PROJECT INFORMATION DOCUMENT (PID)
APPRAISAL STAGE

Report No.: AB3124

Project Name	UY Non Communicable Diseases Prevention Project
Region	LATIN AMERICA AND CARIBBEAN
Sector	Health (100%)
Project ID	P050716
Borrower(s)	MINISTRY OF HEALTH
Implementing Agency	
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Environment Category	[ ] A [ ] B [X] C [ ] FI [ ] TBD (to be determined)
Date PID prepared	May 05, 2007
Estimated Date of Appraisal Authorization	June, 2007
Estimated Date of Board Approval	October, 2007

Introduction

Uruguay is a middle-income country, with a population of 3.5 million and an annual per capita income of US$4,340.00. Uruguay has socio-economic and social spending indicators comparable to those of OECD countries. With 9 percent of GDP devoted to the health sector, Uruguay's burden of financing for health raises concerns about the financial sustainability of the system. This financial stress resulting from health spending is also high for households.

Throughout most of the second half of the twentieth century, Uruguay had the highest or near highest health status and human development indicators in the Latin American and Caribbean (LAC) region. While it remains among the top-ranked LAC countries on human development and health indicators, Uruguay's relative position has slipped in the past few years. The main problems affecting the health status of the Uruguayan population stem from an aging population and the high prevalence of non-communicable diseases (NCDs). Uruguay's

health system currently faces two major challenges: (i) the growing inability of the system to provide adequate financial protection; and (ii) an inadequate response to non-communicable diseases (NCDs). In turn, these two main problems are interconnected.

In terms of the institutional structure, Uruguay's health care system is highly fragmented among participation from four main actors: the public health system; the social-security associations; the private sub-system and the National Resource Fund. The MSP is responsible for regulating the health sector and administering the promotional and preventive health programs.

In addition, Uruguay had experienced a transition in its demographic structure. With more than 13 percent of the population being older than 65, Uruguay is the "older" country in the Western hemisphere. Consequently, Uruguay has changed its epidemiological profile as well as completing its epidemiological transition and changing its health profile to one with a high prevalence of NCDs. Chronic illnesses now claim more people than infectious diseases.

The health system in Uruguay has made only a few adaptive changes to address this change. Moreover, few resources are devoted to primary or secondary prevention of NCDs to health promotion activities. The effects of chronic illness are of particular concern among the poor, who lack the knowledge, the time and the money needed to access health services. There are important and growing economic costs for the health system associated with the care of chronic NCDs, which progressively erode the capability of the health system to provide adequate financial protection. Until now, health reform initiatives in Uruguay have concentrated on financial and design problems. Efforts have never been focused on improving the health system's response to the areas where the disease burden was highest.

As a consequence, the MSP does not have the basic tools to address NCDs effectively, including an appropriate information system; epidemiological surveillance and monitoring systems; and a health promotion and prevention policy. A new national strategy on NCDs is needed to introduce changes in Uruguay health policy.

This briefing note describes the main country health issues that constitute a rationale for a proposed health sector project and the project component

The proposed project will focus on Non Communicable Diseases, which have become more highly prevalent in Uruguay. A national strategy to face NCDs challenge would be developed by Uruguay Government with the support of the proposed project, which will consist of financing support to the Uruguay Ministry of Health, as implementing agency.

The Prevalence of NCDs in Uruguay.

The demographic transition that has been occurring over the past 30 years is now complete. A drop in fertility and mortality rates has contributed to the aging of Uruguay's population, which was exacerbated by a strong out-migration during the 1970s. The drop in fertility rates was the most important factor affecting the shape of the population pyramid, resulting in a narrowing of its base. Likewise, the drop in mortality rates has also affected the shape of the population pyramid, increasing the relative importance of the upper layers. Currently, more than half of the population is more than 31 years of age, and 13 percent is more than 65 years of age. The overall fertility rate is 2.4 births per female; life expectancy is above 74 years and there are only two people younger than 15 for each person who is 65 or older. We can conclude that during the 20th century, Uruguay experienced a transition in its demographic structure that has concluded and, consequently, its epidemiological profile has changed too.

Changes in Uruguay's disease and epidemiological profile have gone hand-in-hand with demographic changes. Today, the prevalence of infectious diseases is low and health and social related indicators are good, as shown below:

Indicators	Results
Life expectancy at birth	75 years
Infant mortality rate	12.7 per 1,000 live births
Births delivered in a hospital or clinic	99 percent
Improved source of water	98 percent

The past good health sector performance has lead to a reduction in infectious and parasitic diseases. However, in parallel, Uruguay has been suffering an increase in health conditions related to unhealthy lifestyles, risky behavior, negative social and economic environment and an aged population. As an illustration, six out of ten deaths are now attributed to cardiovascular diseases and various forms of cancer that are clearly related to older age. Likewise, chronic illnesses now account for an estimated 75 percent of all lost disability-adjusted life years (DALYs), and just two chronic diseases—cardiovascular diseases and malignant tumors—account for 58 percent of all deaths. Table 1 gives a breakdown of the main causes for year 2003.

Table 1. Main Causes of Death

Cause of Death	As a Proportion of All Deaths	Mortality Rate x 100.000 Inhabit.
Cardiovascular diseases	33.5	313.4
Malign tumors	23.8	222.9
Accidents y adverse effects	3.8	35.4
Chronic respiratory diseases	4.1	38.6
Acute respiratory diseases and pneumonia	3.4	31.7

Mental and behavioral problems	2.4	22.2
Infectious and parasitic diseases	2.1	19.8
Diabetes mellitus	2.1	19.6
Suicide	1.6	15.1
Pre-natal affections	0.9	8.9
Chronic renal insufficiency	1.0	9.0
Cirrhosis, fibrosis y alcohol-related diseases	0.7	6.7

Source: INE, 2003

Inadequacy of the Current Health Care System

While it remains among the top-ranked LAC countries on human development and health indicators, Uruguay's relative position has slipped in the past few years.[1] Throughout most of the second half of the twentieth century, Uruguay had the highest or near highest health status and human development indicators in the Latin American and Caribbean (LAC) region. Similarly, Uruguay's health coverage is remarkably high: 52 percent of urban Uruguayans report having contributory health insurance, and 97 percent of urban Uruguayans report either having some type of insurance or a regular source of care, generally the Ministry of Public Health (MOH). In addition, the entire population is covered under the National Resource Fund (*Fondo Nacional de Recursos* - FNR) for 16 high-cost, low-frequency procedures and illnesses.

One of the causes for Uruguay declining results is the fragmentation of its health sector structure that makes it difficult to establish common rules and goals. Uruguay's health care system is highly fragmented among participation from different health sector actors: the public health system; the cooperative (social-security financed) insurers/providers associations (i.e., doctor-owned and managed organizations known as Collective Medical Assistance Institutes—*Institutos de Asistencia Médica Colectiva* - IAMCs); and the private sub-system. The IAMCs provide mandatory health insurance and services to formal workers and, on a voluntary basis, to their families. The FNR is a quasi-public entity that, as mentioned above, provides universal coverage for catastrophic events, with public and contributory financing. The MOH and the IAMCs cover approximately 40 percent each of Uruguayans. There are two additional private health care systems that are particularly noteworthy—private hospitals and a wide assortment of emergency ambulance services—and the police and military health care systems. The MOH is responsible for regulating the health sector and administering the preventive health programs. However, it only devotes a low percentage of overall health expenditures to preventative health. As a result of the existence of a fragmented health care system in the country, a non

[1] Once perennially among the two top-ranked LAC countries in the UNDP Human Development Index, Uruguay's 2000 ranking slipped to third in the region and to fourth in 2004. Although the 2000-2004 change in ranking is due to the incorporation of Barbados for the first time, the gap between Uruguay and Argentina and Chile, which rank second and third, respectively, has also widened during the 2000-2004 period.

coordinated information system is composed of different offices which include the health sector and the national central statistical office (INE).

In addition, the health sector is facing financial problems. With 9 percent of GDP devoted to health sector, Uruguay's burden of financing for health raises concerns about the financial sustainability of the system. The fact that health expenditures have long been increasing at a pace faster than the cost of living and that the share of GDP devoted to health grew by more than 20 percent between 1994 and 2003, underscores concerns about the magnitude and the rapid growth of the system's financial burden. The most important factor contributing to the financial stress in the health system is the deficit of the social security health insurance system, which, in turn, translates into the deficit of the IAMCs. The greater part of IAMCs' operational deficit is coming from the increase in care health services. The long-term financial crisis of the IAMCs has resulted in serious sustainability problems, with increasing long-term debt and a growing number of providers filing for bankruptcy—15 percent of all IAMCs since 1999.

Financial stress resulting from health spending is also high for households. Thirty percent of Montevideo's households and 25 percent of households in the interior spend 20 percent or more of their household income on health. This is a high proportion in relation to other countries (World Bank, 2005). The cost of the premium of the social security's health insurance program has increased twice as fast as the legal wage since 1993, while average co-payments per consultation have increased roughly 75 percent.

There are also important inequities in financing. Through the IAMCs, the private sector receives major subsidies from the public sector: 10 percent of IAMC affiliates report they regularly obtain at least a portion of their care from a public sector provider, which constitutes a cross-subsidy from the public to the private sector. Furthermore, as mentioned earlier, the deficit of the formal social security institution, which in 2004 equaled about 11 percent of the MSP budget, is being absorbed by the Ministry of Economy and financed by general taxpayer contributions. Finally, there is wide variation in the proportion of employers' wage bills that are paid as social security contributions.

Despite the epidemiological transition with its consequent shift toward a higher prevalence of NCDs and the financial difficulties, Uruguay's health system has made only a few adaptive changes to address these changes. Although the epidemiological country profile has changed, the health care system is still organized to assist acute illness more than chronic illness. So, there is not any strategic approach to manage health chronic problems which increases problems regarding health system burden of financing and health care services quality. The high sector fragmentation contributes to aggravate both financing as quality problems. The sluggish pace of change in the health system is troubling because of its financial, individual, social, and economic implications. The effects of

chronic illness are of particular concern among the poor, who lack both the knowledge and time to access health services.

These demographic and epidemiological changes have a direct impact on the health system. A study focusing on the largest social security institutions showed that affiliates who were 65-years of age or more accounted for 20 percent of the membership but 40 percent of the costs. Although there are important and growing economic costs to the health system associated with the care of chronic illnesses, the financing levels for prevention and health promotion services are inadequate. Only 0.2 percent of overall health expenditures are spent on preventive care and health promotion, and the MOH devotes only 7 percent of its expenditures on these areas.

In addition to the lack of focus by the health care system on health promotion, there is a generalized lack of knowledge of preventive care of NCDs among the overall population, in particular among low-income groups. Responsible for it is the weakness of the health promotion and prevention policy. A recent survey has shown that 20 percent of women aged between 20 and 59 have never had a breast examination, with the proportion varying greatly by income group—27 percent, 18 percent, and 10 percent for women in low-, medium-, and high-income groups, respectively. Similar results were found in the prevention of cervical cancer. While 30 percent of women aged between 20 and 59 have never had a Pap smear test, the proportion varies greatly by income group, with 40 percent and 16 percent for women in low- and high-income groups, respectively. A significant difference was also found between women living in Montevideo (22 percent) and those living in the interior of the country (35 percent). A similar correlation between the use of preventive tests and socio-economic status is found among men. While 69 percent of men 40-years old or older has never had a prostate cancer exam, this proportion is higher among low-income men (83 percent) and lower among high-income men (38 percent).

The Importance of an Adequate Health Policy Framework

Financing Problems and the Health Care Model have a strong connection. There are important and growing economic costs for the health system associated with the care of chronic NCDs, which progressively erode the capability of the health system to provide adequate financial protection. Although both factors—i.e., financial and epidemiological factors—need to be addressed concurrently, it is critical to improve the capacity of the health system to respond to the burden of disease appropriately. Merely improving the financing of the health system without addressing the health care model itself, will be insufficient to address the cost explosion. Until now, health reform initiatives in Uruguay have concentrated on financial and design problems. Efforts were never focused on improving the health system's response to the areas where the disease burden

was highest. As a consequence, the MOH does not have the basic tools to address NCDs effectively, including an appropriate information system; epidemiological surveillance and monitoring systems; and a health promotion and prevention policy.

The intensive use of basic health public tools to address NCDs could promote quick improvements in health status. Public health campaigns aimed at promoting healthy lifestyles and the early detection of high-risk diseases such as diabetes, hypertension and hypercholesterolemia could have a considerable impact in reducing health care costs and increasing the quality of life of many Uruguayans. Due to the longstanding and marked mismatch between the epidemiological profile and the health care model, it is estimated that the adoption of even a few simple measures of health promotion and prevention focused on chronic NCDs diseases could reduce the number of years of life lost due to premature death among persons less than 60 years by one-third. It is estimated that 22 percent of all deaths and 32 percent of the deaths of Uruguayans younger than 65 years old are avoidable. Many Uruguayans are suffering unnecessarily and dying prematurely because their health system is not addressing the needs of the population. The burden of chronic NCDs is also distributed inequitably, with the poor enduring more suffering than the rich.

A National Strategy to allocate NCDs problem

Health promotion and prevention strategy of NCDs could yield a mid and long term reduction of country burden of diseases. However, to reach this objective, a new National Strategy for NCDs is needed as a way of strengthening the MSP's capacity to carry out the essential public health functions, including regulation and stewardship, health promotion and prevention, and epidemiological surveillance and monitoring, with focus on and matters related principally to prevalent NCDs, including the improvement of health care, especially by primary care public providers.

This strategic path is proposed to reach two main objectives: One, achieve the delivery health care system to match the new health needs of the population and two, to increase the population's knowledge regarding health promotion and prevention of NCDs, in order to reduce the impact of ageing on the people's health status. Four main axes of a National Strategy for NCDs would be: one, regulatory policy; two, health promotion policy; three, health preventive care policy and four, social and institutional commitment and mobilization.

PROJECT DESCRIPTION

1. **Lending instrument**

The Government of Uruguay has requested a US$ 25.2 million Specific Investment Loan (SIL) to support technical assistance in the health sector during FY 2005-2010.

2. Project development objective and key indicators

The operation would seek to support the Government's efforts to further strengthen its health delivery services and the current health policy framework for NCDs. In this context, the specific development objectives of the proposed operation would be: *(i) To expand accessibility and quality of primary health care services related to selected NCDs' early detection and medical care; and (ii) To avoid and reduce exposure to selected NCDs risk factors as well as theirs medical effects*

3. Project components

The operation would consist of four components: Component 1 – Strengthening MSP's capacity to address the country's changing epidemiological profile; Component 2 - Improve accessibility to quality care services for prevalent NCDs in public primary care facilities; Component 3 - Implementation of the "Previniendo" Pilot Program; and Component 4 – Project management. These components are synchronized with activities to be undertaken by the three main directorships in the MSP: DIGESA, ASSE and DIGESE, with support and coordination from the PSCU

Component 1 - Strengthening of the MSP's Capacity to Address the Country's Changing Epidemiological Profile *(US$ 6.7 million of which US$ 6.3 million would be financed by the Bank loan):* This component would strengthen the Ministry of Public Health (MSP), so it can exercise its stewardship of Uruguay's health system by improving essential public health functions related to NCDs. Finance would be provided for technical assistance, training, and incremental operating costs, within three sub-components, with the MSP's Directorate General of Health (*Dirección General de Salud* – DIGESA) being responsible for the overall coordination of the activities within this component:

Subcomponent 1.1 – Strengthening of Health Intelligence *(US$ 2.3 million of which US$ 2.1 million would be financed by the Bank loan):* This subcomponent would support the further development of a health intelligence information system focusing on optimizing information and monitoring systems, including epidemiological surveillance and health monitoring with a special focus on NCDs, to ultimately enhance DIGESA's capacity for health policy formulation in relation to NCDs. The activities in this subcomponent would include:

i) **The foundations for an Integrated Health Information System** (IHIS) would be established under the proposed operation. In particular, activities for the foundations for an IHIS would be aimed at providing relevant and timely information to ultimately enhance health planning and policy-making, thus enabling the MSP to: i) strengthen epidemiological surveillance—including NCDs and risk factors—and preparation for emerging infectious diseases; ii) optimize monitoring systems of quality of heath care; iii) improve capacity for health policy formulation, especially related to NCDs; iv) ensure the enforcement of health regulations and standards; and v) effectively link resources with performance. The IHIS would build upon the various databases that currently exist within different spheres of Uruguay's health sector. Moreover, this activity would capitalize on the window of opportunity as a result of the proposed operation, which would support the development or consolidation of several information sub-systems—i.e., a public health surveillance system, (*Sistema de Vigilancia Epidemiológica* – SEVES), with a focus on NCDs and corresponding risk factors, M&E of the performance of public and private health care providers, and the health insurance identification database. This would permit adaptation of these sub-systems to predefined standards in order to facilitate the future exchange of information. The MPS would be responsible for facilitating the virtual exchange of information among the existing databases by setting standards for data configuration and data exchange. The administration of individual databases will remain the responsibility of their current administrators.

ii) **Strengthening the response capacity of DIGESA and its departmental units** to make informed decisions about prevention and control priorities; to monitor the impact of the health interventions; to carry out disease monitoring, control and prevention for several diseases that pose a serious public health threat, including tuberculosis, dengue and hospital infections and to develop a health promotion program focusing on education, social mobilization, and advocacy in healthy spaces, related to NCDs.

Subcomponent 1.2 - Health Promotion and NCD Prevention Programs *(US$ 3.2 million of which US$ 3.0 million would be financed by the Bank loan):* This subcomponent would support development of public health programs aimed at promoting healthy lifestyles and NCDs prevention, including:

1. Communication campaigns to educate the public on NCDs risk factors and promote healthy lifestyles.
2. NCDs prevention programs with a focus on:
    a. Vertical prevention programs: Programs aimed at promoting healthy lifestyles and preventing risk factors associated with NCDs, such as smoking, obesity and alcohol and drugs, and sedentary lifestyles.
    b. Horizontal prevention programs: These are setting-based programs to promote good health and NCDs prevention in settings that foster

social participation, such as healthy schools, healthy workplaces, and healthy municipalities, as well as community-based health promotion activities.

Subcomponent 1.3 - Regulatory capacity building in relation NCDs *(US$ 1.2 million of which US$ 1.2 million would be financed by the Bank loan):* This subcomponent would focus on strengthening MSP's capacity to create sound regulatory frameworks, ensure their adequate enforcement, and have in place effective M&E systems to, in turn, enhance the effectiveness and efficiency of NCDs health programs. Activities within this subcomponent would be grouped in two main categories: (i) Review and optimization of the current regulatory framework; (ii) Regulatory enforcement.

Component 2 - Improve accessibility to quality care services for prevalent NCDs in public primary care facilities *(US$ 15.0 million of which US$ 12.5 million would be financed by the Bank loan):* This component would strengthen the capacity of Uruguay's public health system in the screening and control of prevalent NCDs—i.e., hypertension, cardiovascular disease, diabetes and three preventable cancers. It would also improve problem resolution at the primary care level; thus enhancing efficiency of the overall sector. The Health Services Administration (*Administración de Servicios de Salud del Estado* – ASSE), the agency within the MSP responsible for providing medical care to those without social security or private health insurance coverage, would be responsible for the implementation and coordination of the activities in this component. This component would finance technical assistance, the purchase of medical and ITC equipment, training and the incremental operating costs related to the implementation of activities in three subcomponents, as follows:

Subcomponent 2.1 – Enhancing technological infrastructure of the public primary health care network *(US$ 12.9 million of which US$ 10.5 million would be financed by the Bank loan):* This subcomponent would focus on enhancing the technological infrastructure of primary health care facilities as well as secondary referral centers. These would include the purchase of medical equipment critical in the detection and treatment of NCDs and the provision of ITC equipment.

Subcomponent 2.2 – Development of modern health management tools *(US$ 0.7 million of which US$ 0.7 million would be financed by the Bank loan):* This subcomponent would focus on the development and implementation of modern management tools aimed at improving the efficiency of primary care, particularly in relation to NCDs. Activities within this subcomponent would include: strengthening of information and monitoring systems, the introduction of results-based management contracts; the adoption of standards of quality of care and certification mechanisms to assure standards are followed; and improved NCDs referral and counter-referral systems.

Subcomponent 2.3 – Capacity building *(US$ 1.4 million of which US$ 1.3 million would be financed by the Bank loan):* This subcomponent would focus on strengthening the technical capacity of primary health care public providers in health promotion, screening, and management of priority NCDs.

Component 3- Implementation of the "Previniendo" Pilot Program *(US$ 3.8 million of which US$ 3.8 million would be financed by the Bank loan)*: This subcomponent would develop and implement a pilot program (named "Previniendo") to increase NCDs risk factor prevention in three departments. This pilot program is considered one key element to implementing a holistic policy regarding NCDs prevention. Experience has shown that introducing similar health insurance programs requires assuring the operation of a set of mutually interdependent functions in others MSP areas. Other project components would finance all of the interdependent activities necessary to achieve this outcome. The MSP's Directorate General of Health (*Dirección General de Salud* – DIGESA) which would be responsible for the overall coordination of the activities within this component:

29. The objective of the "Previniendo" pilot would be to reduce the impact of risk factors and medical complications for three selected NCDs with high prevalence in Uruguay: hypertension, diabetes and obesity/overweight. This would be done through the identification, follow-up and effects' mitigation of risk factors. The objective would be to decrease the incidence of the selected NCDs and decrease prevalence in the obese/overweight as a risk factor. The target population for "Previniendo" would be the population older than 18 years. Beneficiaries would receive a Package of Preventive Interventions and Activities (PPI), a group of cost effective services and activities, through authorized health service providers owned by public and private departmental health insurance entities (DHIE). To cover costs of establishing a NCDs preventive system and to pay for the costs of providing the PPI, loan financing for each DHIE would be provided, as a capitation payment. The Ministry of Public Health (MSP), through DIGESA and the PSCU would have overall responsibility for program pilot implementation. The participating departmental DHIE would actually implement "Previniendo", with the MSP having a supportive financing and technical advisory role.

30. The pilot insurance program would be expected to have a positive impact on the functioning of the health system. The "Previniendo" pilot program design would change health insurers and health provider incentives in prevention and monitoring services in public sector for the health risks that are to be covered. While per capitation payments to participating DHIE would be calculated on the basis of risk profile population and detection, it would be adjusted depending on effective population coverage and sanitary goals and actual financial focus to the provider would be based on services rendered on a fee-for-service basis.

31. Resources under this subcomponent would be provided to assure conditional grant transfers from MSP- DIGESA/ PSCU to each participating DHIE, in the form of a capitation payment, for preventive health services provision in the "Previniendo"" pilot program for eligible population.

Component 4 - Project Management *(US$ 2.1 million of which US$ 1.7 million would be financed by the Bank loan)*: This component would be responsibility of the Project's Coordination Unit (PCU), a small unit to be financed entirely by national funds. The specific objective would be to coordinate technical and administrative processes. This unit would also carry out administrative processes regarding specific studies for project impact evaluation and studies to support the health insurance reform design process, which would involve more that one MSP sectors. This component would cover the Project's operating expenses, office equipment and specific studies cost, related to the following:

1. Strengthening of the PGA technical and operational capacity, including financial management and procurement, to implement project activities.
2. Strengthening of the MSP operational capacity to monitor and supervise the overall implementation of the Project, including the performance agreements between the MSP and the implantation PGA and the pilot program "Previniendo" implementation.
3. Impact evaluation studies, especially those related to the "Previniendo" Pilot Program
4. Studies and technical assistance to support the Health Insurance Reform Design Process.

32**. Tentative financing**

Source:	($m.)
Borrower	0
International Bank for Reconstruction and Development	20
Total	20

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