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PROJECT APPRAISAL DOCUMENT

ON A

PROPOSED LOAN

IN THE AMOUNT OF US$25.3 MILLION

TO

ORIENTAL REPUBLIC OF URUGUAY

FOR THE

NON-COMMUNICABLE DISEASES PREVENTION PROJECT

July 31, 2007

Human Development Department
Argentina, Chile, Paraguay, Uruguay Country Management Unit
Latin America and the Caribbean Regional Office

CURRENCY EQUIVALENTS
(Exchange Rate Effective July 15, 2007)

Currency Unit	=	Uruguayan Peso (UR$)
UR$1	=	US$0.041
US$1	=	UR$24.24

FISCAL YEAR
January 1 – December 31

ABBREVIATIONS AND ACRONYMS

APL	Adaptable Program Loan
ASSE	State Health Services Administration (*Administración de los Servicios de Salud del Estado)*
BPS	Social Security Bank (*Banco de Previsión Social*)
BROU	Bank of the Oriental Republic of Uruguay (*Banco de la República Oriental del Uruguay)*
CAS	Country Assistance Strategy
CFAA	Country Financial Accountability Assessment
CGN	General Accounting Office (*Contaduría General de la Nación)*
CQ	Consultant Quality
CUN	Single Nacional Account (*Cuenta Única Nacional)*
DALYs	Disability-Adjusted Life Years
DHIEs	Departmental Health Insurance Entities
DIGESA	Directorate General of Health (*Dirección General de Salud)*
DIGESE	Directorate General of Secretariat (*Dirección General de Secretaría)*
ECLAC	Economic Commission on Latin America and the Caribbean
FCTC	Framework Convention on Tobacco Control
FISS-I	First Health Development Project (*Proyecto de Fortalecimiento Institucional del Sector Salud)*
FM	Financial Management
FNR	National Resource Fund (*Fondo Nacional de Recursos)*
FNS	National Health Fund (*Fondo Nacional de Salud*)
GAO	General Accounting Office
GDP	Gross Domestic Product
IADB	Inter-American Development Bank
IAMCs	Collective Medical Assistance Institutes (*Institutos de Asistencia Médica Colectiva)*
IAO	Internal Audit Office
IAS	International Accounting Standards
IBRD	International Bank for Reconstruction and Development
ICB	International Competitive Bidding
IHIS	Integrated Health Information System
ITC	Information and Communication Technologies
INE	National Central Statistical Office (*Insituto Nacional de Estadística)*
INHS	Integrated National Health System
INTOSAI	International Organization of Supreme Audit Institutions
IUFRs	Interim Un-audited Financial Reports
LAC	Latin America and the Caribbean Region
M&E	Monitoring and Evaluation

MEF	Ministry of Economy and Finance (*Ministerio de Economía y Finanzas)*
MSP	Ministry of Public Health (*Ministerio de Salud Pública*)
NCB	National Competitive Bidding
NCDs	Non-Communicable Diseases
NGOs	Non-government organizations
NHEB	National Health Executive Board (*Junta Nacional de Salud*)
NHI	National Health Insurance (*Seguro Nacional de Salud*)
NHPS	National Health Promotion Strategy
OECD	Organization for Economic Co-operation and Development
PAHO	Pan American Health Organization
PCN	Project Concept Note
PGAs	Participating Government Agencies
PHRD	Policy and Human Resources Development
PIs	Preventive Interventions
POM	Project Operation Manual
PPI	Package of Preventive Interventions
PSCU	Project Support and Coordination Unit
QCBS	Quality Cost Based Selection
RUCAF	Health Insurance Identification Database (*Registro Único de Cobertura Asistencial Formal*)
SDA	Segragated Designated Account
SPDPL	Social Program Development Policy Loan
SSAL-II	Second Special Structural Adjustment Loan
SBD	Standard Bidding Documents
SEVES	Epidemiological Surveillance System (*Sistema de Vigilancia Epidemiológica)*
SHNP	Strategy for Health, Nutrition and Population
SIIF	Integrated Financial Information System(*Sistema Integrado de Información Financiera*)
SIL	Specific Investment Loan
SOE	Statement of Expenditure
SRFP	Standard Request for Propossal
STA	Single Treasury Account
TCR	National Auditing Tribunal (*Tribunal de Cuentas de la República)*
UN	United Nations
UNDP	United Nations Development Programme
WHO	World Health Organization
YLS	Year of Life Saved

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URUGUAY

NON-COMMUNICABLE DISEASES PREVENTION PROJECT

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URUGUAY
NON COMMUNICABLE DISEASES PREVENTION PROJECT

PROJECT APPRAISAL DOCUMENT

LATIN AMERICA AND CARIBBEAN

LCSHH

Date: July 31, 2007	Team Leader: Luis Orlando Perez
Country Director: Pedro Alba	Sectors: Health (100%)
Sector Manager/Director: Keith E. Hansen	Themes: Health system performance (P)
Project ID: P050716	Environmental screening category: Partial Assessment
Lending Instrument: Specific Investment Loan	

Project Financing Data

[X] Loan [ ] Credit [ ] Grant [ ] Guarantee [ ] Other:

For Loans/Credits/Others:
Total Bank financing (US$m.): 25.30
Proposed terms: The loan would be a fixed spread loan in US dollars, 15 year maturity including five years of grace, with principal repayments linked to commitments.

Financing Plan (US$m)

Source	Local	Foreign	Total
Borrower	0.00	0.00	0.00
International Bank for Reconstruction and Development	25.30	0.00	25.30
Financing Gap	3.50	0.00	3.50
Total:	28.80	0.00	28.80

Borrower:
Ministry of Economy
Colonia 1089 - Piso 3
Montevideo, Uruguay
Tel: 598-2-1712-2910 Fax: 598-2-1712-2919
dastori@presidencia.gub.uy
www.mef.gub.uy

Responsible Agency:
Ministry of Public Health
Av. 18 de julio 1892 - Piso 2
Montevideo, Uruguay
Tel: 598-2-400-1086 Fax: 598-2-408-5360
apenaloza@msp.gub.uy
www.msp.gub.uy

Estimated disbursements (Bank FY/US$m)									
FY	2008	2009	2010	2011	2012	0	0	0	0
Annual	4.00	7.50	6.60	5.10	2.10	0.00	0.00	0.00	0.00
Cumulative	4.00	11.50	18.10	23.20	25.30	25.30	25.30	25.30	25.30

Project implementation period: Start January 2, 2008 End: December 30, 2011
Expected effectiveness date: January 2, 2008
Expected closing date: December 30, 2011

Does the project depart from the CAS in content or other significant respects? ***Ref. PAD A.3***	[ ]Yes [X] No
Does the project require any exceptions from Bank policies? ***Ref. PAD D.7***	[ ]Yes [X] No
Have these been approved by Bank management?	[ ]Yes [ ] No
Is approval for any policy exception sought from the Board?	[ ]Yes [ ] No
Does the project include any critical risks rated "substantial" or "high"? ***Ref. PAD C.5***	[X]Yes [ ] No
Does the project meet the Regional criteria for readiness for implementation? ***Ref. PAD D.7***	[X]Yes [ ] No

Project development objective ***Ref. PAD B.2, Technical Annex 3***
The operation would seek to support the Government's efforts to further strengthen its health delivery services and the current health policy framework for NCD. 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 NCD's early detection and medical care; and (ii) to avoid and reduce exposure to selected NCD risk factors as well as their health effects

Project description *[one-sentence summary of each component]* ***Ref. PAD B.3.a, Technical Annex 4***
Component 1: Strengthening of the MSP's Capacity to address the Country's Changing Epidemiological Profile
Component 2: Improve accessibility to quality care services for prevalent NCD in public primary care facilities
Component 3: Implementation of the "Previniendo" Pilot Program
Component 4: Project Management

Which safeguard policies are triggered, if any? ***Ref. PAD D.6, Technical Annex 10***

Significant, non-standard conditions, **if any**, for:
Ref. PAD C.7
Board presentation:

Loan/credit effectiveness:

Covenants applicable to project implementation:

1. Country and Sector Issues

1. **Country Context:** Uruguay is a middle-income country with a population of 3.3 million and an annual per capita income of US$4,340.00, slightly above the region's average of US$4,000.00. It is characterized by an export-oriented agricultural sector, a well-educated workforce, and socio-economic indicators comparable to countries of the Organization for Economic Co-operation and Development (OECD), including a literacy rate of 98 percent and a life expectancy of 75 years. Levels of social spending are also comparable to those of OECD countries; with consolidated (private and public) health expenditures for 2004 at 9 percent of GDP, Uruguay is one of the highest spenders on health in terms of GDP in the Latin America and Caribbean Region (LAC), and comparable to France and Germany.

2. While Uruguay experienced a period of macroeconomic stability and steady growth during most of the nineties, it suffered a sharp reversal in 1998 with a recession that persisted for more than three years before collapsing into a deep economic crisis in 2001-2002. The social consequences of the recession and the subsequent economic crisis were severe. Unemployment increased from about 10 percent in 1998 to 17 percent at the end of 2002. Poverty increased from 18 percent to 31 percent of the population between 2000 and 2003, while extreme poverty doubled to 2.8 percent of the population during the same period. Income inequality, which had traditionally been low when compared to the rest of the region, also increased during the period between 1998 and 2002.

3. With the support of the international financial community, the Government was able to weather the economic crisis of 2001-2002 and successfully negotiated a sovereign debt exchange in May 2003. Real GDP growth in 2004 was 12.3 percent and GDP continued to grow nearly 7 percent annually in 2005 and 2006 as a result of good economic management as well as favorable external developments. As a result of the strong economic recovery and concerted efforts on the part of the Government, unemployment is now approaching pre-crisis level (i.e., 10.5 percent in May 2007) and poverty levels are beginning to recede, with poverty and extreme poverty rates reaching 25.3 percent and 1.65 percent in 2006, respectively.

4. Uruguay is also in the midst of a political transition, as the victory of the left-wing *Frente Amplio – Encuentro Progresista – Nueva Mayoría* coalition in the last elections ended the traditional dominance of Uruguayan politics by the two traditional parties, the *Partido Colorado* and the *Partido Nacional.* The new Government, which took office on March 1, 2005, is focused on fostering social inclusion while, at the same time, improving the investment climate. A structural reform of the country's health system was an integral part of the *Frente Amplio's* electoral platform and is now a top priority in the Government's agenda.

5. **Health Sector Issues:** *Health Status.* 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. Today, life expectancy at birth is 75 years, the infant mortality rate is 10.5 per 1,000 live births, 98 percent of the population has access to an improved source of water, 99 percent of births are delivered in a hospital or clinic, and the prevalence of infectious diseases is low. 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—even before the onset of the last macroeconomic crisis.[1] This trend was

[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

further exacerbated by the social impact of the crisis, although it now shows some signs of reversal.[2]

7. Importantly, Uruguay's demographic structure has changed over the last decades. With more than 13 percent of the population being older than 65, Uruguay is the 'oldest' country in the Western hemisphere. Consequently, Uruguay's epidemiological profile has changed and the epidemiological transition is now complete. Presently, Uruguay's health profile is one with a high prevalence of Non-Communicable Diseases (NCDs). Chronic illnesses now claim more deaths than infectious diseases.

8. *Health Sector's Institutional Setup.* Uruguay's health sector is highly fragmented, lacking a coherent set of goals and regulations. Likewise, the country lacks a coordinated health information system, which makes informed policy decisions difficult. There are four main players in Uruguay's health care system. First, the Ministry of Public Health (*Ministerio de Salud Pública* - MSP) is responsible for Uruguay's the public health system. It provides health services to the uninsured population through a deconcentrated dependency, the State Health Services Administration (*Dirección General de la Administración de los Servicios de Salud del Estado* - ASSE), which runs a network of 64 hospitals, 28 health centers and 292 clinics. The MSP is also responsible for regulating the health sector and administering preventive health programs—although it only devotes a low percentage of overall health expenditures to preventive care. Other public systems include the armed forces and police, which have their own comprehensive health care systems for their personnel, dependents, and retirees.[3]

9. Second, the social-security financed insurers/providers associations, which are either (i) doctor-owned and managed organizations; or (ii) mutual organizations. Both are known as Collective Medical Assistance Institutes (*Institutos de Asistencia Médica Colectiva* - IAMCs). The IAMCs provide mandatory health insurance and services to formal workers and, on a voluntary basis, to their families. The premium of the formal worker's health insurance program of the social security system is administered by the Social Security Bank (*Banco de Previsión Social* - BPS). Third, the private health sector consists of two care systems that are particularly noteworthy—private hospitals and a wide array of emergency ambulance services. Finally, the National Resource Fund *(Fondo National de Recursos* - FNR) is a quasi-public entity that provides universal coverage for catastrophic events, with public and contributory financing.

10. *Health coverage.* Access to health services is remarkably high: 52 percent of urban Uruguayans report having contributory health insurance, and 97 percent report either having some type of insurance or a regular source of care, which, for those not insured, generally consists of the MSP. The MSP and the IAMCs cover approximately 43 percent each of the overall population. Together, the armed forces and police systems cover roughly 9 percent of the population, and private coverage accounts for approximately 1.5 percent. In addition, the entire population is covered under the FNR for 16 high-cost, low-frequency procedures and illnesses.

Argentina and Chile, which rank second and third, respectively, has also widened during the 2000-2004 period.

[2] For example, the infant mortality rate declined steadily until 2002 to 13.6 deaths/1,000 live births, to a subsequent increase during the crisis, reaching 15 deaths/1,000 live births in 2003. It dropped again during 2004, 2005 and 2006 to reach 10.5 deaths/1,000 live births the last year.

[3] In addition, the public sector has three others actors: first, there is the *Hospital de Clínicas*, a public university hospital located in Montevideo that services ASSE's beneficiaries on demand. Second, there is the hospital owned by the State Insurance Bank (*Banco de Seguros del Estado - BSE*), which provides specialized care for occupational illness and workplace accidents. Finally, a number of state enterprises provide coverage to their workers, most offering their own outpatient services while contracting inpatient services with IAMCs and private hospitals.

11. *Financial Cost of Health Care System.* 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. 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. An important factor for such increasing cost is the treatment cost of NCDs, many of which are preventable. In addition, the overall fragmentation of the health care system has led to a cost explosion in the IAMCs, which now face serious deficit problems.

12. *The main challenge for Uruguay*, consequently, lies in containing rising health care costs while putting available resources to more efficient use. This will require a fundamental change in the prevailing heath care model, shifting its focus to respond to the country's epidemiological profile by stressing preventive care for NCDs instead of high cost treatment of acute illnesses. Concomitantly, the harmonization of the system could lead to more efficient risk pooling and, at the same time, better financial protection of households. Meeting these challenges would produce significant improvements in health outcomes while reducing the burden of health financing.

13. **The Government's Health Program.** *Health Care Model and NCDs.* The new administration that took office in March 2005 has placed health reform high on its agenda. The two main pillars of the Government's health reform agenda focus on: (i) developing a strategy to better address NCDs; and (ii) implementing a health insurance reform aimed at creating a more harmonized system through the introduction of a National Health Insurance.

14. *NCDs Strategy.* The Government has developed a comprehensive strategy to adjust the health care model to the existing epidemiological profile, focusing more on NCDs through an integrated care model. The new strategy emphasizes enhanced regulation and policy stewardship, health promotion and effective prevention policies, as well as epidemiological surveillance and monitoring. It also focuses on prevalent NCDs and their risk factors, including several common types of cancer and the improvement of health care delivery, particularly by public primary care providers. Support for the proposed measures is likely to be broad, as the population views an increased focus on promotion and prevention as positive. Similarly, the enhanced medical tools (i.e., medical and nursing staff training and new medical diagnosis equipment) that would complement the implementation of the new strategy are expected to help galvanize the support of health care providers.

15. The Government has already begun to implement several of the proposed measures. For example, regulatory measures in the social health insurance have been adopted to improve coverage of NCDs—e.g., diabetic patients, hypertension, cervical, and breast cancer prevention. Also, the Government has enacted tobacco control measures through legislative approval and the implementation of the Framework Convention on Tobacco Control (FCTC),[4] which include a comprehensive package of measures to avoid damage to health from tobacco.

16. *Health Insurance Reform.* A broad health insurance reform is the second pillar of the Government's ambitious health reform program. It aims at creating a more harmonized system through the introduction of a national health insurance that would ensure more equitable access to

[4] The Framework Convention on Tobacco Control (FCTC), is a binding international legal instrument, promoted by WHO, which establishes broad commitments and a general system of governance for the Tobacco area, including, bans or restrictions on tobacco advertising, promotion and sponsorship, a ban on tobacco consumption in public spaces, elimination of illicit trade in tobacco products, banning of tobacco sales to and by minors, and agricultural diversification and the promotion of alternative livelihoods.

services and improved quality of care while reducing the financial burden of the system. The reform would focus on (i) the creation of an Integrated National Health System *(Sistema Nacional Integrado de Salud - INHS)*, which would define a uniform package of comprehensive health services to be provided by public and private health care providers alike; (ii) an extension of the social health insurance coverage to all national public employees and, in successive phases, to family dependents of active workers; and (iii) the unification of insurance rates across the various sub-systems as well as an adjustment of age- and sex-risk premiums. Although several of the specific design features are still to be defined, the overall legislative framework is currently being debated in Parliament (see Box 1).

Box 1
Proposed Health Insurance Legislative Framework and Organizational Arrangements

Legislative changes for the health insurance reform: Three main laws are now being debated in Parliament, seeking to: (i) decentralize ASSE in order to transform it into a public integrated insurer and provider; (ii) expand Social Health Insurance coverage to all national public employees and to unify age- and sex-risk premiums in *per capita* payment to insurances; and (iii) create the new Integrated National Health System *(Sistema Nacional Integrado de Salud – INHS)* and its governing body, the National Health Executive Board *(Junta Nacional de Salud* – NHEB), as well as to implement financial reform and insurance rate unification.
If the proposed legislation is enacted, the INHS is expected to gradually unify the rules for public and private health insurance providers regarding services, quality standards, production, epidemiological information and others aspects. However, these laws are still pending legislative approval and consensus among stakeholder groups is still to be reached.

Organizational Arrangements for the Integrated National Health System. The new INHS would be governed by the NHEB and financed through a National Health Fund *(Fondo Nacional de Salud - FNS)*. The FNS would gather contributions from the state, private households (mainly through mandatory contributions) and private companies. The INHS could also introduce important regulatory changes to focus the whole system on the care of the most common illnesses.

17. The health insurance reform is expected to be complex and difficult. It has already stirred a wide social debate among stakeholders in the health sector, all of which would be affected in significant ways. Furthermore, such a wide ranging reform would have important fiscal impacts, which would have to be assessed at the onset to ensure sustainability of the Government's overall fiscal framework. The implementation of the health insurance reform is contingent on the successful implementation of the first pillar of the Government's health reform strategy. Specifically, the implementation of the NCDs strategy will be necessary to contain the rising costs of Uruguay's health sector, which, in turn, will be crucial for the wider health insurance reform to succeed. If the health insurance reform were to take place without reorienting Uruguay's health care model in line with the country's epidemiological profile, an efficient and effective use of financial resources could not materialize. The proposed Project would focus on supporting Government's efforts to implement its NCDs strategy, the first pillar of its health reform agenda.

18. **The Prevalence of NCDs in Uruguay**. With more than 13 percent of the population older than 65 and more than half of the population older than 31 years of age, Uruguay is the 'oldest' country in the Western hemisphere. Several factors have contributed to the aging of Uruguay's population, including a drop in fertility and mortality rates, as well as a strong out-migration during the 1970s. Presently, 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.

19. 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 outcome indicators are generally good (see Table 1).

Table 1: Uruguay Health Indicators

	Indicators	Results
(i)	Life expectancy at birth	75.6 years
(ii)	Improved source of water	98 percent
(iii)	Births delivered in a hospital or clinic	99 percent
(iv)	Infant mortality rate	10.5 per 1,000 live births

Sources: INE, 2006 and MSP, 2006 for (i) through (iii); MSP, 2006 for (iv).

20. In parallel, however, Uruguay has suffered an increase in illnesses related to unhealthy lifestyles, risky behavior, changes in the social and economic environment, and the aging population. As an illustration, six out of ten deaths are today attributed to cardiovascular diseases and various forms of cancer that are related to older age. Likewise, chronic illnesses now account for an estimated 75 percent of all lost disability-adjusted life years (DALYs). Table 2 gives a breakdown of the main causes for year 2003.

Table 2: Uruguay: Main Causes of Death, 2003

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.

21. Despite the changes in the epidemiological profile and the higher prevalence of NCDs, Uruguay's health system has made only a few adaptative changes. The health care system is still organized to attend acute illnesses rather than chronic illness. Consequently, affiliates of the social security institutions who are 65-years of age or older account for 20 percent of the membership but 40 percent of the costs. The effects of chronic illnesses are of particular concern among the poor, who lack both the knowledge and time to access good quality health services

22. Despite the substantial and growing economic health care costs associated with chronic illnesses, the financing levels for prevention and health promotion services are inadequate. Only 0.4 percent of overall health expenditures are spent on preventive care and health promotion. The MSP only devotes a low percentage of its overall health expenditures to preventive health and promotion. In the year 2006, 93.6 percent of its total budget was allocated to health care services, and the bulk on the remaining resources was absorbed by administrative and management costs (6

percent), with only a small percentage financing others health public functions including health care promotion.

23. As a result of poor health promotion activities, the general knowledge about NCDs is relatively low, particularly among low-income population groups. 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 negative correlation is found among men between the use of preventive tests and socio-economic status. While 69 percent of men 40-years old or older have never had a prostate cancer exam, this proportion is higher among low-income men (83 percent) and lower among high-income men (38 percent).

24. The substantial and growing economic health costs associated with the care of chronic NCDs are progressively eroding the capability of the health system to provide adequate financial protection. Although both 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 would be insufficient to address the ongoing cost explosion. Until now, health reform initiatives in Uruguay have concentrated mainly 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 MSP does not have the basic tools to address NCDs effectively, including an appropriate information system, effective epidemiological surveillance and monitoring systems, and health promotion and prevention policies.

25. The intensive use of basic public health tools to address NCDs could render rapid 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 on reducing health care costs and increasing the quality of life of many Uruguayans. Many Uruguayans are suffering unnecessarily and dying prematurely because their health system is not addressing the needs of the population, as it is estimated that 22 percent of all deaths and 32 percent of the deaths among those younger than 65 years old are avoidable. The burden of chronic NCDs is also distributed inequitably, with the poor enduring more suffering than the rich. 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 could reduce by one-third number of years of life lost due to premature death among persons before age 60.

26. **Proposed Project and the Government planned health reform.** The proposed Project would support the implementation of the Government's public health/NCDs strategy, a main pillar of its overall health reform agenda. It would also finance the implementation of a pilot finance reform for non-communicable diseases. Specifically, the proposed operation would support the implementation of the national NCDs strategy by simultaneously working on the supply side (the health care model) and the demand side (through promotion and communication activities). Supply-side measures would include designing adequate policy tools (regulation, stewardship, and surveillance), encouraging health care providers to conduct prevention programs; training of health personnel, and financing the *Previniendo* Pilot Program. Covering a population of approximately 140,000 in three of the country's 19 municipal departments, this

pilot program would seek to introduce financial incentives among health insurers and providers by linking financing to outcomes from prevention activities for selected NCDs risk factors. The *Previniendo* Pilot Program constitutes a significant innovation, as it would encourage prevention activities by altering the existing financing flows within the health system. Finally, the proposed Project would provide limited funding for selected evaluation studies in relation to the integrated health insurance reform, the second pillar of the Government's overall health reform agenda.

2. Rationale for Bank Involvement

27. The Bank has established an effective working relationship with Uruguay's MSP within the context of the preceding operations and sector work. The Health Sector Development Project (FISS-I), which was the first IBRD operation to support Uruguay's health sector, helped improve the efficiency and the quality of the health services provided by the MPS, supporting increased levels of decentralization and contracting out of services to five public hospitals on a pilot basis. Two policy based loans, the Second Special Structural Adjustment Loan (SSAL-II; FY03) and the Social Program Development Policy Loan (SPDPL; FY05) continued to support the Government's efforts to improve the efficiency and equity of health spending by eliminating regressive subsidies in public hospitals and reforming the FNR to assure its governance.

28. More recently, the Bank completed a comprehensive study, *Uruguay: Health Sector Review (2005)*, which provided an in-depth analysis of Uruguay's health sector as well as the major challenges facing Uruguayan authorities as they move forward in the design of far-reaching reforms. The report, which was presented to the MSP in December of 2005, was well received by the Government and has contributed to the ongoing discussion regarding the health insurance reform process.

1. 29. The Project is fully consistent with the Bank's overall strategy in Uruguay (Uruguay CAS; Report No. 31804-UY; May 10, 2005). Specifically, the Bank Group's strategy assistance over the period covered by the CAS (FY05-10) proposes a program of lending and non-lending services to support the main objective of the new administration's development plan, which is the attainment of equitable and sustainable economic development. To attain this longer-term goal, the Bank will support the Government in meeting challenges in three broad areas: (i) reducing macroeconomic vulnerability; (ii) sustaining growth; and (iii) improving living standards. One of the most important social challenges of the Uruguayans population, especially the poor, is the increasing prevalence of NCDs, such as cardiovascular diseases, diabetes, obesity / overweight and cancer. Such prevalence has an important impact on the quality of life. As the Project strives to make critical health services for high prevalent NCDs more accessible, secure, and of higher quality to the overall population, the proposed operation directly supports the CAS objective of improving living standards.

30. The Bank team is working in close coordination with international partners. The Inter-American Development Bank (IADB) has played an important role in Uruguay's health system, supporting reforms aimed at ensuring the financial sustainability of the FNR and the IAMCs. In 2005, the IADB completed an operation supporting a debt restructuring process linked to the introduction of managerial changes in the IAMC system. Likewise, Bank staff coordinates and collaborates, where possible, on social and technical issues with various United Nations and other international agencies. The Pan American Health Organization (PAHO) has made an important contribution in the area of NCDs risk-factor prevention through the First National Risk Factor Survey. In addition, PAHO has developed a diagnostic of the Uruguay's health surveillance system, which has been a valuable input during Project preparation.

3. Higher level objectives to which the Project contributes

31. The higher level objective supported by this operation is to improve the living conditions, in this case the health status, of the Uruguayan population. This would be achieved by contributing to reduce the prevalence of selected high frequency risk factors and NCDs in Uruguay.

B. PROJECT DESCRIPTION

1. Lending instrument

32. The Government of Uruguay has requested a US$25.3 million Specific Investment Loan (SIL) to support technical assistance in the health sector during fiscal years 2008-2012.

2. Project development objective and key indicators

33. 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 their health effects.*

34. The indicators corresponding to the Project's development objectives include:

- Percentage of selected NCDs cases (hypertension; diabetes; and obesity/overweight) diagnosed by primary care teams under follow-up
- Percent of women between 50 and 69 years of age having had a mammogram in any given year.
- Percent of the estimated number of newborns with disabilities under follow-up by Early Detection and Treatment Units.
- Population being screened for NCDs risk-factors in participating departments.[5]

3. Project components

35. The operation would consist of four components: Component 1 – Strengthening of the MSP's capacity to address the country's changing epidemiological profile; Component 2 - Improving access 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 would be implemented by the three main directorships within the MSP, with overall support and coordination from a Project Support and Coordination Unit (PSCU).

Component 1 - Strengthening of the MSP's Capacity to Address the Country's Changing Epidemiological Profile *(US$6.1 million of which US$5.7 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

[5] Uruguay's territory is divided in 19 departments (*departamentos*), of which three will participate in the *Previniendo* Pilot Program, under Component 3 of the operation.

to NCDs. Finance would be provided for technical assistance, training, office and ITC equipment as well as operating costs within three subcomponents. 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 functions *(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:

a) *Establishing the foundations for an Integrated Health Information System (IHIS):* Activities would be aimed at developing an integrated health information system 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 in relation 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 government and health-sector agencies and actors. Moreover, this activity would capitalize on the window of opportunity that opens as a result of the proposed operation, as it would support the development and/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; a M&E system to monitor 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 among government agencies (such as the MSP, BPS, the Ministry of Economy (MOE), and the FNR) and other relevant health-sector actors. 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.

b) *Strengthening the response capacity of DIGESA:* Activities would be aimed at strengthening DIGESA and its departmental units to make informed decisions about prevention and control priorities; monitor the impact of the health interventions; carry out disease monitoring, control and prevention for diseases that pose a serious public health threat, such as tuberculosis, dengue and hospital infections, and develop NCDs health promotion programs focusing on education, social mobilization, and advocacy for healthy spaces.

Subcomponent 1.2 - Health promotion and NCDs prevention programs *(US$3.2 million of which US$3.1 million would be financed by the Bank loan):* This subcomponent would support development and implementation of a National Health Promotion Strategy (NHPS) consisting of public health programs aimed at promoting healthy lifestyles and NCDs prevention, including:

a) *Communication campaigns* to educate the public on NCDs risk factors and promote healthy lifestyles.

b) *NCDs prevention programs* with a focus on:

i) Vertical prevention programs: Programs aimed at improving early detection and treatment of NCDs, promoting healthy lifestyles and preventing risk factors associated with NCDs, such as smoking, obesity and alcohol and drugs, sedentary lifestyles.

ii) 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 to NCDs *(US$0.6 million of which US$0.5 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 to develop and utilize 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: (a) review and optimization of the current regulatory framework; and (b) regulatory enforcement.

Component 2 - Improving Access to Quality Health Care Services for Prevalent NCDs in Public Primary Care Facilities *(US$15.8 million of which US$13.2 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 and their risk factors—i.e., hypertension, cardiovascular disease, obesity, overweight, diabetes and selected preventable cancers. It would also improve problem resolution at the primary care level; thus enhancing efficiency of the overall sector. ASSE, which is 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$13.8 million of which US$11.3 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. A total of 210 health care facilities would benefit from new ITC equipment and medical diagnosis equipment critical in the detection and treatment of NCDs. This subcomponent builds upon a detailed diagnosis of the equipment needs for NCDs health services within the ASSE's health network that was financed under the Grant JPN TF 52535.

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 the health network, with a particular focus on NCDs. Activities within this subcomponent would include: strengthening of information and monitoring systems, the introduction of results-based management contracts; the adoption of quality-care standards and certification mechanisms to ensure these standards are followed; and improvement of NCDs referral and counter-referral systems.

Subcomponent 2.3 – Capacity building *(US$1.3 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. Approximately 6,000 health-care personnel (from both the public and private sectors) would be trained in prevention, screening and management of NCDs as part of a broad, ongoing permanent capacity building plan..

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—so-called *Previniendo*–to enhance NCDs control and risk factor prevention in three departments. The pilot would modify providers' incentives by introducing additional financing for the coverage and delivery of a package of cost-effective preventive health services. This pilot program is considered a major cornerstone in the implementation of a integrated policy strategy focusing on NCDs control and prevention. Other Project components would finance complementary activities necessary to achieve this outcome. The MSP's General Director of Health (*Dirección General de Salud* – DIGESA) would be responsible for the overall coordination of the activities within this component:

The objective of the *Previniendo* Pilot Program would be to reduce the impact of risk factors and medical complications for selected NCDs with high prevalence in Uruguay, including hypertension, diabetes, obesity/overweight, and colon cancer. This would be achieved through the identification, follow-up and mitigation of risk factors. The objective would be to decrease the incidence of the selected NCDs and decrease prevalence in the obesity and overweight as a risk factor. The target population for the pilot program would be those older than 18 years. Beneficiaries would receive a Package of Preventive Interventions and Activities (PPI) consisting of a bundle of cost-effective services and activities through authorized health services providers owned by public and private departmental health insurance entities (DHIEs). To cover costs of establishing a NCDs preventive system and to pay for the costs of providing the PPI, loan financing would be provided to DHIEs in the form of a capitation payment. The MSP, through DIGESA and the PSCU, would have overall responsibility for the implementation of the pilot program. The participating departmental DHIEs would implement the *Previniendo* Pilot Program, with the MSP having a supportive financing and technical advisory role.

The pilot program is expected to have a significant impact on the overall functioning of the health system, providing added incentives for prevention and monitoring services for the health risks to be covered. Financing under this subcomponent would provide for transfers from the MSP (i.e., through DIGESA and PSCU) to each participating DHIE in the form of capitation payments. While capitation payments to participating DHIE would be calculated on the basis of the risk profile of the population and the actual detection of NCDs, it would be adjusted depending on specific achievements in terms of program coverage and sanitary goals. Specifically, coverage goals will be measured as the percentage of the total population that has received the initial screening, while sanitary goals will be measured as the percentage of population receiving the planned medical services to mitigate identified NCDs risks factors. Financing to health-care providers would be based on services rendered on a fee-for-service basis.

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 the responsibility of the Project Support and Coordination Unit (PSCU), a small unit to be financed entirely by the MSP. The PSCU would be responsible for coordinating all technical and administrative processes. This unit would also carry out administrative processes regarding specific studies for Project impact evaluation and studies to support the design of the health insurance reform. This component would cover the Project's operating expenses, office equipment. In addition, this component would finance the cost of studies focusing on:

a) Strengthening of the participating government agencies' (PGAs) technical and operational capacity required to implement Project activities, including financial management and procurement.

b) 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 implementing PGAs and the *Previniendo* Pilot Program.
c) Impact evaluation studies, including those related to the *Previniendo* Pilot Program.
d) Studies and technical assistance to support the design of the Health Insurance Reform, including analysis of the overall policy framework and the system of incentives of the new health insurance. These activities would be the technical responsibility of the Health Secretariat (*Dirección General de Secretaría* – DIGESE), the agency within the MSP that is now responsible for conducting the health reform strategy. Technical assistance activities would be connected to the design of the various elements of the reform strategy, including coverage package, risk administration, financial mechanisms, and institutional governance. Special emphasis would be placed on reducing the fragmentation of the current health care system and on introducing incentives that are conducive to improve health service delivery and to ensure access to health care for vulnerable groups, including the poor and the geographically isolated. Likewise, alternative policy frameworks would be assessed in terms of their financial and economic impact in the short, medium and long term.

4. Lessons learned and reflected in the Project design

36. The Project design draws on lessons learned through the Bank's health operations both in Uruguay and elsewhere, as well as on the recommendations from the recently completed *Uruguay Health Sector Review (FY06)* and the *Healthy Development Report (FY07)*, the Bank's latest strategy for health, nutrition and population results.

Table 3. Lessons Learned from Bank's Health Projects and Sector Work in Uruguay and Beyond

Lessons Learned	Project Design
Project leadership, clear strategic direction, and commitment are critical for success.	The Bank team has emphasized the need to create a strong but lean PSCU that will play a leadership role during Project implementation. The PSCU will respond directly to the MSP, and will be entirely financed by the Government. Substantive expertise would be drawn from in-house resources within the participating agencies—i.e., DIGESA, ASSE, and DIGESE—to keep the PSCU small and enhance ownership of the participating agencies. The PSCU has already been created and assigned five staff members with financing from the MSP.
It is important to align the bulk of the	Experience from the implementation of the Bank's First Health Development Project

Project's implementation with the government administration cycle.	(FISS-I), which was implemented over three different presidential administrations, points to the need to align project implementation to the election cycle as much as possible to avoid disruptions and delays during implementation. The next presidential and legislature elections will be held in October 2009 and the new administration will take power in March 2010. Thus, the life of the proposed operation would provide a bridge to the new administration but not extend much after this.
Linking 'software' activities (studies, institutional strengthening, and training) to investment components (equipment and facilities) increases the likelihood that reform-related activities would be implemented.	Component 2 has incorporated this lesson, by complementing the development of modern health management tools and capacity building in primary care units with investments in facility upgrading and medical equipment to serve as incentives in Project participation. Also, Component 1 links development and implementation of new information system with ITC investments.
The technical soundness of all implementing units has to be ensured, particularly in primary care units where weak technical capacity could be a potential bottleneck.	Primary care units would also be provided with basic working tools—such as information systems and computers and communication technology—as needed. Training of health-care personnel would also help increase technical capacity in primary care units.
In order to achieve Project objectives, the concept and importance of M&E has to be introduced right from the beginning of the Project.	The Bank team has emphasized the need for strong capacity in M&E within the PSCU. Likewise, M&E systems are to be clearly reflected in the PSCU's functional structure and annual M&E work plans.
Need to establish an inclusive and integrative framework for information system development to ensure integration and replicability	An e-government framework would be established as part of the development of National Health Information System to ensure the interoperability, integration and replicability of information sub-systems to be developed under the Project.
Need to include all actors early on in the design process.	To enhance ownership and ensure a sound Project design, participating agencies have been actively involved in the design process. The remaining challenge would be to increase ownership on the part of primary care units. Training and communication campaigns aimed at primary care units will be implemented at the beginning of Project's implementation.
A mature information system is best conceived as a dynamic system with multiple actors, including those who provide input and those who utilize it.	Early on in the design Project process, an inventory of the needs of the various data providers and users—e.g. agencies within the MSP, Congress, local governments, non-government associations, academia—was conducted and used as an input in the design of the IHIS. A technical committee with representatives from the major stakeholders will be established to oversee the development of the IHIS and to establish the technical standards for data quality and exchange. Annual evaluations will be conducted to ensure that the information produced by the system as well as the processes to collect, aggregate and disseminate information respond to the needs of the various users.

5. Alternatives considered and reasons for rejection

37. *Incremental Reforms vs. Major Health System Reform:* In response to the Government's request, at the time of CAS preparation the Bank had anticipated that the focus of this investment operation would be to support the Government in the implementation of a national health reform program. The Bank has been closely engaged with the MSP's staff in discussions about the health system reform (including health insurance) and significant progress has been achieved in defining the necessary changes within the public care model (including several structural reforms within the public sector). Moreover, a joint working group of the Ministries of Health and Economy has agreed on key design features, such as the overall fiscal parameters, and the proposed health insurance reform law has been recently sent by the Executive branch to the Parliament for approval. However, the political and social consensus building process is still ongoing, and an open debate among key actors is currently taking place. Additional modifications might be needed before the health insurance reform can be further advanced. Given that a complete assessment of the technical and financial implications of the MSP's proposed health insurance reform is still pending, the proposed operation would only support an incremental approach

towards reform, prioritizing the reforms focusing on the health care delivery model as well as creating incentives within the sector to improve performance. These incremental reforms are not only important in their own right but also necessary for the larger health insurance reform.

38. Although the Bank team is fully aware of the ambitious scope of the proposed operation, it opted, in agreement with the Government, to tackle the full spectrum of challenges associated with improving the ability of Uruguay's public health system to prevent, detect and treat NCDs. In particular, the proposed operation would focus not only on regulatory and financial aspects, but would also aim to improve services accessibility and quality of primary care for prevalent NCDs. While expanding the scope of the operation to include health delivery will add additional complexity to the implementation process, this approach is consistent with the recommendations of the recently released *Healthy Development Report* (April 30, 2007), the latest World Bank Strategy for Health, Nutrition and Population (HNP), which points to the need to achieve not only policy changes but also actual results on the ground, improving the lives of individuals, particularly the poor.

39. *Individual vs. Integrated Health Information Systems:* The proposed Project would lay key foundations for an integrated health information system. The development of such a system clearly represents significantly more challenges than the development of multiple, self-standing information sub-systems given the need to coordinate among multiple actors. However, an integrated information system would be a major step toward enhancing Uruguay's health monitoring and evaluation system. As the new Bank strategy highlights, the lack of effective monitoring and evaluation systems has prevented both client countries and the development community in general from gauging the impact of alternative policies. Moreover, the development of an integrated health information system would be very timely, as several information sub-systems would be either developed or consolidated under the proposed Project, which could open a valuable window of opportunity for horizontal coordination.

40. *Type of Lending Instrument - SIL vs. APL:* In defining the most appropriate instrument to support the Government's program, both a Specific Investment Loan (SIL) and a horizontal Adaptable Program Loan (APL) were considered and broadly discussed with the Government. Potential benefits from utilizing an APL would be the possibility of expanding in future phases the *Previniendo* Pilot Program to the entire country, as well as providing all primary health care units with medical equipment for NCDs detection and treatment. The Government opted for a SIL and indicated that potential expansions would be considered separately.

C. IMPLEMENTATION

1. Partnership arrangements

40. Although there are no co-financing arrangements, the Project has benefited from a diagnosis carried out by PAHO regarding the existing epidemiological surveillance and monitoring system. In addition, the MSP, following the Bank's advice and with PAHO's financial support, developed the first National Risk Factor Survey, which serves as a baseline for the Project's health promotion strategy. A follow-up survey would be carried out towards the end of the Project to track the evolution of risk factors over the life of the Project. The participation of a PAHO regional expert in health information systems as a team member has been critical in identifying key problems and adequately designing this activity. Collaboration in health information systems with PAHO experts would be extended during the Project.

2. Institutional and implementation arrangements

41. Project implementation would broadly follow the arrangements introduced under the First Health Development Project (FISS-I), improving it according to the lessons learned during Project implementation. Thus, a major role will be assigned to relevant units of the MSP (ASSE, DIGESA and DIGESE). The implementing agency for the proposed Project would be the MSP, with the Minister of Health serving as the Project's National Director. The PSCU would be hosted in the MSP, reporting directly to the Minister of Health. Entirely financed by the MSP, the PSCU's responsibilities include (a) supporting the Government's technical and administrative dialogue with the Bank; (b) coordinating all administrative and technical aspects regarding Project implementation with relevant units of the MSP, including activities related to studies to be conducted for Project impact evaluation as well as those supporting the health insurance reform design process; (c) monitoring and evaluation activities; (d) working with DIGESA and the participating DHIEs in the implementation of the *Previniendo* Pilot Program; and (e) providing all necessary reports to the Bank. The PSCU would also be responsible for technical support, administration, monitoring and evaluation, and fiduciary issues. In addition, the PSCU would be responsible for all aspects pertaining to the Project financial management including accounting and financial reporting, budgeting, internal control, treasury operations and external audit. Annex 7 sets forth the proposed arrangements, which have already been agreed upon with the Borrower, together with the actions to be completed before implementation. The administrative procedures relating to the Project's fiduciary aspects will be defined in the Project Operational Manual (POM). The PSCU would be constituted by a manager expert, a health system expert, procurement and financial management expert, and a social expert to assist with the implementation and monitoring of major Project components.

42. The MSP will sign management performance agreements with each participating agency—DIGESA, ASSE, and DIGESE. The agreements will identify the technical assistance, training, and goods to be provided under the Project. Likewise, they will commit the agencies to agreed performance indicators and concrete results in the implementation of the activities supported under the Project.

43. Regarding the *Previniendo* Pilot Program, the MSP-DIGESA/ PSCU would have overall responsibility for ensuring its effective and timely implementation. Supporting activities would include:

i. Umbrella Agreements between the MSP and participating DHIEs, covering all permanent technical, financial, administrative and fiduciary aspects pertaining their participation in the program including, *inter alia*, the program objectives, the establishment of the agencies and their responsibilities, operational guidelines, and financial and auditing relationships between the MSP-DIGESA/PSCU and the DHIEs, and the MSP-DIGESA/PSCU and the Bank;
ii. Annual Performance Agreements between the MSP-DIGESA/PSCU and participating DHIEs that would include, *inter alia*, annual sanitary goals and specific coverage targets; and
iii. Performance agreements and contractual or quasi-contractual agreements, as appropriate, between DHIEs and authorized health care providers covering the PPI to be provided and their pricing; quality standards and control measures; payment mechanisms; expected results; information systems to be used; reporting and document support requirements and modalities for supervision and inspection by the auditors; and the Project supervision and monitoring units within the PSCU and the DHIEs.

3. Monitoring and evaluation of outcomes/results

44. Monitoring and evaluation would be the responsibility of the PSCU. An annual comprehensive evaluation of progress would be implemented using a set of key performance indicators. The PSCU will be responsible for the collection and consolidation of information required to track progress against the monitoring plan as described in the results framework. The set of indicators and their expected trajectory over the four-year time horizon of the Project have been agreed on (see Annex 3). The PSCU has already prepared draft work plans for the entire four-year horizon of the Project. The work plan for the first year of the Project has been agreed upon during appraisal and the preliminary work plans for the subsequent three years of the Project will be reviewed at an appropriate time. Annual reviews of the Project will be carried out no later than December 31 of each year, beginning in 2007. Semi-annual progress reports will be presented to the Bank no later than 30 days after the conclusion of each calendar semester, starting December 31, 2007. A Mid-Term Review will be carried out at the end of Year 2 of Project implementation to assess progress on agreed targets and to identify additional support as needed.

45. Performance of the *Previniendo* Pilot Program would be monitored by the MSP-DIGESA based on previously determined targets in terms of screening coverage, sanitary goals, and utilization/production goals of key services provided under the PPI. Data on DHIEs performance would be further monitored by the MSP. These data (i.e., screening coverage and sanitary goals) would be used by MSP-DIGESA in defining the cash flow of the *Previniendo* Pilot Program to DHIEs. Results would be monitored quarterly by DHIEs and MSP as part of the process of establishing annual performance agreements. The quarterly results would be evaluated against the outcomes agreed under the Umbrella Agreements, and in preceding annual performance agreements. The MSP-DIGESA would also conduct independent concurrent audits of DHIEs preventive programs that would lead to modifications as needed. A full review of the program's performance and results would be conducted after about 24 months and at the end of the program. As *Previniendo* Pilot Program will be implemented in three of the 19 departments, a similar monitoring system on sanitary preventive interventions (PIs) results will be implemented in non-participating departments to better assess the impact of the pilot program.

46. Program indicators would track levels of program coverage of the beneficiary population and the effectiveness of the services provided. Data on coverage would be generated by the MSP-DIGESA/PSCU. The PSCU would consolidate this information to monitor Project program coverage. Data on the performance would be collected from periodic reports made by service providers from their service records, which would, in turn, be the basis of their payments. These would be consolidated by the PSCU. The PSCU and MSP-DIGESA would conduct periodic independent audits of the data, including surveys of beneficiaries' participation and satisfaction. Most of the hospitals and clinics from participating departments that would be authorized as 'service providers' for the purpose of the program have functioning medical record systems, adequate to generate basic data on the number of beneficiaries and services rendered. MSP-DIGESA currently compiles such data for sector management purposes. However, additional assistance would be provided to these DHIEs and service providers to upgrade their recording and reporting systems. Similarly, while the MSP currently develops statistics on health care trends, the loan would finance the upgrading and modifying of existing systems to accommodate additional program needs.

47. A mid-term impact evaluation will be conducted using preliminary impact data. A full evaluation will be conducted during the last year of Project implementation.

4. Sustainability

48. The current administration believes that significant reform of the current health system is critical to ensure its efficacy, access, equity as well as its financial sustainability over the medium and long terms. By supporting necessary actions to appropriately address NCDs, the proposed operation would contribute to the overall reform effort by supporting the first pillar of the Government's reform agenda. The Government has already taken measures in this respect, such as increasing the coverage of free medicine for prevalent NCDs (diabetes and hypertension) and decreasing the co-payment for preventive controls for forms of cancer prevalent among women in the social health insurance system. The Project's design process has been fully collaborative and participatory with input from the highest level authorities, managers and staff. While Project sustainability is not related to the Government's ability to afford the Project from a fiscal standpoint, it is heavily dependent on the political will as well as the technical ability to incorporate the incremental reforms supported under the Project into broader reform efforts. Although the irreversibility of the reforms and actions supported under the proposed operation cannot be guaranteed, enhancing Uruguay's public health system is one of the top priorities of the current administration and the proposed operation enjoys broad support.

49. An initial analysis of the financial impact of the *Previniendo* Pilot Program shows that it is affordable, cost effective and within the means of the MSP, which would open the possibility of expanding the pilot to the entire country. Estimations of the fiscal impact of expanding the pilot program to the national level show that the cost would be less than 3 percent of the MSP's health expenditures (see Annex 9).

50. Administrative costs related to Project management represent only about 1.3 percent of total Project costs, and about 60 percent of total cost will be funded by the Government. Bank financing of personnel costs are not recurrent since the PSCU staff would be entirely financed by national funds and only complemented by short-term consultants on specific activities.

5. Critical risks and possible controversial aspects

Table 4. Risks and Risk Mitigation

Risks	Risk Mitigation Measures	Risk Rating with Mitigation
To Project development objective		
Macroeconomic instability	Notwithstanding the satisfactory progress of Uruguay in consolidating its economic recovery, high economic and financial risks still exist. The public sector debt is high, which will require the continuation of current macroeconomic and debt management policies aimed at reducing it over time. The economy remains vulnerable to external shocks, including a global/regional slowdown and/or increased global risk aversion.	M
Health insurance reform; strategy is not fully defined; no consensus	Debate over health insurance reform has been intense and is expected to continue. However, only a small part of the	M

is reached between major stakeholders.	proposed Project would support the design phase of the health insurance reform through specific technical assistance rather than its implementation. The Project can reach its development objectives and attain sustainability without health insurance reform going forward.	
Poor coordination between DIGESA, ASSE, and DIGESE resulting in limited implementation capacity.	Enhancing the MSP's ability to effectively address NCDs prevention, detection and treatment ultimately depends on improving coordination between key actors—DIGESA, ASSE, and DIGESE. These directorates do not have a strong tradition of collaboration in relation to NCDs. The strong commitment expressed by the MSP for the actions supported under the proposed operation is an important mitigating factor. The PSCU has played and would play a vital role in oversight and coordination, functioning as a direct link between the individual agencies and the political authorities in the MSP. The critical stakeholders—i.e., representatives from DIGESA, ASSE and DIGESE—have played an active role in the definition of the actions to be implemented under their jurisdiction, which has enhanced their ownership of the reform efforts.	S
Regarding financial management, there is a modest element of risk given the innovative approach for the *Previniendo* Pilot Program under Component 3, and the fact that Component 2 would be implemented by an agency (ASSE) with a certain degree of administrative decentralization.	To mitigate this risk, PSCU would coordinate all financial management activities in the Project. In addition, the country Integrated Financial Information System (SIIF) would be used for all financial transactions between MSP – ASSE, thereby mainstreaming the financial management of Component 2 and sharing the same risks as Uruguay's SIIF.	M

To component results		
Component 1 – Strengthening MSP's capacity to address the country's changing epidemiological profile		
Agencies' resistance to share their information systems.	Under the proposed NHIS, individual agencies would remain the owners and administrators of their respective information systems. The new system would focus on establishing standards to ensure data quality and to facilitate the exchange of information among legitimate users. Collaborative initiatives among the various agencies have been developed during Project preparation.	S
Resistance and weak institutional capacity can hinder the consolidation of a sound epidemiological surveillance system.	The ultimate success of this activity depends on enhancing reporting practices of a large number of actors. Intense training as well as the adoption of a system of incentives conducive to regular, adequate reporting would help mitigate this risk. Likewise, an M&E system aimed at detecting and reporting irregularities would be developed as part of this activity.	M
Logistical difficulties in ensuring quality in the implementation of numerous communication	To mitigate this risk, the implementation strategy would be gradual, according to a well-defined work plan. Learning mechanisms would be incorporated into these activities,	S

campaigns and community prevention programs administered by decentralized actors, such as municipalities and schools.	including surveys and evaluation workshops. A participatory evaluation involving representatives of municipalities, schools and other community organizations participating in the first implementation round would be conducted to draw lessons to improve implementation of subsequent rounds. The PSCU, in conjunction with DIGESA, would closely monitor implementation and the achievement of specific outcomes.	
Resistance to alter current health regulations and strengthen enforcement on the part of groups with vested interests.	Wide consultations and the incremental approach of the Project would help mitigate this risk, but ultimately a strong determination of the authorities in the MSP would be a critical factor in overcoming potential resistance.	S

Component 2 - Improve accessibility to quality care services for prevalent NCDs in public primary care facilities		
Resistance on the part of primary care units to the adoption of new management tools.	The introduction of management tools would be supported with intensive training and improvements in infrastructure—new ITC and medical equipment and improved facilities—to serve as an incentive for Project participation.	S
Strong logistical difficulties in implementing the proposed activities in primary care units.	To mitigate this risk, the implementation strategy would be gradual, according to a predefined work plan. The PSCU, in conjunction with ASSE, would closely monitor implementation and the achievement of expected outcomes to identify potential bottlenecks early on.	H
Component 3 - Implementation of the Previniendo Pilot Program		
Ambitious objective of participation from both public and private health insurers and providers.	To mitigate this risk, the pilot program would be implemented in three departments where private DHIEs have manifested their willingness to participate.	S
Strong coordination needed on the part of the PGAs and participating public health providers.	To mitigate this risk, a detailed implementation plan has been prepared by all the PGAs under PSCU coordination. This implementation plan has been revised during Project appraisal.	S
Overall Risk Rating:		S
Risk Rating: H (High Risk), S (Substantial Risk), M (Modest Risk), N (Negligible or Low Risk)		

6. Loan conditions and covenants

51. Loan covenants:

i) Section II, B.3 'Standard' wording for Project audits. The annual audited financial statements will be furnished to the Bank not later than six months after the end of each year.

ii) Section II, B.2 'Standard' wording for Interim Unaudited Financial Reports (IUFRs). Semiannual IUFRs will be submitted to the Bank not later than 45 days after the end of each calendar semester, as part of the Project progress reports.

D. APPRAISAL SUMMARY

1. Economic and financial analyses

52. ***Economic analysis.*** During the 20th century, Uruguay has undergone a process of change in its demographic structure and, consequently, in its epidemiological profile that manifests itself in a decrease in infectious and parasitical diseases and an increase in health problems related to unhealthy lifestyles, risky behavior, an unstable economic environment and social adversity. The changes in the epidemiological profile are having significant repercussions on the health system, with rapidly rising costs related to NCDs requiring expensive treatments. Moreover, the current health system's lack of focus on health promotion and prevention of chronic diseases results on a higher incidence of acute inpatient hospitalizations, with the consequent higher costs. For example, a one-day stay in an intensive care unit in an IAMC costs approximately US$343 compared to US$70 in a general care bed. The Project would support campaigns to promote healthier lifestyles—such as better nutrition and regular exercise—as well as measures to promote the early detection of those at risk of diseases such as diabetes, hypertension and hypercholesterolemia. These activities will not only lower the incidence of costly treatments and reduce total health costs, but also improve the quality of life of many Uruguayans.

53. A review of existing evidence indicates that preventive interventions for NCDs are at least 20 times more cost-effective than their treatment. For example, preventing cancer is much more cost-effective than treating it. The cost-effectiveness ratio of preventive interventions fluctuates between US$1,300 and US$6,200 per year of life saved (YLS) in the case of cancers that are more easy to treat such as cervix, breast, mouth, colon and rectum, and between US$53,000 and US$163,000 per YLS in the case of cancers that are more difficult to treat such as liver, lungs, stomach and esophagus. Likewise, the study on the burden of diseases for Uruguay that was carried out under the Bank's FISS-I Project identified a set of interventions and prevention programs that can help reduce the morbidity rate of the most prevalent pathologies and, as a result, increase life expectancy and overall quality of life. The interventions proposed under this Project have been prepared taking these recommendations and evidence into account.

54. ***Financial analysis.*** The fiscal impact of the Project in the MSP budget is small, as it represents an annual variation of less then 3 percent of the MSP budget during the Project's lifetime. This indicates that the Government can generate the financial resources needed for the Project without generating a significant impact on the public accounts. The Project would provide basic tools to the MSP to identify non-priority budgetary items that could be replaced with more cost-effective interventions.

2. Technical

55. Technical aspects of the proposed operation reflect state-of-the-art knowledge in health sector policies, including regulation and stewardship, health promotion and prevention, and epidemiological surveillance and monitoring. Moreover, the Project's design benefits from the Bank's long and successful record of helping improve the health sector's performance in Uruguay through both lending and technical advice. The preceding FISS-I, SSAL-II and SPDPL operations were successful in supporting significant, albeit partial, health sector reforms. Moreover, they were important in generating an increased awareness, both among Uruguay health authorities and decision makers as well as the Bank's technical teams, of the need to deepen the reform efforts and the areas that presented the most serious challenges. As mentioned above, the Project has benefited from a diagnosis carried out by PAHO of the existing epidemiological surveillance and monitoring system, and from the inclusion in the Project's preparation team of a PAHO regional expert in health information system. In addition, the MSP has conducted its first National Risk Factor Survey, which serves as a baseline for the Project's health promotion strategy. Studies financed by a Policy and Human Resources Development (PHRD) Grant contributed to gain deeper understanding of technical aspects critical to Project design. In addition, the operation has

benefited from the in-depth assessment of Uruguay's health sector conducted as part of the *Uruguay Health Sector Review (Report No. 33710-UY).*

3. Fiduciary

56. A Financial Management (FM) Assessment of the arrangements for the proposed Project has been carried out in accordance with OP.BP 10.02 and in line with the Financial Management Practices in IBRD-Financed Investment Operations; document issued by the FM Board on November 3, 2005. The assessment conclusion is that the FM arrangements for the Project are sound and acceptable to the Bank, as they meet minimum Bank requirements. However, there is a modest element of risk given (i) the innovative approach to be used for the *Previniendo* Pilot Program under Component 3 of the Project; and (ii) the fact that Component 2 will be implemented by a government agency (ASSE) with a certain degree of administrative decentralization.

57. Financial Management Risk: From the Financial Management's point of view, the Project is considered as a *Modest* Risk operation. A detailed risk assessment is provided in Annex 7.

4. Social

58. This Project does not currently trigger any of the Bank's social safeguard policies. In addition, the Project is expected to produce positive social impacts by improving prevention, detention and treatment of NCDs at the primary care level, thus enhancing the efficiency of the overall health sector by resulting in a more efficient allocation of responsibilities among different levels of care. Moreover, the Project would help to reduce the incidence of chronic NCDs, thus ameliorating the disproportionately high negative impacts that these diseases have on low-income populations and other vulnerable groups. The pilot program *Previniendo* Pilot Program has a strong poverty and social inclusion focus. First, although universal, the program aims primarily to reach family members of uninsured households, who are generally unemployed or work in the informal sector. These groups have a much higher likelihood of being poor than the insured households. Second, the program is directed especially at people with higher NCDs risk factors, including those suffering from NCDs, which are among the most vulnerable groups. Third, the poor population to be reached has a higher prevalence of NCDs and has less information and possibilities to access to health services.

5. Environment

59. The proposed Project was rated as Category 'B' at PCN stage due to: i) a modest potential to increase waste disposal in primary health care facilities; and ii) the financing of new medical equipment for primary health facilities. The Government already has adequate Legislation and practices in place to manage this minor potential increase of sanitary waste. The MSP had prepared a specific package of mitigation measures to be put in place during Project implementation to assure adequate use of settled norms. This package fulfill the Environmental Assessment (OP/BP/GP 4.01) normative.

6. Safeguard policies

60. This Project currently triggers just one of the Bank's environmental or social safeguard policies.

Safeguard Policies Triggered by the Project	Yes	No
Environmental Assessment (OP/BP/GP 4.01)	[x]	

Natural Habitats (OP/BP 4.04)	[x]
Pest Management (OP 4.09)	[x]
Cultural Property (OPN 11.03, being revised as OP 4.11)	[x]
Involuntary Resettlement (OP/BP 4.12)	[x]
Indigenous Peoples (OP/BP 4.10)	[x]
Forests (OP/BP 4.36)	[x]
Safety of Dams (OP/BP 4.37)	[x]
Projects in Disputed Areas (OP/BP/GP 7.60)*	[x]
Projects on International Waterways (OP/BP/GP 7.50)	[x]

7. Policy Exceptions and Readiness

61. The proposed Project would not require any exceptions from the Bank's policies and would comply with all applicable Bank policies.

62. The Project is ready to be implemented as:

(i) The PSCU has already been legally established and staffed and is working adequately.
(ii) A consultative group for the implementation of the IHIS has been established and is functioning.
(iii) A first inventory of existent databases has been completed.
(iv) An implementation and procurement plan has been prepared.
(v) The preparation of the Project Operational Manual has been completed.

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

ANNEX 1: Country and Sector Background

NON-COMMUNICABLE DISEASES PREVENTION PROJECT

1. Country Issues

Uruguay is a middle-income country with a population of 3.3 million and an annual per capita income of US$4,340.00, slightly above the region's average of US$4,000.00. It is characterized by an export-oriented agricultural sector, a well-educated workforce, and socio-economic indicators comparable to those of countries of the Organization for Economic Co-operation and Development (OECD), including a literacy rate of 98 percent and a life expectancy of 75 years. Levels of social spending are also comparable to OECD countries with consolidated (private and public) health expenditures that raise to almost 11 % in 2002 and was almost 9 percent of GDP in 2004, Uruguay is the highest spender on health in terms of GDP in the Latin America and Caribbean Region (LAC), and comparable to France and Germany.

While Uruguay experienced a period of macroeconomic stability and steady growth during most of the nineties, it suffered a sharp reversal in 1998 with a recession that persisted for more than three years before sinking into a deep economic crisis in 2001-2002. As a result of the events of December 2001 in neighboring Argentina, Uruguay's domestic banking sector came under severe pressure, resulting in the collapse of a number of banks despite emergency government support. The consequences of the financial crisis were severe, as a ripple effect throughout the economy caused GDP to fall by roughly 11 percent in 2002, while unemployment rose to 17 percent by the end of the year.

As a result of rising unemployment and falling wages, household income also experienced a decline, falling by more than a fifth in the period from 1998 to the end of 2002. Likewise, poverty increased from 18 percent to 31 percent of the population between 2000 and 2003, while extreme poverty doubled to 2.8 percent of the population during the same period. Income inequality, which had traditionally been low when compared to the rest of the region, also increased between 1998 and 2002.

With the support of international financial community, the Government was able to weather the economic crisis of 2001-2002 and successfully negotiate a sovereign debt exchange in May 2003. Fiscal and monetary policy were well managed during the crisis, which resulted in a primary surplus of the public sector (excluding sub-national administrations) of 3.8 percent of GDP in 2004—a major turnaround given that the primary fiscal deficit reached 1.5 percent of GDP in 2001. Real GDP grew by 12.3 percent in 2004 and continued to grow by nearly 7 percent annually in 2005 and 2006 as a result of good economic management as well as favorable external developments, including high commodity prices for exports and strong economic growth in both Argentina and Brazil. As a result of the strong economic recovery and concerted efforts on the part of the Government, unemployment is now approaching pre-crisis level (i.e., 10.5 percent in May 2007) and poverty levels are beginning to recede, with poverty and extreme poverty rates reaching 25.3 percent and 1.65 percent in 2006, respectively.

Uruguay is also in the midst of a political transition, as the victory of the *Frente Amplio – Encuentro Progresista – Nueva Mayoría* coalition in October 2004 elections ended the traditional dominance of Uruguayan politics by the two traditional parties, the *Partido Colorado* and the *Partido Nacional*. The new Government, which took office on March 1, 2005, is focused on

fostering social inclusion while, at the same time, improving the investment climate. A structural reform of the country's health system was an integral part of the *Frente Amplio's* electoral platform and is now a top priority in the Government's agenda.

2. Health Sector Issues

Throughout most of the second half of the 20th century, Uruguay had the highest or near highest health status and human development indicators in LAC. Today, life expectancy at birth is 75 years, the infant mortality rate is 10.5 per 1,000 live births, 98 percent of the population has access to an improved source of water, 99 percent of births are delivered in a hospital or clinic, and the prevalence of infectious diseases is low.

While Uruguay remains among the top-ranked LAC countries on human development and health indicators, its relative position has slipped in the past few years—even before the onset of the macroeconomic crisis in 1999.[6] This trend was further exacerbated by the social impact of crisis, although it now shows some signs of reversal. For example, infant mortality rate declined steadily until 2002 to 13.6 deaths/1,000 live births, to subsequently increase during crisis to reach 15 deaths/1,000 live births in 2003. It has subsequently dropped to 12.7 deaths/1,000 live births in 2005 and 10.5 deaths/1,000 live births in 2006.

[6] 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.

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). In addition, Uruguay's health system faces two major challenges: (i) the growing inability of the system to ensure its financial sustainability; and (ii) a mismatch between the country's epidemiological profile and its health care system. In turn, these two main problems are interconnected.

2.1 Structure of Uruguay's Health Care System

Health Care Coverage: Uruguay has a complex array of health care financing and delivery arrangements that, combined, provide access to health care services or health insurance coverage for 97 percent of the population. The trend toward increasing coverage constitutes an impressive achievement, as it was maintained even during the 1999-2002 period despite increasingly difficult macroeconomic conditions. Moreover, during that period—when the economic shock dramatically reduced households' income and employment and many lost their health insurance—the public sector responded by providing more care and becoming the regular provider for an increased proportion of Uruguayans, despite considerable reductions in its real level of funding.

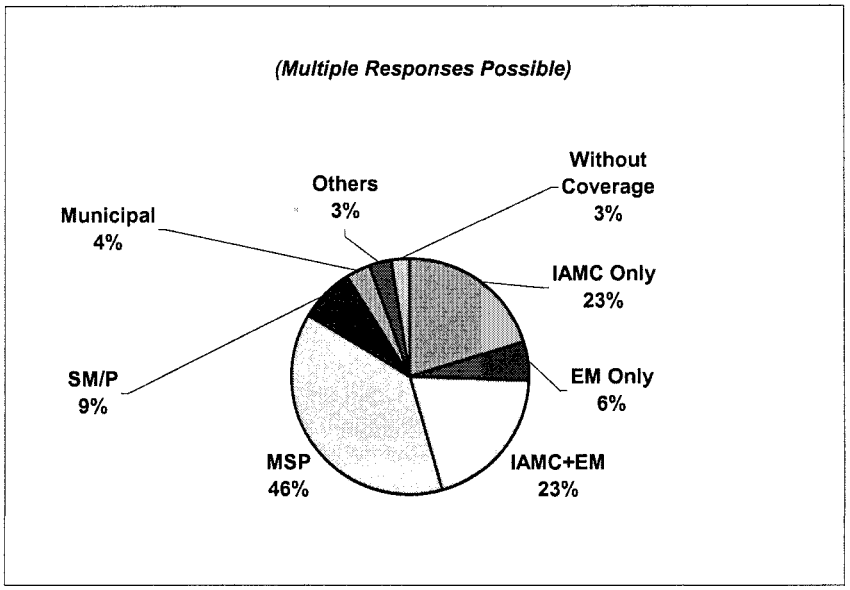
Roughly 52 percent of the population has some type of formal health insurance. Forty-two private, cooperative-type organizations—referred to as Collective Medical Assistance Institutes (*Institutos de Asistencia Médica Colectiva* - IAMCs)—cover about 88 percent of the insured. The most important institutional source of insurance coverage is the social security system (*Banco de Previsión Social* - BPS), which provides coverage for workers and accounts for 41 percent of the IAMC affiliates. The remaining 59 percent of IAMC affiliates have plans that are financed out of pocket. 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.

The Ministry of Health (*Ministerio de Salud Pública* - MSP) provides primary health care to 43 percent of the population. A deconcentrated institution, the Health Care Services Administration (*Administración de los Servicios de Salud del Estado* - ASSE), runs the MSP's network of 64 hospitals, 28 health centers and 292 clinics providing health care—typically at no charge—to the majority of the poor.[7] In addition, there are a host of other, smaller health care delivery systems, including those of the armed forces, the police and a number of other state agencies.

Figure 1.1 shows health care sources and health insurance coverage for 2003. It shows that there is considerable double coverage among the insured: half of the IAMC affiliates also have insurance from other private providers, mainly emergency ambulance and outpatient services—commonly referred to as *Emergencias Móviles*—that offer both insurance and care provision. A second type of double coverage takes the form of persons who, despite being insured by IAMCs, still choose to use MSP services. This type of double coverage characterizes 10 percent of the IAMC-insured. Overall, the MSP is the regular source of health care for 46 percent of the population. Only 3 percent of Uruguay's population lacks health care coverage or a regular source of health care.

Figure 1.1 Sources of Health Care and/or Insurance Coverage - 2003

[7] ASSE tends to serve those that lack coverage under the social security system and private insurance. According to results from a household survey, 55 percent of the regular users of MSP/ASSE services are from the lowest household income quintile. This percentage increases to 80 percent when considering the poorest 40 percent of households (INE, 2003).



Source: Uruguay: An Analysis of the Health Sector (World Bank, 2003).
Note: As multiple answers are appropriate due to double coverage, the sum is more than 100 percent.

Health Care Delivery: Uruguay's health care system is highly fragmented, with an important participation of private-sector providers. Specifically, the public health system accounted for almost a fourth of all health care expenditures in 2004 (24.7 percent), with the private sector accounting for the remaining two-thirds (i.e., 75.3 percent) (see Table 1.1). Among public providers, ASSE is the main responsible for health service delivery, accounting for 13.3 percent of all health care expenditures and 53 percent of public health expenditures in 2004. The IAMCs are the main health care providers, accounting for 43.6 percent of all health care expenditures and 58 percent of private health expenditures in 2004. The BPS purchases the vast majority of the services it finances from IAMCs. In addition, there are also some private hospitals and emergency services that provide health insurance with an extensive health services package aimed at the high-income market niche, as well as a wide assortment of emergency ambulance, diagnostic and other outpatient services serving market niches not served by IAMCs. On aggregate, these private health care providers account for the remaining 42 percent of private health care expenditures in 2004.

Table 1.1: Uruguay's Health Expenditures by Type of Provider – 2004

	UY$ (millions)	US$ (millions)	GNP %	% of Total
Public System	**8,332**	**314**	**2.2**	**24.7**
MSP	301	11	0.1	0.9
ASSE	4,451	168	1.2	13.2
Others	3,580	135	0.9	10.6
Private Providers	**8,332**	**314**	**2.2**	**24.7**
IAMCs	301	11	0.1	0.9
Private insurance	4,451	168	1.2	13.2
Emergency services	3,580	135	0.9	10.6

Private IMAEs	25,368	957	6.6	75.3
Pharmacies & outpatient services	14,683	554	3.9	43.6
Others	1,170	44	0.3	3.5
Total	**1,649**	**62**	**0.4**	**4.9**

Source: Own elaboration based on 2004 health expenditure data from the MSP and the General Controller's Office.

Sources of Financing: In terms of financing, the relative importance of the public and private sector is more balanced. Specifically, approximately half of Uruguay's health care is financed by the public sector through taxes as well as contributions from individuals and employers (see Table 1.2). In addition to the MSP, the BPS and the FNR play an important role in health care financing, accounting for roughly 21 percent of overall financing in 2004. The private sector also plays an important role, with the IAMCs and out-of-pocket household expenditures accounting for 23.5 and 17 percent of overall health financing, respectively.

Table 1.2 Uruguay's Health Expenditures by Source of Financing – 2004

	UY$ (millions)	US$ (millions)	GNP %	% of Total
Public Sources	**16,600**	**626**	**4.4**	**48.8**
MSP	301	11	0.1	0.9
ASSE	4,451	168	1.2	13.1
BPS	5,312	200	1.4	15.6
FNR	1,829	69	0.5	5.4
Others	4,707	178	1.2	13.8
Private Sources	**17,383**	**655**	**4.6**	**51.1**
IAMCs	7,983	301	2.1	23.5
Households	5,784	218	1.5	17
Others	3,616	136	1	10.6
Total	**33,983**	**1,281**	**9.0**	**99.9**

Source: Own elaboration based on 2004 health expenditure data from the MSP and the General Controller's Office.

In contrast to the strikingly different levels of financing of the MSP and the IAMCs, their production levels are comparable. This suggests that the two systems provide markedly different levels of efficiency and/or quality of care that go beyond the differences in their clientele. In 2003, the MSP provided 18 percent more admissions than the IAMCs, and, although that year the IAMCs provided 14 percent more ambulatory visits than the MSP, that differential has been reduced by more than half over the past three years. The expanded role of the MSP in health delivery between 2000 and 2003 occurred at the same time that its real expenditures contracted by 21 percent (the level of social expenditures has gradually bounced back as the economy

recovered). In addition, the MSP is responsible for regulating the health sector and administering preventive health programs. However, it only devotes a low percentage of overall health expenditures to preventive health.

Allocation of the Ministry of Health's Budget by Programmatic Area: The examination of the allocation of the MSP's budgetary resources points to the insufficient allocation of resources for health care prevention and promotion. The large majority of resources are allocated to health care services provided through ASSE, accounting for 93.6 percent of the 2006 health budget. The bulk on the remaining resources is absorbed by administrative and management costs (6 percent), with only a negligible amount being assigned to health care prevention and promotion (see Table 1.3). In the medium and long term, the insufficient attention given to health promotion and prevention results in an increase in high-cost treatments for a larger proportion of patients, thus generating additional health costs and consequences that could have been otherwise avoided.

Table 1.3 Allocation of the Ministry of Health's Budget by Programmatic Area
(In thousands Uruguayan Pesos)

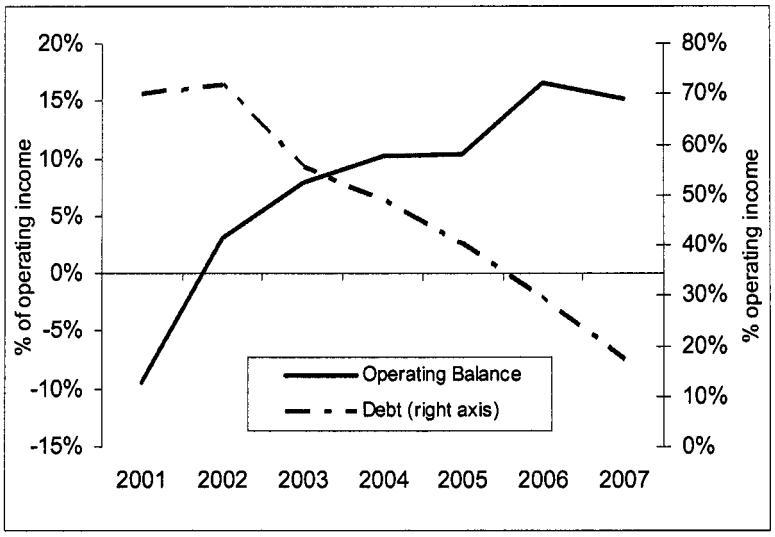
	2005	2006	2007	2008	2009
Administration and management	237,598	319,364	310,111	310,380	310,861
Planning, surveillance, and control of quality of health care	6,482	9,194	9,340	9,456	9,663
Health care delivery	4,177974	4,775,155	4,936,493	5,095,391	5,211,115
Total	**4,422,054**	**5,103,713**	**5,255,944**	**5,415,227**	**5,531,639**

Source: General Controller's Office.

Overall Financial Costs of Uruguay's Health Care System. With health expenditures equivalent to 11 percent of GDP in 2002, Uruguay's burden of financing for health was the equivalent to that of Switzerland, and exceeded only by the United States and Lebanon (UNDP 2004). Although it is estimated that this percentage has decreased to 8.9 percent in 2004, it still raises concerns about the financial sustainability of the system. Concerns regarding the magnitude and the rapid growth of the system's financial burden are underscored by the fact that health expenditures have been increasing at a pace faster than the cost of living. Moreover, the share of GDP devoted to health grew by more than 20 percent between 1994 and 2003. 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. This deficit, which has reached as much as 25 percent of revenues in recent years, is financed by general taxation (Figure 1.2). 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. Another important factor contributing to financial instability is the FNR's cumulative annual operating deficit, which, from 1991 through 2001, totaled UY$1.26 billion real pesos. Although the FNR has achieved an important turn-around in its fiscal balance, it still has an important debt burden and, as a result of a fragile institutional framework, it risks reverting back to an operational deficit.

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 minimum wage since 1993, while average co-payments per consultation have increased by roughly 75 percent.

Figure 1.2 FNR's Annual Financial Balance (as a percentage of operating income)



Source: FNR (2007)

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 health care from a public sector provider, which constitutes a cross-subsidy from the public to the private sector. Furthermore, as mentioned earlier, the health sector's deficit of the formal social security institution (BPS), which equaled about 11 percent of the MSP's budget in 2004, 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 BPS contributions.

2.2 Uruguay's Epidemiological Profile

During the 20th century, Uruguay experienced a transition in its demographic structure and, consequently, in its epidemiological profile as well. With more than 13 percent of the population being older than 65, Uruguay is the 'older' country in the Western hemisphere. A drop in fertility and mortality rates 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 over 31 years of age, and 13 percent is over 65 years. The overall fertility rate is 2.4 births per female, life expectancy is above 75 years and there are only two people younger than 15 for each person who is 65 or older (ECLA, 2000).

Changes in Uruguay's disease and epidemiological profile went hand-in-hand with demographic changes, with a reduction in infectious and parasitic diseases and an increase in health conditions related to unhealthy lifestyles, risky behavior, and negative social and economic environment. As an illustration, six out of ten deaths respond 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. 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 adequately addressing the health needs of the population. The

burden of chronic NCDs is also distributed inequitably, with the poor enduring more suffering than the rich.

Table 1.4 Main Causes of Death in Uruguay

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 *melitus*	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

Changes in the epidemiological profile have a direct impact on the health system. In 1992, a study focusing on the largest IAMCs already showed that affiliates with 65-years of age or more accounted for 20 percent of the membership but 40 percent of the costs (Meerhoff & Rígoli, 1992) and it is likely that this difference has become more pronounced. Likewise, there is a generalized lack of knowledge of preventive care of NCDs among the overall population, in particular among low-income groups. A recent survey has shown that 20 percent of women aged between 20 and 59 have never had a breast examination, with that proportion being negatively correlated with income—i.e., 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 has never had a Pap smear test, the proportion varying 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 negative correlation between the use of preventive tests and socio-economic status is found among men. While 69 percent of men 40-years old or above has never had a prostate cancer exam, the proportion is higher among low-income men (83 percent) and lower among high-income men (38 percent).

Despite the epidemiological transition and the shift toward a higher prevalence of NCD, Uruguay's health system has made only a few adaptive changes to address this change. The sluggish pace of change in the health system is troubling because of its financial, 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. Although there are important economic costs to the health system associated with the care of chronic illnesses, the financing levels for prevention and health promotion services are inadequate. A study carried out over year 2000 health spending (Trylesinski, 2001) showed that only 0.4 percent of overall health expenditures was spend on preventive care and health promotion. 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 younger than 60 years by one-third.

2.3 Interrelationship between Financing Problems and the Health Care Model

There are important and growing economic costs for the health system associated with the care of chronic NCDs, which are progressively eroding the capability of the health system to provide adequate financial protection (for a more in-depth analysis of the economic costs associated to health promotion and the prevention and treatment of NCD, see Annex 9). Although both 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 MSP does not have the basic tools to address NCDs effectively, including an appropriate information system, efficient epidemiological surveillance and monitoring systems; and adequate health promotion and prevention policies.

2.4 Previous Reform Engagement

In the past, Uruguay has shown commitment to incremental reforms in the health sector. The IBRD-financed First Health Sector Development Project (*Proyecto de Fortalecimiento Institucional del Sector Salud* – FISS-I; Loan No. 3855-UR), which was active between 1995 and 2002, helped improve the efficiency and quality of the health services provided by the MSP by contracting out services on a pilot basis to five public hospitals. In 2005, the Inter-American Development Bank (IADB) completed an operation supporting a debt restructuring process linked to the introduction of managerial changes in the IAMC system. The two development policy loans financed by the Bank—the Public Services and Social Sectors Special SAL (SSAL-II; Loan No. 7165-UR; 2003-2005) and the Social Program Development Policy Loan - SPDPL; Loan No. 7302-UY; 2005)—supported the Government's efforts to introduce mechanisms to improve the efficiency and equity of public spending in the health sector by both implementing measures to eliminate regressive subsidies in public hospitals and reforming the FNR to assure its governance and long-term financial sustainability. These operations have been successful in terms of the achievement of their specific objectives. However, these improvements focused too narrowly on the financing aspects of the health system, without taking into consideration a comprehensive reform framework.

2.5 Government's Health Program

The Health Care Model and NCDs. The new administration that took office in March 2005 has placed health reform high on its agenda. The two main pillars of the Government's health reform agenda focus on: i) developing a strategy to better address NCDs; and ii) implementing a health insurance reform aimed at creating a more harmonized system through the introduction of a National Health Insurance.

NCDs Strategy: The Government has developed a comprehensive strategy to adjust the health care model to the existing epidemiological profile, focusing more on NCDs through an integrated care model. The new strategy emphasizes enhanced regulation and policy stewardship, health

promotion and effective prevention policies, as well as epidemiological surveillance and monitoring. It also focuses on prevalent NCDs and their risk factors, including several common types of cancer and the improvement of health care delivery, particularly by public primary care providers. Support for the proposed measures is likely to be broad, as the population views an increased focus on promotion and prevention as positive. Similarly, the enhanced medical tools (i.e., medical and nursing staff training and new medical diagnosis equipment) that would complement the implementation of the new strategy are expected to help galvanize the support of health care providers.

The Government has already begun to implement several of the proposed measures. For example, regulatory measures in the social health insurance have been adopted to improve coverage of NCDs—e.g., diabetic patients, hypertension, cervical, and breast cancer prevention. Also, the Government has enacted tobacco control measures through legislative approval and the implementation of the Framework Convention on Tobacco Control (FCTC),[8] which include a comprehensive package of measures to avoid damage to health from tobacco.

Health Insurance Reform. A broad health insurance reform is the second pillar of the Government's ambitious health reform program. It aims at creating a more harmonized system through the introduction of a national health insurance that would ensure more equitable access to services and improved quality of care while reducing the financial burden of the system.

The reform would focus on:

i) The creation of an Integrated National Health System *(Sistema Nacional Integrado de Salud - INHS)*, which would define a uniform package of comprehensive health services to be provided by public and private health care providers alike;
ii) The extension of the social health insurance coverage to all national public employees and, in successive phases, to family dependents of active workers; and
iii) The unification of insurance rates across the various sub-systems as well as an adjustment of age- and sex-risk premiums.

From an organizational perspective, a National Health Fund (FNS) would finance the demand of services of the INHS in a preliminary arrangement called National Health Insurance (NHI). The FNS would gather contributions from the state, private households (mainly through mandatory contributions) and private companies. The INHS could introduce important regulatory changes to focus the whole system on the care of the most common illnesses. Although several of the specific design features are still to be defined, the overall legislative framework is currently being debated in Parliament (see Box 1).

Box 1
Proposed Health Insurance Legislative Framework and Organizational Arrangements

Legislative changes for the health insurance reform: Three main laws are now being debated in Parliament, seeking to: (i) decentralize ASSE in order to transform it into a public integrated insurer and provider; (ii) expand Social Health Insurance coverage to all national public employees and to unify age- and sex-risk premiums in *per capita* payment to insurances; and (iii) create the new Integrated National Health System *(Sistema Nacional Integrado de Salud – INHS)* and its governing

[8] The Framework Convention on Tobacco Control (FCTC), is a binding international legal instrument, promoted by WHO, which establishes broad commitments and a general system of governance for the Tobacco area, including, bans or restrictions on tobacco advertising, promotion and sponsorship, a ban on tobacco consumption in public spaces; elimination of illicit trade in tobacco products; banning of tobacco sales to and by minors and agricultural diversification and the promotion of alternative livelihoods.

body, the National Health Executive Board *(Junta Nacional de Salud* – NHEB), as well as to implement financial reform and insurance rate unification.

If the proposed legislation is enacted, the INHS is expected to gradually unify the rules for public and private health insurance providers regarding services, quality standards, production, epidemiological information and others aspects. However, these laws are still pending legislative approval and consensus among stakeholder groups is still to be reached.

Organizational Arrangements for the Integrated National Health System. The new INHS would be governed by the NHEB and financed through a National Health Fund *(Fondo Nacional de Salud - FNS).* The FNS would gather contributions from the state, private households (mainly through mandatory contributions) and private companies. The INHS could also introduce important regulatory changes to focus the whole system on the care of the most common illnesses.

The health insurance reform is expected to be complex and difficult. It has already stirred a wide social debate among stakeholders in the health sector, all of which would be affected in significant ways. Furthermore, such a wide ranging reform would have important fiscal impacts, which would have to be assessed at the onset to ensure sustainability of the Government's overall fiscal framework.

The implementation of the health insurance reform is contingent on the successful implementation of the first pillar of the Government's health reform strategy. Specifically, the implementation of the NCDs strategy will be necessary to contain the rising costs of Uruguay's health sector, which, in turn, will be crucial for the wider health insurance reform to succeed. If the health insurance reform were to take place without reorienting Uruguay's health care model in line with the country's epidemiological profile, an efficient and effective use of financial resources could not materialize.

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ANNEX 2: Major Related Projects by the Bank and/or other Agencies

NON-COMMUNICABLE DISEASES PREVENTION PROJECT

During the second half of the 1990s and, in line with Government policies prevailing at that time, the Bank supported Uruguay's health policies with a mix of adjustment and investment lending operations. First, the Bank supported the First Health Sector Development Project (*Proyecto de Fortalecimiento Institucional del Sector Salud – FISS-I;* Loan No. 3855-UR), which was active between 1995 and 2002. This investment operation helped to improve the efficiency and quality of the health services provided by the MSP, promoting the decentralization process and contracting out services on a pilot basis to five public hospitals.

Second, the Bank financed development two policy development loans, the Public Services and Social Sectors Special SAL (SSAL-II; Loan No. 7165-UR; 2003-2005) and the Social Program Development Policy Loan (SPDPL; Loan No. 7302-UY 2005). The –SSAL-II operation suppored the Government;s efforts to introduce mechanisms to improve the efficiency and equity of public spending in the health sector by both implementing measures to eliminate regressive subsidies in public hospitals and reforming the FNR to assure its governance and long-term financial sustainability. The SPDPL contributed to: (i) support efficiency reforms of the FNR); (ii) introduce budget and administration management system for ASSE health providers; (iii) improve the purchasing system for medical supplies; and (iv) reduce cross-subsidies in the health sector benefiting the private, cooperative insurance industry.

Under the SPDPL program, ASSE completed the development of its beneficiary database, which, in turn, allows assigning beneficiaries to a specific health public provider for budget allocation purposes, thus avoiding cross subsidies to other insurers. The SPDPL operation also supported the allocation of ASSE's hospital budget on the basis of per capita and production criteria, which constituted a significant improvement in efficient with respect to the previous allocation practices.

While the three IBRD lending operations have been successful in terms of the achievement of their specific objectives, they focused primarily on the financing aspects of the health system and did not include the development of tools to address the main factors in relation to the burden of diseases.

In 2005, the Inter-American Development Bank (IADB) completed an operation supporting a debt restructuring process linked to the introduction of managerial changes in the IAMCs system. This operation allowed the IAMCa to surmount a deep financial crisis and to improve management capacities and overall governance in the participating social security entities.

Lessons Learned. Important lessons of experience can be drawn from the Bank's support of Uruguay's health sector over the past decade. These lessons have been fully included in the design of the proposed SIL and in the recently approved adjustment operation. First, focusing reforms on the national social health insurance system proved not only difficult but also insufficient to address the health problems of the poor. While structural reforms were moderately successful, coverage of the uninsured did not expand, the quality of health services did not improved significantly, and the health care system as a whole was not adapted to better respond to the current epidemiological challenges.

Therefore, the current Government's strategy (and the proposed SIL) focuses on establishing a mechanism to improve the health status of the entire population, with a special focus on the

uninsured. This would be achieved through the introduction of a system of incentives for health insurers and health care providers to deliver a package of preventive health care for NCDs, which is expected to benefit mainly the most vulnerable groups among the uninsured.

ANNEX 3: Results Framework and Monitoring

NON-COMMUNICABLE DISEASES PREVENTION PROJECT

Table 3.1 Results Framework and Monitoring

PDO	Outcome Indicators	Baseline data 2006	Final target	Use of Outcome Information
(i) To expand accessibility and quality of primary health care services for early detection and medical care of selected NCDs	1. Percentage of cases diagnosed and under follow-up by primary care teams for the following NCDs: a. Hypertension b. Diabetes c. Obesity /overweight	1. Percentage of cases diagnosed and under follow-up by primary care teams for the following NCDs are: a. Hypertension: 49.1 b. Diabetes: 73 c. Obesity /overweight: 0	1. Percentage of cases diagnosed **and under follow-up** by primary care teams for the following NCDs are: Hypertension: 60 Diabetes: 83 Obesity /overweight: 50	YR2: Mid-Term Review focus on data quality and assessment of initial trends to determine whether Project is on course to meet PDO objectives.
	2. Percentage of women between 50 and 69 years of age has had a mammogram in any given year.	2. 25% of women between 50 and 69 years of age had a mammogram.	2. 45% of women between 50 and 69 years of age have had a mammogram in any given year.	YR4: Impact evaluation under course before Project's conclusion in preparation for ICR
	3. Percentage of newborns with disabilities being monitored by Early Detection and Treatment Units.	3. **0%** of newborns with disabilities monitored by Early Detection and Treatment Units in 2006	3. 60% of newborns with disabilities being monitored by Early Detection and Treatment Units.	
(ii) To avoid and reduce exposure to selected NCDs risk factors	4. Percentage of population at NCDs risk being screened in participating departments.	4. 0% of population at NCDs risk screened in participating departments.	4. 65% of population at NCDs risk being screened in participating departments.	

Table 3.2 Indicators for Individual Components

COMPONENT 1 - Strengthening of the MSP's Capacity to Address the Country's Changing Epidemiological Profile

Use of Results Monitoring
YR1: Ensure that all indicators have their corresponding baseline for 2006.
Mid-Term: Review quality of data; determine whether institutional/process indicators are on track and, if necessary, take corrective actions.
YR4: Full Project evaluation at the end of implementation.

INDICATORS	BASELINE	MID-TERM	FINAL OUTCOME
Subcomponent 1.1 -*Strengthening of Health Intelligence Functions*			
a. Establishing the foundations for an Integrated Health Information System (IHIS)			
1. Regularly report of consolidated data on number of patients diagnosed with specific NCDs and currently under treatment	1. 0	1. 3	1. Nine departments regularly report consolidated data on number of patients diagnosed with specific NCDs and currently under treatment
2. Primary health facilities uses regularly the diagnosis s and monitoring system	2. 11	2. 60	2. 205 primary health facilities regularly using the diagnosis monitoring system.
3. **Main health sector** databases virtually integrated into the National Health Information System.	3. 0	3. **Technical design** process to integrate databases is complete and is in the implementation stage.	3. BPS, RUCAF, ASSE beneficiary and FNR beneficiary databases are virtually integrated into the National Health Information System.

INDICATORS	BASELINE	MID-TERM	FINAL OUTCOME
b. Modernizing and consolidating the public health surveillance system (*Sistema de Vigilancia Epidemiológica* – SEVES).			
1. Information reporting r of the health surveillance system requirements are comply by the health public units	1. 10%	1. Information system is being implemented; 20% of units comply with information reporting requirements.	1. 85 % of units within public health surveillance system comply with information reporting requirements.
2. DIGESA key personnel trained in SEVES.	2. 0	2. 20 personnel trained.	2. 50 key personnel trained in SEVES.
3. Data definitions and coding standards for pathologies issued.	3. 24	3. 5 additional data definitions and coding standards have been issued.	3. Data definitions and coding standards for 34 pathologies have been issued.
4. Public Health Bulletins and Surveillance Bulletins published according to norms in any given year.	4. 0	4. 2 published according to norms in any given year.	4. 2 Public Health Bulletins and Surveillance Bulletins published according to norms in any given year.
5. Additional DIGESA staff trained in 'Data for Decision-Making.'	5. 5	5. Activity planned and ready to be carried out.	5. 20 additional DIGESA staff trained in 'Data for Decision-Making.'
6. 10 key staff trained in laboratory safety.	6. 0	6. Activity planned and ready to be carried out.	6. 10 key staff trained in laboratory safety.
c. Strengthening the response capacity of DIGESA and its departmental units			
1. DIGESA additional key staff members trained in outbreak investigation.	1. 10	1. 50 % of additional staff trained.	1. 20 additional key staff members trained
2. Communicable disease outbreaks reported by surveillance system are managed at local level according to norms.	2. 10%	2. 30%	2. 90

INDICATORS	BASELINE	MID-TERM	FINAL OUTCOME
Subcomponent 1.2 - *Health Promotion and NCDs Prevention Programs*			
1. Municipalities carry out 'healthy spaces' campaigns	1. 0%	1. 30%	1. 50 %
2. Health promotion subprojects related to NCDs are implemented in participating healthy spaces and are evaluated.	2. 0%	2. 20%	2. 95%
3. Students in public schools participating in 'healthy school' campaigns.	3. 0%	3. 5% of students have participated.	3. 20%.
4. Disability, Early Detection and Treatment Units are developed.	4. 0	4. 2 Units functioning.	4. 5 Units functioning.
5. Personnel in health promotion unit are trained.	5. 0%	5. 50% personnel trained.	5. 100%
6. Annual Tobacco media campaign is developed in any given year.	6. 0	6. Two campaigns developed.	6. One annual Tobacco media campaign developed each year
7. A National Promotion Advocacy group is conformed.	7. 0	7. Group conformed.	7. National Promotion Advocacy group conformed.
Subcomponent 1.3 - ***Regulatory capacity building in relation NCDs***			
1. Regulatory framework affecting essential NCDs and risk factors is review to assess their effectiveness.	1. ---	1. Framework under review.	1. Regulatory framework affecting essential NCDs **and risk factors reviewed.**
2. Primary health care establishments are certified and quality accredited on NCDs medical care ambulatory procedures.	2. 0	2. 70 establishments certificated and quality accredited.	2. 200 primary health care establishments certified and ality accredited.

COMPONENT 2 – Improve accessibility to quality care services for prevalent NCDs in public primary care facilities

Use of Results Monitoring

YR1: Ensure availability of baseline data.

YR2: Mid Term review: Full evaluation of the indicators.

YR3: Determine whether indicators will be met; if not, corrective measures will be adopted to reach goals.

YR4: Full evaluation at the end of the Project.

INDICATORS	BASELINE	MID-TERM	FINAL OUTCOME
1. Percentage of reduction in hospital admissions for treatments more appropriately provided at lower levels: a. Hypertension crisis b. Stroke c. Ketoacidosis diabetic	1. To be completed in Year 1	1. Percentage of reductions: a. Hypertension crisis 10% b. Stroke 10% c. Ketoacidosis diabetic 20%	1. Percentage of reduction: a. Hypertension crisis 30% b. Stroke 30% c. Ketoacidosis diabetic 50%
2. Percentage of reduction in the number of advanced-stage cases for specific NCDs assisted under the FNR relative to all cases in the same NCDs category: a. Cardiovascular disease by hypertension and Chronic Kidney failure by hypertension	2. To be completed in Year 1	2. 1.5 %	2. 5%
3. Primary care teams members are under permanent training system for prevalent NCDs	3. 100	3. 1,500	3. 4,000 members of primary care teams under permanent training system .

COMPONENT 3 - Implementation of the *Previniendo* Pilot Program

Use of Results Monitoring

YR1: Assure availability of baseline data
YR2: Mid Term review: Full evaluation of indicators.
YR3: Determine if indicators will be met - if not, modify activities to reach goals.
YR4: Full evaluation at the end of the Project, with impact evaluation

INDICATORS	BASELINE	MID TERM	FINAL OUTCOME
1. Percentage of population of pilot departments screened for NCDs risk factor.	1. 0%	1. 30%	1. 65%
2. Percentage of cases diagnosed and under follow-up by primary care teams for the following NCDs: a. Hypertension b. Diabetes c. Obesity / overweight	2. Follow-up: a. Hypertension: 49.1% b. Diabetes: 73% c. Obesity/ overweight: 0%	2. Follow-up: a. Hypertension 60% b. Diabetes 83% c. Obesity/ overweight 30%	2. Follow-up: a. Hypertension 85% b. Diabetes 93% c. Obesity / overweight 65%
3. Percentage of reduction in hospital admissions for treatments more appropriately provided at lower levels: a. Hypertension crisis b. Stroke c. Ketoacidosis diabetic	3. To be determined in Year 1	3. Percentage of reduction: a. Hypertension crisis 30% b. Stroke 30% c. Ketoacidosis diabetic 30%	3. Percentage of reduction: a. Hypertension crisis 70% b. Stroke 70% c. Ketoacidosis diabetic 70%
4. Percentage of reduction in the number of advanced-stage cases for Cardiovascular disease and Chronic Kidney Failure by hypertension assisted under the FNR relative to all cases in the same category:	4. To be determined in Year 1	4. 3% of reduction	4. 10% of reduction
5. Primary care providers under Annual Performance Agreements with DHIE	5. 0%	5. 60%	5. 85 %

COMPONENT 4 - Supporting the Health Insurance Reform Design Process

Use of Results Monitoring
YR1: Ensure availability of baseline data
YR2: Mid-Term Review: Full evaluation of indicators.
YR3: Determine whether indicators will be met - if not, take corrective actions as needed to reach goals.
YR4: Full evaluation at the end of the Project

INDICATORS	BASELINE	MID-TERM	FINAL OUTCOME
To develop and apply a methodology to assess the financial impact on public finances and household budgets of alternative health care reform strategies.	----------	Terms of reference approved by the Bank, methodology in development	Methodology has been developed in conjunction with the Ministry of Finance and is being implemented in any given year

By developing the National Health NCDs Strategy the Project is expected to contribute to: (i) *Expand accessibility and quality of primary health care services related to early detection and medical care of selected NCDs; and (ii) Avoid and reduce exposure to selected NCDs risk factors as well as their health effects.*

Project implementation is organized along four main axes corresponding to the main institutional process objectives:

a. Strengthening the MSP's capacity to effectively address the changing epidemiological profile of Uruguay by (i) enhancing health intelligence tools, including the consolidation of Uruguay's national integrated health information systems to enhance information inputs needed for sound decision-making; (ii) strengthening the MSP's capacity to develop a National Promotion and Prevention Strategy related to NCDs, including implementation of 'healthy spaces' policies related to NCDs in schools and municipalities and prevention under a social inclusion strategy approach and (iii) enhancing the MSP's monitoring and regulatory capacity;.
b. Strengthening ASSE's ability to detect, prevent, and treat NCDs through the public primary care network through improved facilities and medical equipment, the introduction of modern management tools, and training; and
c. Providing technical support to the Government in the implementation of the *Previniendo* Pilot Program, and
d. Providing technical support to the Government in the design of the integrated health system.

Measurement of intermediate indicators will be made at Mid-Term to determine whether the institutional/process indicators are on track and, if necessary, to introduce corrective actions. Intermediate indicators will be assessed bi-annually against their corresponding targets. The large majority of baselines have been established and the determining the few baselines that are still missing will be a top-priority activity during the first year of implementation.

Monitoring arrangements:

COMPONENT 4 - Supporting the Health Insurance Reform Design Process

Use of Results Monitoring
YR1: Ensure availability of baseline data
YR2: Mid-Term Review: Full evaluation of indicators.
YR3: Determine whether indicators will be met - if not, take corrective actions as needed to reach goals.
YR4: Full evaluation at the end of the Project

INDICATORS	BASELINE	MID-TERM	FINAL OUTCOME
To develop and apply a methodology to assess the financial impact on public finances and household budgets of alternative health care reform strategies.	----------	Terms of reference approved by the Bank, methodology in development	Methodology has been developed in conjunction with the Ministry of Finance and is being implemented in any given year

By developing the National Health NCDs Strategy the Project is expected to contribute to: (i) *Expand accessibility and quality of primary health care services related to early detection and medical care of selected NCDs; and (ii) Avoid and reduce exposure to selected NCDs risk factors as well as their health effects.*

Project implementation is organized along four main axes corresponding to the main institutional process objectives:

a. Strengthening the MSP's capacity to effectively address the changing epidemiological profile of Uruguay by (i) enhancing health intelligence tools, including the consolidation of Uruguay's national integrated health information systems to enhance information inputs needed for sound decision-making; (ii) strengthening the MSP's capacity to develop a National Promotion and Prevention Strategy related to NCDs, including implementation of 'healthy spaces' policies related to NCDs in schools and municipalities and prevention under a social inclusion strategy approach and (iii) enhancing the MSP's monitoring and regulatory capacity;.
b. Strengthening ASSE's ability to detect, prevent, and treat NCDs through the public primary care network through improved facilities and medical equipment, the introduction of modern management tools, and training; and
c. Providing technical support to the Government in the implementation of the *Previniendo* Pilot Program, and
d. Providing technical support to the Government in the design of the integrated health system.

Measurement of intermediate indicators will be made at Mid-Term to determine whether the institutional/process indicators are on track and, if necessary, to introduce corrective actions. Intermediate indicators will be assessed bi-annually against their corresponding targets. The large majority of baselines have been established and the determining the few baselines that are still missing will be a top-priority activity during the first year of implementation.

Monitoring arrangements:

General Logical framework

The PSCU will be responsible for the compilation of data of the different components and, as necessary, from other data sources. This unit will emphasize streamlining data collection processes within the Government rather than generating new data collection mechanisms. With oversight from MSP Directors, the PSCU will elaborate proposals to use these data to research, develop, correct and implement Project activities. The Project will finance technical assistance to develop and institutionalize this process.

Component 1 - Strengthening of the MSP's Capacity to Address the Country's Changing Epidemiological Profile

DIGESA will monitor performance of these activities: (i) *Establishing the Foundation of an Integrated Health Information System* (IHIS); (ii) *Health Promotion and NCDs Prevention Programs;* and (iii) *Regulatory capacity building.* Process indicators will be established to ensure appropriate monitoring of Project performance, which will be fully integrally into the Government's own monitoring processes. The PSCU will contribute to reinforcing the monitoring process, demanding periodic information of critical selected processes.
The process of strengthening DIGESA's departmental surveillance structures will be monitored during supervision visits by national staff. The Mid-Term Review will ensure that such structures, as defined by national norms, have been established. Given the emphasis on performance, more resources will be invested in three key processes: (i) improving data coverage; (ii) assuring quality of primary data and; (iii) monitoring their adequate completion.

In relation to NCDs surveillance, the result of the First National Risk Factor Survey has been published, providing a baseline for health promotion and preventive activities. A follow-up risk factor survey will be conducted in Year 4 of Project implementation, using the same methodology as the previous one. The Government and the Bank have agreed to monitor additional indicators related to the evolution of risk factors. Although reaching the proposed targets is beyond the scope of the Project, their evolution is expected to be positively influenced by the actions taken as part of the Project. These targets are shown on Table 3.4.

Table 3.4 Risk Factors Indicators

Indicators and Final Outcome	Baseline
1. Fruits and vegetables intake increases to 25% by 2011, at least 5 days a week.	7%
2. 10% decrease on people adding salt to food, by 2011.	------
3. Population suffering from high blood pressure diminished to 32% by 2011.	34 %
4. Population suffering from high cholesterol levels diminished to 24% by 2011.	27.8 %
5. Population suffering from hyperglycaemia diminished to 11% by 2011.	11.9 %
6. Overweight population diminished to 55% by 2011.	60 %
7. Population who practice at least moderately intense physical activity regularly increases to 45% by 2011.	8 %

Component 2 – Improving accessibility to quality care services for prevalent NCDs in public primary care facilities

The implementation of Component 2, which is mainly the responsibility of at primary care facilities, will be monitored at the central level by the PSCU and ASSE's central administration. DIGESA will be in charge of monitoring quality standards of ASSE's health facilities for NCDs primary care. The Project will support complementary strategies to improve monitoring processes. on actions in Component 2.

Data for health care provided to patients participating in the Project's activities will be directly collected from the information system to implement to monitor levels of production. Data for inpatients will be collected by referral hospital levels and from the FNR's information system. M&E mechanisms will be incorporated in training activities. As these activities will be developed as field activities in the work place, ASSE's regular human resources staff will be responsible for their monitoring.

Component 3 – Implementation of the '*Previniendo*' Pilot Program

Program results indicators will track levels of program coverage of the eligible beneficiary population and the effectiveness of the services provided. Program performance will be monitored by the MSP-DIGESA, against baseline estimates of the size and geographic distribution of the target population. It will be done by tracking down the actual expansion of the program's coverage measured as the percentage of the eligible population that has received NCDs screening and the percentage of population receiving the Package of Preventive Interventions (PPIs) designed to mitigate key NCDs risk factors. Results will be monitored quarterly. Data on the level of program coverage will be generated by the MSP-DIGESE/PSCU. Performance data will be collected from periodic reports made by service providers from their service records. Data will be consolidated by the PSCU. These results will be evaluated against targets agreed as part of the Umbrella Agreements and the preceding annual performance agreements. The PSCU and MSP-DIGESA will conduct periodic independent audits of the data, including surveys of beneficiaries regarding their participation and satisfaction. The MSP-DIGESA will also conduct independent evaluations of DHIEs preventive programs that will lead to modifications as needed. A review of the program's performance and results will be conducted after the first 18 months of implementation and at the end of the program.

As the *Previniendo* Pilot Program will be implemented in three of the 19 departments, a similar monitoring system on sanitary prevention results will be applied in three other departments that will serve as a control group. This activity will form part of the impact evaluation to be financed by the loan.

Component 4 - Project Management

The Project will support the strengthening of the PSCU's operational capacity to monitor and supervise the overall implementation of the Project, including the performance agreements between the MSP and the participating government agencies (PGAs).

The M&E system for Component 4 will build on the information system developed for the supervision and monitoring of the performance agreements to be established between the MSP and PGAs. The PSCU will be in charge of collecting this information and producing periodic reports as part of the performance monitoring system developed by the Project.

Impact evaluation:

Criteria and options considered for measuring the Impact Evaluation of the Project.

There are several challenges identified for the design of an impact evaluation for this operation: (i) health promotion activities under the Project have national universal coverage; (ii) health preventive interventions will be implemented in progressive phases; (iii) a group of preventive and health promotion activities related to healthy spaces will be developed in self-selected areas and will be subject to comparative impact evaluation with areas that choose not to participate in the activity, and (iv) the *Previniendo* Pilot Program will be implemented in three out of a total of 19 departments. Therefore, the evaluations are likely to face some limitations in coverage and methodological rigor and it may not be possible to establish a causal link between the Project and the observed changes.

The strategic approach to impact evaluation action for each part of the Project will be as follows:

i) *Health promotion activities*: The National Risk Factor Survey that has already been carried out has provided data for the baseline of the Project in relation to to health promotion and prevention activities. The Project will include funding for a follow-up survey at Year 4. Because of the time required to make an impact, it will probably not be possible to attribute changes in the prevalence of risk factors to the activities of the Project. However, it will provide the basis to establish trends for future comparisons. In addition, if locally based health promotion activities have had different levels of development in each department, the new survey will provide the basis for comparison between departments. For lifestyle related diseases where the intervention will mostly consist of information campaigns, comparative evaluation impact will be possible if the campaigns were run differently for different sub-samples of the population.
ii) Health prevention activities: A key factor in the design will be to understand the roll-out of ASSE plans–both spatially and temporally–to take advantage of them, so as to try to design impact evaluations in selected areas for a sample of interventions. Understanding roll-out plans will make it possible to identify different types of comparison groups.
iii) Healthy spaces: The possibility of impact evaluation in the first year of Project implementation will be defined based on the proposed interventions in terms of, for example, relative importance in terms of prevalence, the timing of potential impacts, the geographical scaling of the implementation process, the possibility of forming comparison groups and the costs of the possible evaluation process.

Previniendo Pilot Program: Given its strategic importance, a specific iimpact evaluation will be developed for this pilot program. As it will be applied in three out of a total of 19 departments, a set of three other departments will be selected as a control group for the program implementation. The DHIE's department health providers used as a control group will not receive the additional financing from the *Previniendo* pilot program, but will receive support to improve their technological infrastructure and health personnel training to improve quality in prevention care and risk factors for NCDs. A comparable monitoring system will be applied to the six departments—the three departments where the pilot is implemented and the three serving as the control group. Two groups of providers will be monitored (one participating in the Program and one not participating) in terms of their population coverage for the provision of the selected services and in terms of the quality of the services provided.

A protocol defining the methodology or methodologies to be utilized for the impact evaluation will be defined during the first semester of Project implementation.

ANNEX 4: Detailed Project Description

NON-COMMUNICABLE DISEASES PREVENTION PROJECT

The Project, with a total cost of US$25.3 million, would consist of four components: Component 1 – Strengthening of the MSP's capacity to address the country's changing epidemiological profile; Component 2 - Improving access 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 would be implemented by the three main directorships within the MSP—DIGESA, ASSE, and DIGESE—with overall support and coordination from the PSCU.

Components Description

Component 1 - Strengthening of the MSP's Capacity to Address the Country's Changing Epidemiological Profile *(US$6.1 million of which US$5.7 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, including organization of events, media communication services, grants, goods such as laboratory software and equipment, and vehicles. The MSP's Directorate General of Health (*Dirección General de Salud* – DIGESA) being responsible for the overall coordination of the activities within this component. Activities will be grouped three subcomponents:

Subcomponent 1.1 – Strengthening of Health Intelligence Functions *(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 be organized in two main groups: (a) establishing the foundations of an Integrated Health Information System (IHIS); and (b) strengthening the response capacity of selected DIGESA Departmental Units:

a) Establishing the foundations for an Integrated Health Information System (IHIS): This integrated health information sytem would provide 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 in relation 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 government and health-sector agencies and actors. Moreover, this activity would capitalize on the window of opportunity that opens as a result of the proposed operation, as it would support the development and/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; a M&E system to monitor 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 among government agencies (such as the MSP, BPS, the Ministry of Economy (MOE), and the FNR) and other relevant health-sector actors. 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.

Specific activities would include:

i) Inventory of information systems that currently exist within Uruguay's health sector, in terms of their intended use, data collection protocols, data content, data structure, assessment of data quality—including reliability, periodicity, and users.
ii) Design and implementation of the IHIS, including the development of an e-government framework to ensure the interoperability, integration and replication of individual information systems to be developed under the Project in the future.
iii) Strengthening of individual databases: Based on the results from the inventory described in item (i), individual information systems and databases would be strgthened to enhance their quality, completeness, timeliness, and interconnectivity, thus, maximizing their potential contribution to the overall health information system.
iv) Developing additional information subsystems: Based on the needs identified as part of the inventory and the overall design of the IHIS described in items (i) and (ii), respectively, additional information systems or sub-systems would be developed, including a Monitoring and Evaluation (M&E) system to systematically monitor the performance of public and private health care providers.
v) Modernization and consolidation of the public health surveillance system (*Sistema de Vigilancia Epidemiológica* – SEVES): This system, which a focus on NCDs and its risk factors as well as readiness for emerging infectious diseases, would be implemented nationally and in stages. SEVES would serve to strengthen the MPS' institutional capacity to make informed decisions about prevention and control priorities, enhance the monitoring of health interventions and changes in health trends, and allocate resources more effectively. With regard to NCDs, the SEVES would result in a better characterization and prevention of the NCDs and its risk factors.

Expected outcomes include:

i) Nine departments participating in the Project regularly report consolidated data on number of patients diagnosed with specific NCDs and currently under treatment.
ii) 205 primary health facilities are regularly using the diagnosis monitoring system.
iii) Four main databases (BPS, RUCAF, ASSE beneficiary, FNR beneficiary) are virtually integrated into the National Health Information System.

b) Strengthening DIGESA's response capacity: These activities would be aimed at strengthening DIGESA and its departmental units to: make informed decisions about prevention and control priorities; monitor the impact of the health interventions; carry out disease monitoring, control and prevention for diseases that pose a serious public health threat, such as tuberculosis, dengue and hospital infections, and develop NCDs health promotion programs focusing on education, social mobilization, and advocacy for healthy spaces.

Specific activities would include:

i) Capacity assessment of DIGESA's Departmental Units to assess their ability to fulfil their responsibilities in the context of the redesigned SEVES.
ii) Capacity building, including personnel training, provision of office and ITC equipment, communication systems and vehicles.

Expected outcomes include:

i) 85 percent of units within public health surveillance system comply with information reporting requirements.
ii) 50 key personnel trained in SEVES.
iii) Data definitions and coding standards for 34 pathologies have been issued.
iv) Two Public Health Bulletins and Surveillance Bulletins published according to norms in any given year.
v) 20 additional DIGESA staff trained in 'Data for Decision-Making.'
vi) Ten key staff trained in laboratory safety.

Subcomponent 1.2: Health Promotion and NCDs Prevention Programs. *(US$3.2 million of which US$3.1 million would be financed by the Bank loan):* This subcomponent would support development of a National Health Promotion Strategy (NHPS) consisting of public health programs aimed at promoting healthy lifestyles and NCDs prevention. The NHPS would be conceived as a strategic tool to support the MSP develop and implement health promotion and prevention policies and vertical programs targeting the most common risk factors of cardiovascular diseases, diabetes mellitus, overweight/obesity, cancer, and chronic respiratory diseases. The NHPS would be the result of inter-sectoral efforts aimed to reduce major risks to health, improve risk management and increase public awareness and understand of risks for health. A Fund for a Healthy and Inclusive Uruguay would be created as part of the NHPS to stimulate horizontal activities in the same areas in which vertical programs will be implemented to address NCDs prevention and promotion (see Box 4.1). This Fund would seek to create a balance between government, community and individual action by promoting community-based participatory activities in settings that foster social participation (e.g., municipalities, schools and workplaces) and proactively seeking to include special-needs populations (e.g., children, adolescents, the elderly and the disable).

Activities within this subcomponent would include:

(i) Strengthening the institutional capacity of the MSP to design and implement health promotion programs through personnel training and updating of ITC equipment;
(ii) Implemention of social communications strategies, such as education programas, community programs, social marketing and communication campaigns.
(iii) Financing, through the Fund for a Healthy and Inclusive Uruguay, of subprojects for local institutions and community groups to set up or strengthen disease prevention and health promotion programs within their communities.
(iv) Dissemination of Project activities among both the general public and the health community in relation to promoting healthy lifestyles and preventing risk factors associated with NCDs through websites, regular newsletters, workshops, conferences, and technical meetings for stakeholders (such as politicians, government officials, the medical and private insurance community and others).

Expected outcomes include:

(i) 50 percent of municipalities have carried out 'healthy spaces' campaigns
(ii) 95 percent of health promotion subprojects related to NCDs implemented in participating healthy spaces evaluated.
(iii) 20 percent of students in public schools have participated in 'healthy school' campaigns.
(iv) Five Disability, Early Detection and Treatment Units fully functioning.
(v) 100 percent of personnel trained in health promotion unit.
(vi) Annual Tobacco media campaign developed in any given year.
(vii) National Promotion Advocacy group conformed.

Box 4.1
Fund for a Healthy and Inclusive Uruguay

The Fund for a Healthy and Inclusive Uruguay will provide seed money as well as technical assistance to 19 departmental municipalities and schools to support demand-driven activities proposed by the local communities using an inclusive and participatory approach. The main goal of the Fund is to develop and consolidate local capacity to generate and implement policies, programs and activities within the conceptual framework of 'healthy, productive and inclusive spaces and environments.' The interventions should focus on public schools, community centers and others.

The Fund will consist of small grants (i.e., U$S5000, US$10,000 and US$ 50,000 depending on the size of the population) to be provided for selected proposals to be developed and submitted by municipalities through a national public competition. While DIGESA will provide the bulk of the funding, other sources of financing (including NOGs, cooperation agencies and small businesses among others) will also be explored to stimulate public-private partnerships at the local level. Proposals will focus mainly (but not exclusively) on NCDs health promotion and prevention and should be related to the other areas of intervention included in the NHPS and by programs already being implemented by the MSP, such as Tobacco Control. Potential areas of intervention include: physical activity, nutrition, obesity, road safety, alcohol and drugs, activities related to inclusive education, community-based attention and rehabilitation, and others. Projects will be required to adopt a participatory approach and promote social inclusion by involving, among their beneficiaries, elders, persons with disabilities and other marginalized and or vulnerable groups. The type of activities that could be financed by the Fund encompass capacity building and technical qualification, studies and external technical assistance, organization, logistics, social communication, acquisition of goods, services, small infrastructure works, ICT equipment, educational materials and publicity.

Subcomponent 1.3 - Regulatory capacity building in relation to NCDs *(US$0.6 million of which US$0.5 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 to develop and utilize M&E systems to, in turn, enhance the effectiveness and efficiency of NCDs health programs.

Specific activities within this subcomponent would include:

i) Review and optimization of the current regulatory framework in relation to essential NCDs and its risks factors to assess their effectiveness in terms of:
   - Providing adequate consumer protection;
   - Promoting efficiency in the purchase of services from providers;
   - Ensuring the equitable allocation of public subsidies; and
   - Enhancing access to health services for the entire population.

ii) Strengthening the MSP's capacity to enforce public health regulations. Technical assistance, training, and ITC equipment would be provided to entities responsible

for the habilitation, certification and accreditation procedures of ambulatory facilitities.

Expected outcomes include:

(i) Regulatory framework affecting essential NCDs and risk factors reviewed to assess their effectiveness.
(ii) 200 primary health care establishments certified and quality accredited on NCDs medical care procedures at ambulatory level.

Component 2 - Improve accessibility to quality care services for prevalent NCDs in public primary care facilities *(US$15.8 million of which US$13.2 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 and their risk factors—i.e., hypertension, cardiovascular disease, obesity, overweight, diabetes and selected preventable cancers. It would also improve problem resolution at the primary care level; thus enhancing efficiency of the overall sector. ASSE), which is 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$13.8 million of which US$11.3 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 by providing them with new ITC equipment and medical diagnosis equipment critical in the detection and treatment of NCDs. The medical equipment at the primary level is composed largely of diagnosis equipment—endoscopical, traumatological, mammographic and basic standard common X-Ray devices, ECG and ecographic equipment, Holter and portable blood pressure monitors, and the corresponding technical supporting services, as necessary. At the regional level—mainly in inland second-level referral ambulatory facilities--more complex medical equipment will be provided. This subcomponent builds upon a detailed diagnosis of the equipment needs for NCDs health services within the ASSE's health network that was financed under the Grant JPN TF 52535.

The specific beneficiaries from the medical equipment to be provided under this subcomponent would include:

(i) A total of 210 ASSE's health care facilities in the sanitary regions of Montevideo, Canelones East and West, San José, Tacuarembo, Treinta y Tres and Rio Negro;
(ii) All the second-level referral ambulatory facilities—i.e., 11 in Great Montevideo's sanitary regions and 41 in the inland sanitary regions—and
(iii) Five high-complexity facilities that have also a second-level referral ambulatory role for certain NCDs nationwide.

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):* Uruguay health sector lacks appropriate systems to manage care of chronic diseases under standard procedures. An exception is a successful pilot program implemented in 13 of Montevideo's regional primary care facilities and its second- and third-level referral facilities, which permits tracking the most frequent NCDs

diagnosis used in primary care facilities. Otherwise, NCDs monitoring systems are highly underdeveloped and lack the support of even rudimentary information systems, as most of the facilities (both primary care and secondary care ones) do not have computers and Internet connectivity. To address this problem, this subcomponent would focus on the development and implementation of modern management tools aimed at improving the efficiency of primary health care, particularly in relation to NCDs.

Specific activities within this subcomponent would include:

(i) Expanding the successful pilot program to the rest of the health delivery system and to develop complementary applications.
(ii) Developing referral and counter-referral procedures and protocols.
(iii) Strengthening communications among health professionals, including physicians, technicians and nursing personnel, to promote fluid and effective communications.
(iv) Developing and disseminating a set of indicators among health personnel (i.e., physicians, technical, nurses, and administrative and managerial staff) to be used as the basis for results-based evaluations.
(v) Introducing results-based management contracts in relation to NCDs care.
(vi) Introducing others administrative and management tools to support the functioning of the health network.

Expected outcomes include:

(i) Production information and monitoring systems strengthened.
(ii) Adoption of standards for quality assurance of care.
(iii) External certification mechanisms to enssure quality standards.
(iv) Percent of NCDs cases diagnosed and under follow-up by primary-care teams.
(v) Percent reduction in hospital admissions for treatments for specific NCDs more appropriately provided at lower levels.
(vi) Percent reduction in the number of advanced-stage cases for specific NCDs assisted under the FNR in any given year relative to all cases in the same NCDs category.
(vii) Number of primary health facilities under results-based management contracts.
(viii) Number of primary health using the NCDs referral and counter-referral systems.
(ix) Percent increase in the number of women between 50 and 69 years of age that had a mammogram in any given year.

Subcomponent 2.3 – Capacity building (US$1.3 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, prevention, screening and management of priority NCDs. This would be critical to permit Uruguay's health system to solve its current inadequate response in addressing the present epidemiological situation. Currently, the health care model is strongly oriented toward medical assistance of communicable diseases and emergency care. The poor management of human resources and the lack of specific training on NCDs primary and secondary prevention strategies are important factors contributing to this problem.

The main objective of this subcomponent is to increase utilization of primary health care services for NCDs among low-income population, by implementing personnel in-service training oriented to improve the quality of health strategies. A secondary objective is to develop NCDs treatment networks, strengthening referral and counter-referral mechanisms. In order to achieve these

objectives, the Project would support the implemention of a National Programme of Human Resource Development for primary health care teams (physicians, nurses, odontologist, and administrative and technical staff) to reorient the current health model toward one with a more integrated focus on health promotion activities, prevention, and quality standards for NCDs treatments. ASSE's central training unit would be responsible for coordination, management, and monitoring and evaluation of training.

Specific activities within this subcomponent would include:

(i) Strengthening of ASSE's central unit through technical assistance and provision of goods.
(ii) Preparation, publishing and disseimination of guidelines and training manuals for both trainers and trainees.
(iii) Tutorial teams to complement distant training activities.
(iv) Virtual Campus to improve access to ongoing training to ASSE's health teams.
(v) ITC infrastructure to support distance learning.
(vi) Seminars and workshops for all the health personnel.
(vii) Incentives such as funding for attending professional meetings, professional career credits and funding for research Projects related to NCDs prevention and/or management would be provided to trainees.

Expected outputs would include:

(i) 6,000 members of ASSE's health care teams trained for prevalent NCDs.
(ii) Personnel trained in primary and secondary prevention and management of NCDs.
(iii) Improvement of health promotion activities and identification of population at risk.
(iv) Increased Community Health Activities.
(v) Improvements in networks activities with an adequate referral and counter-referral system.
(vi) Educative Virtual campus accessible to 70 percent of ASSE's health primary care teams by the end of Year 3 of Project implementation.

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 the so-called *Previniendo* Pilot Program aimed at enhancing NCDs control and risk factor prevention in three out of the 19 municipal departments in the country. Covering a population of approximately 140,000, this pilot program would introduce financial incentives among health insurers and providers by linking financing to outcomes from prevention activities for selected NCDs risk factors. In this way, the *Previniendo* Pilot Program constitutes a significant innovation, as it would encourage prevention activities by altering the existing financing flows within the health system. This pilot program is considered a major cornerstone in the implementation of an integrated policy strategy focusing on NCDs control and prevention. Other Project components would finance complementary activities necessary to achieve this outcome.

The objective of the *Previniendo* Pilot Program would be to reduce the impact of risk factors and medical complications for selected NCDs with high prevalence in Uruguay, including hypertension, diabetes, obesity/overweight, and colon cancer. This would be achieved through the identification, follow-up and mitigation of risk factors. The objective would be to decrease the incidence of the selected NCDs and decrease prevalence in the obesity and overweight as a risk

factor. The target population for the pilot program would be those older than 18 years. Beneficiaries would receive a Package of Preventive Interventions and Activities (PPI) consisting of a bundle of cost-effective services and activities through authorized health services providers owned by public and private departmental health insurance entities (DHIEs). Table 4.1 summarizes the main risk factors and interventions covered under the PPI. To cover costs of establishing a NCDs preventive system and to pay for the costs of providing the PPI, loan financing would be provided to DHIEs in the form of a capitation payment.

Table 4.1 Risk Factors and Interventions Covered under the PPI

Risk Factors • Hypertension • Diabetes • Obesity and overweigh • Colonic cancer
Clinical Interventions • Weigh measures • Hypertension measures • Fat consumption evaluation • Fiber, vegetables, and fruit consumption evaluation • Physical activity evaluation • Risk-factor evaluation and determination of risk channel for clinical and social follow-up activities
Laboratory Analyses • Rapid cholesterol blood test • Rapid glucose blood test
Rescue Activities • Authorized home and workplace visits and phonecalls by specially trained health personnel to people with identified risk factors to prevent abandoning clinic control
Other Activities Covered • Programming of primary health interventions, including screening activities • Programming of physical activities to avoid sedentary life style • Supervision and monitoring of health interventions • Computarized registers of all PPI activities

The MSP's General Director of Health (*Dirección General de Salud* – DIGESA) would be responsible for the overall coordination of the activities within this component. The MSP, through DIGESA and the PSCU, would have overall responsibility for the implementation of the pilot program. The participating departmental DHIEs would implement the *Previniendo* Pilot Program, with the MSP having a supportive financing and technical advisory role.

This pilot program is expected to have a significant impact on the overall functioning of the health system, providing added incentives for prevention and monitoring services for the health risks to be covered. Financing under this subcomponent would provide for transfers from the MSP (i.e., through DIGESA and PSCU) to each participating DHIE in the form of capitation payments. While capitation payments to participating DHIE would be calculated on the basis of the risk profile of the population and the actual detection of NCDs, it would be adjusted depending on specific achievements in terms of program coverage and sanitary goals. Specifically, coverage goals will be measured as the percentage of the total population that has received the initial screening, while sanitary goals will be measured as the percentage of

population receiving the planned medical services to mitigate identified NCDs risks factors. Financing to health-care providers would be based on services rendered on a fee-for-service basis.

Expected outcomes include:

(i) 65 percent population of pilot departments with risk factor screening.
(ii) Percentage of cases diagnosed and under follow-up by primary care teams in participating pilot program departments have been increased to 85 percent for hypertension, 93 percent for diabetes, and 65 percent for obesity/overweight.
(iii) Reduction in hospital admissions for treatments more appropriately provided at lower levels corresponding to: 70 percent for hypertension crisis, 70 percent for stroke, and 70 percent for Ketoacidosis diabetic.
(iv) Ten percent reduction in the number of advanced-stage cases for specific NCDs assisted under the FNR relative to all cases in the same NCDs category (i.e., cardiovascular disease by hypertension, and chronic kidney failure by hypertension).
(v) 85 percent of primary care providers under Annual Performance Agreements with DHIEs.

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 the responsibility of the Project Support and Coordination Unit (PSCU), a small unit to be financed entirely by the MSP. The PSCU would be responsible for coordinating all technical and administrative processes. This unit would also carry out administrative processes regarding specific studies for Project impact evaluation and studies to support the design of the health insurance reform. This component would cover the Project's operating expenses, office equipment. In addition, this component would finance the cost of studies focusing on:

Specific activities within this subcomponent would include:

(vi) Provision of technical assistance to Participating Government Agencies (PGAs) as part of Project's implementation, especially for Bank rules on procurement and financial management accomplishment.
(vii) Strengthening of the PGAs technical and operational capacity to implement the activities designed under the Project.
(viii) Strengthening of the PSCU's 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.
(ix) Impact evaluation studies, especially those related to the 'Previniendo' Pilot Program
(x) Studies and technical assistance to support the Health Insurance Reform Design Process, including the overall policy framework and the system of incentives of the new health insurance. These activities would be technically responsibility of the Health Secretariat (*Dirección General de Secretaría* – DIGESE), the agency within the MSP that is now responsible for conducting the health reform strategy. Technical assistance activities would be connected to the design of the various elements of the reform strategy, including coverage package, risk administration, financial mechanisms, and institutional governance. Special emphasis would be placed on:
    - Provision of technical assistance for activities connected to the design of the various elements of the reform strategy, including: (i) coverage package, risk

administration, financial mechanisms, and institutional governance; and (ii) studies to reduce fragmentation of the current health care system.

- Financing of studies to develop the design of pilot experiences to introduce the incentives for health providers, especially related to NCDs promotion and prevention, that are conducive to maximize results in the ground and to ensure access to health care to vulnerable groups;
- Assessing alternative policy frameworks terms of their financial and economic impact in the short, medium and long term.

Expected outcomes include:

(i) Develop ethodology in conjunction with the Ministry of Finance to assess the financial impact on public finances of alternative health care reform strategies.

(ii) Developed methodology in conjunction with the Ministry of Finance to assess the financial impact on household budgets of alternative health care reform strategies

(iii) Developed methodology to assess the financial impact on household budgets of alternative health care reform strategies and is implemented in any given year

(iv) Survey on health conditions and determinants completed.

ANNEX 5: Project Cost

NON COMMUNICABLE DISEASES PREVENTION PROJECT

Proyect Cost by Components and Sub-Components	Program Indicative Cost	% of Total	Bank Financing	% of Total Financing
1. - Strengthening of the MSP's Capacity to Address the Country's Changing Epidemiological Profile.	**6.1**	**21.3%**	**5.7**	**92.9%**
1.1 - Strengthening of Health Intelligence	2.3	8.1%	2.1	89.3%
1.2 - Health Promotion and NCD	3.2	11.2%	3.1	94.6%
1.3 - Regulatory capacity building in relation NCDs	0.6	1.9%	0.5	98.0%
2. - Improve Accessibility to Quality Care Services for Prevalent NCD in Public Primary Care Facilities	**15.8**	**55.0%**	**13.2**	**83.7%**
2.1 - Enhancing technological infrastructure of the public primary health care network	13.8	48.0%	11.3	82.0%
2.2 - Development of modern health management tools	0.7	2.3%	0.7	100.0%
2.3 - Capacity building	1.3	4.7%	1.3	93.5%
3. - Implementation of the "PREVINIENDO" Pilot program	**3.8**	**13.2%**	**3.8**	**100.0%**
4. - Project Management	**2.1**	7.4%	**1.7**	**78.2%**
4.1 - Management cost	1.4	5.0%	1.0	67.6%
4.2 - Financing study	0.7	2.4%	0.7	100.0%
Total Baseline Cost	**27.9**	**96.9%**	**24.4**	**87.5%**
Unallocated	0.9	3.1%	0.9	100.0%
Total Project Costs	**28.8**	**100.0%**	**25.3**	**87.9%**
Front End Fee				
Total Costs	**28.8**	**100.0%**	**25.3**	**87.9%**

ANNEX 6: Implementation Arrangements

NON-COMMUNICABLE DISEASES PREVENTION PROJECT

Project implementation would be related to two broad areas: (i) implementation of the Project and (ii) implementation of Project and program monitoring and evaluations functions. The latter arrangements are described in detail in Annex 3.

Project Implementation

Agencies, Roles and Responsibilities: The Project would be implemented through the following agencies:

a) Ministry of Public Health (MSP): The Minister as a National Director of the Project would have overall responsibility for achieving program outcomes and would exercise her role through two General Directorates of MSP; the Health Service Administration (ASSE) and the Project Support and Coordination Unit (PSCU) under her direct supervision. Together, these institutions would aim at strengthening the MSP's capacity to effectively address the changing epidemiological profile of Uruguay, enhancing the MSP's monitoring and regulatory capacity, strengthening MSP's capacity to implement 'healthy spaces' policies, strengthening ASSE's ability to detect, prevent, and treat NCDs through the public primary care network, implementing the *Previniendo* Pilot Program in public and private Departmental Health Insurance Entities (DHIEs), improving health information systems and designing an integrated health information system. The Ministry of Health will sign, with the assistance of PSCU, management performance agreements with DIGESA, ASSE, and DIGESE. The Ministry of Health will also sign Umbrella Agreements and Annual Performance Agreements with the DHIEs, covering all permanent technical, financial, administrative and fiduciary aspects of the DIHEs participation in the *Previniendo* Pilot Program. The agreements will identify the technical assistance, training, and goods to be provided under the Project. Likewise, they will commit the agencies to agreed performance indicators and concrete results in Project implementation activities.

b) *Project Support and Coordination Unit (PSCU)*: The Unit, integrated by line staff of the Ministry of Health, would be responsible for daily management of the Project, which include: i) establishing and monitoring the performance agreements with DIGESA, ASSE, and DIGESE, ii) coordinating with those areas technical and administrative issues of implementation, iii) preparing the consolidated plan of activities and investment to be executed under the agencies, iv) carrying out the Project's technical and administrative dialogue with the Bank, v) monitoring and evaluating Project activities, vi) preparing reports on technical and financial performance and disbursement, and vii) reporting to the Bank. The PSCU would be responsible for all aspects pertaining to the Project financial management, including accounting and financial reporting, budgeting, internal control, treasury operations and external audits. On budgeting and accounting processes, the PSCU would coordinate with two line units responsible for Financial Management in the MSP and ASSE. On the procurement side, the PSCU would coordinate with two specialized institutional procurement offices (Procurement and Supply Department of the MSP and Material Resources Division of ASSE) for activities under Components 1, 2 and 3, and would execute the procurement aspect of the Component 4. The PSCU would be responsible for working with DIGESA and the participating DHIEs in the implementation of the *Previniendo* Pilot Program under the Component 3. The PSCU

would be responsible for procurement planning and request of no objections from the Bank. The PSCU would be staffed by the MSP with a manager (appointed by the MSP), a health expert, a procurement specialist, a financial specialist, an M&E expert and a full-time technical expert to assist in financial management and monitoring and evaluation of the Project.

c) *DIGESA, ASSE and DIGESE:* The agencies would be responsible for carrying out the technical and procurement aspects of the Project in those respective areas with the support of the PSCU and two specialized institutional procurement offices. The agencies would be directly responsible for implementing activities, preparing and costing of activities, preparing drafts of the terms of reference and technical specifications, supervising the performance of contracts, preparing reports on technical aspects of the activities under the Project and implementing the *Previniendo* Pilot Program. The agencies would be accountable for executing activities and for achieving results in terms of the Project.

d) *Procurement and Supply Department of the MSP and Material Resources Division of ASSE:* The specialized institutional procurement offices would be responsible, with the support of the PSCU, for the final preparation of terms of reference and technical specifications and for the procurement process implementation (announcements, reception of bids and bids opening), as well as for preparing the bidding documents and bid evaluation reports. The Procurement and Supply Department of the MSP would execute the procurement aspects for the Components 1 and 3 in close coordination with PSCU and technical staff from DIGESA and DIGESE. The Material Resources Division of ASSE would assume such activities for the Component 2.

Departmental Health Insurance Entities (DHIEs): Participanting public and private departmental health insurance entities (DHIEs) will sign Umbrella Agreements and Annual Performance Agreements with the MSP/DIGESA/PSCU to implement the *Previniendo* Pilot Program. Each participant DHIE will sign service contracts with authorized health service providers for providing a Package of Preventive Interventions and Activities (PPI) to the target population. On an annual basis, each participating DHIE will agree with DIGESA through the Annual Performance Agreements on the program coverage and health service utilization targets. DIGESA will cover the cost of implementing the Project through a capitation payment adjusted by performance with respect to the agreed health service utilization targets. Umbrella agreements would define the rules for both parties regarding the administration; financing, monitoring, auditing and other specific requirements with which participating DHIEs would need to comply. Participating DHIEs will use a reimbursement scheme based on fee-for-service charges to compensate the health services providers of the PPI.

Responsibilities for Project Components

- The MSP would be responsible for assuring that all Project components are implemented and, through the PSCU, would be directly responsible for implementing the overall management and administration of the Project (Component 4).
- The MSP/PSCU/DIGESA/Procurement and Supply Department of the MSP would be responsible for implementing activities to Strengthening of the MSP's Capacity to Address the Country's Changing Epidemiological Profile (Component 1).
- The MSP/PSCU/ASSE/Material Resources Division of ASSE would be responsible for Improve Quality of Primary Care Services for Prevalent NCDs (Component 2).
- The MSP/PSCU/DIGESA/Procurement and Supply Department of the MSP would be responsible for implementing activities related to the *Previniendo* Pilot Program Implementation.(Component 3).

Procedures. The processes and procedures governing Project implementation are outlined in detail in the Project's Operations Manual. Procedures governing the basic relationship between the Government and the World Bank, mainly covering financial management and procurement are detailed in Annex 7 and 8, respectively. In spite of the MSP's previous experience in implementing multilateral financed programs, the decision not to rely on external administrative agencies (UNDP and others) and to use the administrative structure of the participating agencies with the support of a new unit (PSCU) would require a training process with technical support from the Bank. The scope of the training process and the norms and procedures guiding the daily exercise of responsibilities of the staff of the PSCU and the participating agencies are also detailed in the Operation Manual.

ANNEX 7: Financial Management and Disbursement Arrangements

URUGUAY - NON COMMUNICABLE DISEASES PREVENTION PROJECT

Executive Summary and Conclusion

A Financial Management (FM) Assessment of the arrangements for the proposed Project was carried out in accordance with OP.BP 10.02 and in line with the Financial Management Practices in IBRD-Financed Investment Operations; document issued by the FM Board on November 3, 2005. The assessment objective was to determine whether the financial management arrangements in the Ministry of Public Health (MSP) are acceptable to the Bank and recommend the borrower to take the appropriate measures to mitigate identified risks.

The conclusion of the assessment is that the FM arrangements for the proposed Project are sound and acceptable to the Bank because they meet minimum Bank requirements. However, there is a modest element of risk given the use of an innovative approach for the *Previniendo* Pilot Program under Component 3 of the Project and the fact that Component 2 will be implemented by an agency (ASSE) with a certain degree of administrative decentralization.

During appraisal, the MSP through the PSCU prepared and submitted to the Bank the following documentation, which the Bank reviewed and found acceptable:

i) The Chart of Accounts reflecting the Project components and disbursement categories.
ii) The draft format and contents of the annual Financial Statements and Interim Unaudited Financial Reports (IUFRs) for monitoring and evaluation purposes.
iii) An advanced version of the Project Operational Manual (POM) comprising a FM Section with administrative procedures and processes for the Project implementation. The final version of the POM will be submitted to the Bank prior to Negotiations.

Country Background

A Country Financial Accountability Assessment (CFAA) of Uruguay was conducted and a first draft presented to the Uruguayan government in 2003. A second draft was presented to the new administration elected in 2004, and it was finally published in 2005. It is worth to note that the final version of the document does not present substantial changes from the original draft.[9] The report concludes that the country fiduciary risk in Uruguay is **low**. The CFAA has been taken into account to determine the Project fiduciary risk.

Strengths and Weaknesses

Strengths: MSP experience in the implementation of the WB-financed First Health Sector Development Project (Loan No. 3855-UY). Besides, the Integrated Financial Information System (SIIF) will be used to process and maintain the budgetary execution of the Project.

Weaknesses: No critical weaknesses have been identified. The fact that Component 2 will be implemented by an agency (ASSE) with a certain degree of administrative decentralization may pose a modest element of risk.

[9] WB Report 32851-UY.

Risk Assessment and Mitigation

The overall FM risk at entry was assessed as Modest. This level of risk was taken into consideration in designing the mitigation measures which are intended to adequately deal with the assessed risk. A detailed risk assessment is provided below.

Table 7.1 Risk Assessment and Mitigation Measures

Risk	Risk Rating	Risk Mitigating Measures Incorporated into Project Design	Condition
Inherent Risk			
▪ Country Level	Low		
▪ Project/ Entity Level	Modest	- PSCU having a role of coordination and control - Capacity building activities during start up period.	
Project Control Risk			
▪ Budgeting	Low		
▪ Accounting	Low		
▪ Internal Control	Low		
▪ Funds Flow Component 2 implementation by an entity with certain degree of decentralization may pose some risk	Modest	- Increased FM supervision during start up period. - Use of country system (SIIF) for funds flow between MSP - ASSE	
▪ Financial Reporting	Low		
▪ Auditing	Modest	- Capacity building activities to support TCR in auditing the *Previniendo* Program	
Overall Residual Risk rating	**Modest**		

Implementing Entity

The implementing agency for the proposed Project will be the Ministry of Public Health (MSP); with the Minister of Health serving as the Project's National Director. Components 1 and 3 will be carried out by MSP's Directorate General of Health (*Dirección General de Salud* - DIGESA), while Component 2 will be implemented by the MPS's Health Services Administration (*Administración de los Servicios de Salud del Estado* - ASSE), which is the agency responsible for medical care for population without social security or private health insure. The Project Support and Coordination Unit (PSCU), which will report directly to the Minister of Health, will be responsible for all aspects pertaining to the Project financial management including accounting and financial reporting, budgeting, internal control, treasury operations and external audit. The line units in the Ministry (MSP's *Gerencia Financiera* and ASSE's *Gerencia Financiera)* will be in charge of the budgetary execution of the Project.

Budgeting, Accounting and Financial Reporting

The Borrower's proposed budgeting and accounting arrangements for the Project comprise both the integrated financial information system (SIIF) applied by the General Accounting Office (*Contaduría General de la Nación*- CGN) across the public sector, which will control and record the transactions in the implementing units (DIGESA, ASSE), and a dedicated accounting and

reporting system to operate in the PSCU to support Project management, external reporting and the preparation of the justification of funds to the Bank. All transactions related to the Project will be processed in the accounting system with the chart of accounts reflecting the Project categories, components and sources of funding, while supported by documentary evidence for the related goods and services procured in line with the Bank guidelines for the Project. The accrual basis of accounting will be followed and the International Accounting Standards (IAS) will be adopted for the preparation of the annual financial statements.

The MSP-PSCU will prepare annual financial statements and semiannual Interim Unaudited Financial Reports (IUFRs) only for reporting purposes, as follows:

- Sources and uses of funds: source and uses of funds, for each semester and cumulative (uses by category), and uses of funds by component;
- Physical progress: Allocated budget and financial execution compared to physical progress and results achieved.

The proposed format for the IUFRs was submitted to the Bank, reviewed and found acceptable. The IUFR review will be conducted by the assigned FMS during Project supervision missions. The final formats of the financial statements, chart of accounts and IUFRs have been incorporated into the Operational Manual.

Funds Flow and Disbursement Arrangements

The following Disbursement Methods may be used under the Loan:

- Reimbursement
- Advance
- Direct Payment

Loan proceeds to be withdrawn using the ***advance method*** would use a Segregated Designated Account (SDA) in US dollars. The Designated Account will be held by the Ministry of Economy and Finance at the Central Bank of Uruguay (*Banco Central del Uruguay - BCU*) as is the standard procedure in the country. The proposed ceiling for advances to the DA is US$2.5 million, estimated sufficient for peak disbursement periods of Project execution.

As expenditures arise, funds will be converted to local currency and deposited into a Project account open in the Bank of the Oriental Republic of Uruguay (*Banco de la República Oriental del Uruguay* - BROU) under control of the MSP through the PSCU, which will meet the Project's costs either as payment to consultants, suppliers, small grants under Subcomponent 1.2 and reimbursement of the costs of the Package of Preventive Interventions (PPI) to the public (ASSE's *Centros Departamentales y Auxiliares*) and private (IAMCs) Departmental Health Insurance Entities (DHIEs).

<u>Flow of funds for the 'Uruguay Healthy and Inclusive Fund' (Subcomponent 1.2)</u>
The Fund for an 'Uruguay Healthy and Inclusive' will be launched through a mass communication campaign and will consist of small grants to be provided for selected proposals to be developed and submitted by 19 Municipal Departments, NGOs and schools at departmental level through a national public competition. The Fund will be financed from the proceeds of the Loan through the MSP's Directorate General of Health (*Dirección General de Salud* - DIGESA). There will be 3 different levels of amount for grants: US$5,000; US$10,000 and US$50,000, according to the size of the population served by each grant. Grant funds to beneficiaries will be disbursed as per provisions included in the grant agreements. It is envisioned that the first

installment will be disbursed upon signature of the grant agreement, and additional installments will be made on the basis of achieved objectives and documented expenditures. Under the Grants expenditure category, recipients could use the grant proceeds to pay for very small rehabilitation works, goods, including ICT equipment, and services.

Flow of funds for Component 2

Funds from the MSP to ASSE will be transferred from the DA to a segregated account within the Single Treasury Account (STA), *Cuenta Única Nacional* (CUN) under ASSE's control, from which payments of Project eligible expenditures will be made. As eligible expenditures arise, ASSE will submit an application of funds to the PSCU. After that, PSCU will review the eligibility of expenditures, and authorize the transfer from the DA to ASSE's account in the STA. Transfers from the DA to ASSE will be executed and recorded in the country Integrated Financial Information System (SIIF) and subject to the government-wide internal control over the budgetary execution process.

Flow of funds for the *Previniendo* Pilot Program - Component 3

Component 3 will support the implementation of the *Previniendo* Pilot Program, covering a population near to 140,000 in three of the country's 19 municipal departments. This pilot program aims to reduce risk factors impact and medical complications for three selected Non-Communicable Diseases (NCDs) in Uruguay: HTA, Diabetes and Obesity/Overweight.

The *Previniendo* Pilot Program will finance a health services package, the Package of Preventive Interventions and Activities (PPI) defined by the MSP-DIGESA, which is highly cost-effective for the current epidemiological Uruguay profile to target population of 18 years old and above. The interventions included in the PPI are included in the PPI Health Services List *(Nomenclador),* and have been agreed upon by the Government and the Bank.

Through an in-depth study that considered actual costs of inputs to the PPI services, the average unit cost for providing the PPI to the eligible population has been estimated. The cost of the benefit has been developed through analysis of the actual costs of its component parts, accounting for actual prices that prevail in the markets for medical goods and services, technology improvements and efficiency standards, and expected economies of scale. These costs have been brought to a per-capita average accounting for the size of the social security and public beneficiary database for all Departments covered by the *Previniendo* Pilot Program. These costs are considered to be reliable proxies, on average, for actual costs of delivering the PPI. The PPI cost would be reviewed annually by the MSP and agreed with the DHIE, with the Bank providing its No Objection to the estimate.

The estimated unit cost of the PPI is US$0.7 per-capita per month. The MSP will pay 100 percent of that PPI unit cost incurred to each participating DHIE based on the elegible population on a monthly basis. Disbursement to a participant DHIE would depend on the implementation of an acceptable Umbrella Agreement with the MSP-DIGESA covering all regular technical, financial, administrative and fiduciary aspects of DHIEs participation in the Pilot Program, the signing of the first annual performance agreement between the DHIE and the MSP-DIGESA, and the installation of the NCDs preventive information system.

Given the implementation complexity of the medical screening process (i.e., coverage of the population with NCDs risk factors) and the NCDs preventive system, disbursements to participanting DHIEs during the initial nine months after the signing of the Umbrella Agreement would be made at 100 percent based on the eligible population in each DHIE beneficiary registry

The Project will provide financial incentives for the DHIEs to participate in the *Previniendo* Pilot Program. For that purpose, achievement of the program coverage and sanitary goals will be monitored closely. From Month 10 and thereafter, the amount of the monthly payment to each participating DHIE will be adjusted on a quarterly basis, according to: (i) effective program coverage goal over the eligible population potentially with NCDs risk factors, measured through the percentage of the eligible population that has received the initial screening; and (ii) sanitary goals expressed as the percentage of population receiving the planned medical services to mitigate identified NCDs risks factors.

If the program coverage and sanitary goals are not reached, the total amount for eligible population in the DHIEs beneficiary registry will be adjusted accordingly. Otherwise, achievement of coverage and sanitary goals would entitle the participant DHIEs to be paid 100 percent of the per capita unit cost for the total eligible population.

Performance information in terms of program coverage and sanitary targets will be produced by each DHIE and reported to DIGESA. Departmental Directorates of DIGESA will verify and validate it on a sample basis the against DHIEs health service records, thus, ensuring that funds transferred from the MSP are linked to the provision of specific health services received by intended beneficiaries. Further, the reasonableness of the: (i) methodological process to calculate the unit cost and (ii) the methodology to control the registry of the *Previniendo* Pilot Program will be reviewed as part of the ex-ante external audits to be developed by the Uruguay's Supreme Audit Institution (*Tribunal de Cuentas de la República* - TCR).

Supporting documentation of Project expenditures

Supporting documentation for documenting Project expenditures under the advances and reimbursement methods would be:

- Records evidencing eligible expenditures (e.g., copies of receipts, suppliers/contractors' invoices) for payments for goods against contracts valued at US$350,000 or more; and payments for consultant services against contracts valued at US$100,000 or more for consulting firms, and US$50,000 or more for individuals

- Statement of Expenditure (SOEs) for all other expenditures for payments for contracts below the thresholds mentioned above, for operating costs and training;

- Customized Statement of Expenditure with supporting documentation for the *Previniendo* Pilot Program under Component 3. Certification of the registries of beneficiaries of the participating DHIEs is conducted by the DIGESE's Health Economics Division (*División Economía de la Salud*), as DIGESE exercises external control over these registries. Uder the Project, it will certify and approve the DHIEs's list of beneficiaries of 18 years and older under the *Previniendo* Pilot Program and the *Previniendo*'s registry itself (i.e., eligible population receiving the PPI). The registries comprise both the social security system (IAMCs) and public beneficiaries (ASSE) databases for each Department participating in the pilot.
- Customized Statement of Expenditure (SOEs) for grants under Subcomponent 1.2; and
- List of payments against contracts that are subject to the Bank's prior review.

All consolidated SOEs documentation will be maintained by MSP-PSCU for post-review and audit purposes for up to one year after the final withdrawal from the loan account. Direct Payments supporting documentation will consist of records (e.g.: copies of receipts, supplier/contractors invoices).

The minimum value for applications for **direct payments** and reimbursements will be US$500,000.

Retroactive financing
The MSP may request retroactive financing of eligible expenditures for an amount as specified in the Loan Agreement.

The MSP-PSCU already has access to the Bank's Client Connection webpage to access the 2380 Form and to perform the reconciliation process periodically between their bank account and the resources received from the different sources.

Loan proceeds will be disbursed against the following expenditure categories:

Table 7.2 Disbursements per Expenditure Category

Category	Amount of the Loan Allocated (in US$)	Percentage of Expenditures to be financed
(1) Goods (except as covered by Category (3) below)	13,500,000	82%
(2) Consultant and non-consultant services, training and operating costs (except as covered by Category (3) below)	6,300,000	100%
(3) Goods and services for Subprojects under Parts 1(a)(vii) and 1(b)(ii) of the Project	800,000	100%
(4) Capitation Payments under Part 3 of the Project	3,800,000	100%
(5) Front-end Fee*	-0-	
(6) Unallocated	900,000	
TOTAL AMOUNT	25,300,000	

* 1 percent of the Loan amount subject to a Bank's waiver.

Internal Control & Internal Audit

One of the most relevant instruments of the internal control in Uruguay is the Central Accountant. Key internal control functions in each ministry are in charge of the Central Accountant, who reports directly to the General Accounting Office's (GAO) Budget and Accounting Division. Central Accountants review transactions for legality and control the budget costs. The Internal Audit Office (IAO) is responsible for internal audits of the Central Administration. It depends functionally and financially on the Ministry of Economy and Finance. It has technical autonomy and unlimited access to financial records. The IAO prepares an annual audit plan and periodically progress against the plan is measured. To perform its audits, the IAO uses International Organization of Supreme Audit Institutions (INTOSAI) standards.

External Audit Arrangements

The annual financial statements of the Project would be audited by an acceptable auditor, following terms of reference and conducted in accordance with auditing standards acceptable to the Bank as well. It is proposed that the TCR be the external auditor for the Project. The TCR has

satisfactorily performed external audits in the Bank portfolio in Uruguay. Annual audits would cover all funding and expenditures reported in the Project financial statements. Audit reports will be due within six months following the end of the reported year. The standard covered period is the calendar year.

Table 7.3 shows the audit reports that will be required:

Table 7.3 Audit Reports' Schedule

Audit Report	Due Date
1) Project Specific Financial Statements	**June 30**
2) Special Opinions	**June 30**
▪ **SOE**	**June 30**
▪ **Designated Account**	**June 30**
▪ **Internal Control**	**June 30**

In addition to standard financial audit requirements, the annual audit scope shall include: (i) a sample review and assessment of the reports produce by DIGESE to validate and control the *Previniendo* Pilot Program's registries; (ii) the reports produce by DIGESA departmental directorate to validate and control the fulfillment of the sanitary goals of each DHIE. As part of the Project implementation, specific training on financial management accomplishment will be delivered to Government Participating Agencies (GPAs) including the TCR.

Action Plan

Completion status of the action plan agreed to by the Bank and the MSP is presented in Table 7.4.

Table 7.4 Financial Management Action Plan

Action	Responsible Entity	Completion Date	Status
1. Chart of accounts for the Project (to be included in OM).	MSP- PSCU	By appraisal	Completed
2. Draft Financial Sts. & IUFR formats submitted to the Bank	MSP- PSCU	By appraisal	Completed
3. Preparation of the final version of the Operational Manual (POM)	MSP- PSCU	Prior to or by Negotiations	Completed

Supervision Plan

The initial supervision plan is presented in the Table 7.5. The supervision scope will be adjusted by the assigned FMS according to the fiduciary performance and updated risk

Table 7.5 Financial Management Supervision Plan

Type	Timing	Mechanism	Objective
Visit	General Supervision. Twice a year during start up period. If Audit opinion is clean, once a year.	Integrating supervision missions.	♦ Review FM performance. ♦ Follow up on External Auditors recommendations/ raised issues. ♦ Review controls/staffing. ♦ Update assigned risk. ♦ Review SOE as needed ♦ Review IUFR information consistency. ♦ Raise issues disclosed in IUFR.
Audit Review	Once a Year	Over the Audit Report submitted to the Bank	♦ Review Audit Report. ♦ Raise issues disclosed in the Audit.

ANNEX 8: Procurement Arrangements

NON COMMUNICABLE DISEASES PREVENTION PROJECT

A. General

Procurement for the proposed Project would be carried out in accordance with the World Bank's Guidelines: Procurement Under IBRD Loans and IDA Credits (dated May 2004, revised October 2006); and Guidelines: Selection and Employment of Consultants by World Bank Borrowers (dated May 2004, revised October 2006), and the provisions stipulated in the Legal Agreement. The various items under different expenditure categories are described in general below. For each contract to be financed by the Loan, the different procurement methods or consultant selection methods, the need for pre-qualification, estimated costs, prior review requirements, and time frame are agreed between the Borrower and the Bank in the Procurement Plan.

Procurement of Goods: Goods procured under this Project basically would include medical equipment and medical instrument. International Competitive Bidding (ICB) procedures would be followed for contracts estimated to cost US$250,000 or more. National Competitive Bidding (NCB) procedures might be followed for contracts estimated to cost less than US$250,000. Shopping procedures might be followed for contracts estimated to cost less than US$50,000. The procurement will be done using Bank's Standard Bidding Documents (SBD) for all ICB and National SBD satisfactory to the Bank for all NCB and Requests of Quotations.

Procurement of services (other than consulting services): Non-consulting services under this Project would include services necessary to deliver Social Communication Campaigns, IT connection, among others, would be procured under the same methodologies and thresholds specified for goods.

Selection of Consultants: Consulting services from firms and individuals required for the Project would include: (a) strengthening of MSP health intelligence, (b) non-communicable disease prevention, (c) health promotion, (d) generation of regulatory capacity, (e) design of the national health insurance, and (f) support of the PSCU. Consulting Firms would be selected following Quality and Cost Based Selection (QCBS). Least Cost Selection and Consultant Quality (CQ) might be followed for contracts estimated to cost $100.000 or less. Short lists of consultants for services estimated to cost less than $200,000 equivalent per contract may be composed entirely of national consultants in accordance with the provisions of paragraph 2.7 of the Consultant Guidelines.

Operational Costs: The Project will finance operational costs up to an amount for individual transaction of US$3,000 to be procured using the implementing agency's administrative procedures, which were reviewed and found acceptable to the Bank. This includes transportation costs and per-diem for public entities and expenses for implementation supervision and monitoring

Training: the Project would also finance 'Training', which means expenditures (other than those for consultants' services) incurred by the Project to finance reasonable transportation costs and per-diem of trainees and trainers (if applicable), training registration fees, and rental of training facilities and equipment under the Project up to ceiling amounts to be established biannually in the Procurement Plan. The procurement would be done using the implementing agency's administrative procedures that were reviewed and found acceptable to the Bank.

Others: Competitive grants to the Fund for a Healthy and Inclusive Uruguay and to Epidemiological Investigation Activities will be financed under the Project. Procurement of goods and services would be carried out by the grantees entities pursuant to commercial practices if the grantee is from the private sector and in accordance with the procedures set forth in this Annex if the grantee is from the public sector. Grantees will decide on what investments to make in accordance with the competitively selected proposal. In the application for the grant, the beneficiary will list the goods and services, and the estimated cost as part of the business plan, required under the grant in lieu of an individual procurement plan. Grants under the program will be awarded competitively through advertisement. Particular attention will be paid to involving recognized sectoral health and social experts in grant selection processes. Procedures regarding the capitation payments to the public and private Departmental Health Insurance Entities (DHIEs) to fund the per capita cost of providing the *Previniendo* Pilot Program coverage to target population are not dealt with in this Annex since the above mentioned grants would not follow procurement procedures. The Operational Manual will describe such procedures in detail. The Project Operational Manual along with the SBD to be used for each procurement method, the Standard Request for Propposal (SRFP), as well as model contracts for goods and services procured, will be presented in the Project's web page within thirty days of receiving no-objection by the Bank.

B. Assessment of the agency's capacity to implement procurement

Procurement activities will be coordinated by the PSCU, with a strong participation of the specialized institutional procurement offices of the MSE: the Procurement and Supply Department of the MSP, for the Components 1 and 3, and the Material Resources Division of ASSE, for the Component 2.

Both procurement offices will assume responsibility for the preparation of technical specifications and for the procurement process implementation (announcements, reception of bids and bids opening), as well as will decisively contribute, with the support of the PSCU, in the preparation of bidding documents and bid evaluation reports.

The PSCU will also intervene in procurement planning and in the request of no objections to the Bank at the different stages of the procurement process, as well as in the whole implementation of the Project Management Component.

The PSCU would be constituted by a manager expert, a health system expert, procurement and financial management experts, and a social expert to assist with the implementation and monitoring of major Project components.

An assessment of the capacity of the Implementing Agency to implement procurement actions for the Project has been carried out by Ricardo Lugea in March 2007. The assessment reviewed the organizational structure for implementing the Project and the interaction between the Project's staff responsible for procurement activities and interviewed the staff responsible for the procurement function.

The capacity assessment did not identify any major issue concerning the procurement process. The experience of the agency in previous Bank-financed operations, as well as the qualifications of the procurement staff, is acceptable. National procurement law and regulations are not fully consistent with Bank rules. The agency should be supported by the PSCU in order to improve the timeless of procurement implementation and the observance of Bank procedures.

The following actions are recommended to alleviate risk and to facilitate Project implementation: (i) the PSCU should recruit a procurement specialist acceptable to the Bank that will help draft the Project OM and carry out procurement work on an on call basis, providing the implementing agencies with technical assistance on procurement, (ii) because of their small size, prior review of procurement actions would necessarily be limited, therefore, special attention should be given to procurement supervision and post-review, (iii) Special Procurement Provisions, as described above, should be agreed and included in the Loan Agreement, (iv) a detailed Procurement Plan for the first 18 months has been prepared, and (v) the POM should include (a) shopping procedures and standard documents for requesting quotations under shopping, (b) procedures for filing and handling correspondence, (c) frequency of six months for updating the Project Procurement Plan. The POM should also establish that the Borrower will get the Bank's authorization before undertaking any procurement process not included in the approved procurement plan and that such plan should be updated every six months.

The overall Project risk for procurement is **Average**.

C. Procurement Plan

The Borrower, at appraisal, developed a Procurement Plan for Project implementation that provides the basis for the procurement methods (the initial Procurement Plan). The initial Procurement Plan has been agreed between the Borrower and the Project Team on June 15, 2007 and is available at the Project files. It will also be available in the Bank's external website. The Procurement Plan will be updated in agreement with the Project Team every six months or as required to reflect the actual Project implementation needs and improvements in institutional capacity.

D. Frequency of Procurement Supervision

In addition to the prior review supervision to be carried out from Bank offices, the capacity assessment of the Implementing Agency has recommended two post-review missions for the first year of Project implementation and annually from there on.

E. Details of the Procurement Arrangements Involving International Competition

Goods and Non Consulting Services

(a) List of contract packages to be procured following ICB and direct contracting:

1	2	3	4	5	6	7	8	9
Ref. No.	**Contract (Description)**	**Estimated Cost**	**Procure ment**	**P-Q**	**Domesti c**	**Review by Bank**	**Expected Bid-Opening**	**Comme nts**

		$ million	Method		Preference (yes/no)	(Prior / Post)	Date	
1	Procurment of vehicles	0.70	ICB	No	No	Prior	April 2008	
2	Biosecurity laboratory equipment	0.25	ICB	No	No	Post	October 2009	
3	Medical equipment for primary health care facilities	7.35	ICB	No	No	Prior	May 2008	
4	250 PCs and desk for health capacitation network	0.45	ICB	No	No	Prior	April 2008	
5	Medical equipment for primary health care facilities (2nd phase)	6.44	ICB	No	No	Prior	March 2009	

(b) Contracts for Goods estimated to cost above US$350,000 and direct contracting will be subject to prior review by the Bank.

(c) The first contract procured under each procurement method will be subject to prior review regardless of amount.

1. **Consulting Services**

(a) List of contract packages to be procured with short-list of international firms and direct contracting:

1	2	3	4	5	6	7
Ref. No.	**Description of Assignment**	**Estimated Cost US$**	**Selection Method**	**Review by Bank (Prior / Post)**	**Expected Proposal Submission Date**	**Comments**
1	Baseline for health reform evaluation design	0.22	QCBS	Prior	April 2008	

(b) Short lists of consultants for services estimated to cost less than US$200,000 equivalent per contract, may be composed entirely of national consultants in accordance with the provisions of paragraph 2.7 of the Consultant Guidelines.

(c) Consultancy services to be provided by firms estimated to cost above US$150,000 per contract, consultancy services to be provided by individuals estimated to cost above US$50,000 and single source selection of consultants will be subject to prior review by the Bank.

(d) The first contract procured under each selection method will be subject to prior review regardless of amount.

E. Special Procurement Provisions

The following shall apply to procurement under the Project:

(i) The time allowed for the preparation and submission of bids shall be at least 10 days for Local Shopping, 30 days for NCB and 45 days for ICB.

(ii) The Borrower shall open all bids at the stipulated time and place. The name of the bidder and total amount of each bid, and of any alternative bids if they have been requested or permitted, shall be read aloud and recorded when opened and a copy of this record shall be promptly sent to the Bank.

(iii) The disclosure of information related to the contents of each bid, other than as set out in paragraph 2 above, shall not be permitted.

(iv) The lowest evaluated bid which has been determined by the Borrower to be substantially responsive to the bidding documents shall be selected for contract award.

(v) There will be no prescribed minimum number of bids to be submitted in order for a contract to be subsequently awarded.

(vi) After the public opening of bids, information relating to the examination, clarification and evaluation of bids and recommendations concerning awards shall not be disclosed to bidders or other persons not officially concerned with this process until the successful bidder is notified of the award.

(vii) Foreign bidders shall not be required to authenticate *(legalizar)* their bidding documents or any documentation related to such bidding documents with Uruguayan authorities as a prerequisite of bidding.

(viii) The Borrower shall award the contract, within the period of validity of bids, to the bidder who meets the appropriate standards of capability and resources and whose bid has been determined: (a) to be substantially responsive to the bidding documents; and (b) to offer the lowest evaluated cost. A bidder shall not be required, as a condition of award, to undertake responsibilities for work not stipulated in the bidding documents or otherwise to modify the bid as originally submitted.

(ix) Promissory notes issued by bidders or checks issued by local banks (whose validity lasts only 30 days) shall not be accepted as Bid Securities nor as Performance Guarantees,

(x) The price of the bidding documents will represent the cost of the copies of the documents; it cannot be fixed in relationship with the estimated contract amount.

(xi) Foreign consultants shall not be required to authenticate *(legalizar)* their proposals or any documentation related to such proposals with Uruguayan authorities as a prerequisite for participating in the selection procedure.

(xii) The prices of contracts over one year duration may be adjusted.

ANNEX 9: Economic and Financial Analysis

NON-COMMUNICABLE DISEASES PREVENTION PROJECT

Cost effectiveness of proposed interventions. A review of existing evidence indicates that the cost of prevention of NCDs as those supported under the proposed Project is lower than that of other illnesses.Table 9.1 includes data on the cost-effectivess of public health interventions. It can be seen that, for example, some anti-nicotine interventions are equally as cost-effective as some vaccination programs, such as the one for Polio (triple virus) or even more than cholera. Early detection programs for cervix and breast cancers, or integrated programs for primary and secondary prevention of cardiovascular diseases, are more cost-effective than some diarrhea preventive interventions (programs to improve personal and domestic hygiene practices) or than some vector control programs for malaria or dengue.

In general terms, to prevent cancer, is much more cost-effective than it is to treat it. Cost effectiveness of the initial treatment fluctuates between US$1,300 and US$6,200 for years of life saved (YLS) in the case of cancers that are more easy to treat in cervix, breast, mouth, colon, rectum, and between US$53,000 and $163,000 per YLS in the case of cancers that are more difficult to treat such as liver, lungs, stomach and esophagus.

Preventive strategies directed towards people at high risk of suffering from cardiovascular diseases (measured by a set of factors that include the presence of below-optimum values for arterial pressure and serum cholesterol, lifestyle and genetic risk factors) can be effective, especially when applied together with population type measures. A previous episode of a cardiovascular disease is an important indicator of a possible second episode. The cost-effectiveness of primary prevention of cardiovascular diseases can vary widely in terms of underlying risk factors, the age of the patient and the cost of medicines.

Overall, preventive interventions of the NCDs are at least 20 times more cost-effective that clinical treatment for those same illnesses.

From the analysis of the morbidity burden, a study of cost–effectiveness carried out as part of the Health Sector Institutional Strengthening Program (FISS-I, 1997) identified a set of interventions and prevention programs that can reduce the burden of morbidity. The study recommended measures of primary prevention in order to reduce the impact of risk factors of cancer, including nicotine poisoning, alcohol consumption, obesity, inappropriate exposure to the sun and risk factors in the workplace. As regards secondary prevention a breast cancer screening is recommended for women aged between 50 and 64 and cancer of the cervix for women aged between 25 and 64 years. The study also identified detection and treatment of arterial hypertension and prevention, early detection and treatment of diabetes as cost-effective interventions. In relation to congenital diseases in the maternal-child population, prenatal diagnosis of congenital anomalies, through morphological ultrasound scans, biochemical tests and invasive tests were identified as priorities and cost effective. Courses of action and strategies in proposed interventions in this Project have been prepared taking these recommendations and evidence into account.

Table 9.1 Cost-Effectiveness of Public Health Interventions

(Promotion and Prevention) versus Clinical Interventions

Problem	Public Health Strategy		Clinical Strategy	
	Intervention	Cost by DALYS	Intervention	Cost by DALYS
Diarrheas	Vaccination against rotavirus (80% effect.) Vaccination against cholera (70% effect.) Vaccination against measles (85% effect.) Change in behavior in order to improve personal and domestic hygiene Promotion of breastfeeding Education for weaning	10 75 10 170 30 30	Education and therapy for oral rehydration	35-350
Malaria	Vector control (according to incidence, type of mosquito and geographical area)	5-520	Treatment passively in moderate to high endemic zones and vector control	200-500
IRA	Sifting and derivation according to mortality Promotion of breastfeeding Protein-calorie supplements Pneumonia vaccination (18 months)	20-50 50 65 70	Antibiotic treatment of pneumonia in children	20-50
STD	Education for reduction of the number of sexual partners and to increase the use of the condom	1-50	Antibiotic treatment of STD	1-55
Polio	Triple vaccination (according to incidence and mortality)	20-40		
Measles	Vaccination (according to incidence, age at vaccination, dosis and antigen)	2-30		
TBC	BCG administered with Triple Virus	7	Chemotherapy with hospitalization	3
Diabetes	Primary prevention through DNID education Sifting of glucose intolerance and education	Not known Not known	Metabolic control with oral hypoglycemics and DMID education Insuline injection and education	25 240
Cancer	Early detection of cervical cancer (PAP smear test) Annual clinical breast examination Education for giving up nicotine	100 50 20	Surgery, chemotherapy and support for cervical cancer Breast cancer Colon and rectum	2,600 300 5,000
Cardiovascular	Behavioral change as well as sifting of high risk	150	Clinical handling of hypertension Clinical handling of hypercholesterolemia Care of stable angina Care of unstable angina or myocardial infection Angioplasty or bypass	2,000 4,000 100-200 30,000 5,000

Source: Escobar *et al* (2000).

Sustainability of proposed interventions. Fiscal sustainability refers to the capacity of governments to cover future costs associated to the execution of a determined investment Project

or to sustain the broadening of the coverage of a certain social policy. This implicates the capacity of a government to create the necessary fiscal space in order to pay for such intervention without generating a significant impact on the public accounts (Heller, 2006).

The fiscal space can be created through different instruments. Using tax policy measures or modernization of the tax administration, it is possible to generate these additional resources that guarantee the sustainability of an investment Project. In the same way, by means of reducing non-priority budgetary items, it is possible to generate a space for the incorporation of the most cost-effective interventions into the budget. Financing policies can also be adopted from internal and external sources.

In Uruguay, where health expenditure represents nearly 9 percent of GDP, the main way to sustain the Project is to maximize the productive efficiency according to demographic profiles, socio-economic conditions and specific risks for the population, allowing the most cost-effective resources to be used in each case. Because of this, the Project is able to underpin at certain essential public health functions, such as surveillance, regulation and health promotion and at the same time strengthening the execution of a reduced number of primary and secondary prevention programs that attack pathologies that lead to a greater morbidity burden, such as NCDs and congenital diseases.

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 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.

Fiscal Impact. The first step in evaluating the fiscal impact of the Project is to establish the basis of the calculation of public expenditure in health. This information is shown in Table 9.2. The data come from National General Accounts (budget execution 2004-2006) and the current budget that covers the 2007-2009 period.[10] Public spending for health, as shown on the table, has been increasing over the last few years. For the period of 2008-2010 moderate growth in public resources is anticipated.

The fiscal impact of the Project in the MSP budget is marginal, and represents an annual variation of less then 3 percent over the life of the Project.

[10] Uruguay is one of the few countries in the region to successfully use a multiannual budget template. The 2005-2009 budgets can be consulted at www.cgn.gub.uy.

Table 9.2 Fiscal Impact Second Health Development Project Analysis (US$ million)

	2004	2005	2006	2007	2008	2009	2010
Public Health Expenditures without Project							
MSPMSP (MSP/ASSE)	179	197	236	259	275	290	301
Public Health Expenditures with Project							
MSPMSP (MSP/ASSE)					282	297	307
Budget variation (var %)					2.5%	2.4%	2.0%

Source: Bank staff calculations based on Contaduría General de la Nación and pluriannual budget.

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ANNEX 10: Safeguard Policy Issues

NON-COMMUNICABLE DISEASES PREVENTION PROJECT

Introduction

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 their health effects.

As part of the environmental and social assessment, meetings with MSP staff were held during May 2007, and a list of health equipments (to be procured with bank financing during the Project implementation) was reviewed using as criteria the complexity of equipments, human exposure to radiation, concentration, geographical distribution and density of equipment and others usual criteria.

The risk of lacking institutional capacity has been evaluated as low. An analysis of the MSP's Environmental and Occupational Health Management Division was conducted in May 2007 and found it satisfactory. The MSP has a clear set of policies and procedures which can be considered as consistent with the Bank's environmental safeguards policies.

In addition, the Project is a Category B, with only the Environmental Assessment Safeguards being triggered. The Project does not involve nor does new civil work do neither rehabilitation work. The only aspect with minimal environmental impacts is the equipment procurement, which its functioning and probable potential increase in the waste generation associated.

The medical equipment, whose acquisition will be financed by the Bank loan, is mainly composed by diagnosis equipment: endoscopical; traumatological; mammographic and basic standard common X-Ray devices; ECG and ecographic equipment; Holter and portable blood pressure monitors.

Project Location

The Project would focus on enhancing the infrastructure of primary health care facilities as well as secondary referral centers. These would include the purchase of critical medical equipment to detection and treatment of NCDs as well as other pathologies required as differential diagnosis of NCDs.

Project activities would include:

1. Primary care facilities of ASSE in the sanitary regions of Montevideo, Canelones East and West, San José, Tacuarembo, Treinta y Tres and Rio Negro;
2. All the second level referral ambulatory facilities - 11 in Great Montevideo's sanitary regions and 41 in the inland sanitary regions, and
3. Five high complexity facilities that has also a second level referral ambulatory role for

certain NCDs nationwide.

The medical equipment with potential minimal environmental impacts will be located in the second level referral ambulatory facilities mentioned in points 2 and 3 above.

Environmental Assessment

Environmental impacts are expected to be positive in the long run, as the components and equipments financed by the Project will help to improve already existing health quality and services by strengthening MSP's capacity to address the country's changing epidemiological profile; improving quality of primary care services for prevalent NCDs; and supporting the health insurance reform design process.

Nonetheless, the functioning and maintenance of some equipment to be procured may have very limited and very temporal negative environmental impacts, which can be avoided or mitigated through Environmental Management Protocols defined by the package of regulatory instruments implemented and supervised by MSP. In particular, the potential impacts include: (i) human exposure to high complexity equipment (radiation), and (ii) disposal of waste from health facilities.

Environmental Evaluation

An Environmental Evaluation was carried out by the Department of Environmental and Occupational Health, and focused on four main areas: (a) compliance with environmental legislation; (b)Existing environmental management systems and capacity assessment of the environmental unit of MSP; (c) review of existing mechanisms (protocols) and tools to carry out environmental activities; (d) potential negative and positive impacts.

The report concluded that the Project did not include works, with exception of those smalls related to medical equipment installation. No resettlements will take place, and no natural habitats or cultural heritage areas were affected.

Environmental Screening

During Project preparation, in May 2007, a Bank mission lead by the Environmental Management specialist from the LCC7 took place to (i) assess current environmental and social practice and procedures regarding MSP interventions; (ii) verify the level of institutional strengthening of MSP environmental unit; and (iii) conduct an environmental screening of a set actions to be financed under the NCDs Prevention Project.

The mission met representatives from MSP, including the Head of Environmental and Occupational Health Division; technical staff and the PSCU coordinator. The mission also learned about the complete array of tools that said division has to face environmental issues liked with human health. The mission also screened a set of medical aid equipment to be procured during the Project; in order to assess potential environmental impact of this planned procurement.

The mission reviewed the Environmental Evaluation report prepared by MSP, which includes information about compliance with legal framework, existing environmental management systems and potential impacts, and found it acceptable. The final version of the report was sent by the client to the Bank. The entire Project is expected to have a positive impact on the social and health side and very low, almost inexistent, environmentally negative impacts, which can be easily avoided and mitigated through environmental management protocols to be followed by the

health centers. In addition MSP confirmed that the Project will not finance works involving involuntary resettlements or crossing natural habitats or cultural heritage areas in Uruguay.

The assessment also concluded that all the Project components have a very low environmental and social risk, considering the sensibility of the environment and the category of activities to be developed. The mission concluded that the environmental impact of the proposed Project can and should continue to be managed by the existing environmental protocols mandatory for each health centre in Uruguay and supervised/monitored by MSP.

Institutional Capacity

MSP has a clear set of policies and procedures consistent with an appropriate environmental management. Medical equipment (high complexity) to be procured under the Project should comply with all environmental licenses and permits required by Law, and to follow the MSP allowances procedures.

The MSP Environmental and Occupation Health Division have already built in procedures to screen and assess environmental sensitivity of procurements, so that particular recommendations can be made to improve or to mitigate environmental impacts.

Identification of Potential Environment and Social Impacts

During the increase of the national health system capacity to attend selected Non-Communicable Diseases, the contaminants that may be produced, as an indirect impact linked to the use of new and more equipment, include waste from materials and residual products as well as pathologic waste. In both cases the health systems as well as the solid waste management system are well coordinated and enabled to continue with best practices implementations. MSP confirmed that the country is prepared to process a hypothetical increase in the solid waste generation originated by an expanded health system.

Environmental Management

The compliance of legal framework for hospitals and complex medical equipment acquisitions include a set of terms of reference indicating the need to implement safety protocols. These procedures have already been tested, demonstrating an important and solid advance in the environmental and safety work management capabilities of MSP.

All procurement will have to comply with all country environmental permits and should identify the environmental risks attached to all functioning and maintenance activities, and set up the mitigation measures including the organization and resources allocation, if required.

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NON-COMMUNICABLE DISEASES PREVENTION PROJECT

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ANNEX 12: Statement of Loans and Credits

NON-COMMUNICABLE DISEASES PREVENTION PROJECT

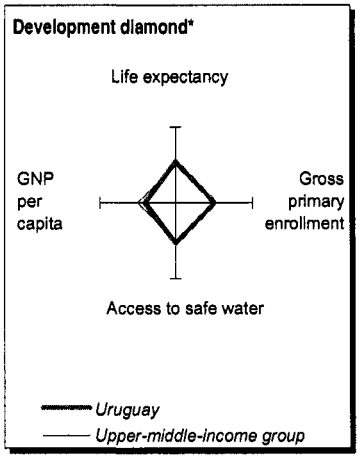
		Original Amount in US$ Millions					Difference Between Expected and Actual Disbursements[a/]	
Project ID	**Project Name**	**IBRD**	**IDA**	**Grant**	**Cancel**	**Undisb.**	**Orig.**	**Frm Rev'd**
P101432	UY OSE APL 2	50				50		
P057481	UY Transp. Inf. Maint. & Rural Access	70				57.98	21.05	
P068124	UY Energy Efficiency Project			6.88		6.30	3.58	
P074543	UY Foot & Mouth Disease – ERL	25				6.50	-0.38	-0.385
P083927	UY First Prog. Reform Imp	100				100	33.33	
P077676	UY GEF-Biod & Integrated Ecosystem			7		6.52	3.19	
P097604	UY Institutions Building TAL	12.1				12.1		
P070653	UY Integr. Nat. Res. & Biodiveristy Mgmt	30				26.73	5.90	
P070058	UY Public Services Modernization TA	6				3.09	3.87	1.623
P095520	UY Promoting Innovation	26					1.3	
P070937	UY Basic Education III	42				20.19	20.19	
Overall Result		361.1		13.87		311.90	89.94	1.238

Uruguay
Statement of IFC's
Held and Disbursed Portfolio
As of 02/28/2005
(In US Dollars Millions)

		Held				Disbursed			
FY Approval	Company	Loan	Equity	Quasi	Partic	Loan	Equity	Quasi	Partic
1985	Azucitrus	0	0.19	0	0	0	0.19	0	0
2007/07	Botnia s.a.	140	0	0	100	44.68	0	0	63.83
2002/07	Conaprole	75	0	27.5	0	45	0	27.5	0
1995	Consorcio aerop.	0.55	0	2.16	0	0.55	0	2.16	0
2005	Surinvest	0.02	1.5	0	0	0	1.49	0	0
2001	UMontevideo	8.07	0	0	0	8.07	0	0	0
Total Portfolio:		223.64	3.45	29.66	100	98.3	3.44	29.66	63.83

ANNEX 13: Country at a Glance

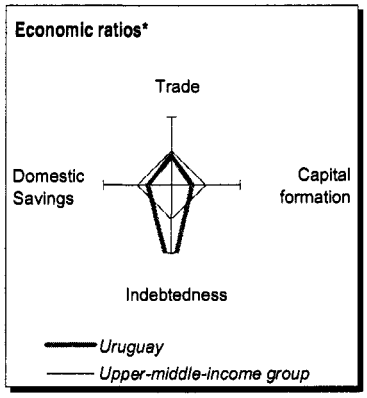
POVERTY and SOCIAL	Uruguay	Latin America & Carib.	Upper-middle-Income
2005			
Population, mid-year *(millions)*	3.3	551	599
GNI per capita *(Atlas method, US$)*	4,570	4,008	5,625
GNI *(Atlas method, US$ billions)*	15.1	2,210	3,368
Average annual growth, 1999-05			
Population *(%)*	0.7	1.4	0.6
Labor force *(%)*	1.6	2.2	1.2
Most recent estimate (latest year available, 1999-05)			
Poverty *(% of population below national poverty line)*	29	..	..
Urban population *(% of total population)*	92	77	72
Life expectancy at birth *(years)*	76	72	69
Infant mortality *(per 1,000 live births)*	14	27	23
Child malnutrition *(% of children under 5)*	..	7	7
Access to an improved water source *(% of population)*	100	91	94
Literacy *(% of population age 15+)*	97	90	94
Gross primary enrollment *(% of school-age population)*	109	119	107
Male	110	121	108
Female	108	117	106



KEY ECONOMIC RATIOS and LONG-TERM TRENDS

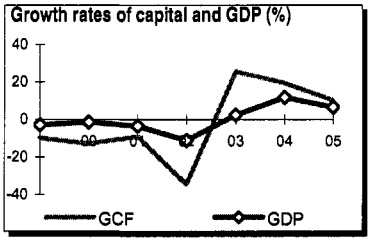
	1985	1995	2005	2006(e)
GDP *(US$ billions)*	4.7	18.3	16.9	19.6
Gross capital formation/GDP	11.4	15.4	13.2	14.3
Exports of goods and services/GDP	26.8	19.0	30.1	29.5
Gross domestic savings/GDP	17.0	15.3	15.4	16.1
Gross national savings/GDP	9.8	14.1	12.9	13.4
Current account balance/GDP	-2.1	-1.2	0.0	-0.8
Interest payments/GDP	6.2	1.6	5.0	5.3
Total debt/GDP	83.1	29.0	67.5	...
Total debt service/exports	42.6	21.8	53.1	...
Present value of debt/GDP	..	..		...
Present value of debt/exports	..	..	..	...

	1985-95	1995-05	2005	2006(e)	2005-09
(average annual growth)					
GDP	3.7	1.4	6.6	6.8	4.8
GDP per capita	3.0	-0.6	6.3	6.8	...
Exports of goods and services	6.9	0.3	18.6	13.4	11.3

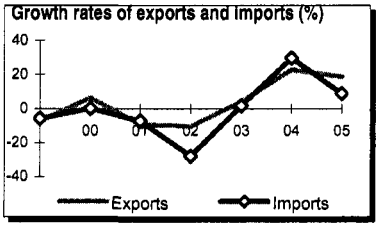


STRUCTURE of the ECONOMY

	1985	1995	2005	2006(e)
(% of GDP)				
Agriculture	13.6	8.4	9.3	8.7
Industry	35.9	28.1	31.1	31.7
Manufacturing	29.4	19.1	22.2	23.1
Services	50.5	63.6	59.6	59.6
Household final consumption expenditure	68.5	72.9	73.5	72.5
General gov't final consumption expenditure	14.4	11.8	11.2	10.7
Imports of goods and services	21.1	19.1	27.6	28.7



	1985-95	1995-05	2005	2006(e)
(average annual growth)				
Agriculture	2.6	0.3	3.2	6.0
Industry	1.5	-1.6	8.5	8.7
Manufacturing	0.2	-2.1	9.5	10.8
Services	5.0	-0.1	6.5	6.3
Household final consumption expenditure	4.9	-0.6	2.5	7.3
General gov't final consumption expenditure	1.9	-0.9	2.5	1.8
Gross capital formation	9.0	-4.9	10.1	18.4
Imports of goods and services	11.6	-1.8	8.8	14.7

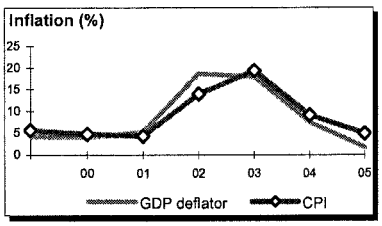


Note: 2005 and 2006 data are preliminary estimates.

* The diamonds show four key indicators in the country (in bold) compared with its income-group average. If data are missing, the diamond will be incomplete.

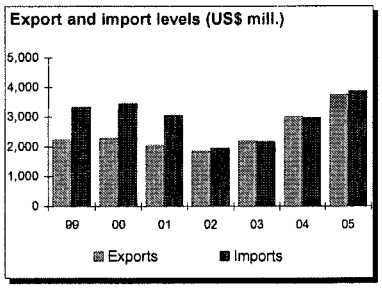
PRICES and GOVERNMENT FINANCE

	1985	1995	2005	2006(e)
Domestic prices				
(% change)				
Consumer prices	72.2	42.2	4.9	6.4
Implicit GDP deflator	74.0	41.0	1.7	6.2
Government finance				
(% of GDP, includes current grants)				
Current revenue	16.0	17.5	31.8	31.7
Current budget balance	-1.4	0.3	6.2	6.0
Overall surplus/deficit	-3.1	-1.8	-0.7	-0.5



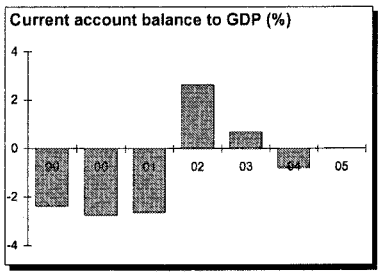
TRADE

	1985	1995	2004	2005
(US$ millions)				
Total exports (fob)	854	2,106	3,145	3,758
Meat	202	562	602	736
Vegetables	141	304	472	489
Manufactures	391	980	963	1,079
Total imports (cif)	708	2,875	3,114	3,879
Food	51	262	264	319
Fuel and energy	107	340	657	865
Capital goods	130	987	335	514
Export price index *(2000=100)*	68	116	106	106
Import price index *(2000=100)*	66	98	97	97
Terms of trade *(2000=100)*	104	118	103	93



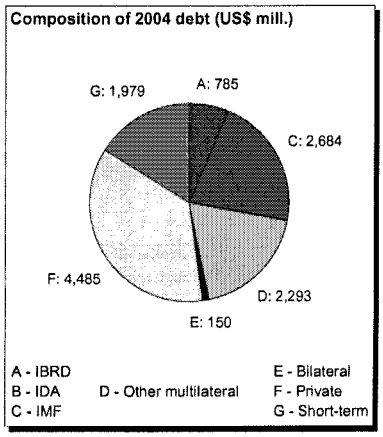
BALANCE of PAYMENTS

	1985	1995	2005	2006(e)
(US$ millions)				
Exports of goods and services	1,257	3,507	5,093	5,775
Imports of goods and services	1,015	3,569	4,656	5,423
Resource balance	242	-62	437	352
Net income	-351	-227	-585	-614
Net current transfers	..	76	149	115
Current account balance	-98	-213	1	-147
Financing items (net)	164	431	453	1,098
Changes in net reserves	-66	-218	-454	-951
Memo:				
Reserves including gold *(US$ millions)*	..	1,675	3,438	3,074
Conversion rate *(DEC, local/US$)*	0.1	6.7	24.5	24.0



EXTERNAL DEBT and RESOURCE FLOWS

	1985	1995	2004	2005
(US$ millions)				
Total debt outstanding and disbursed	3,919	5,318	12,376	11,408
IBRD	152	513	785	816
IDA	0	0	0	0
Total debt service	568	862	1,543	2,704
IBRD	30	117	102	138
IDA	0	0	0	0
Composition of net resource flows				
Official grants	2	15	16	..
Official creditors	10	4	-6	..
Private creditors	17	183	-309	..
Foreign direct investment (net inflows)	0	157	311	715
Portfolio equity (net inflows)	0	0	0	..
World Bank program				
Commitments	4	29	0	0
Disbursements	23	32	144	134
Principal repayments	19	78	80	104
Net flows	4	-46	64	30
Interest payments	11	40	22	34
Net transfers	-7	-86	41	-4



MAP SECTION

URUGUAY

- SELECTED CITIES AND TOWNS
- DEPARTMENT CAPITALS
- NATIONAL CAPITAL
- RIVERS
- MAIN ROADS
- RAILROADS
- DEPARTMENT BOUNDARIES
- INTERNATIONAL BOUNDARIES

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