ICRR 11425
Report Number : ICRR11425

ICR Review
Operations Evaluation Department

1. Project Data: Date Posted : 04/03/2003

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|---|---|---|---|
| PROJ ID : P008161 | | Appraisal | Actual |
| Project Name : Uy-health Sector Development | | Project Costs (US$M) | 28 | 17.94 |
| Country : Uruguay | | Loan /Credit (US$M) | | |
| Sector (s): Board: HE - Central government administration (50%), Health (50%) | Loan/ | US$M ) | 15.6 | 9.26 |
| | | Cofinancing (US$M) | 0 | 0 |
| L/C Number : L3855; LP209 | | | | |
| | | Board Approval (FY) | 95 | |
| Partners involved : | | Closing Date | 06/28/2000 | 06/28/2002 |

| Prepared by : | Reviewed by : | Group Manager : | Group : |
|---|---|---|---|
| Roy Jacobstein | Jorge Garcia-Garcia | Alain A. Barbu | OEDST |

2. Project Objectives and Components

a. Objectives

The Project addressed the Government's policy goal of rationalizing health sector spending and contributing to health sector reform. Given the complexity of this goal, the Project focused on two objectives felt to be attainable and likely to lay a foundation for incremental and sustainable improvements. These two objectives were: (a) To improve the efficiency and quality of the health services provided by the Ministry of Public Health (MSP) to the poor and uninsured by reducing the MSP's role as a
direct service provider; and (b) To establish the framework for the development of health sector institutions. The Project was restructured in 1998 and the objectives were unchanged according to the ICR, though it could be argued that the changed implementation strategy for Component 1 (see Section 2b) represents a change in objectives.

b. Components

The Project had three Components: (I) Delegation of MSP's Service Delivery Responsibilities ($US 5 million, 18% of total Project cost), which was to promote gradual delegation of MSP service responsibilities to eligible entities, primarily in the private sector. This original strategy was modified in November 1998 at project restructuring, with contracting to the private sector abandoned in favor of decentralization of public hospitals; (II) Institutional Development ($17 million, 61% of total Project cost), which was to strengthen institutional capacity and management, and included professional training, MIS upgrading, and strengthening of regulatory and financing systems and capacities; and (III) Establishment of Health Sector Disease Priorities ($6 million, 21% of total Project cost), which would rely on burden-of-disease and cost-effectiveness analyses to support priority public health programs as well as service delivery standards and accreditation systems.

c. Comments on Project Cost, Financing and Dates

Financial information presented for total Bank contribution at Appraisal is given in the SAR and on the ICR cover sheet as US$15.6 million; however Annex 2's Table on Project Financing by Component shows
total Bank contribution at Appraisal as $10.6 million. This error may be due to the fact that $5 million of the

Bank loan was cancelled in 1998, mostly related to cancelled investments in MIS and less intensive international technical assistance for hospitals. Because of this error, the Percentages of Appraisal for the Bank given in the same table are erroneously high. Actual Government contribution was 70% of the level indicated at Appraisal ($8.68 million of $12.4 million), and counterpart funds always lagged during project implementation, requiring repeated Bank intervention. Frequent turnover of Government (3 during the 9 years from preparation to completion) and staff (6 Ministers of Health, 5 PCU Directors) resulted in three Project extensions, which totaled two years.

3. Achievement of Relevant Objectives:

Relevant objectives were largely achieved. Despite an environment traditionally resistant to even minor reform, the Project succeeded in transferring greater autonomy to public hospitals, exceeding initial expectations about the breadth—though not the depth—of reforms. Public hospitals in all Departments entered into performance agreements that now are used as a legally mandated resource allocation instrument. The greater decentralization and significant management autonomy at the public hospital level

led to improved organizational and management processes and to documented, notably increased, service outputs and efficiencies. Thorough institutional restructuring of the MSP and the ASSE (The Administration for State Health Services), in order to separate health financing from health provision, was approved (July 2002), and partial progress has been made in implementation. Useful sector studies were conducted that led to cost savings, and clinical protocols were developed and put in use to varying extent.

4. Significant Outcomes/Impacts:

From the standpoint of cost savings, initial implementation of a restructured National Resources Fund, which covers complex medical care, saved $US 25 million (16.6%) out of an annual budget of $150 million, and another $4 million (8.5% of total expenditures) was saved by the 10 public hospitals that signed performance agreements by 2001. By project close, 32 public hospitals, including all the Departmental ones, had signed performance agreements. From the standpoint of service delivery volume and quality, the 10 hospitals with agreements signed in 2001 achieved over 80% of their organizational strengthening objectives, while increasing service delivery volume and quality. For example, ambulatory visits rose 60% at primary care centers, average length of hospital stay declined 20%, and ASSE's average cost per consumer in these hospitals declined 19%. From the standpoint of improved institutional capacity and management, a Health Insurance Identification Database that enables all public hospitals to identify who is or is not insured was established, better enabling hospitals to target the uninsured and recover costs from third party payers. Over 700 managers were trained and 27 clinical protocols were developed and are being used in public hospitals. Three of the largest private insurers, who cover 40% of the private insurance market, have accepted these protocols.

5. Significant Shortcomings (including non-compliance with safeguard policies):

The reform effort fell disappointingly short, with the Government proving unwilling to contract the provision of health services to the private sector and none of the ASSE public hospitals functioning as fully autonomous units. The Monitoring and Evaluation system for these hospitals remains weak (reflecting an absence of a culture for using objective indicators to measure outcomes and guide decisionmaking). Although new structures for the MSP and ASSE were approved in July 2002, needed staff appointments and transfers had not yet been made, and pertinent budgetary changes were still pending. The ASSE was not yet able to identify and categorize its users by ability to pay, impeding the introduction of user fees. In addition to the delays and turnover noted above, the PCU was oversized, requiring Bank intervention to reduce over-staffing.

| 6. Ratings : | ICR | OED Review | Reason for Disagreement /Comments |
|---|---|---|---|
| Outcome : | Satisfactory | Satisfactory | |
| Institutional Dev .: | Modest | Modest | |
| Sustainability : | Likely | Likely | |
| Bank Performance : | Satisfactory | Satisfactory | |
| Borrower Perf .: | Satisfactory | Satisfactory | |
| Quality of ICR : | | Satisfactory | |

NOTE:

NOTE ICR rating values flagged with ' * ' don't comply with OP/BP 13.55, but are listed for completeness.

7. Lessons of Broad Applicability:

The Project demonstrates several key lessons typical of those from other health reform projects: (1) Simple design and modest objectives are warranted, and even then achieving fundamental reform is labor-intensive and difficult. (2) Communication strategies that promote widespread ownership need to be both a part of project design and a continuous implementation responsibility, given the predictable existence of resistance to the major threats that reform represents to various established interests. This type of policy and communication effort is even more important in a milieu of political instability. (3) Not only are good M&E indicators and systems needed up front at the project level, a project should also consciously serve to catalyze and advance an “M&E culture‿ in the sector. (4) Well-conceived and implemented pilot programs that are highly congruent with Government policies and commitment can be replicated widely, particularly when the benefits that such programs accrue are measurable and demonstrated. (5) Presenting a Project to the Board for Approval immediately before a new government comes to power entails risk of non-support by the successor government.

8. Assessment Recommended? Yes No

9. Comments on Quality of ICR:

The ICR is concise, complete, well-written, and internally consistent (except for the aforementioned financial discrepancy in Annex 2). Its analyses are sound, it focuses on the important aspects of the Project and it provides useful quantitative and qualitative data to support its points. The judgments it makes are fair and balanced. The Lessons Learned section is ample.