1. Country and Sector Background

(a) Introduction

The Federal Republic of Yugoslavia (FRY -- now Serbia and Montenegro (SAM)) succeeded to the membership of the former Socialist Federal Republic of Yugoslavia in the World Bank in May 2001. Initial Bank Group support to SAM was provided in two stages: first, a pre-membership phase funded through a US$30 million Trust Fund for FRY. The second phase, outlined in a Transitional Support Strategy (TSS – Report 22090-YU, June 26, 2001), provided a three year program of support for the Economic Reconstruction and Transition Program (ERTP), to be financed with a $540 million temporary and exceptional IDA envelope. A TSS Update (Report 24476-YU, July 18, 2002), described progress in the first year of implementation (FY02) and laid out plans for the FY03 program. A further (currently in draft) TSS Update for FY04, due to be presented to the Board in January 2004, describes progress during FY03, including FRY’s constitutional transition to Serbia and Montenegro, and provides the strategic framework for the final year (FY04) of the three year Bank Group assistance program. A full three year participatory CAS covering FY05-07 will be developed jointly with the IFC during the course of FY04 and presented to the Board for consideration in summer 2004. The SAM PRSP and Bank-Fund Joint Staff Assessment accompany the FY04 TSS Update under separate cover.

(b) Political and Socioeconomic Context

Political Outlook. The past fifteen months have seen the introduction of the new constitutional union State of Serbia and Montenegro in February 2003. Although there is some doubt about the duration of the union beyond the three year period specified in the Belgrade Agreement, the new union is now fully established and functioning. Both Serbian and Montenegrin leaders have placed high priority on seeking early accession to the European Union. Montenegro’s ruling coalition garnered a strong majority in the
2002 elections, but differences within the coalition still resulted in delays in processing various important items of legislation in Parliament. The economic reform program has been somewhat hesitant, although positive progress continues to be made.

**Economic Developments.** The effects of poor economic management, compounded by international sanctions and conflict (1992–96 and 1998-2000) which severely inhibited trade and investment in the country, led to a sharp decline in economic conditions. By 2000, recorded per capita GDP had fallen to about one half of its 1989 level. SAM had accumulated large domestic and external debts, with the latter reaching around 131% of GDP in 2000. SAM’s external debt remained a very high 76 percent of GDP at end-2002. Absolute poverty roughly doubled since 1990 and a deterioration in social protection and health services occurred, as available financing fell below existing entitlement levels.

Since late-2000, the adjustment of fiscal deficits towards levels financeable from non-inflationary sources has been the key policy instrument for restoration of macroeconomic stability. In Montenegro, the adoption of the DM in 1999 along with substantial levels of donor support successfully insulated the Republic from some of the more severe impacts of economic mismanagement after 1998, such as high inflation and growing arrears on pensions and social benefits. The DM was replaced by the Euro as legal tender in Montenegro in 2002.

Progress in **structural reform** remained positive despite several domestic and external shocks. The Montenegrin government adopted an extensive ‘economic reform agenda’ which covers a wide range of sectors. Montenegro enacted a new law on pension and disability insurance, a new labor law to increase the flexibility of the labor market, and a number of reforms focused on creating a more favorable business environment. The government successfully introduced a VAT in 2003. After concluding mass voucher privatization, the government is now focused on the sale of banks, hotels and large enterprises to strategic investors. The strong implementation of stabilization and reform has brought visible progress while laying the foundations for a more sustained recovery. In Montenegro, real GDP is estimated to have grown at low but positive rates of about 4 percent in 2000 and about 2 percent annually in the past 3 years. Recent growth has been driven by a recovery in the key tourism sector as well as in transport (primarily increased transit of goods to and from Kosovo), and construction. Montenegro’s consolidated **fiscal deficit** was cut from about 8 percent of republican GDP in 2000 to 4.3 percent in 2002. Foreign grants remained the main source of deficit financing, though domestic financing has been recently increased.

**Poverty.** Over the past 18 months, the Serbian and Montenegrin authorities and NGOs initiated a broad based data collection process and data analysis to support the Poverty Reduction Strategy Paper (PRSP). According to national poverty lines (€3.50 a day in Montenegro) around 10 percent of the population was living in absolute poverty in 2002. Growth is expected to reduce the incidence of poverty by a half. However, widening income inequality and growing regional disparities are likely to pose a challenge to poverty reduction. Moreover, vulnerability to even small shocks remains high. Poverty among refugees and IDPs is significantly higher than within the local populations. Unemployment is particularly high in Montenegro, reaching one of the highest levels in the region (above 20 percent of the labor force). Progress toward meeting the Millennium Development Goals is described in Annex 1, Box 1. In general, Montenegro is on track to meet the MDGs, but the combination of currently low prevalence and growing risk factors is likely to make achievement of MDGs for HIV/AIDS difficult.

The just completed **PRSP** for Serbia and Montenegro represent an overall plan of activities aimed at reducing key types of poverty while supporting the present market-economy developmental orientation.
In view of the main strategic directions of the PRSP, poverty reduction priorities to begin in 2004 will be in the areas of education, employment and SME development, health and social protection. The estimated need for the implementation of the Development and Poverty Reduction Strategy in Montenegro covering the same period equals 439,8 million Euros. It is envisaged that cost of the PRSP will be covered by a combination of reallocation of existing budgets, increased domestic resource mobilization, and new external financial support, including the proposed HSIP.

(c) Main Health Sector Issues

Montenegro’s health system faces problems that need urgent intervention both in finance and governance, and in the delivery of health services. The major issues in the first of these areas are as follows (Issues highlighted in italics are proposed for intervention supported by the Project): (i) public and total health expenditure are high (see 2002 PEIR for SAM) and the current public health financing and delivery system is not financially sustainable due to problems of revenue (contributions waivers, difficulty collecting from informal sector, lack of budget transfers for uninsured including refugees and IDPs) and expenditure (through failure to adjust the generous benefits package and capacity to reduced economic circumstances); (ii) pharmaceutical expenditure is out of control, at almost 30% of HIF expenditure, plus widespread out-of-pocket payment and the 2002 CPAR for SAM found evidence that drug prices are significantly above international reference prices; (iii) capacity for policy-development, planning, forecasting, managing and monitoring the system is weak and fragmented, and information systems and data for these functions are deficient. Major issues in the service delivery area include the following: (iv) primary health care (PHC) is not playing a large enough role in prevention or diagnosis and treatment, and staff are not optimally distributed, creating access problems in some places even though PHC employs a large share of health sector staff; organization of PHC is fragmented and overlaps with hospital care: reform of PHC based on a family-medicine model has been considered as an option to address some of these problems, but has become controversial; (v) health sector staff are poorly paid, poorly motivated, poorly managed, inadequately trained and often work to low standards. Unregulated private practice, financed by out-of-pocket payments, and informal payments in the public sector have emerged spontaneously in response to these problems, to the detriment of access to care, there is no framework for the HIF to contract with the private sector nor for private supplementary insurance, though there has been no privatization of public services; (vi) health and social care services for the growing proportion of old people, and people with long term mental illness and disabilities are limited. The interface with the responsibilities of the Ministry of Social Affairs and Labor (MSAL) needs to be clarified; (vii) the public hospitals network and the Institute of Public Health (responsible for surveillance and disease prevention), are run-down and inefficient: standards need to be defined and improved.

The proposed project would help the Government of Montenegro (GOM) to support development of health reform strategy with the aim of supporting the Ministry of Health (MOH) and Health Insurance Fund (HIF) to develop priority areas of policy and regulation and build their capacity; improving quality, efficiency and access in primary health care; and taking measurable steps towards financial sustainability of the health care system.

The Government is committed to this goal. The Government’s strategy for the health sector was presented to the Parliament and approved in November 2003. The Ministry of Health has prepared new draft framework laws on Health Protection, Health Insurance and Medicinal Products, to underpin their strategy for reform. These laws are planned to be adopted in 2004. There is a high degree of joint ownership by the Montenegro MOH and HIF of the health strategy, including the priorities proposed for support by the MHSIP, and the Government of Montenegro also supports the need to give priority to health reform at this time. The health strategy is reflected in the Government's draft PRSP.
2. Objectives

The proposed Health System Improvement Project would put in place the first steps towards a reformed health system, including priority elements of reform to begin stabilizing health financing and improving primary care service delivery. Specifically, the project would support the MOH and HIF to (i) improve quality, efficiency and access to primary health care services, including prescription drugs; (ii) begin improvement in financial sustainability of the health care system by strengthening institutional capacity and information systems for health policy, planning, regulation and management in the MOH and HIF; and (iii) improve services for the elderly and people with long term mental illness and disabilities in primary care, and foster improved coordination between primary care and social care for these patients.

The following key indicators would be used to assess project performance:
(i) drug prices and growth in the drugs bill are reduced by (target to be agreed);
(ii) HIF annual deficit reduced to (target to be agreed) by end of project;
(iii) (target percentage to be agreed) of PHC doctors/nurses trained and using evidence-based protocols of care;
(iv) adoption of bylaws and administrative documents under the new framework laws currently under development covering health insurance, health care, and pharmaceuticals, to implement the priority elements of the Government’s reform strategy (to be specified);
(v) operational health information systems in HIF, primary health care providers and pharmaceutical supply chain, to provide timely, accurate data on key elements of performance (expenditure, service utilization, referral, health status indicators, service quality indicators).

The Bank's strategic program with SAM, outlined in the draft TSS Update for FY04, due to be presented to the Board in January 2004, includes the proposed Montenegro Healthcare System Improvement Project (HSIP) in the planned lending program for FY04. The draft TSS Update for FY04 explicitly notes the expected contribution of the health investment project to two of its four development objectives: improving the social well-being of the most vulnerable, and building human capacity and improving governance and building effective institutions. The Project also aims to contribute to a third development objective - to restore macroeconomic stability - through support for development of policies to improve the fiscal sustainability of the Montenegro health system.

3. Rationale for Bank Involvement

The Bank has acquired cross-sectoral knowledge of the country (through a PEIR and CPAR in 2002, and a PA in 2003), and is in the process of deepening sectoral knowledge of the country through project preparation and through a Western Balkans HIV/AIDS study, and so is well placed to build upon this knowledge base in the proposed operation, which is knowledge-intensive and requires a lot of know-how with which the Bank is well placed to assist, drawing on evidence and lessons learned in the region and sub-region. The Bank has been involved in providing assistance to SAM in various sectors including energy, environment, water supply and sanitation projects. The proposed project is consistent with the explicit goals of the TSS of June 2000, and subsequent draft TSS Update covering FY04. These goals include the alleviation of poverty and the development of human capital through improved health status by ensuring quality and cost-effective health services at all levels. The Bank also has a comparative advantage at sectoral approaches as well as at supporting coordinated policy dialogue between health and other relevant government ministries, notably the Finance and Social Affairs and Labor Ministries. A second Structural Adjustment Credit (SAC 2) proposed for FY04 will include health-related conditionalities to support movement on adoption of new framework laws for the health sector and related implementation plans and milestones, which would complement the investment operation.
Other donor support for policy, financial and institutional reform in the Montenegro health sector, current and planned is limited, by comparison with Serbia, so that at this point, the Bank is the main source of support for policy and system reforms in the Montenegro health sector. UNICEF and CIDA have small programs, focusing on child and youth health, HIV/AIDS surveillance, and development of the public health profession. EAR is considering assistance from 2005 in the areas of pharmaceuticals regulation and together with EIB, may finance some hospital refurbishment and associated TA. The Greek Government recently announced its intention to provide 5-10 million euros to upgrade the Institute of Public Health in Podgorica; EAR may provide TA to assist preparation and project management. The Ministry of Health is exploring with CIDA the scope for CIDA to co-finance some primary health care education and training activities (estimated to cost approximately $1 million) in the proposed project, and if approved, CIDA has indicated a desire to integrate this assistance into the design of the proposed project and coordinate implementation. USAID is providing support for NGO development, community-driven initiatives at municipal level that may include health sector initiatives, and technical assistance in some areas that have potentially major implications for the health sector, including decentralization and policy for Treasury management and tax/contribution collection.

4. Description

It is proposed that the Project would have the following three components:

A. **Support for health reform program of Ministry of Health (MOH) and Health Insurance Fund (HIF)** This component would be directed at helping the government to identify best practice in health policy, financing and selected areas of service delivery. There would be two sub-components: (i) policy development and capacity building for the MOH and HIF, focused on issues which the Government has decided are highest priority for Bank support; and (ii) concrete investments in additional modules for the information system already under development, to improve data contracting, monitoring and management of primary health care, and related services.

B. **Phased implementation of primary health care development, beginning in Podgorica** This component would support phased implementation of policy and plans to develop primary health-care (developed under Component A). This component will have three sub-components, (i) a first phase of implementation in Podgorica which would be used to develop the reform model and learn lessons before scaling up reforms to other parts of Montenegro; key elements of the reform model include patient choice of and registration with a primary care doctor; reorganization of these “chosen doctors” into group practices, alongside consolidation of specialized primary-care-based services into a Primary Care Reference Center (including diagnostics, specialized primary care clinics, day services for the elderly and mentally ill, and teaching facilities); implementation of a new contract with these doctors to improve staff motivation based on a re-defined benefits package and a new payments model; improvement in the organization of services to reduce waiting and crowding and give medical staff more effective time with patients. These activities will be coordinated with information systems development under Component A to support these changes, and with training of staff in evidence-based protocols of care under sub-component B(ii), so as to improve the value-added by primary care and reduce inappropriate use of medicines and inappropriate referral to hospitals; (ii) support for development of specialization training of primary health care professionals and continuing professional development for all categories of primary care medical staff; and (iii) support for phased implementation of key elements of the reform in the rest of Montenegro. The key areas to be scaled up first include: implementation of patient choice of and registration with a primary care doctor; implementation of a new contract with these doctors based on a re-defined benefits package and a new payments model; information systems to support these changes. Medical staff from outside Podgorica will
also participate in training under sub-component B(ii). Mobilization of additional resources from local and donor sources will be necessary to fully implement all aspects of the primary care development strategy, extending beyond the life of the Project.

C. Project management, monitoring and evaluation The Ministry of Health will be the implementing agency for the Project. This component would have two sub-components: (i) support for a Project Management Network in the health sector organizations involved in the project activities, led by a Project Coordinator in the MOH; and (ii) a central Technical Services Unit providing procurement, financial management and disbursement services for the health project and for other upcoming Bank-financed projects.

5. Financing
Source: ($m.)
BORROWER/RECIPIENT 2
INTERNATIONAL DEVELOPMENT ASSOCIATION 7
DONOR 1
Total 10

6. Implementation

The Ministry of Health would be the lead implementation agency for the project, responsible for project management, and has established a Project Management Network (PMN), consisting of a full time Project Coordinator, and administrative assistant. It is envisaged that the Project would support engagement of a full time project coordinators in the HIF and Podgorica Dom Zdravlja, to embed capacity developed under the Project in existing institutions, while ensuring adequate resources to coordinate the health technical content of project preparation and implementation, under the overall coordination of the Project Coordinator in the MOH.

To ensure smooth implementation of the Project, a Steering Group of the Minister of Health, the HIF Director, high-level representatives of other agencies involved in the Project and a representative of the TSU, would be established and made responsible for strategic decisions on project coordination and monitoring.

The Prime Minister’s Department is establishing a central Donor Coordination/Portfolio Liaison Unit to oversee the portfolio of Bank operations in Montenegro and potentially other international projects. This Unit could also be represented on the Project Steering Group.

The GOM recently decided to establish a central Technical Services Unit (TSU), responsible for carrying out core procurement and financial management functions for all future Bank-financed projects, and potentially for other donor-supported projects. This TSU is being established with TORS that define clear boundaries of responsibility between the MOH and the TSU, giving the line Ministry clear overall responsibility and decision-making authority, and making the TSU accountable to line Ministries for providing prompt, professional services. A memorandum of understanding has been drafted and will be signed before negotiations, setting out the respective responsibilities and service standards for the PMN and TSU. The MHSIP would be the first project to work with this new arrangement. The TSU has employed a full time procurement officer and accountant. The head of the TSU will be a part time role for the first year, likely to be taken by a senior staff member of the Department of the Prime Minister. Once other projects come on stream, a full time person will be appointed to head the TSU.
7. Sustainability

Sustainability of investment in information systems and in primary health care facilities and equipment are the key issues regarding financial sustainability of the Project. The primary health care investments include a component of planning for rationalization of existing facilities and human resources, which is expected to realize some savings in existing operating costs which can be redeployed to sustain new investment in higher quality facilities with more efficient space utilization. The Project also includes technical assistance to cost the package of services provided in primary health care, review the package to ensure that it is financially sustainable, and reform the payment method for primary care based on this exercise. The health information systems investments in the project are also intended to achieve some improvement in collection of contributions, and improvement in management of the supply and utilization of pharmaceuticals. Successfully implemented health information systems in these areas are likely to improve financial sustainability. Some aspects of the Project-financed investments are likely to involve some redistribution of resources to ensure sustainability. Close involvement of the Health Insurance Fund in the Project design and implementation is planned to ensure that these types of requirements for redistribution of resources are planned and implemented to achieve sustainable improvement.

8. Lessons Learned from Past Operations in the Country/Sector

Montenegro is fortunate to be able to benefit from more than ten years of experience of health project implementation in the ECA region by the World Bank and other donors. OED has released an in depth study of four completed health projects in ECA and the ECA Region's Human Development Department is currently preparing its own assessment of all thirty health projects that have been completed or are under implementation. Some of the main lessons are clear, including: (i) health sector reform is a lengthy, politicized process and expectations for the reform process have been too optimistic for both the World Bank and the client countries; (ii) institutional aspects of reform are as important as technically proficient strategies; (iii) greater attention needs to be paid to the political economy of the reform through marketing reforms to lawmakers, the medical community and the public; (iv) projects have been too complex, particularly in smaller countries with low capacity; and (v) adequate resources need to be committed for supervision of projects.

Given this experience over the past ten years, the project design is very simple and flexible, and includes emphasis on capacity building (including training of staff and long term technical assistance) and institutional development in both of the substantive components. In order to address the political economy issues, the project preparation process and the project design itself include resources for consultation and communications strategies. The project design pays a lot of attention to transition path to reform – not only to the end point – in order to address concerns of stakeholders.

In addition to these general lessons, the OED four-country review points to emerging lessons that can be gleamed from a number of other countries in ECA and in the states of former Yugoslavia about primary health care development and reform. Successful reform of primary has involved coordinated and consistent intervention across a number of dimensions: training and professional development, organization and ownership of service delivery, financing and related incentives for staff, and legislation and regulation governing standards and norms. The project design works on all four of these dimensions. As well, local professional ownership and leadership of the new primary health care model has been a critical factor in the most successful case study country in the OED review (Estonia) and among more successful instances of primary health care reform in neighboring countries (successful pilot sites in Bosnia). The Bank’s team includes a Bosnia PCU Director who is able to provide in depth transfer of lessons from that experience. The Montenegro Minister of Health has appointed a committed primary
health care professional to lead the primary care component of the Project, and has a strategy of identifying “focal points” of change-oriented professionals to form working groups for Project preparation and implementation.

The ECA-wide review also provides some lessons that are relevant for the first component of the project which supports health policy and health financing. Reforms in health financing have been undertaken in the region often times without a clear governance structure, skilled and committed health care management and administration, and support from health care professionals and the public for the aims and goals of the reforms. Even when carefully designed in sufficient detail, the implementation of activities are often not sequenced correctly. The project is able to address this in part through its close ties to the adjustment program, and through coordination with parallel reform initiatives in public administration, tax and revenue administration and public expenditure management. Close links to SAC-2 and potentially to future adjustment operations in the upcoming CAS are a key complement to this component of the project’s design.

9. Safeguard Policies (including public consultation)

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<td>Environmental Assessment (OP/BP/GP 4.01)</td>
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Environmental Assessment Category:

[ ] A   [ ] B   [X] C   [ ] FI   [ ] TBD (to be determined)

It has been agreed that the project is "C" environmental safeguards category as it does not raise concerns of major health or environmental impacts. Environmental assessment is not required, but certain environmental issues need to be taken into account during project preparation and implementation (discussed in section 5 above and in Annex 10). Other safeguards policies are not applicable.

10. List of Factual Technical Documents

*Full titles, author, publication location date to be completed*

- Public Expenditure and Institution Review for Serbia and Montenegro
- Poverty Assessment for Serbia and Montenegro
- Poverty Reduction Strategy Paper for Montenegro
- Primary Health Care Analysis for Montenegro
- Health Strategy for Montenegro
- Institute for Strategic Surveys and Prognoses Reports (from 2002-present including recent Roma report)

*By supporting the proposed project, the Bank does not intend to prejudice the final determination of the parties' claims on the disputed areas*
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