

**Document of  
The World Bank**

**FOR OFFICIAL USE ONLY**

Report No. 23249

**PROJECT PERFORMANCE ASSESSMENT REPORT**

**ESTONIA**

**HEALTH PROJECT  
(LOAN 3835)**

**November 14, 2001**

*Sector and Thematic Evaluation Group  
Operations Evaluation Department*

This document has a restricted distribution and may be used by recipients only in the performance of their official duties. Its contents may not otherwise be disclosed without World Bank authorization.

## Currency Equivalents (annual averages)

*Currency Unit* = Estonian Kroon (EEK)

EEK 17.37 = US\$ 1.0

US\$ 0.06 = EEK 1.0

## Abbreviations and Acronyms

GOE	Government of Estonia
MSA	Ministry of Social Affairs
OED	Operations Evaluation Department
PCU	Project Coordination Unit
PPAR	Project Performance Assessment Report
SAR	Staff Appraisal Report

## Fiscal Year

January 1—December 31

Director-General, Operations Evaluation	:	Mr. Robert Picciotto
Director, Operations Evaluation Department	:	Mr. Gregory K. Ingram
Manager, Sector and Thematic Evaluation	:	Mr. Alain Barbu
Task Manager	:	Mr. Timothy Johnston

November 14, 2001

**MEMORANDUM TO THE EXECUTIVE DIRECTORS AND THE PRESIDENT**

**SUBJECT: Project Performance Assessment Report on Estonia  
Health Project (Loan 3835)**

Attached is the Project Performance Assessment Report prepared by the Operations Evaluation Department (OED) on the Estonia Health Project. The project was the first Bank project in the health sector in Estonia. It was a US\$34.5 million project at appraisal, with a Bank loan of US\$18 million, Government contribution of US\$14.5 million, and \$3.87 million in cofinancing from the European Union through the PHARE project. The project was approved on January 19, 1995, and closed on July 1, 2000.

The objective of the Estonia Health Project was to support the government's health reform efforts so as to improve health status of its population, by (i) reorienting health services to emphasize health promotion/disease prevention and family medicine; (ii) supporting the restructuring of health care financing; and, (iii) developing human resources, by supporting modern public health training, pre-clinical medical training, and continuing education for doctors, administrators and other health personnel.

The project met its development objectives. While complex, it was coherent, and government "ownership" was high throughout design and implementation, as well as subsequent to it. The project contributed to significant, ongoing, and promising change nationwide in the delivery and financing of health care services. The basic dimensions of the project have been—and remain—the framework for the overall national program of health sector reform and restructuring. "Centers of excellence" in public health and in family medicine were supported. A critical mass of family doctors (650) was trained, with family medicine now constituting Estonia's largest medical specialty. Overall project outcome is rated **highly satisfactory**, consistent with the rating in the Implementation Completion Report (ICR). A second health project is under preparation.

Institutional development impact is rated as high, in contrast to the ICR's rating of substantial. Sustainability is rated as highly likely, consistent with the ICR rating. Bank performance is rated as highly satisfactory, in contrast to the ICR rating of satisfactory, and borrower performance is rated as highly satisfactory, consistent with the ICR rating. The Bank provided technical assistance and training that was timely and comprehensive. All key informants pointed to the important role the Bank played throughout as catalyst, partner and "honest broker." The borrower embraced Bank priorities, and the sequencing of interventions was careful, orderly and systematic. There was effective project management and implementation, overseen by both an active and engaged steering committee and a competent, stable project coordination unit.

This document has a restricted distribution and may be used by recipients only in the performance of their official duties. Its contents may not otherwise be disclosed without World Bank authorization.

Experience with the project confirms a number of well-established OED lessons including: borrower commitment, vision and plans should be aligned with project objectives; attention by the Bank to “political” support of project design and implementation is as important as the “purely technical” aspects of the project; attention to optimal sequencing and location of sector investments and reforms is important. The project also illustrates that the Bank can make important contributions even in a middle income country that is a relatively advanced reformer. Creation of “centers of excellence” in family medicine and in public health can endow these specialties with legitimacy and equal footing to other “prestigious” specialties. Use of population-level measures of health status (such as changes in mortality or life expectancy) for project indicators must be complemented by intermediate outcome indicators of health status and health system change (such as coverage, access, and quality of health care, or changes in health behavior). These need to be identified at design and tracked during implementation.

**Robert Picciotto**  
**by Gregory K. Ingram**

Attachment

## Contents

<b>PRINCIPAL RATINGS .....</b>	<b>III</b>
<b>KEY STAFF RESPONSIBLE .....</b>	<b>III</b>
<b>PREFACE.....</b>	<b>V</b>
<b>SUMMARY AND OUTCOME.....</b>	<b>1</b>
<b>FINDINGS AND LESSONS .....</b>	<b>1</b>
<b>PROJECT DESIGN AND IMPLEMENTATION.....</b>	<b>3</b>
Health System Reorientation: Development and Realignment of the MSA.....	3
Health System Reorientation: Health Promotion and Disease Prevention .....	4
Human Resources Development.....	5
Financial Resources Management Efficiency.....	7
Project Management and Coordination.....	7
<b>RELEVANCE .....</b>	<b>7</b>
<b>EFFICACY.....</b>	<b>8</b>
<b>EFFICIENCY.....</b>	<b>8</b>
<b>INSTITUTIONAL DEVELOPMENT IMPACT.....</b>	<b>9</b>
<b>SUSTAINABILITY .....</b>	<b>9</b>
<b>BANK PERFORMANCE .....</b>	<b>10</b>
<b>BORROWER PERFORMANCE.....</b>	<b>10</b>
<b>LIST OF SUPPORTING DOCUMENTS.....</b>	<b>11</b>
<b>ANNEX A. BASIC DATA .....</b>	<b>13</b>
ESTONIA—HEALTH PROJECT (LOAN 3835) .....	13
<b>COMMENTS FROM THE MINISTRY OF SOCIAL AFFAIRS OF ESTONIA .....</b>	<b>17</b>

This report was prepared by Timothy Johnston, Task Manager and Roy Jacobstein, Consultant, who assessed the project in May 2001. William B. Hurlbut edited the report. Pilar Barquero provided administrative support.



## Principal Ratings

	<i>PPAR</i>	<i>ICR</i>
Outcome	Highly satisfactory	Highly satisfactory
Sustainability	Highly likely	Highly likely
Institutional Development	High	Substantial
Borrower Performance	Highly satisfactory	Highly satisfactory
Bank Performance	Highly satisfactory	Satisfactory

## Key Staff Responsible

<i>Project</i>	<i>Task Manager/Leader</i>	<i>Division Chief/ Sector Director</i>	<i>Country Director</i>
Appraisal	Antonio Campos	James Harrison	Basil Kavalsky
Completion	Toomas Palu	Amin Fidler	Basil Kavalsky



## Preface

This is a Project Performance Assessment Report (PPAR) for the Estonia Health Project. The project supported national health reform efforts that aimed to improve the health status of the population and the efficiency and financial sustainability of the health system. The project was financed through IBRD Loan No. 3835 for US\$20 million; it was approved in January 1995 and closed in July 2000 with all funds disbursed.

This assessment report is based on information gathered by an Operations Evaluation Department mission to Estonia in May 2001. The mission team also reviewed completed health projects in Hungary and Romania, which are the subject of separate reports. The mission reviewed the performance of the project and interviewed government officials, Bank and donor field staff, academics, and nongovernmental organizations. Documentary sources include the project's Implementation Completion Report, the Staff Appraisal Report (SAR), independent audit reports, and project files.

The authors gratefully acknowledge all those who made time for interviews and provided documents and information, including officials at the Ministry of Social Affairs, the University of Tartu, the Central Sickness Fund, the Ministry of Finance, and former World Bank staff. The authors also gratefully acknowledge the support from staff in the Project Coordination Unit, who coordinated the mission and arranged interviews.

Following standard OED procedures, copies of the draft PPAR were sent to the relevant government officials and agencies for their review and comments. Comments received from the Ministry of Social Affairs of Estonia have been reproduced in the report as Annex B.



## SUMMARY AND OUTCOME

1. The overall objective of the project was to support health reform efforts by the Government of Estonia to improve the health status of the Estonian population and the financial sustainability of the health system. Specific objectives included: (i) reorienting health services to emphasize health promotion and disease prevention programs; (ii) developing human resources by strengthening modern public health training, integrating pre-clinical medical training, and continuing education for doctors, administrators, and other health personnel; and (iii) supporting the ongoing health care financing reform to ensure its sustainability, cost-effectiveness and equity to establishing sound cost, performance analysis, and health management information systems.

2. Project outcome is rated **highly satisfactory**, consistent with the Implementation Completion Report (ICR). The project contributed to significant, ongoing, and sustainable change nationwide in the delivery and financing of health care services through strengthening primary health care, prevention and promotion; strengthening training and human resource development; and further strengthening and consolidating health finance reforms. As elaborated below, the basic dimensions of the project became—and remain—the framework for the overall Estonian national program of health sector reform and restructuring. Sustainability is rated as **highly likely**; institutional development is **high**; Bank and borrower performance are both rated **highly satisfactory**.

## FINDINGS AND LESSONS

3. At independence in 1990, Estonia inherited a centralized Soviet-style health system burdened by excess hospital capacity, an overemphasis on curative, specialist care, and limited primary health care and preventive programs. Although the majority of mortality and morbidity was due to lifestyle factors—particularly smoking, alcohol, and diet—little attention was given to health promotion or behavior change. Central government health financing and delivery provided few incentives for quality, client responsiveness, or efficiency. The new government launched a number of significant reforms soon after independence, including establishment of a national health insurance fund in 1991 (financed through a 13 percent wage tax), which now finances 2/3 of all health expenditure; decentralizing responsibility for health service delivery; reducing hospital bed capacity; and initiating reforms to strengthen primary health care. The Health Project, approved in 1995, assisted in elaborating and consolidating these reforms.

4. As in nearly all the transition economies, adult life expectancy worsened in the initial years of transition, driven primarily by increased mortality among men. Male life expectancy fell by 5 years between 1989 and 1995 (to 65 years), with a male/female gap of over 10 years. There are signs this trend has stabilized and possibly reversed. In addition, infant mortality rates have improved, from 17 per thousand in 1980 to only 9 per thousand in 1999. Estonia is among the most successful economic reformers among the countries of the former Soviet Union, and economic recovery undoubtedly contributed to some of these improvements—through improved household welfare and increased revenues available for health. But evidence suggests that improved health system performance (including health promotion) was also a factor.

5. Although the project's ultimate objective was to improve health status, there is often a lag between health care and behavior change interventions and improved health status—particularly for heart disease and cancers. The project included a number of key performance indicators, including health outcomes, health behavior, and system performance (see Annex 1 of the ICR). Most of the targets were achieved, including improved immunization coverage, modest improvements in key health behaviors (dietary practices, exposure to and use of tobacco); and

improved reproductive health (increased contraceptive prevalence, and reduced abortions). The target for reduced heart disease death rates was not met, however. The project's focus on strengthening primary health care appears to have contributed to improved immunization coverage; this together with improved maternal and child care may have contributed to declining infant mortality. An evaluation of health promotion activities supported by the project suggests that these have contributed to improved health behaviors, which are likely to improve health outcomes in the future. The health disease target was probably too ambitious, however. But failure to meet it highlights the continuing challenges facing the Estonia health system, despite the project's success. Smoking prevalence is still high, as are risk factors for heart disease. In terms of system efficiency, reforms in health financing proved insufficient to catalyze significant restructuring of the hospital sector—although a “Hospital Master Plan” provides a framework for restructuring, which will be supported by a follow-on project.

A number of factors unique or specific to Estonia contributed to project success, including:

- Estonia's small size and relatively homogenous population.
- The presence of a single, influential medical school.<sup>1</sup>
- Stable, enlightened, and committed leadership at the Ministry for Social Affairs (MSA) and within the university. This has been manifested in the willingness of key individuals to champion such project emphases as primary health care, health promotion, public health, and health system restructuring.
- The director of the Project Coordination Unit (PCU) was an employee of the MSA, but all other PCU functions were contracted out to a local firm. Also, the PCU has remained largely intact over the life of the project.
- There was relatively less organized opposition to health sector reforms from groups such as specialized medical groups and the tobacco and pharmaceutical industries than has been seen in other transition countries.
- The presence of only a minimal informal economy, so that contributions to the unitary Health Insurance Fund can be fully “captured.”
- Estonia's proximity to Scandinavia, which meant widespread exposure to Western media and values even during the Soviet period.
- The many observation visits Estonian health professionals made to the progressive health systems of neighboring countries (e.g., Finland), which also exerted a strong influence upon the direction and pace of system change.
- Estonia seems to share with other Scandinavian countries certain cultural expectations, including relatively transparent and evidence-based decision-making with a concomitant sense of accountability and predictability, as well as traditions of social welfare, equity, and “healthy living.”

6. Experience with the Estonia Health Project confirms a number of longstanding OED lessons, including (i) borrower commitment, vision and plans should be aligned with project objectives;<sup>2</sup> and (ii) attention by the Bank to “political” support of project design and

---

1. All Estonian M.D.'s have graduated from Tartu University. Thus, there is high interpersonal “connectivity” in the medical community. Also, for that reason, the university became the logical and valued implementing body for training/retraining. To be sure, a single medical school per se—one that generates all the physicians in a country and has no “competition” in terms of ideas or approaches—is no guarantee that health sector reform will proceed well. Indeed, it is easy to imagine an opposite scenario in which a single medical institution would be a bottleneck. Rather, in this instance, the single institution had a progressive orientation, and was located in a small and relatively homogenous country, with a fairly high degree of consensus about what changes needed to be made in the health sector.

2. Key elements of the borrower's reform program—including passing a health insurance law (1991) and initiation of training for family doctors (1992)—were put in place before project design. The general direction of reform thus was already agreed among government and stakeholders, and the project helped implement and consolidate those reforms.

implementation is as important as the “purely technical” aspects of the project. Other important findings are:

- *Finding 1:* The Bank can make important contributions to health sector reform even in a middle-income country that is a relatively advanced reformer. In Estonia, the Bank’s ability to bring appropriate international experience and high-quality expertise, to act as an “honest broker,” to help mobilize other donor resources, and to provide guidance (technical assistance and training) in project implementation was highly valued by the borrower, and was an important factor in project success.
- *Finding 2:* Attention to optimal sequencing and location of sector investments and reforms is important. Thus in Estonia, training to build a critical mass of family doctors was introduced first, before significant restructuring of service delivery. That cadre could then meet its new mandate of being the primary care providers to the populace as well as the gatekeepers to higher-level referral services. Similarly, primary health care reforms were first introduced in localities less likely to resist change, i.e., outside the capital city, Tallinn. After those reforms were established, they were introduced incrementally in Tallinn through a series of pilot programs.
- *Finding 3:* Creation of centers of excellence in “new” fields such as public health, and family medicine, with robust training and research functions as well as links to similar international centers, can help endow these technical areas with legitimacy and equal footing to other medical specialties. This was done in Estonia, and now family medicine is considered as “prestigious” a specialty as other medical specialties. Family doctors have become the most numerous specialty and an important force for restructuring both service delivery and financing.
- *Finding 4:* The use of population-level measures of health status (such as changes in mortality or life expectancy) for project indicators is inappropriate; rather, intermediate outcome indicators of health status and health system change (such as coverage, access, and quality of health care, or changes in health behavior) need to be identified at design and then tracked during implementation.

## PROJECT DESIGN AND IMPLEMENTATION

7. Project design was closely linked to project objectives, and it was consistent with, and linked to, government and ministry plans for health system restructuring. While the project was *complex*, i.e., it had many aspects and activities that needed to be attended to simultaneously, it was also *coherent*, i.e., its components were closely related and activities were mutually reinforcing. In part because of the complexity, robust initial training and technical assistance was provided, contributing to steady and solid project management and implementation.

8. The project had four components, each of which had two or three subcomponents, many of which in turn had identifiable and important subactivities. The many significant achievements within these components contributed to the overall success of the Estonian health restructuring/reform effort. The project’s four components were Health System Reorientation (with major subcomponents of Institutional Development and Realignment of the MSA and Health Promotion and Disease Prevention,) Human Resources Development, Financial Resources Management Efficiency, and Project Management and Coordination.

### Health System Reorientation: Development and Realignment of the MSA

9. This subcomponent aimed to strengthen the ministry’s capability to implement health reform and improve efficiency within the health sector. Key activities included establishment of a

Policy and Economic Analysis Unit at the MSA, implementation of National Health Accounts and formulation of a public health strategy. To improve hospital efficiency, a National Hospital Master Plan (NHMP)—a systematic review and rationalization of the Estonian hospital sector—was to be prepared and readied for approval and implementation. Additional efficiency measures included facility planning and redesign, medical equipment support, and training in hospital management. Accreditation of facilities, licensing of health professionals, and various quality assurance initiatives were also supported, and the Health Protection Service was broadened and reoriented.

10. Establishment of a policy analysis unit within the MSA was a project covenant, but was delayed for several years due to (i) commitment to decentralization, and aversion to central planning in the post-Soviet era by GOE officials; and (ii) widespread perception that “policy” was the responsibility of political leaders (e.g., Parliament) not MSA. These concerns were eventually overcome through continued dialogue, and through growing recognition within MSA that a central planning function was necessary.

11. Significant achievements included improvement in the MSA’s capacity to generate and use policy-relevant health analyses, and establishment and annual update of National Health Accounts, beginning in 1998. In addition, the project supported training of over 100 managers in hospital management and facility planning. Finally, the project supported the systematic review of outcome and cost-effectiveness evidence, which informed the adoption of national practice guidelines and standards.

12. Despite initial delays, the NHMP was completed in April 2000, and was approved by the Government of Estonia (GOE) in May 2000. The NHMP is already being implemented, and the Bank is providing funds and high-level technical assistance for the process.<sup>3</sup> The NHMP will be a central part of the GOE’s ongoing reform/refinancing program, guiding further reduction of hospital capacity and optimization of facility use. It comprises the main part of the government’s Health Sector Development Plan through 2015 and its implementation will be a central focus of the Bank’s Second Estonia Health Project.<sup>4</sup>

### **Health System Reorientation: Health Promotion and Disease Prevention**

13. This subcomponent supported various health promotion activities in four identified priority areas associated with the largest disease and disability burden in Estonia, namely smoking reduction, cardiovascular disease prevention, injury prevention, and women’s health/family planning (to reduce high abortion levels). Some of the activities were “top-down” national-level health promotion campaigns; others emerged, “bottom-up” from local community proposals.

---

3. The Swedish consortium, Scandinavian Care/SWECO, provided technical assistance to prepare the NHMP. The implementation of the NHMP is being financed from both the state budget and from the PHRD grant allocated for preparation of the second loan.

4. Estonia has already reduced hospital capacity from 1992 levels of 127 hospitals and 16,000 beds to levels in 2000 of 78 hospitals (27 of which were acute care hospitals) and 8,200 (acute care) beds, mostly through closure or conversion of small facilities. The restructuring proposed by the NHMP are more fundamental, however, and thus more politically contentious. Some hospital managers have reportedly complained that the consultant team recommended downsizing or closing facilities based on very brief visits. At the least, this illustrates that the stakeholder and political dimension of hospital restructuring requires equal attention to the technical and financial aspects.

14. Consolidation (from 700–800 physicians to 400) and redirection/broadening of a reorganized Health Protection Service from its narrow “sanitarian” role<sup>5</sup> in Soviet times into a modern public health service has begun to take hold. With project support, more than 1,300 individuals received short-term training in such topics as applied epidemiology and disease surveillance at the Center for Continuing Education of Health Professionals. The training contributed to the reorientation of the Health Protection Service, and contributed to upgrading of skills among nurses and administrative staff. Course evaluations show high levels of participant satisfaction. In addition, many of the physicians who left the Health Protection Service were trained as family doctors. The role of the Health Protection Service will need to continue to evolve as the family doctor reform takes hold, and as Estonia proceeds with EU accession. Moreover, relatively few doctors and senior hospital administrators (most of whom are doctors) participated in the short-term training, and the individualized approach was not always sufficient to change organizational behavior in hospitals or clinics.

15. Other achievements included the successful introduction of an innovative Health Promotion Fund, patterned on a Finnish model, whereby 0.5 percent of Health Insurance Fund revenues were earmarked for health promotion activities at both the local and national level.<sup>6</sup> The government agreed to establish this fund during project design. The Public Health Development Council allocated funds on a transparent and competitive basis to interested local communities. In 1995, 61 local projects were funded, the number rising by 1999 to 314 (of over 500 applications for funding). Over time, the share of local project funding increased from 20 percent to 50 percent. An annual conference was also held at which experience was shared and “best projects” were designated. It is difficult to discern the impact of this program on improvements in health behavior or health status, given the short time frame and disparate nature of the activities, as well as the lack of an overall evaluation plan with common indicators. The major contributions may have been more in mobilizing community interest in health promotion, and strengthening social and political acceptance of such activities, than in achieving specific health outcomes. The predominance of a demand-driven funding mechanism also made it more difficult to design comprehensive national programs. Further progress may be needed to better integrate health promotion and health protection activities at the district level. For these reasons, under the Second Health Project, the MSA plans to consolidate efforts in order to achieve national scale as it confronts major current or future public health problems such as those noted above, as well as HIV/AIDS prevention and control. Nonetheless, the number of projects funded and the widespread interest demonstrated in this program area where political, programmatic, and financial support is usually lacking, is itself a legitimate and noteworthy indicator of success, given that Bank attempts to foster health promotion in other ECA countries have often been unsuccessful.

### **Human Resources Development**

16. This subcomponent aimed to redefine and expand the Department of Public Health and the Department of Polyclinic and Family Medicine at Tartu University. It also was to establish a Center for Continuing Education of Health Professionals and to support the building of Tartu

---

5. In the Soviet public health system, health protection agencies focused on vaccination, communicable disease control, food safety, and environmental health, but were not integrated with primary health care. Responsibility for health promotion activities as well as attention to prevention of noncommunicable disease was generally absent.

6. The actual allocation has fluctuated somewhat from year to year. According to recent National Health Accounts, 0.4 percent of CSF revenues went to the health promotion fund in 1998, but nearly 1 percent in 1999. In addition, other health promotion and prevention activities are financed by the CSF and MSA, such that health promotion and prevention represents about 2 percent of total health expenditure.

University's Biomedical and Health Sciences Building (Biomedicum), which also was to house the Department of Public Health.

17. Significant achievements included the redesign, reorientation, and strengthening of primary health care in Estonia. A robust family doctor cadre was created, with family medicine becoming the single largest medical specialty in Estonia and family doctors central to the restructuring of the health system.<sup>7</sup> As of May 2001 over 650 of the needed 800 family doctors had been retrained in a rigorous and well-designed three-year retraining program at the Tartu University Family Medicine Department, which culminated in the certification and licensing of the 94 percent of trainees who passed the qualifying examinations. Over 2/3 of Estonia's population is now served by licensed family doctors as their physician of first contact. Coverage has lagged in the capital city of Tallinn, due to the strong presence of and resistance from polyclinics. The project responded by sponsoring several primary health care pilots in Tallinn, which has contributed to overcoming resistance.

18. A number of studies have confirmed the positive impact of the family doctor program. Public surveys have found steady and high levels (more than 75 percent) of public satisfaction with this approach and with the quality of health care they are receiving. The percentage of visits to family doctors in the total number of ambulatory care visits increased from 7 percent in 1997 to 16 percent in 1998. Measles immunization rates increased from 74 percent in 1994 to 88 percent in 1998. A recent study on immunization found no difference in immunization coverage and timing between children on the "lists" of family doctors compared with those cared for by pediatricians. The "gatekeeping" function of family doctors was less effective initially—in 1999, 65 percent of people seeking medical assistance turned directly to a specialist, especially in Tallinn, while 36 percent had a referral from a primary care doctor. Now that public acceptance of family doctors is high, however, the Central Sickness Fund has begun to require referrals for patients seeking specialist care.

19. The Biomedicum, which represented about 2/3 of project costs, replaced a building some 200 years old. It was designed, built and equipped to modern standards, with low cost overruns (12 percent above appraisal estimate). Most important, the Department of Public Health has a prominent and visible place within it, underscoring the centrality and importance of public health to present and future generations of medical students. This department has emerged as a dynamic academic unit. This is reflected in the training and hiring of new faculty (only two of the current 14 faculty were in the department a decade ago), in the increased prominence of public health in the medical school curriculum, in the department's development of a small post-graduate (Masters and Ph.D.) program, and in the international recognition and certification it has received. The department's research is informing key health sector reform policies; e.g., a study on tobacco use noted the monetary benefits of proposed changes in excise taxes, and advocated significantly higher taxation on cigarettes. Ministry of Finance officials have resisted calls from the public health community to increase tobacco taxes, in part because of concerns with smuggling, as well as a general aversion to earmarked taxes. Given the predominant role of

---

7. A family doctor system in Estonia existed in the 1930s and 1940s, so the movement in the late 1980s and early 1990s to establish family doctors as an important cadre actually represented, in a certain sense, a symbolic re-establishment of the status quo ante. Furthermore, the family doctor system predominates in neighboring Scandinavia, thus serving as a dynamic and viable model for Estonia. The small group of Estonian physicians who were first trained as trainers of family medicine in Finland in 1989 soon began to train other physicians, with a first group of 25 "enthusiastic doctors," trained by 1991. So when the Bank project was being designed, a cadre of motivated "champions" for the restructuring/retraining effort was already in place. This group remained active and continued to grow in numbers during the period of project implementation. The Family Medicine Department reorganized in 1995 to provide residency training at the university itself, where there are six full-time faculty and 25 tutors (practicing physicians in Tartu). In addition, there are another 40 practices around Estonia that serve as practical clinical sites for training.

smoking in the present and future disease burden, however, the Bank may wish to continue dialogue with the Ministry of Finance on this issue.

### **Financial Resources Management Efficiency**

20. As discussed above, the government “separated purchasing from provision” of health care in 1991 with the establishment of national health insurance, financed through a wage tax. The initial law established semi-autonomous funds in each county (district); during project design, the Bank raised concerns regarding the size of risk pools and the administrative capacity of the local funds. This component contributed to the development and improved efficiency and management of the various (22 local) Estonia Sickness Funds, which were consolidated in 2000 into a unitary Central Sickness Fund. The fund is adequately staffed and equipped and has a full-range of functioning planning and operating systems. Responsibility for revenue collection has been transferred to the government’s tax bureau, and compliance is high, particularly because of the relatively small informal sector in Estonia. The CSF is financing services nationwide, including contracting with providers. The project supported improvements in accounting and management information systems, and contributed to further refinements in the payment system to strengthen incentives for efficiency and quality of care. Payment for family doctors is based on a mix of capitation and fee for service, and contracts with hospitals are capped. In close coordination with the GOE/MSA, the fund is playing a central role in the so-far successful, still-evolving shift in health sector financing. As noted above, containing hospital costs will require further restructuring on the supply side, however. Estonia has opted for public financing of health services. Health insurance currently represents two thirds of health spending, with an additional 9 percent from central government. Out of pocket expenditures represent only about 14 percent of total health financing. The tax burden of health insurance plus social insurance is relatively high (35 percent)—although in line with Scandinavian countries. But continued macroeconomic stability plus further efforts to improve efficiency bode well for financial sustainability.

### **Project Management and Coordination**

21. This subcomponent supported the establishment and strengthening of a Project Steering Committee and a Project Coordination Unit (PCU). The Steering Committee was actively engaged in the project. It was composed of high-level individuals from key stakeholder organizations, e.g., the Minister of Social Affairs and other top MSA leadership, the Vice Rector of Tartu University and the Director of the Central Sickness Fund, as well as representatives from the Ministry of Finance and the PCU. Over the course of the project, the PCU became an independent contractor of the MSA, having won the contract through a competitive process. Through a novel contracting arrangement, the PCU was able to keep its original trained staff and it maintained its effective working relationship with—and for—the MSA. The PCU monitored the project well, including smoothly overseeing the procurement complexities inherent in constructing and equipping the Biomedicum, on into its operational phase, without usurping the MSA’s responsibility for policy and programs.

### **RELEVANCE**

22. Project relevance is rated **high**. The project was very relevant to the central tasks facing Estonia in the health sector during transition. This is perhaps most clearly demonstrated by the fact that the project framework became the framework for the overall GOE reform and restructuring effort. Thus, on the health services side, the project helped to consolidate and validate the emerging emphasis on the family doctor as a specialist cadre central to the provision

of continuous, high-quality primary care. Simultaneously, on the infrastructure and financing side, Bank support and dialogue contributed to the timely and successful strengthening of the health insurance system, culminating in a capably-staffed Central Sickness Fund that, in 2001, is financing services nationwide and playing a key role in health sector financing and reform.

23. On its face the Biomedicum, which absorbed 66.8 percent of project funds and is primarily devoted to undergraduate medical education, might seem less than fully relevant to project objectives. However, tempering that judgment is the fact that the Department of Public Health is so prominently housed there, where every future Estonian doctor will see it and be exposed to it. Also, the percentage of medical education devoted to public health was increased and is substantial. The OED Team encountered universal support for the Biomedicum's construction as a major component of the project. The Biomedicum investment thus helped sustain strong support for the project politically and in the medical community, while serving as a vehicle for a much broader range of policy reforms and "software" investments. The project's other equipment purchases, such as computers or basic equipment for family doctors, were also relevant to clinical and/or management needs. Project investments in "development software," i.e., training and technical assistance to develop human resources that accompany investments in infrastructure or equipment, were highly relevant, linked both to project objectives and to the restructuring/reform needs.

## EFFICACY

24. Project efficacy is rated **high**, as reflected in the project's having met or exceeded most of its many objectives and in the widespread impact it had and continues to have on the direction of health sector restructuring and financing. In almost every component, substantive and sustained change was effected. The link of these changes to improvements in health status was initially meant to be a project outcome. However, such a goal was unrealistic given the inherent difficulty of demonstrating causal links between inputs and short-term objectives on the one hand, and long-term, multi-factorial outcomes such as improvement in life expectancy or reduction in prevalence of major chronic diseases on the other.

## EFFICIENCY

25. Project efficiency is rated **substantial**, both in terms of the types of interventions and reforms sponsored by the project, and in the overall efficiency of resource use.<sup>8</sup> With respect to allocative efficiency, the project supported a shift toward more cost-effective interventions within the Estonia health system, e.g., the establishment of family doctors and reduced reliance on specialists for primary health care. As discussed above, the project also contributed funds and technical assistance toward improving the efficiency of health financing, e.g., through the development of National Health Accounts, the now-unitary health insurance system (Central Sickness Fund), and the evolving implementation of the National Hospital Master Plan. Project implementation was generally efficient, with relatively few cost overruns. Most project investments were completed on schedule and within original budgets.

---

8. Project efficiency is the extent to which the project achieved, or is expected to achieve, a return higher than the opportunity cost of capital and benefits at least cost compared to alternatives. Quantitative rate of return analysis is not required for health projects.

## INSTITUTIONAL DEVELOPMENT IMPACT

26. Institutional development impact is rated **high**, in contrast to the ICR's rating of substantial. The upgraded rating is warranted in light of the contribution made to capacity building as well as improving the policies and institutional framework for the sector. Institutional development was widespread, with positive changes occurring in organizations responsible for health service delivery, medical education, and health care financing. The capability of the Ministry of Social Affairs to generate and use policy-relevant analyses and to direct the health reform process was strengthened. This is reflected in such achievements as the development of the new specialty of family medicine, and in the finalization of the National Hospital Master Plan that will be guiding the rationalization, downsizing, and reorientation of the hospital sector. In addition, the management and efficiency of the Estonian Central Health Insurance Agency was strengthened so that it is now well-staffed by trained and capable individuals and its Central Sickness Fund is serving as a unitary payer for all Estonian health services. In close coordination with the GOE/MSA, the fund is continuing to play a central role in the evolution of health sector financing. Finally, the Health Protection Service was reorganized into a more modern public health service via short-term training at the Center for Continuing Education of Health Professionals, the creation of which was funded by the project.

27. The Medical School of Tartu University was also strengthened in a number of important and lasting ways. The infrastructure aspect of the project led to the replacement of the antiquated, 200-year old Biomedicum by a new state-of-the-art building where all of Estonia's future physicians will study basic sciences as well as modern public health. Both the Department of Public Health and the Department of Polyclinic and Family Medicine were also significantly strengthened. The Department of Public Health trained new faculty, developed a post-graduate (Masters and Ph.D.) program and achieved international recognition and certification. The Department of Family Medicine in Tartu re-trained a substantial number—650 of the 800 needed nationally—of physicians to be family doctors. Largely through the efforts of department faculty, and with project support, this discipline, which was non-existent in Estonia until the late 1980s, has achieved unquestioned acceptance as a medical specialty, now the single largest in Estonia. The department is closely involved with other developments in the organization of the family medicine specialty, from certification to policies on practice and funding, and one of its faculty members is the president of the Estonian Society of family doctors.

## SUSTAINABILITY

28. Project sustainability is rated **highly likely**, consistent with the ICR rating. Given that the project's dimensions and framework overlap significantly with the Estonian Health Sector Development Plan for 2015, sustainability is highly likely across almost all project components in the medium term. Even in the short term, sustainability has been demonstrated, with reform and restructuring proceeding apace, and most of the ongoing costs that had been generated by project activities being met by the benefiting organizations. For example, the Biomedicum is fully operational and is being maintained. The Department of Public Health of Tartu University is expanding, conducting policy-relevant research and receiving more recognition both domestically and internationally. The Center for Continuing Education of Health Professionals conducted 72 courses in 2000 alone, with more than 1,000 participants. The new specialty of family medicine, which is an important aspect of restructuring, is well established, with over 2/3 of the Estonian populace now being served by licensed family doctors as their primary physician and point of first contact. Centrally directed and funded health promotion activities are occurring and planned. The Central Sickness Fund is functioning well, contracting with providers and hospitals, and taking in adequate revenues. Finally, the GOE has maintained a stable macroeconomic

framework and a disciplined approach to government investment and budgeting. Funding for the recurrent costs of project investments are therefore assured.

### **BANK PERFORMANCE**

29. Bank Performance is rated as **highly satisfactory**, in contrast to the ICR rating of satisfactory. The OED team's reasoning for upgrading Bank performance is that all key informants pointed to the vital role the Bank played throughout the project period, from appraisal to implementation. The Bank provided technical assistance and training that was timely and comprehensive, and of high quality, not only during the period of design, but equally crucially, during project start-up. While the project and overall direction of the health reform program largely originated with the borrower, the Bank often served as a catalyst in moving the project along, as well as an "honest broker" for health sector reform. The Bank also helped the MSA to mobilize other donor resources, and the project served as a framework for coordinating donor investments. The project "did things right, and did the right things" in large part thanks to the Bank's guidance in such matters as project structuring, management, supervision, and procurement. The PCU was developed carefully, with adequate technical assistance, and has remained a stable part of overall Bank-borrower interaction. The Bank's priorities (primary care, public health, health promotion, and achieving greater sector efficiency and equity) found fertile territory and nascent evolution along a same path such that an effective, mutually valued and ongoing partnership was forged. The Bank also paid attention to the political as well as the technical dimensions of the project, which also helped to ensure country ownership of the project.

### **BORROWER PERFORMANCE**

30. Borrower performance is rated as **highly satisfactory**, consistent with the ICR rating. While there were some early problems in the project (e.g., delay in the construction of the Biomedicum), these were dealt with expeditiously and satisfactorily. Estonia is a model ECA country in the strong and sustained government commitment at the technical, programmatic, and political levels. Parliamentarians of all political leanings were kept informed, decisionmaking was transparent, and there was early and effective involvement of other key stakeholders such as the university establishment and sympathetic members of the medical community. Finally, there was careful, orderly, and systematic sequencing of interventions, and effective project coordination, management, and implementation, which was overseen by both an active and engaged Steering Committee and a very competent and stable Project Coordination Unit. The continue strong borrower ownership of the project is perhaps best demonstrated by the MSA and GOE request for a second Health Project, despite the government's general aversion to borrowing and its decision to discontinue Bank borrowing for all other sectors. The follow-on project will be a continuation of the overall process of reform and restructuring which the first health project did so much to support.

## List of Supporting Documents

### Aide-Memoires and Back-to Office Reports

Estonia Health Project, Staff Appraisal Report, January 19, 1995

Estonia Health Project: Implementation Completion Report, August 5, 2000. Hollo, I., Radelescu, S., Kleysteuber, P.

*Health Care Systems in Transition*. Estonia. European Observatory on Health Care Systems, 2000. Jesse, M., author, Schaefer, O., editor.

“Integration of General Practice/Family Medicine Reform in Polyclinic System,” Abstract Book, International Conference, Tartu, Estonia, April 13-15, 2000.

*Social Sector in Figures, 2000*. Ministry of Social Affairs, Estonia

Health Promotion in World Bank Financed Projects in Europe and Central Asia (ECA). Joanna Godinho. The World Bank, December, 1998.

*A Health Sector Strategy for the Europe and Central Asia Region*. Verdon S. Staines. The World Bank, September 1999.



## Annex A. Basic Data

### ESTONIA—HEALTH PROJECT (LOAN 3835)

#### Key Project Data

	<i>Appraisal Estimate</i>	<i>Actual or current estimate</i>	<i>Actual as % of appraisal estimate</i>
Total project costs (US\$)	34.5	35.56	103
Loan amount (US\$)	18	18	
Cancellation (US\$)	0	0	
Date physical completion: July 1, 2000			

#### Project Dates

<i>Steps in project cycle</i>	<i>Original</i>	<i>Actual</i>
Approval		01/19/95
Effectiveness	04/26/95	07/10/95
Signing/Agreement		01/26/95
Closing	07/01/99	07/01/00

#### Staff Inputs (staff weeks)

<i>Stage of project cycle</i>	<i>Planned</i>	
	<i>Weeks</i>	<i>US\$</i>
Identification/Preparation	93	294,864
Appraisal/Negotiations	49	125,726
Supervision	82	367,241
ICR	10	25,000
Total	232	812,831

**Mission Data**

<i>Stage of project cycle</i>	<i>Date (month/year)</i>	<i>No. of staff in field</i>	<i>Specializations represented</i>	<i>Performance ratings<sup>b</sup></i>	
				<i>Implement. Status</i>	<i>Develop. Objectives</i>
Identification/Preparation			A. Campos (TL & Health Management Specialist); P. Huitima (Hospital Planning); L. Cernerud (Medical Training); A. Bento (Facilities Planning-		
Preparation Mission	November 1993	9	A. Campos (TL & Health Management Specialist); A. Bento (Facilities Planning-Biomedical Engineer); L. Fernandez (Hospital Architect); K. Koskela, R. Madeley, J. Lepisk (PHC & Public Health); Kdi Tullio (Operations); N. Grande (Pre-clinical Training); H. Barnum, F. Kanach (Hospital Planning & Management)		
Pre-Appraisal Mission	February 1994	12	(TL A. Campos (TL & Health Management Specialist); A. Bento (Facilities Planning-Biomedical Engineer); J. Hogstedt (Programming Architecture); D. Routenbert (Data Systems Planning & Civil Works); K. Koskela, R. Madeley (PHC & Public Health); Kdi Tullio (Operations); N. Grande (Pre-clinical Training); H. Barnum (Health Financing); F. Kanach (Hospital Efficiency & Quality); S. Sjolund (Hospital Planning)		
Final Preparation Mission	April 1994	8	A. Campos (TL & Health Management Specialist); N. Maraviglia (Operations); A. Bento (Facilities Planning & Biomedical Engineering); J. F. Hogstedt (Facilities Programming); J. Wemans (Mechanical Engineering); H. Nobakht (Costing); J. Steensberg (Health Restructuring)		
<b>Appraisal/Negotiation</b>					
Appraisal	June 1994	8	A. Campos (TL & Health Management Specialist); N. Maraviglia (Operations); R. Saltman (Health Policy Reform); K. Koskela (Health Trends and Health Promotion); R. Madeley (Human Resources Development); O. De Messieres (Architect); T. Ensor (Health Financing); D. Routenbert (Implementation)		
Project Launch Preparation	December 1994		D. Routenbert (Implementation Specialist)		
Project Launch	June 1995	6	A. Campos (TL & Health Management Specialist); I. Cheng (Operations Officer & Financial Analyst); L. Rose (Health Economist); T. Palu (Health Specialist); O. De Messieres (Architect); T. Lim (Operations)		
Technical Assistance	Sept/Nov 1995	2	S. Cucic (Accreditation & Quality Assurance); C. Neal (IT Specialist)		
Supervision	March/April 1996	6	I. Cheng (TL & Financial Analyst); A. Campos (TL & Health Management Specialist); T. Palu (Health Reform); M. Suzuki (Logistics); O. De Messieres (Architect)	S	S

Stage of project cycle	Date (month/year)	No. of staff in field	Specializations represented	Performance ratings <sup>b</sup>	
				Implement. Status	Develop. Objectives
Midterm Review	February 20, 1997	4	I. Chen (TL & Fin. Analyst) ; S. Cucic (Accreditation & Quality Assurance); C. Neal (IT Specialist); O. De Messieres (Architect); L. Bogg (Health Financing)	S	S
	January 9, 1998	3	I. Chen (TL & Fin. Analyst) ; O. De Messieres (Architect) ; A. Campos (TL & Health Management Specialist)	S	S
	June 12, 1998	3	T. Palu (TL & Health Specialist); L. Bogg (Health Financing); A. Campos (TL & Health Management Specialist);	S	S
	May 8, 1999	3	T. Palu (TL & Health Specialist); J. Godinho (Health Promotion); T. Novotny (Public Health)	S	S
	December 24, 1999	4	T. Palu (TL & Health Specialist); L. Hawkins (Health Economist); S. Kokko (PHC); O. De Messieres (Architect)		
	June 15, 2000	3	T. Palu (TL & Health Specialist); A. Fidler (Health Specialist); A. Fidler (Health Sector Manager); P. Kleysteuber (Operations Officer)	HS	HS
	November 30, 2000	1	T. Palu (TL & Health Specialist)	HS	HS





EESTI VABARIIGI SOTSIAALMINISTEERIUM  
MINISTRY OF SOCIAL AFFAIRS OF ESTONIA

Mr. Alain Barbu, Manager  
Sector and Thematic Evaluation Group  
Operations Evaluation Department  
The World Bank  
Washington, D.C.  
U.S.A.

29 October, 2001 *14.1-7/6922*

Re: Estonia – Health Project (Loan 3835)  
Draft Project Performance Assessment Report

Dear Mr. Alain Barbu,

The Ministry of Social Affairs of Estonia has reviewed the draft Project Performance Assessment Report prepared by the Operations Evaluation Department at the World Bank and has no disagreements with the findings of the report.

Yours sincerely,

A handwritten signature in black ink, appearing to read 'K. Saluvere'.

Katrin Saluvere  
Deputy Secretary General for Health  
Ministry of Social Affairs of Estonia