PROJECT INFORMATION DOCUMENT (PID)
APPRAISAL STAGE

Report No.: AB1117

Project Name	**HEALTH SECTOR REFORM APL II**
Region	**EUROPE AND CENTRAL ASIA**
Sector	Health (100%)
Project ID	**P078971**
Borrower(s)	**MINISTRY OF HEALTH**
Implementing Agency	
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Environment Category	[ ] A [X] B [ ] C [ ] FI [ ] TBD (to be determined)
Safeguard Classification	[ ] S_1 [ ] S_2 [ ] S_3 [ ] S_F [ ] TBD (to be determined)
Date PID Revised	October 14, 2004
Date of Appraisal Authorization	October 4, 2004
Date of Board Approval	December 16, 2004

1. Country and Sector Background

Country Overview:

Romania is a lower middle-income country with GNI per capita of US$ 2,260 and a population of 21.7 million. It is the second largest country in Central and Eastern Europe, and is larger than 19 of the 25 current members of the European Union (EU). Since 2000, the new Government has implemented macroeconomic policies which are supportive of growth. A disciplined fiscal policy, which complemented a tight monetary policy, and was augmented by strong advances on structural reforms, led to improved financial discipline in the enterprise sector, and has placed public finances and the financial system on much firmer footing.

This resulted in robust GDP growth for four consecutive years – 5.3 in 2001, 4.3 in 2002, 4.9 in 2003 and expected to be over 6% in 2004. In addition, inflation and interest rates have declined steadily, the fiscal deficit was brought under control, foreign exchange reserves increased to historic highs, and the external balance was comfortable. Export growth remained vigorous, fuelled by private investment and the competitive depreciation in real terms of the currency against Euro (3.7% in 2003). The competitiveness of the enterprise sector was boosted by productivity gains. Romania is now a visible and attractive destination for international investors as a result of better sovereign ratings and improved access to international capital markets.

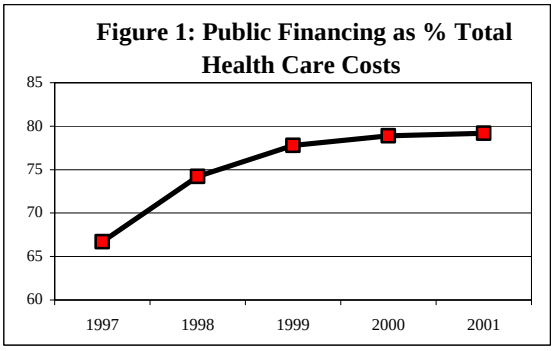
Key issues in the Health Sector and Government Strategy:

In 1997, Romania began to enact key reforms in the health sector, aimed at shifting the health system from the model of centralized government financing and delivery of services to a more decentralized and pluralistic approach. The main change was the establishment of a compulsory health insurance fund, paid for through an earmarked wage tax and contracting services from public and private providers. The ongoing program supported by the World Bank in the health sector was based on a reform strategy elaborated by the Government in 1997-1998 and outlined in the 1999 Letter of Sector Development Strategy, which identified the following key issues:

- weaknesses in governance of the system and the legislative framework;
- shortcomings in the efficiency, equity and transparency of sector financing;
- inefficient use of physical capacity and human resources in health care delivery;
- critical infrastructure deficiencies resulting from inadequate maintenance and investment;
- mismatch between population health needs and health services distribution and priorities;
- consumer dissatisfaction with the health services.

Substantial progress has been made on this agenda, and a clear sector strategy is in place for addressing the remaining reform needs. In the area of **governance**, there have been major revisions of the health insurance law to strengthen accountability of insurance fund, increase the role of local authorities in ownership and accountability of health care provider units, new organization form for physicians' offices, regulation of public-private partnerships, a new law on hospital organization, and development of planning capacity at MoH and local level. Although much of this activity has been undertaken by the Ministry itself, there has also been assistance from DFID, and APL1. The remaining agenda includes further improvements to the legal framework for the organization of providers, developing and implementing governance and management arrangements for hospitals conducive to greater efficiency, and develop a modern health services accreditation body and adequate quality management monitoring systems. The Government is actively taking the lead in these reforms, although the PAL process is providing key support and technical assistance.

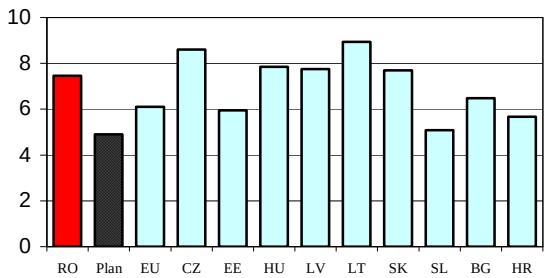
In terms of the **efficiency, equity and transparency of health sector financing**, there has been an increase in public funding for the health sector, capacity building for health insurance, and piloting of new case-based payment mechanisms for hospitals. Again the Government has taken the lead in this, although USAID and Phare have also provide important assistance. Figure 1 shows the progress in the area of public financing for health services through the end of 2001. The remaining agenda includes increasing the resources allocated for primary care services, ambulatory care, and hospital day surgery; rolling out new payment mechanisms for hospitals; containing the escalation of pharmaceutical costs; better defining the benefit package to be covered by health insurance, and ensuring the more transparent and affordable contribution of private financing. In addition to the Government resources, support for these efforts are being pursued from the EU and other donors. The related PAL conditionality is keeping the attention of the broader government focused on these issues.



Progress in the area of **capacity and efficiency improvements** have included preparing and approving a high-level rationalization strategy and regional health service plans; closing about 15% of acute hospital beds, converting acute hospitals to medico-social care units; developing contracting approaches for home

care; and piloting public-private partnerships, with support from IFC. APL 1 and PAL 1 played a key role in supporting the overall thrust of these reforms, while APL 2 and PAL 2 and 3 will continue to support the remaining agenda, through improving distribution of human resources with incentives for medical staff to practice in remote or underprivileged areas; and developing models of care adapted to rural and remote population needs and continuing to close, convert or restructure unnecessary or underutilized hospital facilities. Figure 2 shows the current situation comparing Romania to other countries in the region, as well as the target based on the adopted rationalization strategy (marked as Plan). It should be noted that this target assumes significant investments in complementary services, such as home care, social long-term care, and ambulatory/ day care services.

Figure 2: Hospital Beds/1,000



The need for **improved infrastructure** has been addressed through the upgrade of equipment for essential hospital services and pre-hospital emergency care, a major upgrade of hospital equipment financed through commercial credits with Government guarantee, and a lease scheme for medical offices. APL 1 has played a key role in a number of these areas, and APL 2 will help address the continued need for investments, especially rehabilitation of buildings, modernizing the maternity and neonatal care system, and completing investments in the emergency care system. By introducing new financiers to the health system in Romania, and supporting the development of capacity to apply for and utilize EU structural funds in the future, APL 2 is also helping to ensure that financing is available for further infrastructure improvements.

Population health needs have been addressed through the development of a public health strategy, capacity building, and strengthening national programs (especially TB, reproductive health and HIV/AIDS). Important tobacco control legislation has also been passed and community nursing has been implemented on a pilot basis. There are many development partners in this area, including the Bank (APL 1), the Global Fund, USAID, and UNFPA, and the MoH has greatly increased its capacity in this area. These partners and the MoH will assist in expanding the scope of prevention and health promotion activities, and also focus on improving key health indicators. In this regard, the Bank is taking a lead through APL 2 by focusing on maternity and neonatal MDG's. Figure 3 and 4 below illustrate the critical need for attention to these areas.

Figure 3: Infant Mortality

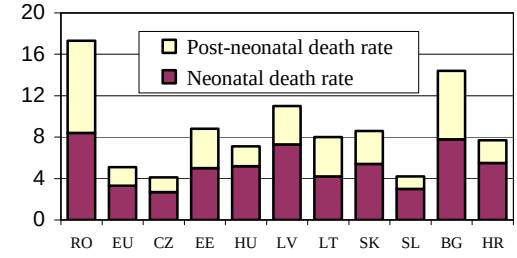
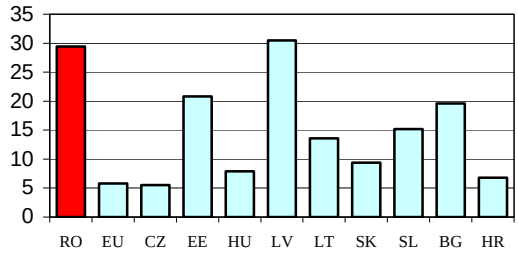


Figure 4: Maternal mortality



The area of **consumer satisfaction** has seen relatively little activity, although there have been some information campaigns on rights of insured. In the future, however, this agenda will be moved along through and increasing focus on informal payments and explicitly addressing patient satisfaction. Both

APL 2 and PAL 2 and 3 will play a key role in putting these issues in front of policy-makers and developing working models to address these issues.

2. Objectives

The project will have the following objective: provide more accessible services, of increased quality and with improved health outcomes for those requiring maternity and newborn care, emergency medical care and rural primary health care. This objective is consistent with the overall program objectives defined at the beginning of APL phase 1.

The principal beneficiary groups would be the users of services targeted for improvement by the project: pregnant women and newborns, rural populations, and those needing emergency services. In addition to the obvious benefits of reducing maternal and infant mortality, general mortality in rural areas, and overall improvement of quality of care, this project would demonstrate the impact of the rationalization approach across a vertical program throughout Romania. This would support more extensive implementation of the rationalization plans developed in Phase I.

Proposed project performance indicators include: the review of maternal deaths, neonatal and post-neonatal death rates, low birth-weight, utilization rates for primary and emergency care (stratified by residence and income status), survival rates of major emergencies arriving alive at the hospital emergency department, and response time for emergency calls.

The proposed project is included in the FY02-04 CAS, that sets as one of its objective the improvement of delivery of health services. This is one of the targeted poverty interventions identified in the CAS to address inequity of access to basic social services across regions and for vulnerable groups.

3. Rationale for Bank Involvement

To date, the Bank has had two investment operations in the health sector. The first project, with a total cost of $224 million (including $150 million WB loan) was implemented in 1992-1999 and supported the upgrade of selected primary health care, maternity and emergency medical services, procurement of essential drugs, tuberculosis control and capacity building. The second project, Health Sector Reform phase 1 was completed in June, 2004. The $69 million project (including $40 million WB loan, disbursed over 98%) covered the upgrade of essential hospital care (operating room and intensive care services), further improvements in emergency medical services, support for primary care in six judets, strengthening of planning capacity within the MOH and judets, including the development of judet-level rationalization plans, and selected public health interventions.

The current health sector support strategy envisions a combination of adjustment and investment lending to support key reforms and priority investments. Key sector reforms would be leveraged by the proposed PAL / policy actions aiming to:

- improve performance of health sector financing regarding predictability, risk protection of the insured, equity and efficient management of public resources;
- revise arrangements for health insurance revenue generation, improve provider contracting and accountability mechanisms of National Health Insurance House;
- reduce corruption and increase transparency in the health sector;
- support implementation of a National Hospital Rationalization Strategy and create a legal/regulatory framework conducive for the organizational reform and rationalization of hospitals.

Technical assistance was supported by APL Phase 1 (for rationalization activities) and continues through the PPIBL (TA loan that supports the PAL program) in the area of health sector financing. Additional TA needs are being addressed by APL 2 including monitoring and evaluation of health services performance, development of National Health Accounts as well as further support for future investment planning.

4. Description

The project has five components as follows:

COMPONENT 1: Maternity and Neonatal Care Component (US$ 129 million) This component will fund facility rehabilitation for maternity and neonatal care units, as well as medical and other equipment necessary for high quality neonatal and maternity services. Technical assistance and training will be provided to ensure implementation of best international practices, building on already existing partnerships between the Government and WHO, UNICEF, UNFPA. and bilateral donors (USAID and Swiss Cooperation). Support will be provided to improve the capacity of health care authorities and provider units to monitor service quality and access.

COMPONENT 2: Emergency Care Services (US$ 60 million). This component would help to develop an implement integrated ambulance dispatch capability and upgrade hospital emergency areas. Both interventions are essential to maximizing the impact of the investments that have been made to date, and the effectiveness of the emergency medical services system generally.

COMPONENT 3: Primary Health Care and Rural Medical Services (US$ 14.5 million). This component will focus on improvement of accessibility and quality of basic medical services in rural and small urban areas, and will support two of the most important activities included in the Primary Care Strategy recently approved by the Government:

COMPONENT 4: Policy and Planning (US$ 0.6 million). This component will support the development of National Health Accounts and the preparation of proposals for rationalization and service development projects.

COMPONENT 5: Project Management (US$ 2.5 million). Component. would support the operation of the Project Management Unit, building up on the implementation arrangements of the first phase project and expanding the its responsibilities in order to properly cover the new activities related to the physical rehabilitation of the buildings infrastructure and the on site equipment delivery.

5. **Financing**

Source:	($m.)
BORROWER	47
INTERNATIONAL BANK FOR RECONSTRUCTION AND DEVELOPMENT	80
EC: EUROPEAN INVESTMENT BANK	80
Total	207

6. Implementation

To date, the Government has worked with a number of partners in the health field —IBRD, DFID, USAID, SDC, UN agencies – but it is interested in broadening this base, both to access EU structural funds and loans from other EU financial institutions. For this project, the Government is working with the EIB to co-finance a substantial proportion of the project costs. Other donors have also been asked by the MoH to participate in financing some of the technical assistance and training activities. Although

confirmation is not yet available, there appears to be a high probability that other donor funding can be mobilized prior to effectiveness. Should this happen, loan funds would be reallocated to other uses within the overall program, as the MOH prefers to utilize other donor funds for these purposes.

In terms of technical assistance for the development process, support has been obtained from WHO experts, UNFPA, UNICEF, USAID/JSI and others, especially in the conducting a baseline survey, which serves the dual purpose of providing both a baseline for project interventions, and a follow-on to previous Reproductive Health Surveys. The Government is also working closely with these partners to align services and programs in Romania to evidence-based interventions recommended in Safe Motherhood/PEPC (Promoting Effective Perinatal Care) and IMCI (Integrated Management of Childhood Illnesses) programs. Efforts are also ongoing to ensure close collaboration with USAID, especially with regard to their current interventions in the reproductive health area.

In the last year of the APL1 implementation, the PMU has been reorganized and expanded in order to cope with the increased responsibilities generated by the implementation of the GFATM Grant. (US$38 million). Although additional staff dealing with procurement, financial management, monitoring and evaluation and information technology have been recruited, several key (core) staff are still assigned to perform tasks related to both projects. To date, the costs associated to the PMU activities for both projects were supported by the GFTAM. Additional staffing will be put in place, including a project coordinator and staff with clearly defined responsibilities and dedicated full time to the Bank financed project. In this way, the current PMU will continue to exist and implement the two programs under a two pillar structure, one pillar for GFTAM and one pillar for the WB/EIB financed project.

The PMU will provide management and logistical support only to the implementation process, while all technical inputs will come from line departments within the Ministry of Health. During project implementation the PMU will also engage in extensive capacity building and "technology transfer" in the areas of monitoring and evaluation and project planning and execution, so that by the end of the project the capacity will exist within the MoH to independently perform these functions. Organizationally, the PMU will continue to be closely tied into the MoH structures, with a formal reporting relationship to the Secretary of State for International Cooperation, and a direct contractual relationship with the Minister.

The Bank will also need to provide intensive supervision and implementation support. This will be accomplished through day-to-day interaction with technical experts based in the Bank office in Romania, as well as frequent visits by appropriate headquarters-based staff. About 20-30 weeks of staff time will be spent on these activities.

7. Sustainability

All of the interventions planned in this project, with the exception of the component on National Health Accounts, are already part of the Ministry of Health or NHIH funded activities, so ongoing sustainability assured. The PAL process and vehicles will be pursued to ensure the sustainability of the health system as a whole. Long-term system sustainability also depends upon ongoing efforts to implement the regional health services master plans, and to shift resources and health services from hospital to outpatient, primary care, and social care settings. This project will contribute to these rationalization efforts by providing concrete examples of the types of interventions that are needed in this area, as well as a specific case study of service rationalization in a vertical health program (maternal and child care).

8. Lessons Learned from Past Operations in the Country/Sector

Phase 1 provided valuable lessons for the design of the second phase. Despite a significant number and varied activities, a good implementation plan which was developed in advance proved to be critical in

ensuring that project execution remained on schedule. The availability of committed counterparts, not only a the PMU level, but also in each of the subject matter areas, was also critical to success. Where there were breaks in this continuity, due to changes in working group composition, for example, the impact on project implementation was fairly clear and immediate. Additional efforts on the part of both the Bank and the PMU were needed to get things back on track. Phase 1 also showed that more effort is needed up front on these two areas: (i) planning for the training associated with the project interventions, including lining up the necessary funding in advance, and (ii) clearly developing and planning for project monitoring and evaluation, including methods for ensuring data accuracy and consistency.

9. Safeguard Policies (including public consultation)

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 (OD 4.20, being revised as OP 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]

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

10. **List of Factual Technical Documents**

Quality Enhancement Review (QER) Final Report, August 4, 2004

National Public Health Strategy, document prepared by the Ministry of Health by the Center for Health Policies and Services from a World Bank Loan, June 2004

Cost-Benefit Analysis of Telecommunication Services Used by Pre-Hospital Emergency Medical Services in the Seven REMSSY III-Program Countries, Copyright CPSS 2004

Ministry of Health and Family - DECREE No. 910/2002, November 18 Concerning the Hierarchical Parting Criteria for Obstetrics and Gynecology and Neonatology Specialty Hospital Departments

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