1. Country and Sector Background

The sector issues are best considered in the larger context of reforms and the changing environment in Russia. The situation in Russia has changed dramatically since the last full Country Assistance Strategy (CAS) for the World Bank Group was prepared in 1999. For example: The aftereffects of the 1998 crisis in conjunction with the ruble devaluation and high energy and commodity prices on world markets have generated strong growth performance in the context of good macroeconomic management. A strong economic reform team has developed a comprehensive program of legislative measures to improve the social and economic well-being of Russia’s citizenry in a variety of critical areas, including deregulation, civil service modernization, public administration reform, fiscal federalism, legal and judicial reform, and restructuring of infrastructure and the social sectors. Renewed growth has led to the first signs of a turnaround in poverty rates and reduced inequality. The substantial changes in Russia since the 1998 crisis have also led to equally major changes in the nature of the Government’s demand for external assistance. From the Bank’s ongoing dialogue with Russian counterparts at various levels of government and society, such changes have been expressed in the following terms: Given the budget surplus and strong current account position, large-scale lending for budget and balance-of-payments support is no longer a priority. However, recognition of the vulnerabilities arising from fluctuations in external prices for natural resources suggests the potential importance of “insurance instruments” that could provide quick-disbursing budgetary support through flexible draw-down facilities in case downside risks should materialize. As the reform agenda has advanced, demand has increased for highly skilled
and narrowly targeted advisory services in specific areas of institutional design that combines international best-practice experience with a deep understanding of the Russian environment. The Government has set an ambitious timetable for adopting and implementing reforms across a wide range of areas. To be relevant, any external inputs into this process must be prepared and delivered quickly and efficiently to meet the more rapid pace of client demand. The shift in emphasis from adopting reforms to implementing reforms has partially shifted demand for assistance to the regional and municipal levels where the main implementation challenges are located. For the health sector, there is a new emphasis on the need for quality advice and relatively less emphasis on lending per se. This was also emphasized in recent discussions between officials of the Ministry of the Economy and the World Bank’s health team for Russia in September 2001.

This sub-section is based on ongoing discussion notes for a Country Assistance Strategy for 2002-2004.

SECTOR ISSUES

Overview

Russia’s health sector presents a complex picture of weak governance at the federation level, inefficient allocation of resources despite financial constraints at the regional level, inequities across and within regions, as well as underperformance in terms of aggregate health status. Table 1 below shows selected economic and health indicators for Russia and a few other countries in Europe and Central Asia.

Table 1. Economic and health indices from selected countries in Europe and Central Asia

<table>
<thead>
<tr>
<th>Country</th>
<th>GNP/capita (US$)</th>
<th>Gini index 1997</th>
<th>Health expenditures per capita at official exchange rate</th>
<th>Health expenditures per capita in international dollars</th>
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<tbody>
<tr>
<td>Bulgaria</td>
<td>33030.85</td>
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<td>Denmark</td>
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<td>Spain</td>
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<td>32.5</td>
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<td>Sweden</td>
<td>23,750</td>
<td>25.0</td>
<td>2,456</td>
<td>76.781</td>
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<td>Turkmenistan</td>
<td>920</td>
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<td>249061</td>
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<td>United Kingdom</td>
<td>18,700</td>
<td>32.6</td>
<td>1,303</td>
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<tr>
<td>Probability of dying between ages 15 and 59 years (male, per 100)</td>
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<td>Male</td>
<td>Female</td>
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<td>United Kingdom</td>
<td>18,700</td>
<td>32.6</td>
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<td>74.6</td>
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<tr>
<td>Life expectancy at birth (years)</td>
<td>Probability of dying between ages 15 and 59 years (male, per 100)</td>
<td>Bulgaria</td>
<td>33030.85</td>
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<td>Male</td>
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Fragmentation of sector governance and weak management

By the late 1980s, major socio-economic changes were happening in Russia. These in turn led to changes in the structure and functions of state authorities, ownership relations, financing and crediting policy, distribution of powers among the federal administration, administrations of the subjects of the Russian Federation and local administrative bodies. Such changes had to be grounded in an adequate legislative basis. Two basic federal regulations were developed and implemented: the "Fundamentals of legislation in public health care in the Russian Federation"; and the Russian Federation Law "On public medical insurance in the Russian Federation". These two laws provided for delegating sufficient regulatory powers to various authorities in a decentralized system. Consequently, numerous by-laws appeared, not always in compliance with the basic federal laws and generating a fairly contradictory regulatory basis for the sector. Thus, health system reform in Russia has been impeded not only by financial constraints but also by the inconsistencies and contradictions in the operating legislative and legal basis, which defines obligations and responsibilities of the sector management stakeholders at different levels (federal, regional, municipal), but does not provide clarity of authority necessary for effective operation between the health administration and the health insurance system. As a result of reforms started in the early 1990s, the Russian health system is a decentralized one. In broad terms, financing comes from payroll contributions in the...
regions, complemented by regional budgets for the non-working population. While the regions have taken a more active role, that of the federal level remains unclear. Some regions still expect guidance from the federal level, but many have assumed significant autonomy. About 10-15 of them have introduced various degrees of innovations, experimenting with new methods of organizing health care and paying providers, often in contradiction with outdated federal norms. As a result, there is little consistency in the quality and scope of state-sponsored care across regions. The majority of regions lack the capacity to correctly manage health resources or develop appropriate reform strategies. At the federal level, the capacity to carry out the regulatory, policy making guidelines and economic and financial analysis is limited. Since decentralization, the Ministry of Health (MOH) has occasionally made some attempts to take the lead on health care reform, but it lacks resources to develop the technical and regulatory basis for consistent reform countrywide and its financial leverage to influence the regions is limited. In many ways, the MOH has been bypassed by the more reform-minded regions, and its credibility has suffered. Since 1990, the legislation governing the health sector, and its enforcement, have been uneven, unclear and, at times, contradictory, and supporting regulation is often missing. At the facility level, managers are mostly physicians without management training, and are not appropriately trained to plan and manage physical, human and financial resources. Fragmentation and poor quality of health services Shifting from specialized inpatient care to outpatient services has been the main strategic focus of restructuring in the past decade, particularly at the level of primary care. However, despite introduction of the State Family Medicine Program in 1992 and the General Practice (family medicine) Program in 1999, the efforts to improve the primary medical care system have progressed slowly, largely because of weak interactions with the rest of the health care system. Besides, training and accreditation of family doctors have not been standardized in line with global best practices. Experience to date shows that expansion of primary medical care is not possible without withdrawal of resources required for improvement of primary care from other parts of the healthcare system. This will call for significant restructuring of secondary care, which at the moment absorbs a disproportionately high share of resources. The healthcare system is built around an inefficient structural scheme. Its quality, sustainability and accessibility may be improved by reducing this inefficiency. The infrastructure of inpatient care, emergency care and diagnostics is too broad and overstaffed. Duplication of responsibilities across the various sectors of the healthcare system is widespread. Few attempts are made to maximize the effect of scale in using buildings, equipment, bed stock, auxiliary services, personnel and management staff. Inadequate attention is paid to the potential of relatively low-cost services such as home nursing, consultations provided by highly qualified hospital specialists at outpatient facilities, day-care hospitals, nursery homes or rehabilitation centers, which could replace resource-intensive inpatient services. Since the late 1980s, pilot projects have been implemented in Russia to introduce new provider payment systems, which could create financial incentives to improve service outcomes. While some pilots had rather impressive outcomes, it is clear that changes in provider payment system alone cannot reform the entire health care system in the fundamental way as it is required. This is especially true if facility sizes are to be reduced and if facilities have to be merged or closed. Introduction of a proper scheme of financial incentives is a must.
but not the only prerequisite of rationalization. Political, organizational, economic and administrative measures, which are proposed to be developed and tested under this Project, are necessary to conduct a profound restructuring. As a result of limited resources and sometimes out-dated practices, the health system generally offers poor quality of care. The Soviet system emphasized specialist and hospital care, while essential services were neglected. Now in the constrained financial environment, there are few resources available to replenish the equipment and facilities. Patient dissatisfaction is growing. Weak and inequitable health finance regime.

In summary, the current system is fragmented, confusing to providers and fails to provide the incentives and continuity of funding for high quality and efficient services. It fails to offer adequate financial protection to consumers. Currently, the regions suffer from a fragmentation of funds and poor allocation of funds. A first stream of budget funds is received through top down allocations from Moscow to the regions and from the oblast finance departments. These funds go the oblast/regional health department, and funds are used for public health, facility infrastructure, for so-called emergency services and "priority services" such as tuberculosis and AIDS, and tertiary services generally. The money is allocated for these programs across municipalities and rayons. The allocation formula tends to be the same as in Soviet times - input-based, such as numbers of beds or staff. The money reaches facilities on a line-item budget basis, which fails to allow use of funds across lines or across budget years. The result is less innovation and little local responsiveness. A second stream of funding derives from the regional health insurance fund, which levies a 3.6% payroll tax on formal sector workers in the region. Of the 3.6%, 0.4% is sent to the Federal Health Insurance Fund in Moscow; the remainder stays in the region. The regional fund covers a "basic benefit package" of primary and secondary care services. Money is allocated typically on a service-by-service basis, according to some payment formula (which differs by region). A third stream of money is the local governments which typically subsidize utilities and special equipment purchases. A fourth stream of money - perhaps the most important - is the patient out-of-pocket spending, estimated at over half of all spending (54%).

Financially unsustainable health care system. Unstable economic conditions and fiscal constraints limit the possibilities for increasing public or private financing for the health sector. At the same time, the health care delivery system inherited from Soviet times is overextended. There are excessive numbers of personnel that are too specialized and too hospital-based, while the primary and emergency care systems remain weak. Despite this discrepancy between the low level of resources and the excessive infrastructure, the norms and standards for clinical practice and for the organization of health care have not been adjusted. As the norms are set nationally, their defects are obstacles to reform at the regional level where there is a need to introduce more cost-effective and better quality service based on clinical evidence. The same is true for the state guaranteed benefit package which nominally guarantees almost the whole spectrum of health benefits to the whole population. Finally, the current system of financing care lacks appropriate incentives to providers to improve efficiency or quality. Introduction of mandatory health insurance. In 1991 and 1993, Russia adopted a series of laws introducing payroll-tax financed mandatory health insurance (MHI) to supplement public budgets for health. This involved the establishment of a Federal Health Insurance Fund (FHIF) to oversee the system country-wide, Territorial
Health Insurance Funds (THIFs) to implement the system at the regional level, and health insurance organizations (public and private) to receive capitation payments from the THIF on behalf of consumers and in turn purchase services from providers on their behalf. The implementation of MHI has not generated the expected favorable results. Rather than increasing resources for health as intended, the introduction of MHI has actually led to the erosion of local budgetary allocations for health, made worse by the deteriorating fiscal situation. Financing, purchasing and paying arrangements have been complicated with the entry of Health Insurance Funds and health insurance organizations. The establishment of a new, separately-managed source of funding has led to the dispersal of public resources for health, and has made it more difficult to adopt consistent reforms at the regional level. Furthermore, with each region adopting its own approach to the introduction of MHI, there is no consistency across regions and no transparency with respect to health care entitlements for the population. Per capita spending variations for the public sector are now estimated at 7 or 8 fold across the 89 regions, with rural-urban disparities within regions and a burgeoning underclass in Russia. The private sector is largely unregulated but out-of-pocket expenditures are estimated at about 54%. This suggests significant risks of impoverishment for theoretically "free" health care services and drugs. The system is highly fragmented: the health budgets, the HI funds, the parallel enterprise sector, and the new private sector all play largely unregulated roles. This further contributes to the above mentioned problems. Second, it means public sector delivery system restructuring would cover only a part of the problems. The insurance system varies from region to region, both in terms of private/public intermediaries, but also in terms of benefits packages (though conversations with MOH officials in September 2001 indicated that policymakers are moving to better standardize this situation). This is problematic because there are typically two benefit packages in each region -- one covered by the traditional health department and the other covered by the health insurance funds. Poor health outcomesOverview. The main problems are threats to economic growth and productivity due to illnesses and premature deaths. Death rates remain high from chronic non-communicable diseases and are projected to grow due to infectious diseases - - in particular, due to the dual epidemic of tuberculosis and HIV/AIDS. The standardized death rate (SDR) from cardiovascular diseases (for ages 0-64, per 100,000 population) is 211 compared to the EU average of 53. As result of the resurgence of TB, AIDS and other sexually-transmitted infections, the SDR from infectious diseases became also significantly higher (19.7 in Russia compared to 6.3 in the EU). Without rapid and effective interventions the burden of non-communicable diseases would push Russia’s decrepit health system onto a high-cost trajectory, made even worse by the prospect of antiretroviral therapy for large numbers of HIV+ve persons. Since the Russian Federation began reforms of its health system a decade ago, Government has stated an intention to modernize the public health and disease control services. However, real progress has been limited in the areas of institutional development and modernization of the approaches to surveillance, health promotion and disease control.Trends in health status Source: Shkolnikov, M., McKee, M., Leon, D. Changes in life expectancy in Russia in the mid-1990s. The Lancet. Vol 37. March 24, 2001. 917-921.. Between 1987 and 1994, life expectancy in Russia declined substantially. Between 1994 and 1998, this trend reversed, and mortality rates returned to those of
the early 1980s. Death rates among children fell steadily throughout the 1990s, and those in elderly people changed little. The reduction in mortality since 1994 was mainly due to a decrease in the death rate among middle-aged adults, which had increased until 1994. Deaths among those aged 15-30 years, which rose during 1991-94, remained high. Some causes of death, such as stomach cancer and road traffic accidents, declined throughout the 1990s, whereas others, such as breast and prostate cancers and tuberculosis, increased. The decline in mortality since 1994 was, however, due to a reduction in the rates of deaths from a group of causes associated with alcohol consumption. The causes that showed an increase during 1991-94, followed by a decline in 1994-98 were mainly those that, at least in Russia, have been linked to heavy drinking. In some cases, the link is obvious, e.g., acute alcohol poisoning and cirrhosis. There is also documented evidence linking alcohol with different types of injuries, homicide and suicide. The association between alcohol and respiratory diseases, particularly pneumonia, is also well recognized. The association with cerebrovascular disease is complex: although there is no consistent correlation with ischemic strokes, rates of hemorrhagic strokes increase steeply with alcohol consumption. Cardiovascular disease is not usually associated with alcohol, but evidence from Russia and elsewhere links deaths from ischemic heart disease with episodic (binge) drinking, a pattern of consumption that is common in Russia. Mortality from tuberculosis, cancer of the female breast and prostate cancer increased throughout the 1990s.

Government Strategy. The government’s strategy in the health sector was originally documented in the “Concept for Development of Health Care and Medical Science in the Russian Federation”, adopted in November 1997. The MOH is designated to lead the government’s effort under this program. The central theme of the document is the urgent need to improve the efficiency of health care services by: (i) rationalizing the structure of health services at all levels - with an increased role for preventive measures, primary care services and more efficient use of diagnostic and hospital resources - and improving the interface among all levels and types of care; (ii) improving financial and resource management and introducing appropriate incentives for providers; and (iii) improving sector-wide governance and clarifying governance relationships between different levels of government Federal, regional, municipal, and district. Much of this is included in the document "Basic Trends in Social and economic policy of the Government of the Russian Federation over the long term (2000). This report also underlines the need to establish a unified medical-social insurance system (MSI) so as to avoid the problems caused by the present fragmentation. Because the Russian health system is highly decentralized, the MOH will have to assert its leadership in achieving countrywide reform in a consistent and timely manner while respecting the autonomy of regions and other local authorities.

Early Reform Measures. During the 1990s, Russia introduced a number of measures to improve efficiency in the health sector and expand sources of financing. Among these have been the following: New methods of paying providers. A number of regions have experimented with payment determined by the level or type of service (e.g., capitation for primary care providers, fee-for-service for outpatient specialist care, case-based payment for hospitals) rather than by level of inputs (e.g., beds or staff). These experiments have had mixed success, but have not been fully evaluated. There is need at this time to review them thoroughly and consolidate and disseminate lessons to be learned. Introduction of the concept of family medicine. In 1992, the MOH issued a decree calling for
an expansion of the role of primary care in the health system and instituting family medicine as the foundation for primary care. To enhance the role of primary care, new training programs were introduced for family doctors and nurses, regions were authorized to offer incentive bonuses to primary care providers, and a program was initiated to establish a high-level diagnostic center in each region to support primary care providers. Implementation of the family medicine program has been slow, and the MOH is concerned that the substitution of inpatient care by primary care is not taking place as expected. The establishment of diagnostic centers has been delayed by their high cost, and less than half of the 89 regions in the country have established a diagnostic center.

Introduction of mandatory health insurance. In 1991 and 1993, Russia adopted a series of laws introducing payroll-tax financed mandatory health insurance (MHI) to supplement public budgets for health. This involved the establishment of a Federal Health Insurance Fund (FHIF) to oversee the system country-wide, Territorial Health Insurance Funds (THIFs) to implement the system at the regional level, and health insurance organizations (public and private) to receive capitation payments from the THIF on behalf of consumers and in turn purchase services from providers on their behalf. The implementation of MHI has not generated the expected favorable results. Rather than increasing resources for health as intended, the introduction of MHI has actually led to the erosion of local budgetary allocations for health, made worse by the deteriorating fiscal situation. Financing, purchasing and paying arrangements have been complicated with the entry of Health Insurance Funds and health insurance organizations. The establishment of a new, separately-managed source of funding has led to the dispersal of public resources for health, and has made it more difficult to adopt consistent reforms at the regional level. Furthermore, with each region adopting its own approach to the introduction of MHI, there is no consistency across regions and no transparency with respect to health care entitlements for the population.

2. Objectives
The general objective of the proposed Health Reform Implementation Project (HRIP) is to strengthen the capacity of the Federal-level institutions, particularly the Ministry of Health, in the stewardship of health sector reform in Russia. In that context, the Project would also support regional-level initiatives aimed at improving the equity and efficiency of health services, including the testing of Federal guidelines at the regional level. More specifically, the Project Development Objectives are to: (i) develop Federal-level competencies and instruments that are required for effective regulation and support of a highly decentralized system; (ii) develop and implement strategic approaches to health sector reform in selected regions; (iii) improve the efficiency and effectiveness of the MOH as a regulatory agency; (iv) draw lessons from the implementation of small-scale regional programs and disseminate them to other regions; (v) develop and implement a more equitable and efficient financial regime and (vi) improve the quality and efficiency of health services that would benefit from direct investment under the project.

3. Rationale for Bank’s Involvement
The Russian Federation would benefit from the financial and technical assistance that the Bank can provide in restructuring its health care system, as follows: (i) Financial Support. Although Bank funds are insignificant relative to overall health spending in the country, they add...
value by: (i) providing seed money to try out new approaches to reform; (ii) acting as catalyst and leverage for adoption of politically sensitive long term reform strategies. (ii) International Experience. In comparison to other donors, the Bank’s technical assistance inputs are notable for the fact that they are not wedded to one model of reform, often a characteristic of bilateral or region-specific multilateral assistance. Rather, the Russian clients are able to explore a wide range of models, selecting whichever would be most relevant to particular circumstances. (i) Generate Additional Donor Support. The Bank has been successful in arranging for international support (Canadian International Development Agency and Swedish International Development Agency) for the two regions in preparing their respective restructuring strategies. (ii) Know-how in Project Design and Implementation. The Bank has long standing experience in (i) project management; (ii) provision of technical assistance for project preparation; and (iii) assistance in the competitive and transparent selection of firms and consultants. (iii) Stakeholder Coordination. The Bank is well positioned to facilitate the coordination of different stakeholders having an influence on health reform. As a health reform is an inter-sectoral exercise, it is sometimes difficult for ministries of health to find ways for a dialogue with representatives of other sectors. Internal coordination is necessary among key actors including the Parliament, the Ministry of Finance (MOF), MOH, Ministry of Economy, trade unions, medical chamber, regional administrations, private sector, and NGOs.

4. Description
Project Components. The Project has four components: (i) rationalization of health services, (ii) strengthening of financial and economic management, (iii) improving policy and governance and (iv) project management. In line with the basic design of a Federal-level project with small-scale application in two regions, there is no separate regional component. Component (i) would be implemented in part at the federal level and in part at the regional level, where health restructuring plans would be implemented. Components (ii) and (iii) would be implemented principally at the federal level, but in coordination with the regions. Component (iv), project management, would cut across all components. Out of the total IBRD loan of US$30 million, about $10 million would be spent on Federal-level activities while about $20 million would be spent on activities at the regional level. Component I - Rationalization of Health Services This component is aimed at the development (at the Federal level) and implementation (at the Regional level) modernization of health services delivery at the regional level and its long term financial sustainability by shifting as much as possible from in-patient to out-patient care and from specialist to primary health care using modern guidelines. These changes would result in improved access to health services and better quality of care. Federal level The project would support the following: (i) The development of strategic approaches to comprehensive restructuring of health service delivery aiming at a balanced and well interconnected system of primary care, diagnostic services, specialist in- and out-patient care as well an integrated emergency medicine system with an upgraded ambulance services; (ii) the development of new norms and standards for health service institutions based on pilot program experience and a package of benefits to be offered by primary care facilities that would provide services currently delivered in specialist and in-patient care. (iii) the
development of guidelines and best practice manuals for implementation and phasing of comprehensive restructuring based on pilot experience; (iv) the development, dissemination, implementation and review of the use of new clinical practice guidelines based on the principle of evidence-based medicine; (v) the development of new quality and outcome oriented criteria for licensing and accreditation of health providers; and (vi) the update and unification of licensing and accreditation processes across regions and strengthen institutional capacity of licensing and accreditation bodies, as well as the introduction of a "certificate-of-need" requirement for major investments in health.

Regional Level
At the regional level, the Project would support the implementation of guidelines specified above. The design and implementation of this component will be done in close connection with the activities in the other components that are facilitating the restructuring. The scope of the project will be mainly on publicly funded and provided curative services, but with attention to the regulation and development of privately funded and provided services. It would also relate closely with the sanitary and epidemiological system (SANEPID). Health services as organized and provided under the jurisdiction of other ministries would also be taken into account. Within federal guidelines, emphasis would be on the preparation and implementation of restructuring and rationalization programs in two regions (Subjects of the Russian Federation). In these regions all developed models and guidelines for planning and financing would be used to start the rationalization process. Careful monitoring and evaluation would help in specifying the technical parameters of the reform program, testing the broad range of choices to be made, fine-tuning the reform process and its instruments as well as provide for future Federation-wide implementation as soon as feasible. Chuvashia and Novgorod (supported by CIDA and Sida, respectively) would be the first two subjects of the Russian Federation to benefit from the reform. The Federal Ministry of Health would ensure that other subjects also have access to the models and instruments to guide their reform processes.

Disbursement from the IBRD loan for the procurement of lumpy equipment at the regional level would be contingent upon the completion of regional restructuring plans and the passage of enabling laws and regulations for implementing those plans. These would include, for example, the rationalization of hospital bed capacity and shifting of resources from in-patient care in hospitals to out-patient care at the primary health care level.

Component II - Strengthening of Financial and Economic Management
This component would help: (i) develop analytical tools including national and regional financing models and equalization formula, and apply the models to the costing of benefit package and regional restructuring plans; (ii) develop training programs in economic and financial analysis; (iii) develop best practice methods and manuals for financial management and business planning; (iv) develop institutional capacity to carry out technology assessment; and (v) develop new approaches to contracting and paying health workers. The project would restructure both the sources and uses of financing. The details of the regional strategies are not yet fully developed, but there are certain principles guiding the process: Improved pooling of all resources, optimally into a single-payer fund, organized either through the regional department or the local HI fund. This would improve purchasing power. A unified benefit package, and one which improves incentives for allocative improvements. For example, current benefits packages cover drugs for inpatient care, but fail to cover pharmaceuticals on an outpatient basis,
discouraging the movement of services to an outpatient setting. Changing the benefits package can also improve levels and distribution of financial protection. Improved incentives through new provider payment systems that integrate with objectives to restructure the delivery systems, encourage new patterns of staffing, and encourage improved technical and allocative efficiency. There are also current legislative proposals in Moscow which could affect the project. The most significant proposal is to integrate the current social insurance and health insurance funds, and to collect and pool all funds in Moscow. This proposal promises improved pooling across all of Russia, but it is not clear how the money would be allocated and the impact of these decisions for the region. Once passed, the law would need to be integrated into the regional pilot strategies.

Component III - Sector Policy and Governance
This Component would support the design of a consistent body of laws and other regulations to ensure adequate governance of the health sector on the federal level and compliance with federal regulations at the regional level. It would also support a process of advocacy to secure the endorsement of the Government of the Russian Federation, the Ministry of Health and respective regional authorities. The institutional potential of the Ministry of Health and regional authorities would be enhanced in terms of generating future adequate laws and regulations. The component would help to close existing gaps, provide the legal framework for health reform implementation activities and help to create new regulations as appropriate. This component is thus also a condition for the restructuring of the health system in the pilot regions. The activities under this component would help to: a. review existing health care legislation and correct inconsistencies; b. increase the capacity of the MOH, Duma Health Committee, and pilot regions to develop appropriate health legislation; c. develop new legislation and regulation to support reform measures under components I and II, including new proposals on regulatory arrangements for health care delivery and health financing as well as amendments/additions to the current acts to ensure a practicable, reliable and monitorable legislative system; d. review and clarify governance relationships between MOH, regional health authorities, Federal and Territorial Health Insurance Funds, and providers; e. review and strengthen the role of the MOH in preparing and implementing health sector laws and regulations; f. undertake a public information campaign on the project at the federal level; and g. undertake monitoring, evaluation and dissemination of lessons learned.

Component IV - Project Management
This component would finance the support provided to the project in terms of technical coordination, procurement, and financial management by the RHCF.

Phasing of the Project. The selected regions have already started working on the regional strategies, the implementation of which would be financed by the project, starting from the end of year 1. The Chuvash Republic has been receiving technical assistance from the Canadian International Development Agency (CIDA), and the Novgorod region from the Swedish International Development Agency (Sida). During the project preparation there has been a regular dialogue between the Bank, the federal level and the regions. The regional investments, included in Component I of the project, would start after the proposed restructuring strategies of the regions are presented and approved. The strategy for each region would be elaborated on the following basis: (i) it would follow the guidelines for restructuring included in the Operational Manual; and (ii) it would be financially sustainable. To ensure proper phasing/synchronization of activities, the implementation of regional-level work would be phased in
after the preparation of the required guidelines at the Federal level.

Component I - Rationalization of health services
Component II - Strengthening of financial and economic management
Component III - Improving policy and governance
Component IV - Project management

Front-end fee

5. Financing
   Total (US$m)
   IBRD 30
   Total Project Cost 50

6. Implementation
   The project would be the fourth lending operation in the health sector in Russia. It would be implemented by the federal and regional Ministries of Health. An Interministerial Working Group (IWG) would be the main oversight committee coordinating the activities of the ministries and departments involved in the project. The IWG includes representatives of the MOH of Russia (principal executing agency for the project), Administrations of the Chuvashia Republic and Novgorod oblast (co-executing agencies), MOP, Federal center for Project Financing and the RHCF. The IWG would approve the project strategy and ensure compliance with it, develop and ensure compliance with the project financing schemes, ensure conformity of the project activities with the government health sector policy, coordinate activities of federal and regional authorities, monitor project implementation and schedule, apply the lessons learned in the sector to the government’s broad sector policy, and review and approve regulatory and methodological documents developed under the project. The Chair of the IWG is the First Deputy Minister of Health.

   To provide technical support to the IWG and carry out project activities at the federal level, an Expert Council will be established. Its main functions will be to: (i) provide methodological support for project implementation; (ii) appoint coordinators for each of the project components; (iii) review TORs and technical specifications to be prepared for contracting of goods and services; (iv) provide technical support to the RHCF in the preparation of bidding documents; (v) review reports and proposals prepared under the project; review project plans and progress reports; (vi) prepare documentation and reports for decisions to be taken by the IWG. The Chair of the Expert Council is the First Deputy Minister of Health.

   To carry out their functions, the IWG and the Expert Council would be assisted by the Russian Health Care Foundation (RHCF) as regards the functions of procurement, disbursement and financial management. The RHCF has been assisting in project implementation for the Health Reform Pilot Project (currently under implementation) and the Medical Equipment Project (closed June 30, 2001). The RHCF has the status of an autonomous non-commercial organization, but it is overseen by key ministries (Health, Finance, and Economy) whose representatives sit on the Foundation’s Trustee Council. The minister of Health is the President of the Foundation. The RHCF has acquired significant experience in assisting in the implementation of Bank-financed projects. During 2001, the RHCF has strengthened its accounting and financial management systems, and has improved its project management reports. To help implement the project efficiently, a Project Group has been established within the administrative structure of the Foundation, with a full-time Project
Director. A draft Operational manual has been prepared. Presentation of the final version is a condition of negotiations. A project Implementation Plan (PIP) is being prepared. Implementation at the regional level. Each of the regions would have bodies similar to the IWG and the Expert Council. In addition, project teams would be responsible for project implementation at the regional level. These teams would consist of a Project Manager and a staff in charge of each of the project components. The teams would include health specialists, economists, and draw upon the services of engineers, accountants, and administrative staff. The federal level would enter into participating agreements with the two regions. The agreements would summarize the technical contents of the restructuring program, the conditions under which inputs would be transferred to the regions, and the results expected. Financial Management. To fully comply with the Bank’s requirements for this project, the following actions are being taken by the Foundation: (i) its Operating Manual is being revised and will then be approved by the Bank and the Trustee Council of the Foundation; and (ii) terms of reference for the auditors have been approved by the Bank; and (iii) integration of financial management systems is finalized. The RHCF will prepare and submit Project Management Reports (PMRs) for Bank review on a quarterly basis. The formats of PMRs has been agreed with the Bank. The PMRs will not be used for disbursement purposes. In addition to PMRs, the RHCF will also prepare and submit equipment and inventory registers to confirm the proper custody of equipment and distribution of drugs. The project financial statements as well as entity financial statements would be audited annually by a competitively selected independent auditor in accordance with International Standards on Auditing (ISA). They would be submitted to the Bank no later than six months after the end of the reporting period. The audit is to be paid for through the loan. Current auditing arrangements of the RHCF for the Medical Equipment Project and the Health Reform Pilot Project are in full compliance with Bank requirements.

7. Sustainability

This issue will be assessed at two levels: (i) the impact of restructuring activities on sustainability of health services in the pilot regions; and (ii) the sustainability of TA and institution-building activities at the federal and regional levels. Sustainability in the pilot regions. Issues of sustainability are at the core of the proposed project. The central objective is to render health services more sustainable in the long run by restructuring health services and developing new standards for clinical practice. Strategic choices described in Section B.3 above have all been selected because they are expected to contribute to this goal. To this end, restructuring plans of the pilot regions will be designed on the basis of their impact on long-term investment and recurrent costs. The regional financing model will serve as a tool for projecting the impact of proposed restructuring activities as well as evaluating their actual impact on long-term capital and recurrent costs. New clinical practice guidelines and methodologies for carrying out technology assessment would be assessed on the basis of cost-effectiveness and other economic evaluation methods. Training programs in economic evaluation methods and research programs applying these methods would develop in-country capacity to carry out these assessments. The national financing model would serve as a tool for projecting the impact of proposed changes in norms and standards and clinical practice protocols on long-term capital and recurrent costs country-wide of the new Russian model of health care.
delivery. Sustainability of technical assistance and institution building. A large part of the project involves procurement of TA services aimed at developing the technical, regulatory and institutional framework for health reform. Sustainability of outcomes from TA activities will be increased by emphasizing skills-transfer to local counterparts is emphasized in TA assignments. In addition, by working together with international consultants, local consultants and government staff would acquire the necessary skills. Sustainability of institution-building activities, particularly training would be ensured by implementing them through existing institutions. No new institutions would be established. Government strategy. In the long run, the project’s outcomes will be sustainable if the government continues to promote actively the idea of implementing comprehensive and serious health reform throughout the country. The project would build a solid basis, both in terms of health services cost effectiveness and rational organization, for further implementation of the long-term reforms envisaged by the government.

8. Lessons learned from past operations in the country/sector
Lessons from the ongoing Health Reform Pilot Project (HRPP) During the preparation and implementation of the Health Reform Pilot Project (HRPP), involving the regions of Tver and Kaluga, it has become obvious that: (i) reform efforts in the regions were constrained by outdated national-level norms and standards; and (ii) the federal MOH still lacks the financial and institutional resources to lead reform efforts in the country. This experience has confirmed the important role that the "center" must play in a decentralized health system, and the need for mutually supportive relations between center and regions. It has provided the main motivating force in the design of this Bank-funded health reform project which has a strong focus at the federal level. Although implementation of the HRPP is only about halfway, the lessons already learned from it have been applied in the specific design of this project. One key lesson is the need for continued discussions to keep building multilateral support in an evolutionary process during project implementation, instead of a single, drastic revolutionary change. Others include: (i) the appropriate design of provider payment mechanisms and the pay-off in cost savings that could result from an output-based global budgeting system for hospitals; (ii) the need for a unified approach to health services restructuring involving facilities at all levels of care in a given region and not just individual facilities; (iii) the need to assess the cost-effectiveness of diagnostic services also on a system-wide basis involving primary care, in- and out-patient specialist facilities, and free-standing diagnostic centers; (iv) the importance of changing clinical practice patterns in Russia; and (v) the quick returns to be gained from relatively simple changes, such as in protocols for responding to ambulance calls. Lessons from the HRPP will continue to be shared with the new project, and vice-versa, as implementation of both progresses. Lessons from the proposed Tuberculosis and AIDS Control Project In order to avoid the impasse that was experienced with the proposed Tuberculosis and AIDS Control Project, the proposed HRIP project is being subjected to (i) frequent and explicit reconfirmations of commitment by government, partner agencies and the Bank and (ii) a strong and explicit emphasis on developmental steps during project implementation. At the same time, it must be noted that the HRIP (a systemic reform project) is not a disease control project (which combines some reforms with relatively clear-cut technical interventions), hence some of the lessons learned from the Tuberculosis and AIDS Control
Project may not be directly relevant. The following paragraphs present a summary of the current status of the Tuberculosis and AIDS Control Project as of mid-October 2001. Following an Invitation to Negotiate, the Bank received from the MOH a letter (dated July 20, 2001, #19/2088) requesting a stop to further processing of the loan and indicating that the MOH did not require this loan anymore as the budgetary allocations from the federal budget for 2002 and beyond for TB and AIDS are sufficient. In addition to this formal communication, there had been widely publicized reports in the print and electronic media, of domestic dissatisfaction with some of the likely terms of the proposed loan for TB and AIDS. For example, there were reports of fears that International Competitive Bidding might put Russian pharmaceutical firms at a disadvantage if they did not meet Good Manufacturing Practice Standards. There were also indications that some senior medical professionals preferred to keep their traditional approach to diagnosis and treatment of tuberculosis (include mass use of x-ray diagnosis and institutional care for patients) instead of newer approaches that were advocated by technical colleagues - and agreed upon - during the early stages of project preparation.

During the health sector mission of September 17-24, the mission noted these developments, and stated its preparedness to continue to collaborate with the MOH and partner agencies such as WHO and UNAIDS. The mission learnt that the Ministry of Justice (MOJ) would still require both additional funding as well as technical collaboration in order to contain the epidemics within the prison system and to avoid the further spread of both TB and HIV to MOJ personnel as well as the population at large. The mission learnt that Minister of Justice Mr. Chaika had sent a request to the Prime Minister asking to proceed with a MOJ-led TB-AIDS Control Project. Furthermore, the mission was informed that the MOH would not object to Bank support for the MOJ as long as MOH-approved treatment protocols are followed. The mission informed the MOJ and the MOH representatives that, given the overall epidemiological situation, and given the urgent request by Minister Chaika, the Bank would be prepared to regroup and extend its support for the MOJ if an explicit request came from the Government of the Russian Federation. In case of such written endorsement, the Bank would initiate a dialogue with the inter-ministerial working group as well as representatives of the MOJ to redefine the program, in order to fit with the needs of the MOJ. The mission also briefed the international donor community on these developments. It was the mission’s understanding that most of the bi- and multilateral agencies working in Russia would support such a program. Discussions continue among government officials, the Bank, local institutions and international agencies on the best way to tackle the epidemics of tuberculosis and AIDS in Russia. Other health projects in the ECA region Limited resources and excess capacity is a general feature of the health care sector in all former socialist countries. In addition, all ECA countries have health systems heavily focused on specialized and inpatient care. Therefore, restructuring and downsizing are on the agenda of all these transition economies. The following lessons can be drawn from the ECA experience: (i) Health sector reform is a lengthy, politicized process. Expectations for the reform process have been too optimistic for both the Bank and the client countries. (ii) Institutional aspects. Institutional aspects of reform are as important as technically proficient strategies. The project is largely designed to provide institution building and technical assistance for the federal and regional levels of the government. (iii) Information, consultation and education of other
stakeholders. Greater attention needs to be paid to the political economy of the reform through marketing reforms to lawmakers, the medical community and the public. The project has a public information strategy element that would inform the public in the regions about the motives of the changes in their health care sector and their expected outcome.(iv) Excessively complex project designs. Projects have been too complex in the current portfolio. This is due to the fact that it is nearly impossible to single out areas in health care to be reformed effectively, without changing other elements of the system. The proposed project provides significant institution building and technical assistance. Its primary aim is to test comprehensive reform measures in two selected regions. This has helped limit project complexity without compromising the basic design and expected outcome.(v) Restructuring cannot be forced from the top. Local participation is a key in the restructuring process. Without appropriate incentives, reform measures have been torpedoed by local resistance in other Eastern European countries. On the other hand top level steering is essential. Both of these lessons are built into the project design.(vi) Adequate resources have to be committed for supervision of projects. Involvement of senior technical experts into the supervision process greatly enhances the value added of the World Bank assistance. This is especially true for a TA type of project.(vii) Primary and emergency services are underdeveloped in ECA countries. Despite international evidence shows that primary care and emergency care are the most cost effective ways of providing health services, they are still underdeveloped in most formerly socialist countries. The HRIP puts a great emphasis in developing these services in the selected regions. The decision to start with a modest technical assistance and pilot project rather than to go nationwide with a large-scale loan, reflects the cautious approach supported by these lessons. The current project emphasizes institution building and governance relations between the center and regional authorities, and pays attention to issues related to health legislation, an often-neglected aspect of health sector governance especially critical in a transitional country. Recognizing the importance of gaining the support of regional political authorities when introducing politically sensitive health reform, the MOH determined that signing of the tripartite agreement to implement the government’s Concept by regional political authorities would be a criterion for selection of pilot regions. The two pilot regions were also selected for having started implementation of the Concept ahead of all other regions, demonstrating support from regional health sector leadership and the local medical community for the project’s objectives. Project Implementation. The Bank’s portfolio in Russia currently has about 40 projects and the 1998 Country Portfolio Performance Review identified lessons for project preparation and implementation. To avoid delays between negotiations, board approval and effectiveness the project takes into account these lessons that include [the use of an existing implementing/coordinating unit if possible], early agreement on project design and documentation (including sub-loan agreements, if needed), and preparation of draft bidding documents for the first year of implementation.

9. Program of Targeted Intervention (PTI) N

10. Environment Aspects (including any public consultation)
   Issues  : not applicable

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Note: This is information on an evolving project. Certain components may not be necessarily included in the final project.

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