARE SUB-SECTOR. AID WILL NOT BE REQUIRED TO TRACE LOCAL CURRENCY TO SPECIFIC LINE ITEMS UNDER ACTIVITIES COMPRISING THE PROGRAM. ON THE TECHNICAL SIDE, CONSISTENT WITH LOCAL CURRENCY GUIDANCE AND OUR RATIONALE FOR PROVIDING THE ASSISTANCE, THE AID\REP. WILL RECEIVE PERIODIC TECHNICAL REPORTS ON THE PROGRAM IN GENERAL FOR APPROXIMATELY TWO YEARS.

TECHNICAL ASSISTANCE AND EVALUATION/AUDIT REQUIREMENTS WILL BE FUNDED THROUGH A SEPARATE A.I.D. MANAGED DOLLAR ACCOUNT. DETAILS OF THE EXACT TECHNICAL ASSISTANCE AND EVALUATION/AUDIT REQUIREMENTS WILL BE DEFINED DURING PAAD PREPARATION. END QUOTE.

3. DECISIONS. DURING THE MEETING THE DAA AGREED WITH THE APPROACH SUMMARIZED ABOVE AND PROVIDED THE FOLLOWING GUIDANCE:

A. THE BUREAU, WORKING THROUGH LEG, SHOULD DISCUSS THE PROPOSED NPA WITH APPROPRIATE CONGRESSIONAL STAFF. THIS

SHOULD OCCUR AS SOON AS POSSIBLE-EITHER BEFORE OR WHILE THE DESIGN TEAM IS IN SANTIAGO WORKING ON THE PAAD.

B. GIVEN CONCERNS WITH QUOTE BUY AMERICA UNQUOTE AND CONGRESSIONAL INTEREST IN THIS PROGRAM, IT IS IMPORTANT TO FINANCE HEALTH-RELATED IMPORTS FROM THE U.S. WITH THE FOREIGN EXCHANGE.

C. THE PAAD DESIGN TEAM AND THE AID\REP. SHOULD ASCERTAIN THAT THE GOC DEDICATE SUFFICIENT STAFF (AT LEAST ONE FULL TIME PERSON) TO ENSURE TIMELY PROCESSING OF AND ACCOUNTING FOR THE DOLLAR ASSISTANCE.

D. THERE SHOULD BE TWO DOLLAR DISBURSEMENTS: THE FIRST SHOULD BE BASED ON SATISFYING CERTAIN CONDITIONS/BENCHMARKS AND THE SECOND ON A FORMAL PROGRESS REVIEW AND THE AID\REP'S ASSESSMENT THAT THE GOC HAS MADE REASONABLE, SUBSTANTIAL PROGRESS IN IMPLEMENTING THE PROGRAM DURING THE FIRST SIX TO NINE MONTHS OF THE PROGRAM. THE INFLATION RATE IN CHILE MAKES IT INADVISABLE TO DISBURSE DOLLARS SUBSTANTIALLY FASTER THAN THE LOCAL CURRENCY IS REQUIRED FOR THE PROGRAM.

E. THE PAAD SHOULD BE CONSISTENT WITH NEW, DRAFT LOCAL CURRENCY GUIDANCE, SOON TO BE ISSUED.

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4. FUTURE STEPS. THE AID REP. IS REQUESTED TO DISCUSS THE PROPOSAL CONTAINED IN PARA. 2 WITH GOC OFFICIALS, PRIOR TO THE ARRIVAL OF THE PAAD DESIGN TEAM. THE PAAD DESIGN TEAM WILL INCLUDE TWO LAC\DR OFFICERS (JULIE KLEMENT AND PETER LAPERA), WHO WILL COMPLETE THE PAAD DURING A TWO TO THREE WEEK PERIOD BEGINNING SEPTEMBER 27. THE TEAM WILL FOCUS ON DEFINING APPROPRIATE CONDITIONS/BENCHMARKS, MONITORING AND EVALUATION PROCEDURES FOR THE PROGRAM, AS WELL AS THE PROGRAMMING AND USE OF DOLLARS AND LOCAL CURRENCY. IN THE LATTER AREA, THE TEAM WILL BE ASSISTED BY JERRY MARTIN OF THE CONTROLLER'S OFFICE, USAID/LIMA AND WILL BE ABLE TO CONSULT WITH JAMES WESBERRY, WHO WILL BE WORKING ON THE REGIONAL FINANCIAL MANAGEMENT PROJECT. BOTH WILL BE IN SANTIAGO DURING THE FIRST WEEK OF OCTOBER.

5. THE BUREAU WILL ADVISE AID/REP. OF REVIEW DATES FOR THE PAAD (TENTATIVELY THE THIRD OR FOURTH WK. IN OCTOBER). BAKER

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A. Socio-political Analysis

1. Socio-political Context

Chile has had a long tradition of health care delivery to its general population. Numerous independent systems of delivery evolved early in this century in such areas as mining and the civil service, which were subsequently combined into a National Health System (SNS). There is also a tradition of independent private health care providers. The development of these systems of care reflects a widespread attitude among Chileans that health care is a social responsibility within their nation.

Although the SNS became a highly centralized, essentially monopolistic system operating under the direct control of the Minister of Health, with little competition from the small private system, most Chileans were reasonably satisfied with the SNS and proud of the general progress in health status which it had helped to accomplish. Even with the very long geography which characterizes Chile, the SNS did improve and unify health status throughout the country.

Given the importance of health care within Chilean society, it is not surprising that the Ministry of Health became a politically powerful organization. Many politicians served as Ministers of Health (MOH), and many have been physicians, including former President Allende. The extension of their concern from health care to other more general living conditions and social issues was a political phenomenon with a long-standing tradition in Chile.

The evolution of the SNS also held economic implications for Chile as well. The Chilean economy prior to 1973 was generally based on import substitution and extensive governmental control. Chile's inability to compete in international markets at this time can, in part, be attributed to high unit labor costs. One, among many factors contributing to high labor costs, were social programs on behalf of workers, which included the SNS. Since health care was not being provided by the SNS in an efficient manner (i.e., without long waiting lines, suboptimal utilization, top-heavy administration, etc.), health care services were contributing to rising labor costs.

With the advent of the military government in 1973 and its free market approach to economic development, an all-out effort was made to reduce unit labor costs in order to meet international price competition. In line with this goal, the

(2)

Military Government sought to privatize many of the previously existing social programs, including health care. The popularity of health care, and the concept that it was a social responsibility, made privatization of the SNS a politically difficult task for the Military and the last to be accomplished. In short, the Military sought to weaken the political influence of the MOH and its system for delivery of health care services through the gradual privatization of health care in Chile, through a total restructuring of the SNS, and through the process of decentralization.

The new public system introduced to replace the SNS is known as the National Health Services System (SNSS). It is based on a decentralized system which corresponds to the regionalization process also undertaken by the Military Government. There are 27 Servicios de Salud (SS), which might loosely be viewed as comparable to Health Service Areas (HSA) in the U.S. Instead of the highly centralized approach of the previous SNS, the new SNSS has endeavored to establish more autonomy for the individual SS. Decisionmaking at the level of the SS is also shared with municipal government officials. The MOH under the new system retained only the responsibility for general policy formation and for the establishment of standards. The delivery of health care service and the financing thereof became the responsibility of the local SS. A new method of collecting funds to finance health care expenditures was established and a new institution called the National Health Fund, or FONASA, and autonomous of the MOH was created to carry out this task. The new health care system also paved the way for development of private health insurance companies known as ISAPRES which operate under a variety of financing mechanisms.

As the decade of the 1980s unfolded, it became clear that the theory of how the SNSS and private sectors were to operate was quite different from the reality. The decentralization of the MOH and SNS frequently resulted in confusion. The expectation that the private sector could expand rapidly, and at a pace sufficient to absorb the population previously covered by the public sector, was not met. For those people whose only recourse was the public system, another problem arose. As the Military Government enacted laws to foster expansion of the private health care sector, it simultaneously commenced to reduce funding for the public sector. In short, the public health care system was allowed to languish while the private sector, specifically the ISAPRES, were encouraged. Presently, approximately 80 percent of the total population of Chile receive their care from the public sector. The ISAPRES account for between 15 to 20 percent.

The list of problems associated with the current health care system in Chile have been elaborated upon earlier in this

84

document. It should be readily apparent that confronted with the health care expectations of the general Chilean population, combined with the inadequacy of the current health care system, the newly elected democratic government of Patricio Aylwin faces an enormous challenge. In order to satisfy political pressures, the new government will need financial and technical assistance from international sources. In order to maintain a low rate of inflation and to remain competitive in international markets, the new government must establish a modern and efficient health care sector. Change in the health care sector will require several years for completion. It is to be hoped that the general population will manifest sufficient patience to allow creation of an efficient new system of health care delivery.

2. Beneficiaries

The beneficiaries of the Program will include the following groups:

- the sectors of extreme poverty in the rural and marginal urban areas and intermediate size cities.
- the high priority health program target groups of the Aylwin Administration: women, workers, youth, and the elderly.
- the civil servants at the municipal primary health care level who will be better trained and motivated, and able to participate in the creation of a professional civil service as well as the process of restructuring the national health system.
- the municipal health system which will be truly decentralized, promote self-management and be better financed to provide adequate salaries and other resources.
- the secondary and tertiary care levels of the health system which will coordinate better with the primary level in order to avoid the heavily used and expensive emergency services for minor disease treatment.
- the technicians at the primary care level who will be better trained to implement the results of efficiency improvement studies, development of new information systems, epidemiological surveillance, and mental health programs.
- the development of new health fields such as family health, preventive health care, information systems, and participative evaluation.

- the social sciences which will apply scientific discipline to the development and management of the SICOS and Community Councils.

3. Impact

The significant socio-political feasibility issue to be addressed is whether any specific group or groups in Chile will be adversely affected by the policy changes contemplated under this Primary Health Care Program.

The most prominent group which may be adversely affected (or perceive to be adversely affected) by this Program are the Mayors who control and are responsible for provision of basic Primary Health Care at their municipal level. The data are not sufficient enough to make this kind of analysis. However, it is worth noting that these organizations, while interdependent, function at different levels of capacity as semi-autonomous units from the MOH system. The mayors may not positively respond to the increased demands of the MOH supervision system.

B. Economic Analysis

1. Introduction

It is not possible to complete a rigorous economic analysis for the Program for the Immediate Improvement of Primary Health Care. Aside from the fact that the assistance being provided is for a human resources project, one of the purposes of the program and AID assistance is to provide a bridge to much larger efforts being financed by the IDB and IBRD. Therefore, many of the constraints discussed in Part II. Description of the Problem will be addressed under the IDB and IBRD efforts, and the Program will "set the stage", at least in the area of primary health care.

Furthermore, the GOC, with IBRD assistance, proposes to address macro financial and economic issues affecting the health sector, including, among other issues: 1) reform of health care financing, in general; 2) incentive systems for health care personnel; 3) strengthening of health management at the national level; 4) establishment of joint ventures between public and private institutions in health care delivery; and 5) development of integrated health care systems and physical investments in the low-income areas. The IDB will concentrate on the improvement of health care delivery, management capacity, and information and maintenance systems at the local level, starting with a pilot project in selected Health Service Areas.

Thus, the Program which A.I.D. is supporting will feed

9/10

directly into the major improvements contemplated under the IDB and IBRD-backed efforts which total \$450 million. The GOC's Program has a total cost of \$27 million, of which AID is contributing \$10 million or 37%.

Another reason why it is not possible to complete a rigorous economic analysis is because no data on primary health care delivery costs is available. The GOC will begin to collect cost data on delivering primary health care under the Program, and the issue of all health care delivery costs will be thoroughly examined under the IBRD financed project. In this sense, there will be an ongoing economic analysis built into the Program, and into the effort to improve the entire health system, beginning in one year.

2. General Cost Effectiveness of Intervention

Other sections of the PAAD (Introduction, Description of the Problem, and the Technical Analysis) discuss the appropriateness of the type of intervention contained in the Program for the Immediate Improvement of Primary Health Care. Essentially, the Program will improve the public sector's current primary health care system. The current system, described in detail in I. Introduction and II. Description of the Problem is a decentralized system in which the municipalities have the major responsibility for providing primary health care and the Government of Chile, through the Ministry of Health has responsibility of overseeing the financing of the system and quality control. Decentralization of health care system is a world wide phenomenon which makes technical sense and is supported by AID in a number of health projects and programs.

The GOC's Program is an initial attempt to improve the current primary health delivery system, through specifically addressing the constraints and bottlenecks of the system (see D. Specific Constraints and Bottlenecks of the Primary Health Care System and E. GOC Strategies for Overcoming Identified Constraints and Bottlenecks.) In addition to technical arguments for improving the current system, it is logical that improving that system is more cost effective than installing either a purely municipality-based system or centralized health delivery system. As discussed in the Background, the current system has produced impressive results when compared to other developing and advanced developing countries. This was accomplished at a relatively minor cost-the health sector budget averaged approximately 9% of total central government expenditures from 1980 though 1987.

31

However, improving the primary health care system entails additional costs: current funding for primary care is at \$11.5 million and the GOC has budgeted another \$5.2 million, aside from AID's \$10 million assistance for the program. Therefore, total additional cost (to the Central Government) is approximately \$15 million. The cost of providing primary health care would be much more, but the Program will encompass two activities which should minimize costs and begin to resolve the problem of chronic under-funding of primary health care. One of the activities is to improve the health fund resource distribution system in order to make more funds available to the municipalities, as described under E. Strategies for Overcoming Identified Constraints and Bottlenecks. The other activity will be that NGOs will be incorporated into the primary health care system through joint delivery of primary services with the municipal sector.

3. Examples of Potential Benefits

One of the major economic consequences of the present system of primary health care delivery is the extremely long amount of time lost by public health beneficiaries waiting to receive care. Estimates range from 3 to 4.2 hours on average per visit. Most of the burden of lost time falls on the lowest income groups, for whom lost time is very critical. One consequence of improved primary health care delivery should be the reduction in waiting time for the beneficiaries. Using the only data available-1983 cost data-a health economist contracted to complete the economic analysis made calculations on the benefits of reducing waiting time. (His full analysis is available in LAC/DR files.) The calculations were conservative, i.e. biased toward underestimating the value of lost labor time. Basically, the methodology used was to calculate values of time lost assuming 4 1/2 hours and comparing that to value of time lost assuming 3 hrs, thereby arriving at the value of saving 1 1/2 hours in waiting time.

The 1983 data indicated that the average number of visits per patient per year was 6.4. At 4 1/2 hours waiting time per visit, this translates to 26.9 hours of lost time per year for each patient. It was found that hourly wage rates varied according to whether work days were 8, 10 or 12 hours long (high, medium, low, respectively). . Multiplying the three different hourly wage rates by 26.9 hours of average time lost and the resultant figure by the number of public health

6

beneficiaries, 9.2 million yielded values of total time lost of \$119 million (high), \$95 million (medium) and \$79 million (low).

Doing the same calculation on 3 hours of waiting time yielded values of total time lost of \$85 million (high), \$68 million (medium) and \$57 million (low). Subtracting the second set of figures from the first yields the annual value of reducing waiting time by 1 1/2 hours: \$34 million (high), \$27 million (medium) and \$22 million (low). A weighted average arc elasticity was calculated and a value of $E = 1.33$ was obtained. This suggested what may seem the obvious: that reductions in the value of lost labor time are more than proportional to reductions in waiting time.

There is also likely to be a significant economic benefit as a result of improved primary health care delivery is in the reduction of emergency room services. In Chile, there has been a trend to substitute emergency room services for clinical services to obtain primary health care. While use of non-emergency clinics has decreased, use of emergency rooms have increased. Between 1963 and 1987, emergency room visits as a percentage of total consultations more than doubled from 13% to 29%. Likewise, the ratio of emergency care to non-emergency care almost tripled from 30% in 1963 to 80% in 1987. While comparative cost data are not available, reversing the trend would yield substantial benefits as non-emergency care (including primary care) is considerably cheaper than emergency care, as indicated by U.S. data.

Finally, another general area where savings will accrue will be the shifting from curative care to preventive care. The extent and benefit of this shift cannot be quantified at this time, but with the collection of cost data under the IBRD project, the MOH will be able to measure the benefit of the shift.

C. Financial Analysis Considerations

Handbook 3 suggests that financial analysis of Project Papers determine financial viability of proposed activities and "that the stream of projected expenses can actually be financed as envisioned in the implementation plan." The financial analysis should also contain discussion on Methods of Implementation and Financing as required by payment verification policies.

Although health sector expenditures as a percentage of total central government expenditures declined from 1979 through 1987, the new government has made effective health care delivery a high priority. As mentioned previously, the GOC is designing two major health projects, totalling \$450 million, with the IDB and IBRD and is lining up European donor support in the order of \$65 million. All of these projects will begin within the next two years, so that the financing of the GOC's health care is budget is assured in the near and medium term.

As discussed under E. GOC Strategies for Overcoming Identified Constraints and Bottlenecks, funding for the Program for the Immediate Improvement of Health Care is assured. The cost of the program totals \$27 million and the GOC has budget \$17 million in normal and supplemental resources, in addition to the \$10 million contribution by AID. Therefore, the stream of expected expenses will actually be financed as envisioned in the implementation plan.

In terms of the discussion on Methods of Implementation and Financing, except for the technical assistance and auditing which A.I.D. will contract for directly, financial and contracting capabilities of the GOC will be relied upon. This is consistent with program assistance (i.e. non-project assistance). Other financial management procedures of program assistance are discussed in detail under VI B. Dollar Transfer and Local Currency Procedures and Management. Provisions for assessing the financial management and contracting capabilities of the GOC are discussed in VIII. Compliance with Non-Project Assistance Cash Transfer and Local Currency Guidance.

D. Institutional Analysis

1. Structural Organization of the Health Sector

Chile has a long tradition of health care delivery to its general population and that health care is a social responsibility of the state.

Recognizing this tradition, the Political Constitution of 1980 guarantees that all persons living in Chile have the right to protection of health (Section 9 of Article 19). Consequently, the function of the state is to create the necessary conditions which provide adequate access to health services for the population.

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Actually, all working persons pay a universal health care tax of 7% of their salary. The employee could decide if this tax would go to the public or private system.

Since 1952 the National Health system (SNS) is the principal provider of all curative and preventive health care in the country. In 1979, the Military Government began to change this system with the introduction of decentralization and privatization.

The government undertook major institutional and financial reforms of the health care system. They included, among others: 1) decentralizing the National Health Service (SNS) into 27 autonomous Health Service Areas (HSAs) of the National Health Service System (SNSS) capable of providing preventive and curative services in 26 specified geographical areas ; 2) transferring responsibility for primary health care services and infrastructure to the municipalities; 3) allowing workers to chose whether to apply their payroll deductions to public or private health providers; 3) continuing the role of the Ministry of Health as the policy-making, normative, supervisory, and evaluating agent; and 4) creating a public sector financial institution to collect health sector revenues and to distribute these funds.

The following descriptions highlight the primary responsibilities of the public sector:

- The Ministry of Health (MINSAL) has the responsibilities for establishing norms and controls in addition to formulating and evaluating plans and programs, and for coordinating the activities and the organization of the system.

- The National Health Service System (SNSS) is a decentralized system of 27 autonomous Health Service Areas (HSAs) providing curative and preventive services in 26 specified geographical areas in addition to an environmental unit based in Santiago.

- The Regional Secretariates of the Ministry of Health (SEREMIs), which represent the Ministry in the 13 Regions, form the link with the Ministry in terms of supervision and control of the Health Services. Moreover, they formulate the budget together with the Directors of the Health services.

- The Institute of Public Health (ISP) is responsible for the national reference laboratory, standardization and supervision of the laboratories of public health of the country. They carry out the quality control of pharmaceuticals activities and are the official institution for the

manufacturing of biologics as well as a center for investigation and training.

- The National Health Fund (FONASA) is responsible for the administration of the financial revenue collected from the national budget and the payroll deuctions for health care, and for distributing these funds, including paying the providers of services.

- The Central Supply (CA) of the SNSS provides the medicines and other necessary medical supplies for the development and functioning of the system.

Private health insurance companies (ISAPRES) were established in 1981 and currently provide mainly curative health services to approximately 15% of the population. These institutions receive the 7% universal health tax directly.

2. Ministry of Health Administration and Management of the Program

The A.I.D. Chile Sector Assistance Program constitutes assistance to the larger global Ministry of Health Program for the Immediate Improvement of Primary Health Care (PII/PHC) which will be carried out by the Department of Primary Health Care. The Office of International cooperation (OIC) is responsible for the management of all bilateral assistance in the health sector which includes the A.I.D. assistance. Within this Office is a coordinator specifically dedicated to maintaining the liaison between A.I.D. and the MOH. This coordinator also acts as the primary link with the Department of Primary Health care, and other entities of the MOH, and the Office of International Cooperation (refer to the Organizational Chart of the Ministry of Health).

The Department of Primary Health Care administers the technical and developmental aspects of the global PII/PHC Program and its sub-components. The OIC, as coordinator of the A.I.D. assistance, is responsible for all aspects of the A.I.D. Program and for keeping A.I.D. informed regarding Program status.

The Program Coordinator will provide semi-annual written reports describing the status and achievements of the Program. Specifically required are details regarding implementation efforts, achievement of the benchmarks, problems and bottlenecks encountered, and what changes have been made in the plan or the model. The report will include expenditures.

3. Problem Analysis

Ministry of Health officials are aware of their management shortcomings. The development of the Organizational Chart of the Ministry of Health was a key effort by newly appointed officials (the new government was installed in March 1990) to define and establish agreed upon responsibilities and relationships within this politically diverse institution. The mutual development of the A.I.D. Program served as a catalyst for the Ministry to begin the difficult process of reorganization. Some of the constraints facing the Ministry are as follows:

a) Lack of information for decision-making is a critical obstacle to effective and efficient use of resources. Current information gathering by the ministry includes massive compilation of data on multiple reporting forms. Unfortunately, the data are often not appropriate to current needs or are never analyzed. The Program will assist with review of the data needs with regards to decision making. A refined management information system will be developed.

b) Lack of material resources at the local level seriously limits the timely and appropriate provision of quality primary health care services. Laboratory equipment, including service and maintenance, supplies, pharmaceuticals and other medical commodities are severely limited and are simply inadequate for maintaining operations of the existing primary care delivery system at an optimal level.

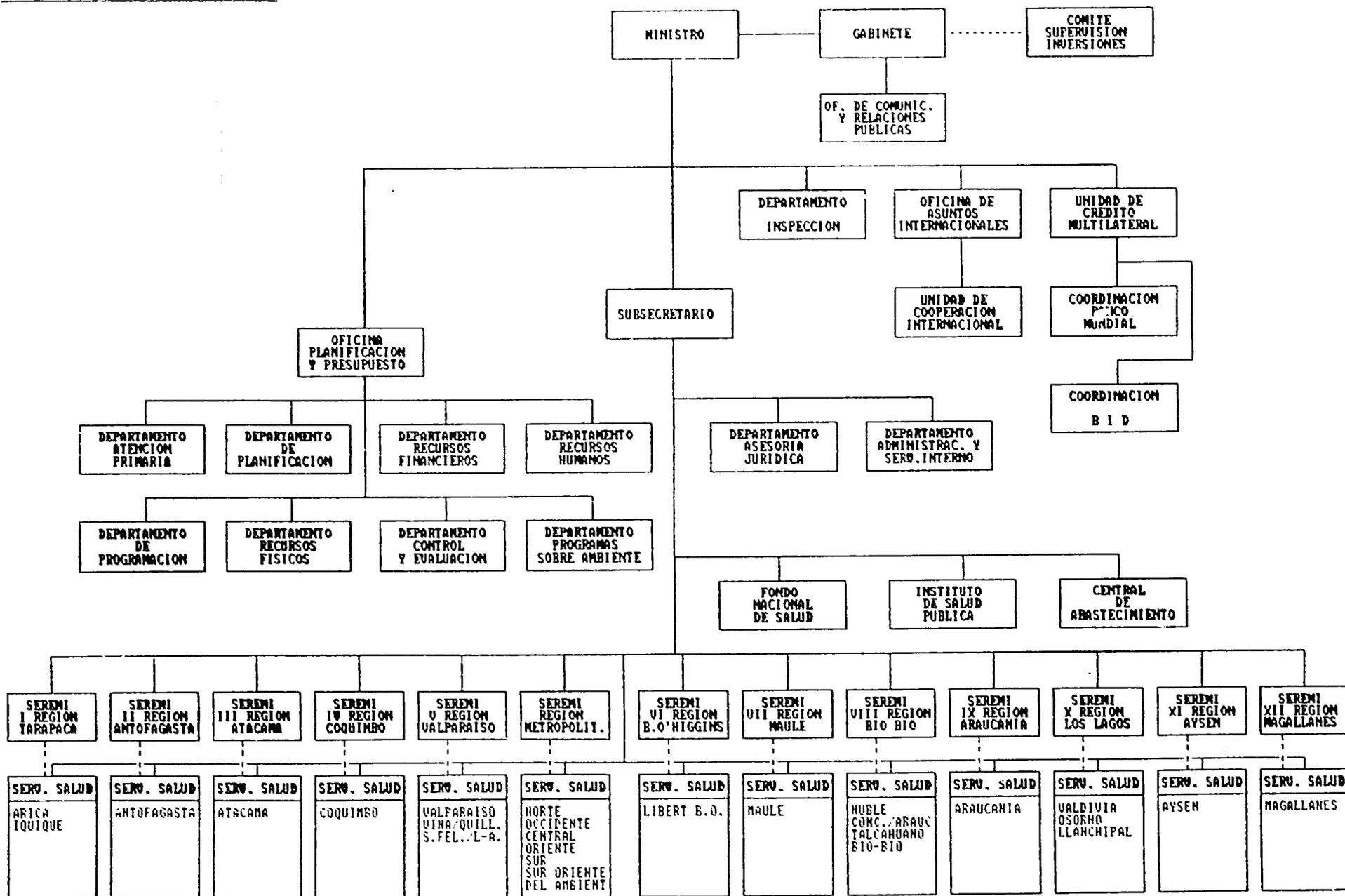
c) In view of the decentralized administration and provision of primary care services, there has not been a commensurate increase in administration and financial management training. This has had a direct impact on personnel morale and performance.

4. MOH Capability

Clearly the Ministry of Health has successfully planned and implemented a wide variety of health service program activities throughout Chile. However, current administration and management of services (and donor assistance) may be hampered by lack of internal coordination. The sheer quantity of funds being programmed for the MOH as well as the responsibility to monitor pose a major challenge to the absorptive capacity of the MOH. Therefore, the role of the Program Coordinator becomes the key to successful management and monitoring of the A.I.D. assistance.

92

**ORGANIGRAMA
MINISTERIO DE SALUD
REPUBLICA DE CHILE**



Embassy of the United States of America
UNITED STATES AGENCY FOR INTERNATIONAL DEVELOPMENT
Santiago - Chile

October 10, 1990

Doctor
Jorge Jimenez
Minister of Health
Mac-Iver 541, 3 floor
Santiago

Dear Mr. Minister:

The purpose of this letter is to convey basic financial procedure requirements of the US \$10.0 million in assistance which the U.S. Government, through the Agency for International Development (A.I.D.), is providing to the Government of Chile for Program for the Immediate Improvement of Primary Health Care. Such procedures have been discussed by Ministry of Health, other Chilean government officials and the A.I.D. design team during the past several weeks. I anticipate that your government will apply the basic procedures and requirements described below to formulate specific financial procedures suitable to the Chilean financial system and institutions. The specific procedures should be presented to A.I.D. . either before the signing of the Program agreement or before the disbursement of the first dollar tranche (anticipated on or about November 30, 1990).

A distinction should be made between two modes which A.I.D uses to provide assistance. One mode is project assistance, by which A.I.D. and the host country government jointly implement a project. Under this mode A.I.D. must very carefully monitor the implementation of the project and must track project funds to their end use. The other mode is program assistance. Under this mode, A.I.D contributes to a

15

program of the host country government. With program assistance, A.I.D. monitors implementation in a general way and wishes to assure itself only that program funds have reached the program. Unlike project assistance, tracking funds to specific end use is not required.

Program assistance is appropriate for Advanced Developing Countries such as Chile, where A.I.D. can rely on sophisticated implementation and financial management capabilities. This was the primary reason for selecting the program assistance mode for A.I.D. assistance.

A.I.D. has basic financial procedures under program assistance. They are as follows:

1. Under program assistance, the host government is provided with a dollar grant. Dollars are disbursed into an interest bearing, separate dollar account after certain agreed-upon conditions or benchmarks are met.
2. The dollars are to be used to finance U.S. made equipment and supplies imported after the signing of the agreement. In the case of this program, imports must be for the health sector (public or private).
3. Once acceptable import documentation is presented to A.I.D. dollars can be released from the separate dollar account to the Government of Chile.
4. Preferably at the time the dollars are disbursed to the separate dollar account, the host government will deposit the local currency equivalent of the dollar disbursement into a special local currency account. The special account will also be a separate, non-commingled account. If justification is adequate, the deposit of local currency can be made when dollars are released from the separate dollar account.
5. As the host government needs local currency for implementation of the program, it may draw down on the special local currency account.
6. A.I.D. wishes to be able to track local currency from the special account to program or sector being supported, not to specific line items or activities.

In the system described above, there are minimum requirements which have been authorized by the U.S. Congress and cannot be waived. These minimum requirements are as follows:

96

-There must be a separate dollar account to receive dollar disbursements. The account can contain only dollars disbursed under the agreement and must be interest bearing.

-There must be a special local currency (peso) account which contains only that local currency equivalent to the dollar disbursements or withdrawals from the separate account. This account must also be interest bearing, unless prohibited by the laws of the host country government.

-Interest earned in either the separate dollar account or the special local currency (peso) account accrues to the program and must be used for program purposes.

In addition to the financial procedure requirements, there are also minimum, standard auditing requirements. Basically, both the dollar procedures and the local currency transactions, as described above must be audited annually by an independent C.P.A. firm. In addition, a financial assessment of institutions managing the dollar separate account and the special local currency account must be performed at the beginning of the Program.

Sincerely,



Paul Fritz,
Representative

01