1. Country and Sector Background

POLITICAL AND SOCIOECONOMIC CONTEXT

The union of Serbia and Montenegro consists of two republics - Serbia and Montenegro - with a combined population of 10.6 million and an estimated end 2001 GDP of US$10.6 billion. Serbia is the larger republic, with around 95 percent of the population and a similar share of its GDP. A new Constitutional Charter and associated Implementation Law ratified in January 2003 created a new looser union of the two republics, replacing the constitution of the previous Federal Republic of Yugoslavia (FRY) that was established in 1992 following the SFRY’s dissolution. Under the provisions of the new constitutional charter, Serbia and Montenegro have some joint institutions, including a Presidency, Parliament, and a Council of Ministers, but operate separate economic, fiscal, monetary and customs policies.

Given that health care was a function substantially devolved to the Republican level in the former Yugoslavia and maintained as such in FRY, the constitutional changes have fewer consequences for the health sector than for other sectors. Under the new constitutional charter, the former Federal Ministry of Health, which had a relatively limited regulatory role, has been abolished and its functions delegated to Republican level. The Project covers only Serbia and does not include Montenegro. As part of the constitutional changes, an increase in decentralization of health functions to the Autonomous Province of Vojvodina is envisaged. Note that the discussion that follows refers only to Serbia and does not cover the province of Kosovo which remains under UN administration according to UN Security Council Resolution UNSC-1244.
During the 1990s, the economy declined, so that by 2000, GDP was 45 percent and per capita income less than 40 percent of levels recorded in the late 1980s. (GoS I-PRSP) Since 2000, the economic performance of Serbia has been encouraging. Inflation fell by two thirds in 2001, to 39 percent by year end, and real GDP grew by an estimated 5.1 percent. Inflation has continued to fall to 17 percent in 2002. Growth is expected to be lower in 2002 (around 4 percent) and 2003. Unemployment as measured in the labor force survey has fallen only modestly, from 16 percent in the mid-1990’s to 29 percent in 2002.

The Poverty Survey 2002 indicates that approximately 20 percent of the Serbian population lives in poverty or at the edge of poverty - consuming less than US$90 per month, of which 10.6 percent of the population consumed less than US$70 per month. The survey indicates that certain groups are more at risk of falling into poverty than the rest of the population: families with unemployed heads, the elderly, school age children, large families (with 3 or more children), rural population, people with low educational levels, and the elderly. Other data sources indicate vulnerability among Roma, refugees, displaced persons and single parents. There are approximately 472,000 refugees and 190,000 internally displaced persons (IDPs) residing in Serbia today. The number of refugees and IDPs varies greatly by municipality. In Kraljevo (one of the regions which will participate in the Project), with an estimated population of 152,000 as of 1991, 25,694 IDPs are estimated to have migrated from Kosovo and Metohija and 6269 refugees to have migrated from other countries of former Yugoslavia. Relatively few data in Serbia are analyzed by gender and consequently, little is known about gender differentials. This has been identified as a priority for the PRSP.

MAIN SECTORAL ISSUES

Health Status

Despite all the difficult factors during the 1990s (economic crisis, war, sanctions, bombing) in FRY (excluding Kosovo), all vital indicators improved during that time period according to data based on household surveys conducted by UNICEF in 2000. Under five mortality rate decreased by 29.5 percent while infant mortality rate decreased by 31.5 percent to 11.23 deaths per 1000 live births in 2000. Today, life expectancy at birth is estimated to be 69.8 years for males and 74.5 years for females. Access of the population to improved drinking water sources and sanitary means of excreta disposal is almost universal and vaccine preventable diseases are under control. When looking at causes of death, the picture is clearly one of a developed and transitional country with high levels of heart disease, strokes, and cancer. Smoking is estimated to cause 30% of the mortality in Serbia. Poor nutrition is another major risk factor.

Some minor declines in health status have been reported recently, however, and although not well documented, are of concern given the other conditions in the health sector and experiences in other countries in the region where health status has deteriorated significantly. A high annual incidence of tuberculosis (39 per 100,000 population) indicates a need to continue to be vigilant about infectious diseases as well, particularly given the living situation of the most vulnerable population such as IDPs and refugees and the affordability of drugs. The Government’s view that there has been a deterioration in health status (Government of Serbia, Interim Poverty Reduction Strategy, June 2002) has not been documented by
reliable data, which is in itself a main issue. Of the MDG's health specific goals, the most challenging for Serbia are those around poverty, hunger, and HIV/AIDS. The Republic is very much at risk for future outbreaks of HIV/AIDS, given existing transmission patterns in the region (IV drug use, commercial sex activity). The Republic of Serbia has received some donor assistance in these areas and has developed programs for HIV/AIDS and TB prevention and control for financing by the GFTA, so far receiving approval for a US$3.5 million grant in support of HIV/AIDS prevention.

Health Care Financing and Expenditure

According to the recent Public Expenditure and Institutions Review (PEIR, 23689-YU), public spending on health care in Serbia was over 6 percent of GDP in 2001, and has apparently been slowly decreasing over the past few years. When estimates of private expenditure are added, total health expenditure would range between 9 and 11 percent of GDP - among the highest in the region and close to the levels registered by high income countries. These rather high ratio primarily reflect low GDP numbers. However, as Serbia's per capita health expenditure, approximately $62 per person per year in 2001 was one of the lowest in the region, although planned expenditure for 2002 increased to US$82 per person.

Financing the health care system takes place via a combination of public finance and private contributions. The cornerstone of the public financing system is the Republican Health Insurance Fund (HIF). The former Yugoslavian health care system was unique in Eastern Europe because it was historically financed by compulsory social insurance and not directly from the budget. This provides the Republic with an advantage in terms of experience with provider contracting and payment, data on insurees and some of the basic functions of insurance that other countries in the region have had to learn from scratch. On the other hand, the existence of separate contribution laws and revenue collection responsibilities for health and other social funds creates some administrative complexity and inefficiency. The HIF currently has regional branches that are not independent units and essentially perform administrative functions for the central fund. In the past, however, the system was much more decentralized. There is a separate Federal Health Insurance Fund for Military Personnel and their families (FMHIF).

Public Health Expenditure In Serbia

<table>
<thead>
<tr>
<th>YUD million</th>
<th>1998</th>
<th>1999</th>
<th>2000</th>
<th>2001</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Insurance Fund (HIF)</td>
<td>9,727.1</td>
<td>11,757.9</td>
<td>20,473.7</td>
<td>40,968.2</td>
</tr>
<tr>
<td>HIF's budget, percent of GDP</td>
<td>6.6%</td>
<td>6.1%</td>
<td>5.7%</td>
<td>5.7%</td>
</tr>
<tr>
<td>Republic Ministry of Health</td>
<td>82.1</td>
<td>77.0</td>
<td>60.1</td>
<td>210.3</td>
</tr>
<tr>
<td>Republic Directorate of Properties (health facilities)</td>
<td>24.3</td>
<td>32.1</td>
<td>59.6</td>
<td>120.4</td>
</tr>
<tr>
<td>Health Expenditure of Federal Ministry of Defense</td>
<td>202.0</td>
<td>266.4</td>
<td>494.5</td>
<td>1,000.0</td>
</tr>
<tr>
<td>Federal Expenditure on Health</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>0.1</td>
</tr>
<tr>
<td>Additional public revenues of health institutions</td>
<td>361.2</td>
<td>436.6</td>
<td>760.3</td>
<td>1,521.3</td>
</tr>
<tr>
<td>Total Public Expenditure on Health</td>
<td>10,396.8</td>
<td>12,570.0</td>
<td>21,848.2</td>
<td>43,820.3</td>
</tr>
<tr>
<td>Total Public Health Expenditure, percent of GDP</td>
<td>7.1%</td>
<td>6.5%</td>
<td>6.1%</td>
<td>6.1%</td>
</tr>
<tr>
<td>Nominal GDP, YUD billion</td>
<td>146.3</td>
<td>192.9</td>
<td>358.1</td>
<td>724.1</td>
</tr>
</tbody>
</table>

- 3 -
The Republican HIF receives earmarked payroll contributions from employees, employers, self-employed, farmers and the Pension and Labor Market Funds. Transfers from the Republic Government MOH budget are intended for financing investments and for covering health care provision for the ‘vulnerable groups’ including refugees (from 2003), and covering the deficit in the HIF. Vulnerable groups include the long- term unemployed and other recipients of social assistance, the elderly (via transfers from the pension fund), the very young, and independent artists.

The amount of private expenditure on health is unknown, although one survey by UNICEF estimates it to be 40 percent and a small household survey conducted in the Krajlevo region for ICRC found a similar percentage. Private. Out-of-pocket spending is considered one of the major issues by the government. It has attempted to capture some of this expenditure through co-payments, but with limited success. The co-payment system has extensive exemptions: around 30 percent of users are required to pay, according to the MOH’s estimate. The Poverty Survey 2002 indicates that on average, patients pay considerably more than the official copayments for healthcare provided by state institutions: for example, people who were admitted to hospital in the past year on average paid 9752 dinars over the year for hospital care, including drugs, diagnostic tests and procedures.

The financial performance of the HIF over the past five years has been poor, and achieving fiscal sustainability in the HIF is one of the main sectoral issues to be addressed by the Project. The net accumulated arrears of the Serbian HIF by the end of 2001 were 6.7 billion dinars (1.0% of GDP). The Serbian HIF has in the past met its deficit by (i) taking out commercial loans; (ii) delaying payments to suppliers, especially pharmaceutical companies; (iii) delaying payments to providers; and (iv) artificially maintaining low reimbursement prices or setting contractual revenues at levels that do not cover all of the costs of services provided to insurees. Sustainability requires that the gap between HIF revenues and its expenditures be bridged, which in turn, calls for either an increase in revenue or a reduction in expenditure or, preferably, a combination of the two. It is important too that in bridging the gap, costs are not simply pushed to patients in the form of higher out-of-pocket payments for pharmaceuticals and medical and other supplies that are necessary for their treatment under the HIF benefits package. The HIF has taken steps to halt further accumulation of arrears, and has begun to reduce arrears.

On the revenue side, the main issues are evasion of contributions and informal payments. In a system that was designed to provide universal coverage and where the link between contributions and entitlement to services has grown increasingly weak, the incentives to pay the required contributions for the self-employed and the farmers are minimal and, as a result, they are rarely paid. According to the PEIR, these two categories of workers contribute only 3% and 1% of total contributions respectively, while the share of GDP derived from the private sector and non-public agriculture are 40% and 20% respectively. Accumulation of large arrears
to the HIF became the norm, and included the Pension and Labor Market Funds falling behind with their contributions.

Any increase in revenue is unlikely to come from further increase contributions from the wages of workers and their employers in the formal sector, which already account for 81 percent of the HIF’s revenue. The exemptions from contribution payments previously granted to employers appear to have been eliminated recently as a measure supported by SAC-I (IDA-35590). Similarly, the social funds have begun to pay their contributions more regularly, which was also a measure under SAC-1. In compliance with the policy conditionalities for the Social Sectors Adjustment Credit or SOSAC (P7566-YU, FY03), the Republic MoF has budgeted for transfers to the HIF for 2003 sufficient to cover the contributions of IDPs, refugees and vulnerable groups, through a combination of increased budget transfers for these groups and a general subsidy to finance the deficit in the HIF. The focus of future efforts to increase revenue therefore must shift to two other potential measures: (i) increasing the proportion of self-employed and farmers who pay their contributions; and (ii) ensuring that contributors pay an amount which reflects ability to pay.

The other side of the equation is expenditure reduction and cost containment. The PEIR concluded that there are still insufficient data to fully understand all of the sources of the inefficiencies in the health systems, but suggests that two of the largest are over-capacity in the hospital sector relative to utilization and a highly monopolistic market and poorly controlled supply chain for pharmaceuticals.

In Serbia, both hospital occupancy rate (68.7 percent) and the average caseload per physician (133) are low by international comparison, and while the official number of hospital beds (5.9 per 1,000 population) is lower than in many transition and high income economies, one very preliminary estimate calculated as part of the master planning exercise suggests that there may be 17,000 more beds than necessary in Serbia. This would imply an excess capacity of 30 percent. These numbers must be used with caution, however, because in the absence of improved data for service planning, it is not possible to assess whether hospital utilization should be expected to increase as barriers to access are addressed. Hospital utilization appears to be low relative to other European countries with similar population age structure. Administrative measures indicate hospital admission rates in the range 9.5-12 per 100 population (compared to CEE and EU average of 18.3 per 100), and the Poverty Survey 2002 found a rate of 8.3 hospital admissions per 100 interviewed. Moreover, service planning needs to take account of the social protection that many hospitals provide in the region, caring for the both the poor, elderly, and mentally ill. Any future restructuring program would look specifically at the future use of these beds in the context of planning for population needs. The need to convert some beds for other purposes such as long term care, would also need to be considered. Restructuring is likely to entail redistribution of capacity and personnel.

Preliminary findings of a project preparation study in Kraljevo bear out republican estimates that there is scope to reduce hospital capacity. It appears possible to maintain the existing level of hospital activity with a reduction from 700 to around 400 beds, and to consolidate hospitals.
functions onto a smaller number of its existing buildings, freeing up one or more buildings for alternative use. The study identified opportunities to shift care from inpatient to outpatient settings and reduce lengths of stay within some specialties (dermatology/venereology for example, currently has an average length of stay of 21 days), through evidence-based changes in clinical practice. The study also identified areas of excess staffing relative to case load.

Public procurement of pharmaceuticals in Serbia has historically taken place in a highly controlled marketplace, typified by excessive closeness between the main public consumer, the MoH, and a small number of domestic manufacturers, represented by a fifteen member cartel, the Industry Lobby of Pharmaceuticals Manufacturers. Five of the fifteen local companies comply with Good Manufacturing Practice standards and local companies together share approximately 70 percent of the market. Recently, a case study of procurement of pharmaceuticals was undertaken as part of the Country Procurement Assessment Report (CPAR, June 2002), which describes in detail the many flaws in existing practices. According to the recently completed CPAR, the health sector is considered the “epicenter” of procurement-related corruption in Serbia. The CPAR did two simulations from different data sources and found the savings on those particular drugs would have been 25 percent if they had been procured competitively. Estimates of pharmaceutical expenditures as a portion of HIF expenditures varies significantly, with the PEIR noting that the HIF reports 17 percent while its own analysis was closer to 11 percent. Another source of inefficiency in drug procurement is the repeated failure of the public health care system to make available, through public pharmacies, approved drugs which patients have a right to obtain under prescription. In all cases where a public pharmacy fails to fulfill such a prescription, the patient has the right to obtain the prescribed drug from a private pharmacy and obtain a refund from the HIF. The EAR estimates that in 2002, this cost the HIF an additional US$15 million per month. During 2001, in order to mitigate these problems, the number of drugs on the reimbursable list was reduced.

The final and most obvious way to reduce expenditures is to reduce the level of entitlements, which is under consideration in Serbia. The current package is very generous (in theory) and includes coverage of treatment abroad and in military hospitals as well as a set of benefits that are non-health related such as funeral expenses and sick leave which totaled more than 4 percent of total expenditures of the HIF in 2000.

While it is difficult to reduce entitlements, the HIF has taken steps to reduce expenditures. They have developed new contracts with health care providers, and while imperfect, this is reflective of a wish to increase control over public expenditures and to monitor service delivery. However, the current contract does not create incentives for health care providers to increase efficiency (savings in the wage bill, for example, would result in equivalent cuts in revenue). They have also begun to monitor the prescription patterns of health care providers, identifying the outliers. A main objective of the proposed Project would be to work with the HIF to further develop these activities and others to improve the incentives for provider performance via contracting and monitoring and evaluation.
The existing infrastructure in Serbia is in disrepair and needs basic repairs and re-equipping to restore it to where it can provide a level of minimally acceptable health services. The system is characterized by an extensive network of public facilities, from the ambulantas - the health stations that are scattered throughout the country - to the Clinical Centers - tertiary university hospitals located in Belgrade, Nis, and Novi Sad. Overall, there are approximately 58,500 beds. The level of service inputs (staff numbers, infrastructure) is almost identical to that which was operating in 1990, but the financial resources flowing into the sector have significantly declined. The cut in resources was accommodated by cuts in non-salary operating costs, in capital maintenance, repairs and replacement, and in reduction in the real value of salaries. Only one third of hospitals in Serbia have functioning sterilization systems. Seventy-five percent of the medical equipment in the health facilities is more than 10 years old, an age which most of the producers consider the upper time limit for the manufacturing and stocking of spare parts. (EAR, Assessment of Equipment Needs in Hospitals and Health Centers in Serbia, January 2002) Most facilities use coal or oil for heating, spending more than they would if they switched to gas, and adding significantly to the pollution problems. EAR estimates that energy efficiency investments of 100,000 to 300,000 Euro per hospital could save up to 30-40% in fuel costs (EAR, A Report of the Status of Hospitals in Serbia out of Belgrade, February 2002).

Given the excess capacity in the hospital sector described above, there is a need to prioritize facilities for investments. The vision of the system has been developed (see below on discussion of Government strategy), and the next step is to develop Standards and Guidelines which will determine such things as bed and staff ratio to population for planning purposes, guidelines and on what services will be provided at primary, secondary and tertiary levels. Background data necessary to prepare a facilities master plan are being collected with financing from the European Agency for Reconstruction (EAR), and development of local service restructuring plans and national planning standards and guidelines are being undertaken with the support of funds from the Social Protection Economic Assistance Grant (SPBAG, TF050017), a PHRD grant for health project preparation (TF051137) and further EAR funds. Preparation of national planning standards and guidelines and a masterplan are planned activities to be supported by the Project and is also supported in the Bank’s adjustment program as a SOSAC policy conditionality. There is also a need to develop skills in technology assessment to ensure the most cost-effective procedures and devices are selected. This too will be supported by the Project.

Approximately 115,000 people work in the health sector in Serbia. This figure does not include the health employees from Kosovo. There are reportedly large imbalances by specialty and by region. Physicians have dominated the system, with less emphasis on nursing and other paramedical specialties. Today, 1,400 doctors are reported to be unemployed in Serbia while 1,000 more graduate each year. In the short term, no plans have been made to cut enrollment in medical school and the annual graduating class is around 1000. Temporary cuts have been made in specialist training positions. The average monthly salary (excluding private practice or informal payments) of health professionals as of 2000 stands at
for doctors and 90 for nurses, as opposed to the 176 of the national average gross salary. As wages have fallen in real terms and basic means for delivering health services have deteriorated, the morale and motivation of the work force has deteriorated. The government has collected baseline data and is preparing a Human Resources Strategy, with the support of Project preparation grant funds.

A rudimentary framework is in place to allow private practice, and some parts of the system such as dentistry are rapidly moving in that direction. There are, reportedly, 3000 registered private institutions, doctors and services, employing over 6000 workers full time with 12,000 part time consultants. It is a parallel system that is serving a small portion of the population: those that can pay for services in cash. Many doctors from public services work within the private sector as consultants, creating potential conflict of interests between their two (or more) professional engagements.

GOVERNMENT’S STRATEGY

The highest levels of the Serbian government have publicly declared that reforming the health system is a national priority. In August 2002, representatives of the Ministry of Health, Health Insurance Fund, and Institute of Public Health participated in an exercise to articulate an overall health vision for the health sector in Serbia. This was based on several policy and strategy documents that already exist, including "Basic Principles of the Health Care System Reform in the Republic of Serbia - Policy Paper", the program the Government adopted and presented at the June 29, 2001 donors conference and reflected in the Medium Term Economic Recovery and Transition Program, the National Health Policy (February 2002), and the Interim Poverty Reduction Strategy Paper.

The Government’s vision statement agreed in August 2002 set out the following nine "guiding principles" or strategic directions (The full text of the vision statement is available on Project files.):

The health care delivery system will be clearly organized in three functional levels to ensure an affordable and effective service to the population by rendering the care at the lowest possible level with sufficient competence and equipment.

There will be equal availability of and access to basic health care services for all citizens and financial coverage for these services from HIF regardless of socioeconomic status of the individual citizen.

Basic health care services will be selected based on cost-effectiveness of reducing the disease burden and HIF-financed basic health care will be affordable and will be efficiently delivered.

There will be a high priority on preventive and primary health care services.

There will be an increase in the involvement of the private profit and non profit sector in the delivery of HIF-financed health care.

The main resource base for the financing of health care will continue to
be the mandatory HIF basic health care scheme, but the resource will be expanded through the development of the supplementary HIF and private insurance schemes.

Categorization of health care institutions and development of a master plan will be undertaken as preparation for a later step-by-step decentralization of lower level planning, management and delivery of health services.

The role of users, payers and providers will be well-defined and separated.

Quality of services and facilities will be promoted, strengthened, monitored and controlled based on a national quality assurance and licensing system.

2. Objectives
To build capacity to develop a sustainable, performance oriented health care system where providers are rewarded for quality and efficiency and where health insurance coverage ensures access to affordable and effective care.

3. Rationale for Bank’s Involvement
After working in the region for more than ten years on many of the very same issues that Serbia is now facing, the Bank brings a wealth of experience and valuable lessons learned that can be applied in Serbia. In many of these areas, such as health care financing, hospital restructuring, and pharmaceuticals, we are able to provide in-house expertise and consultant services. We are also able to take a multi-sectoral approach by calling upon colleagues from other departments within our own institution (such as the linkages with Energy Efficiency, Labor Restructuring and Public Expenditure Capacity Building Projects). The Bank together has already demonstrated its ability to bring various players such as the HIF, IPH, and MOH as well as to facilitate donor coordination when required. Our ability to simultaneously engage the Ministry of Finance helps to ensures the compatibility of any proposed health reform program with overall economic reform, and this linkage is supported by our adjustment operations. Finally, the level of donor financing in the sector meets only a small fraction of the needs, particularly for capital investment. There is potential for the proposed Project to provide some capital investment and leverage more from other donors and the private sector, through coordination with EAR, EIB in particular.

4. Description
Health Services Restructuring (estimated total US$13.0 million, including contingencies): This project component, the largest in the proposed project, would support planning and initial steps in implementation of the Government’s strategy for improving the efficiency of healthcare delivery while maintaining quality. At the republican level, it will provide continued support for development of a masterplan for the health care provider network, development of national planning standards and
guidelines, and health management training. In four regions (Kraljevo, Valjevo, Vranje and Zrenjanin), the project will support initial restructuring and rehabilitation of physical and human capacity at secondary care level in the regional hospital, with a focus on optimising the relationship between primary, secondary and tertiary levels of care, and improving the linkages between regional Institutes of Public Health and healthcare planning and management. The regions participating in the Project have been invited to develop proposals with technical assistance financed by PHRD and SPEAG funds. Kraljevo has already developed proposals and will be the first region to carry out these initiatives, and will serve as a demonstration site, building upon the development of basic health services and of local capacity that has already taken place with the support of an ICRC-supported Basic Health Services Pilot project in Kraljevo (also supported by a grant from the Post Conflict Fund). There will be an emphasis on improvement in management and evidence-based clinical practice, supported by training, technical assistance, evaluation and dissemination of lessons learnt. Investments in new medical equipment and refurbished buildings will be used to help leverage facility consolidation and restructuring in order to make the delivery system more efficient, accessible, and of higher quality. The planning, management, and environmental management tools developed in the Kraljevo demonstration site will serve a model for other regions. The development of a masterplan and national planning standards and guidelines is also supported by the Bank’s adjustment program (SOSAC) and is consistent with PEIR recommendations. Labor restructuring in Kraljevo will be assisted by the Employment Promotion Project (Learning and Investment Credit). Costs of redundancy payments will not be financed by the Health or Labor Credits.

Health Finance, Policy and Management (estimated total US$8.9 million, including contingencies): This component would build the capacity of the GoS to develop, communicate, and effectively implement health financing mechanisms, health policy and health sector regulation. There are five sub-components to be included: (i) benefits package and provider payment system: development of institutional capacity in the HIF and MOH to review and improve the benefit package, the public/private mix of financing and delivery, the provider payment and contracting systems, including monitoring mechanisms; and to increase the equity of distribution of health resources; (ii) public health finance: review of public health expenditures and financing (that is, expenditure and financing for disease prevention and health promotion) to address priority public health problems more effectively and efficiently. (iii) licensing and accreditation: development of a system of licensing for health professionals and a system of accreditation for healthcare providers; the Project will support the establishment of a licensing agency for health professionals and begin licensing and re-certification; it will also support establishment of an accreditation agency for health care providers, though full implementation will extend beyond the life of the project as a long term process to continually improve the quality and safety of health services; (iv) health information systems: development of a health information systems masterplan, data standards for the Republic and a republican health information service, to assist policy advisers and leaders in the GoS in using existing data for decision-making; piloting of a regional integrated health information system based on these plans and standards in Kraljevo, followed by implementation of regional health information systems in Valjevo, Vranje and Zrenjanin; (v) MOH
capacity-building and communication: building capacity in the MOH, HIF and IPH in health management, analysis and decision-making; assisting these three organisations to clarify and develop their mandates; assisting the health sector decision makers in the MOH, HIF and in their communications strategy for health reform, including enhancement of the flow of information on public, patient and staff perceptions and opinions to health sector decision-makers. Needs assessments for the MOH and the IPH have already been carried out with EAR funding, and Credit-financed developments will be coordinated with planned EAR and UNDP programs to support capacity development in the MOH and IPH. This component would provide technical assistance, training, recurrent costs for new agencies and policy units (on a declining basis), hardware, software and office equipment.

Project Management, Monitoring, Evaluation (estimated total US$1.5 million, including contingencies): The project would support operation of a Project Coordination Unit (PCU) within the Ministry of Health. The PCU Director reports to the Assistant Minister responsible for International Relations. The PCU is staffed by full time local consultants (PCU Director, Procurement Specialist, Financial Specialist/accountant, Project Assistant). The PCU will be responsible for day-to-day coordination with MOH sectors and with other agencies benefiting from project activities (notably the HIF and the health centers in Kraljevo, Vranje, Valjevo and Zrenjanin). The PCU will be responsible for all procurement, disbursement and monitoring and reporting. The PCU will also engage four full-time field coordinators to work in each of the four regions participating in project activities, to provide an operational link between the PCU and the local counterparts. A Project Steering committee chaired by the Minister of Health will be the decision-making forum for strategic decisions and approval of plans for project implementation. A significant portion of the financing will be used to develop and maintain a project monitoring and evaluation system. Financing would be needed for technical assistance and training of staff, office equipment, recurrent costs of PCU staff, and project audit.

1. Health Services Restructuring
2. Health Finance, Policy and Management
3. Project Management, Monitoring, and Evaluation

5. Financing
   Total ( US$m)
   BORROWER $3.48
   IBRD
   IDA $20.00
   Total Project Cost $23.48

6. Implementation
   Project Coordination Unit

A Project Coordination Unit (PCU) has been established within the Ministry of Health's Sector for International Relations, which also serves as the donor coordination unit of the MoH. The unit is already using funding from the Social Protection Economic Assistance and PHRD grants to prepare the project. The existing link between the new MoH PCU team and existing SPEAG Project Implementation Unit at the Privatization Agency has helped to pass information about procurement and financial management procedures.
in World Bank’s operations.

The PCU will be responsible for monitoring the use of funds, including procurement and disbursement, and reporting on the use of project funds. The PCU is headed by a Director, who will have overall responsibility for the proposed project. The PCU Director will ensure that all project objectives and targets that can be monitored, as specified in the Project Operations Manual (POM), are on track and achieved. The PCU includes a procurement officer (who is supported by an experienced consultant), a project accountant and an administrative assistant.

Funds Flow

The International Development Association (IDA) would make funds available to the Government of Serbia and Montenegro (SAM) under the Credit Agreement, governing the terms and conditions of the IDA credit and specifying the project. The Government of SAM would on-lend the funds on IDA terms to the Republic of Serbia based on the Subsidiary Credit Agreement with terms and conditions satisfactory to IDA.

Project funds will flow from: (i) the IDA, either via a single Special Account which will be replenished on the basis of SOEs or by direct payment on the basis of direct payment withdrawal applications; or (ii) the Government, via the Treasury at the Ministry of Finance (MOF) on the basis of payment requests approved by the Treasury. There are 3 banks in Serbia which have been pre-qualified to hold Special Accounts; Societe Generale, Raiffeisen and HBV.

A Dinar denominated project bank account, funded by an advance from the Special Account will be opened in the same bank as the Special Account. The balance on the project bank account will be limited to not more than 30 days worth of anticipated expenditures. The project bank account will be used to facilitate small payments to local suppliers.

7. Sustainability

Sustainability of the restructuring activities is the primary issue. Project funding is already scarce and while supporting the preparation of a national facilities based master plan, only providing funding for a micro-portion. This will be considered during preparation of the Plan. For example, are there facilities that are more amenable for private investment (as in Latvia), or others that can be converted for other public sector uses?

8. Lessons learned from past operations in the country/sector

Serbia 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 important; (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; and (v) adequate resources need to be committed for supervision of projects.

Given this experience over the past ten years, the proposed Project includes a significant institution building component which will include activities to reach out to the public and make sure they are engaged in the reform process. Support to an institute for training in public health, management, and health policy is also envisaged as part of the project as well as the means by which capacity can systematically be strengthened in these important areas. The OBD report noted that support for the establishment and accreditation of health management institutes has helped to increase the credibility of these "new" disciplines, built national capacity, and strengthened constituencies for reform.

In addition to these general lessons, there are also lessons that can be gleaned from the more than 15 countries that have undertaken "restructuring" projects. First, and most importantly, is that the market alone is not sufficient to reduce the size of the sector. Countries that have assumed this, are more likely to see financial failure in their health insurance systems as they are unable to control costs. Second, the most successful restructuring projects have been actively supported by adjustment conditionality. Successful examples in ECA include Moldova and Georgia. Close links to SAC-1 and the proposed SOSAC are a key component of this Project’s design. Third, many of the earlier projects only provided financing for civil works and medical equipment, but did not cover other expenses associated with restructuring. The ICR for the Albanian Health Project aptly notes:

"The project design provided no resources or activities to support [this streamlining] process, and assumed that staff redeployment and resource allocation would automatically be implemented by the local health authorities. The design underestimated the level of effort and resources required to achieve a health service rationalization and may have overlooked the technical and political complexity associated with such activities."

Fourth, it is necessary to ensure that there is consistency between future provider payment systems, reforms concerning decentralization and ownership of facilities, and legal issues around closing facilities and reducing staff. This project would place a significant amount of attention on getting these things right. Inclusion of health financing in the proposed Project ensures that there will be consistency between future provider payment system and the goals of the restructuring program.

The ECA-wide review also provides some lessons that are relevant for the health financing component. As with restructuring, 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, or support from health care professionals and the public for the aims of the reforms. Even when carefully designed in sufficient detail, the implementation of activities is often not sequenced correctly. The proposed project would be able to address this in part through its close ties to the adjustment program. One of the main issues to be resolved is the responsibilities of the key players in the systems and the
9. Environment Aspects (including any public consultation)

The government is preparing a health facilities master plan. That plan will be completed by the end of 2003. It will include an assessment of the current status of health facilities, including their ability to treat medical waste. It will also include a map for the future, which in all likelihood will involve relocating health services and shutting down some facilities. The map for the future will be based on new standards and guidelines that take into consideration the economic reality, current clinical practices, etc.

The EAR and the Bank are currently helping the GoS to prepare this map, or master plan and to prepare national standards and guidelines for health services planning. These standards and guidelines will include measures to align environmental and health protection standards with EU requirements. It is beyond the scope of the project to support implementation of part of the plan. The project will focus on shorter term, incremental improvements in quality and efficiency in four regional hospitals. This will involve repairs and maintenance (roofs, windows, electricity, gases, heating systems) and some minor civil works that are expected to make limited changes in the internal partitions and access ways of existing buildings in order to make them more efficient and safe. These repairs and minor works are expected to be in the range of $1,000,000 - $2,000,000 per facility. Improvement in energy efficiency is likely to be achievable through investment in minor civil works and in heating systems. In one or more of the regions in which the Project is working, the Serbia District Heating and Energy Efficiency Project may provide support for investment in improving hospital energy efficiency.

How radiological, chemical and biomedical hazards (principally infection control) are handled in the hospital will be part of the national standards and guidelines and will be encompassed in the Environmental Management Plans (EMPs) for the regions participating in restructuring. The proposal development, business plans and EMP for Kraljevo will serve as a model for other regions participating in the project. The Kraljevo EMP has been published. The MOH will require the other three participating regions to prepared EMPs based on this model, acceptable to IDA, as a condition of any civil works investment under the Project.

The project envisions some relatively minor civil works (repairs and rehabilitation of existing buildings). Overall, the project should have a positive environmental impact by improving infection control and safety within the hospital, reducing the amount of medical waste in Serbia that is not disposed of properly and by improving energy efficiency. The national standards and guidelines to be developed with EAR/IDA support will include regulations for safety in relation to fire, medical radiation, hazardous chemicals, and biomedical waste in the health system. Any hospitals refurbished under the project are required to have an environmental management plan, including a medical waste plan, and to disclose this locally in Serbian in concert with planned communication.
about health services restructuring.

An environmental management plan has been developed for the Kraljevo demonstration site and published, and disclosed in the Kraljevo region. For the remaining three regions participating in the restructuring activities (Valjevo, Vranje and Zrenjanin), the MoH and regional health center managers will prepare environmental management plans using the Kraljevo EMP as a model and disclose these in their regions once detailed regional restructuring plans have been completed (during project implementation). Health facilities waste management issues will be covered in the EMP. The EMP will, among other things, ensure compliance with local environmental and hygiene laws.

A working group will be formed to develop the health facilities master plan and design the project’s health services restructuring component. It would be the responsibility of this group to consult stakeholders as they prepare the master plan. The main stakeholders would be health care providers and local and republican government officials.

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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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