THE WORLD BANK OPERATIONS EVALUATION DEPARTMENT

Supporting A Healthy Transition

Lessons from Early World Bank Experience in Eastern Europe

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2002
The World Bank
Washington, D.C.

OPERATIONS EVALUATION DEPARTMENT

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Abbreviations and Acronyms

APL	Adaptable Program Loan
ECA	Eastern Europe and Central Asia (Region)
ESW	Economic and sector work
GDP	Gross domestic product
GP	General practitioner
HIS	Health information system
HNP	Health, nutrition, and population
IBRD	International Bank for Reconstruction and Development
IDA	International Development Association
LIL	Learning Innovation Loan
MOF	Ministry of Finance
MOH	Ministry of Health
OED	Operations Evaluation Department
PMU	Project management unit
PPAR	Project Performance Assessment Report
QAG	Quality Assurance Group
WHO	World Health Organization

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Preface

This report is the result of an effort by the World Bank's Operations Evaluation Department (OED) to synthesize emerging lessons from the past decade of Bank support for health sector reform in Eastern Europe. It is based primarily on OED Project Performance Assessment Reports (PPARs) for completed health projects in Estonia, Hungary, and Romania, together with desk reviews of completed projects in Albania, Croatia, and Turkey. The primary purpose of the paper is to provide lessons for the Bank's efforts in the region, although the findings have wider implications for other donors and policymakers in Eastern Europe, as well as for health reform efforts in other regions.

Key documentary sources included project Implementation Completion Reports, Staff Appraisal Reports, project files, and evaluations and reports from other donors, international agencies, and nongovernmental organizations (NGOs). The author also reviewed available research and policy literature regarding health sector reform in Eastern and Central Europe (ECA). In addition, OED distributed a short questionnaire to assess the views of government officials and stakeholders regarding the strengths and limitations of the projects in Estonia, Hungary, and Romania.

The focus is on Eastern Europe, rather than the Eastern and Central Europe (ECA) region as a whole, because no Bank health projects had yet been completed in either Russia or Central Asia when this review was initiated in 2001 (a project in the Kyrgyz Republic was completed in 2002). Estonia, Hungary, and Romania were chosen for in depth field evaluations because they represented a range of experiences with health sector reform, but they are not a fully representative sample of countries in the region. Because of the constrained sample, when discussing lessons health reform (social health insurance, strengthening family practice and health promotion), the paper seeks to validate findings with the available research literature from the region. Some important health sector issues (for example, pharmaceutical reform or addressing HIV/tuberculosis) are not discussed in detail because only one or two project included them as components.

The author expresses appreciation to all those who made time for interviews and provided documents and information, including current and former World Bank staff, as well as government officials, donors, clinicians, researchers, and nongovernmental organization representatives in Estonia, Hungary, and Romania. The author also wishes to acknowledge the contributions of OED consultant Roy Jacobstein, who led the Hungary project evaluation, participated in the field evaluation of the Estonia project, and undertook desk reviews of several other completed ECA health projects. Armin Fidler, Sector Manager for health, nutrition, and population (HNP) in the Bank's ECA region, provided advice and encouragement for this synthesis review. A number of Bank staff provided written comments on the draft report, including John Langenbrunner, Olusoji Adeyi, Dominic Haazen, Loraine Hawkins, Ruth Levine, Joana Godinho, and Silviu Radulescu; several other staff made useful suggestions during a review meeting in early 2002. Joan Nelson and Péter Gaál provided comments as external reviewers, and Martha Ainsworth served as peer reviewer within OED. Comments from the governments of Estonia, Hungary, and Romania were incorporated into the OED project performance reviews for their respective countries, which are reflected in this report. William Hurlbut edited the report, and Pilar Barquero provided administrative assistance.

Summary

Over the past decade, the transition countries of Eastern Europe and Central Asia (ECA) have faced the challenge of introducing market reforms, while also seeking to reform their health systems and improve health outcomes for their citizens. The outcomes of reforms have varied considerably among countries, with some achieving improvements in system performance and outcomes (Estonia), while others have seen continued deterioration in health services and stagnation in health indicators (Romania).

Health reform is a difficult and long-term process involving a wide range of stakeholders, and is further complicated by the absence of a single agreed model for the "right" approach to the financing and structure of health systems. Although the Bank is often among the most important international agencies in a given country, its financial contribution is typically small relative to total health financing. And the Bank has only a peripheral role in domestic political bargaining and coalition building around health reforms. Thus the Bank's influence depends on catalyzing wider reforms.

The World Bank approved the first health, nutrition, and population loans in ECA in the early 1990s, and Bank lending and non-lending activities have grown substantially. The HNP portfolio in the ECA region is relatively young, but the first cohort of seven projects has been completed in the past two years. While these projects shared many objectives, outcomes differed—from highly satisfactory in Estonia to moderately satisfactory in Romania and moderately unsatisfactory in Hungary. Despite common challenges of transition, country characteristics also differed. Estonia has been among the most advanced reformers in the region both economically and within its health sector, while Romania has lagged on both fronts. Hungary has progressed in economic reform, but it has made slow progress in reforming its health sector.

Major Findings

The Bank's initial projects in the region underestimated the political and institutional difficulties of reforms, and were thus unduly optimistic regarding the pace and prospects for reform. Several other major findings emerge.

Finding 1: Despite over ten years of reform experience, there is remarkable little evidence regarding the impact of various reforms on service quality and efficiency, health behaviors, or health outcomes. Lack of priority to monitoring and evaluation threatens to become the "Achilles Heal" of health reform.

Finding 2: The design and sequencing of sector reforms—as well as the Bank's strategy, policy advice, and project design—must be matched to the political and sectoral context of the country, particularly the degree of consensus for reform, and capacity for design and implementation of projects and reforms programs.

Finding 3: The outcome of structural reforms—including introduction of compulsary national health insurance or privatization of family doctors—depends on progress in complementary reforms, as well training and capacity development for both health managers and providers.

Finding 4: The Bank's most successful project investments—and most significant contributions to the sector reform process—resulted from lending and nonlending support

for strengthening capacity and building consensus for reform. These activities typically represented a small proportion of total lending.

Finding 5: Capital investments can complement and reinforce the reform process, if used properly. But for most of the completed projects, capital investments had only modest success in bringing about reforms or significant improvements in health service quality or efficiency. Outcomes were better when investments were carefully linked with institutional reforms and complementary support for capacity development (whether financed by the Bank or donors).

Finding 6: Project investments were more likely to be successful when carried out in partnership with other donors, nongovernmental organizations, or research institutes. Many governments are reluctant to borrow for technical assistance, and other organizations may have a comparative advantage in technical areas or capacity building.

Design and Implementation of Sector Reforms

What additional lessons arise from some commonly implemented reforms, and what has been the Bank's role and contribution?

National health insurance – great expectations, mixed results: Most countries in Eastern Europe have established some form of compulsory national health insurance, financed through a payroll tax. The reforms were expected both to increase resources available to health and to catalyze improvements in system efficiency and quality. But outcomes have been mixed. In some advanced reformers, like Estonia and Hungary, the new insurance system is well established and beginning to yield benefits, although in Hungary cost containment remains a challenge. In countries like Romania, where the economic and institutional context is weaker, the reforms remain fragile, with continued shortcomings in capacity and the legal framework. Experience in Estonia, Hungary, and Romania also shows that insurance and payment reform alone are insufficient to significantly rationalize or improve the efficiency of the hospital sector. The Bank's ability to influence the development of national health insurance has been limited, largely because the decision to implement social insurance has usually been driven by domestic political considerations. Thus the Bank's role has been limited toencouraging refinements in the system, and strengthening management systems and capacity, as it has done in Estonia and Croatia.

Strengthening family practice—importance of sequencing training and reforms. To strengthen primary care, countries throughout the region have either piloted or implemented reforms to establish family medicine as a distinct specialty, and to contract family doctors as independent practitioners. Estonia, a leader in these reforms, established a Department of Family Medicine at its medical school in the early 1990s (and expanded it with project support). By the time the reforms were fully implemented in 1997, a critical mass of well-qualified family doctors had been trained, increasing acceptance among the public and medical community. In Romania, a project-sponsored pilot tested family doctor reforms in eight districts. The pilot built support and helped refine legislation., but reforms were implemented nationally before family doctors had been trained in their new roles. The reforms created the potential for improving primary care, but further refinements are needed. For example, the recently established health insurance fund has limited ability to monitor the quantity (billing) or quality of care.

Health promotion – limited progress: Strengthening health promotion and prevention of noncommunicable diseases—including reducing tobacco and alcohol consumption and improving diets—requires both efforts to influence individual behavior (through information, education, and

communication), as well as changes in policies, laws, and taxes. But progress has been limited in most ECA countries—in part because most governments in the region initially assigned health promotion a low priority. Project-sponsored health promotion components were relatively successful in Estonia and Croatia (where governments were generally supportive), but unsatisfactory in Romania and Hungary (where support was weak). The Bank needs to give greater emphasis to building capacity and commitment for health promotion activities in project design, supervision, and policy dialogue, particularly when government commitment is weak.

Strengthening Capacity and Consensus for Reform

How can the Bank use its lending and nonlending activities to help strengthen local capacity and to build consensus for reform among stakeholders?

Strengthening capacity for design and implementation of reforms: Several findings emerge from project experience. First, project support for establishment or strengthening of health management institutes (Hungary, Romania), schools of public health (Estonia, Hungary), and departments of family medicine (Estonia) has helped increase the credibility of these "new" disciplines, built national capacity in skills critical for reform, and strengthened constituencies for sector reform. Their direct impact on policy depended on relations with government, however. Second, reforming existing organizations—such as ministries of health or Soviet-era sanitary-epidemiological agencies—has proven more difficult than establishing new ones (Estonia, Hungary). But long-term dialogue and support for training can pay off. Third, despite contributions to training and capacity by a variety of donors, the demands of sector reforms on both managers and providers outstrips the supply of training in many countries.

Building consensus for reform: Experience highlights several findings. First, given regular turnover of governments and ministers, engagement with a wide range of stakeholders, including Parliament and opposition parties, is essential. Second, pilot projects can contribute to refining and building consensus for reforms, but need to be well-designed, evaluated, and relevant to government priorities. Third, Bank studies and analyses were often influential, but the impact depended on the extent of local involvement and dissemination (Albania, Hungary, Romania), and on the government's absorptive capacity for technical analysis (Romania, Albania). Fourth, although project conditions cannot force governments to take actions, the Bank can use targeted policy conditionality to strengthen the hand of reformers and help "lock in" reforms (Estonia, Romania).

Recommendations

The Bank can enhance its contribution to sector reform by:

- *Strengthening the knowledge base for sector reform*, through improved monitoring and evaluation at the project and sector level, and by sponsoring analytic work on how to adapt reforms to differing institutional and political contexts.
- *Strengthen focus on neglected priorities*, including health promotion, reducing under-the-table payments, and equity (including for ethnic minorities).
- *Continue to experiment with new lending instruments*, including Adaptable Program Loans, Learning and Innovation Loans, and Sector Adjustment Loans—and selectively incorporating health sector-related conditions into macroeconomic adjustment loans.
- *Further strengthen partnerships with donors, nongovernmental organizations, and research institutes,* within the region as well as at the country level.

1. Introduction

Health and Health Reform in Eastern Europe

1. Over the past decade, the transition countries of Eastern Europe and Central Asia (ECA) have faced the challenge of introducing market reforms, while also seeking to reform their health systems to increase efficiency, better address the disease burden, improve service quality, and increase consumer choice. During the communist era, nearly all countries in the region adopted the Soviet-style *Semashko* health system. While emphasizing universal access to free health care, the model was characterized by centralized control; a strong emphasis on curative, specialist care; excessive hospital capacity; limited consumer choice; and few incentives for efficiency. A strong emphasis on environmental health, prevention of communicable diseases—administered by national sanitary and epidemiological agencies—contributed to near-universal child vaccination coverage. By the 1960s, life expectancy in the region was comparable to that in Western Europe. But with success in control of communicable diseases, the disease burden shifted toward noncommunicable diseases. These were largely related to life-styles, and exacerbated by high levels tobacco and alcohol consumption and poor dietary practices (Adeyi and others 1997; Rokx and others 2000), but health systems gave little attention to promoting healthy behaviors and prevention of noncommunicable diseases. Abortion was widely used as the primary means of contraception, contributing to maternal mortality rates several times higher than in Western Europe.

2. The economic dislocations of the early 1990s were associated with a worsening of health outcomes, driven primarily by increases in adult male mortality (Table 1). The causal factors behind these increases are subject to some debate; while health systems were put under stress by economic declines, the main influences appear to be outside the health sector—including household well-being, health behaviors, and psycho-social stresses (Becker and others 1998; World Bank 2000). Economic contraction led to declines in real government health spending, by as much as a third in some countries. Low salaries for physicians contributed to growth of the already widespread practice of informal payments for services, which has disproportionately affected the poor (Lewis 2000). The desire to "catch-up" with Western European counterparts has led to strong demand by providers and clients for high-technology medical equipment and improved infrastructure (facilities and ambulances), despite continued constraints in funds for operation and maintenance. Rapid liberalization of pharmaceutical sectors improved drug availability, but contributed to cost escalation and growing pressure on national health budgets, particularly in countries without essential drug policies.

3. Health indicators generally have improved since the transition, albeit with considerable variation among countries, and among regions, income groups, and ethnic minorities within countries (Belli 2000; Ringold 2000). But smoking prevalence among males still averages 40 percent or higher. Female prevalence tends to be less than 25 percent, but has been rising in response to aggressive advertising by tobacco companies (WHO 1997). Finally, AIDS and tuberculosis have emerged as new threats, with HIV prevalence rates growing rapidly among high risk populations, including prison inmates and intravenous drug users (World Bank 2000).

Table 1. Income and Health Indicators in ECA Fell in Early 1990s, but Are Recovering

	1980	*1990*	*1995*	*1999*
GDP per capita (constant 1995 US$)		2,709	2,017	2,133
GDP growth (Annual %)		-1.9	0.2	1.8
Infant mortality (per 1000 births)	41	28	25	21
Life expectancy at birth (years)	68	69	68	69
Female	72	74	73	73
Male	64	65	63	64

Source: World Bank Statistical and Information Management and Analysis (SIMA).
Note: ECA regional mortality data may be underestimated, since some countries report only deaths in hospitals.

4. Since the early 1990s, most countries in the region have sought to implement health sector reforms.[1] The scope, pace, and outcomes of those reforms have varied from country to country, but the reforms themselves share many characteristics.[2] Most have sought to decentralize care, increase private sector involvement in service delivery, rationalize or downsize hospital services, and strengthen the role of family practice physicians. Many have introduced various forms of national health insurance, with the intention of improving system efficiency and responsiveness by "separating purchasing from provision" of health services. Some countries have taken steps to strengthen public health programs and regulations (such as controls on public smoking and tobacco advertisement), and to improve reproductive health services for women. The reform process typically has required a series legislative acts by parliaments. As such, reforms proposed by government ministries may be only partially implemented, or stalled for years, and important aspects of the regulatory framework for reforms—such as the relationship between ministries of health and the new national health insurance agencies—remain unclear.

The Growth of Bank Support for Health in ECA

5. The World Bank's first health loans in Eastern Europe—to Poland and Romania—were approved in 1991 (a loan to Turkey was approved in 1989). Bank lending and non-lending activities have grown substantially since then, currently totaling 23 projects with commitments of more than US$900 million (Annex A). Since most of the region's countries are in the middle-income category, most of the lending is on nonconcessional (IBRD) terms, although some of the former Soviet republics qualify for concessional (IDA) loans. The Bank has sought to encourage sector reforms while also financing investment activities. It also supports some regional initiatives—including the European Observatory for Health Reform, jointly with the World Health Organization (WHO) and academic institutions in the region—through (limited) grant

1. "The choice for ECA countries is not between reforming their health sectors and having them remain unchanged. Fiscal and other pressures make change inevitable…The real choice is whether policymakers will allow change to occur haphazardly or will instead direct and guide it through a rational reform program, to the extent that circumstances allow." (Staines 1999)

2. These similarities reflect several factors, including the common influence of recent health sector reforms enacted earlier in Western Europe, common financial and other pressures, and similarity histories. For example, many countries in Eastern Europe had health insurance systems in place prior to the Second World War, based on a Bismarkian model of a single national insurer financed through dedicated wage taxes, with services delivered by a mix of public, private, and charitable providers. Hungary, for example, established its first health insurance program in the late-1800s, and by WWII most formal sector workers were covered by health insurance (Orosz and Burns 2000). Following the war, these insurance systems were eliminated, and private health facilities were taken over by government. This in part explains why (re)establishment of national health insurance was among the first health reforms enacted in most transition countries—often by the early 1990s.

financing. The World Bank Institute trains policymakers through its flagship course on Health Reform and has established a regional training institute in Hungary. The Bank articulated a broad strategy for its health, nutrition, and population (HNP) work in the region in 1998, which characterized the major reform challenges, summarized emerging lessons, and identified priorities to improve the effectiveness of Bank support (Staines 1999). The ECA region is currently planning a retrospective evaluation of the past decade's experience.

6. The HNP portfolio in the ECA region is relatively young, but the first cohort of seven projects has been completed in the past three years (Table 2). The World Bank's Operations Evaluation Department (OED) has conducted desk reviews of all these projects[3] and recently completed Project Performance Assessments Reports (PPARs) for completed health projects in Estonia, Hungary, and Romania, which included field visits to each country. The Romania and Hungary projects are representative of the first-generation "mega-projects" in the region, designed in the early 1990s with loans exceeding $100 million (a similar project in Poland is not yet complete). The Estonia, Croatia, and Kyrgyz Republic projects are more typical of "second generation" projects, with smaller loans and more focused objectives.

Study Purpose and Methodology

7. This report draws lessons from the Bank's emerging experience with regard to supporting the health sector reform process in ECA. The focus is on health projects completed in the past two years in Eastern Europe[4] (Table 2). No projects are yet complete, however, in Russia or the Central Asian republics (Annex A). As part of the PPARs, OED reviewed project documents and academic literature, conducted interviews with key informants inside and outside government, visited selected project sites, and administered a confidential questionnaire to about a dozen stakeholders in each country. The stakeholders were asked to rate project outcomes and Bank performance on a variety of dimensions. This report also selectively draws on examples from desk reviews of other completed projects in the region and research literature on health reform, where appropriate, to support the findings.

8. There are many evaluation findings contained in the PPARs for the three Eastern European projects, but this report highlights findings concerning success and lessons for support of health sector reform. Following a discussion of the political economy of health reform, section two briefly describes health conditions and health sector reforms in Estonia, Hungary, and Romania, and the role that Bank-sponsored projects played. The third section reviews evaluation findings on three key sector reforms (health insurance and financing, introduction of family medicine, and strengthening public health). Section four highlights several cross-cutting findings regarding the Bank's role in supporting health sector reform. The final section offers several recommendations.

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3. Romania Health Services Rehabilitation Project (Loan 3409); Hungary: Health Services and Management Project (Loan 3597). Project Performance Assessment Report No. 23362 - December 12, 2001; Estonia: Health Project. Project Performance Assessment Report No. 23249, November 14, 2001; Turkey First Health Project (Loan 3057), Implementation Completion Report No. 19477. June 30, 1999; Croatia: Health Project (Loan 3843). Implementation Completion Report No. 20336, June 20, 2000; Albania: Health Services Rehabilitation Project (Credit 2659), Implementation Completion Report No. 22929, November 2, 2001.

4. Although Turkey is part of the ECA region, the health challenges it faces are somewhat different than in the transition countries of Eastern Europe. The paper therefore does not draw heavily on the Turkey experience. The Kyrgyz Republic Health Project was completed in 2002—after this study was initiated—so does not figure prominently despite its apparent success.

Table 2. Completed ECA Health Projects Evaluated by OED

Country/Project name (years)	*Cost (US$)*	*Major Objectives/Components*	*OED Outcome rating* [a]
Albania Health Services Rehabilitation (1994-00)	15 m	(i) Upgrade selected primary and secondary facilities; (ii) strengthen treatment skills of hospital physicians and nurses; and (iii) build central and district capacity to manage health resources and reforms.	*Satisfactory*
Croatia Health Project (1995-99)	49 m	(i) Improve the managements system of the Croatia Health Insurance Institute; (ii) strengthen primary care and health promotion services; and (iii). upgrade Essential Hospital and Emergency Services, through the provision of equipment and training.	Satisfactory
Estonia Health Project (1995-2000)	34 m	(i) Re-orient health services to emphasize health promotion and disease prevention programs; (ii) strengthen modern public health training and pre-medical training; and (iii) support ongoing health financing reforms through establishing sound cost, performance analysis and health management information systems.	Highly satisfactory
Hungary Health Services and Management (1993-2000)	56 m (133 m)*	(i) Support public health programs to reduce non-communicable diseases; (ii) support the Government's program of health sector restructuring; and (iii) strengthen the institutional capacity of the health sector in policy-making, management and evaluation.	Moderately unsatisfactory
Kyrgyz Republic Health Project (1996-2002)	20.6 m	(i) Reorient health services away from hospitals and toward primary health care; (ii) health facility rehabilitation and maintenance; (iii) support medical provider payment reforms; and (iv) essential drugs distribution and reforms to improve pharmaceutical regulations and rational drug use.	Highly Satisfactory
Turkey Health Project (1989-98)	208 m (146 m)*	(i) Improve health status in 8 underserved provinces, (ii) improve service quality and efficiency (through facility upgrades and training), and financial sustainability, and (iii) strengthen the management capacity of the MOH.	Moderately satisfactory
Romania Health Service Rehabilitation (1991-99)	225 m	1) Upgrade Rural Dispensaries; 2) improve reproductive health; 3) train health practitioners; 4) procure and distribute drugs and consumables; 5) improve management of emergencies; 6) strengthen health promotion; 7) develop a national health strategy; 8) develop a health information system; 9) establish a school of health services and management.	Moderately satisfactory

a. OED rates project outcome on a six-point scale: highly unsatisfactory, unsatisfactory, moderately unsatisfactory, moderately satisfactory, satisfactory, and highly satisfactory.

* Estimates of project costs and loan amounts at the time that the projects were approved are shown in parentheses if they significantly differed from final costs.

The Political Economy of Health Reform

9. Experience in both developed and developing countries over the past two decades have demonstrated that health reform is a slow and contentious process. Major changes in health systems face four significant obstacles. First, health sectors have multiple stakeholders and

engage competing political interests, many of which may oppose aspects of reforms. Second, the long timetable for health sector reform means political battles continue even after reforms are approved, sometimes leading to changes or reversals. Third, there is no single agreed model for the "right" approach to the financing and structure of health systems. And finally, unlike financial or macroeconomic crises, there is less apparent urgency in health sector reform, and politicians may prefer to delay action than provoke powerful interest groups (Nelson 1999). Even in industrialized countries, health reform is typically an ongoing process that evolves over the course of several decades.

10. In addition, several factors have made health reform in transition countries especially difficult. First, reforming an inefficient system with excessive hospital capacity is more difficult than expanding a system with inadequate service access—since downsizing is likely to be resisted by health workers, affected consumers, and local politicians. Second, while many countries have a long tradition of specialist medical training, knowledge and capacity for health policy, planning, and management are scarce. This same specialist tradition can also contribute to resistance to family medicine, or to more cost-effective treatment protocols. Third, the economic transition in many countries has been slow and painful; reforms are more difficult where GDP and health sector budgets are stagnant or declining. As a result, most international agencies, including the World Bank, underestimated the difficulty of reforms and the time required to implement them (Belli 2000).

11. The Bank is often among the most important international agencies in a given country, in terms of both total financing and policy influence. But even among the less developed countries in the ECA region, its financial contribution is typically small relative to total public and private health financing—usually less than a few percent of annual health expenditure. Moreover, the Bank—like other international partners—has only a peripheral role in domestic political bargaining and coalition building around health reforms (Nelson 1999).[5] Thus, the outcome of specific project investments—while potentially important—provides a somewhat narrow perspective on the Bank's role and impact. While project investments may be useful, experience suggests that the Bank's role is catalytic: using its lending and nonlending activities to strengthen capacity and build consensus for reform. Subsequent sections will explore these points in more detail.

5. "... credibility and commitment must be developed locally, usually by a long process of accumulating evidence on the nature of the problems…and by improving understanding of the likely effects of alternative approaches to reform. Donors can help clients improve data and deepen understanding of sector problems. They can provide comparative perspective by expanding knowledge of how reforms have fared and how sectors have performed elsewhere...But outsiders cannot drive the formulation of reforms or the process of building consensus...The lengthy period needed to implement many reforms also has implications: donors must adjust their own instruments, procedures, and monitoring criteria to the demands of a long and highly unpredictable game." (Nelson 1999)

2. Bank Support in Context

12. OED ratings of the outcomes of completed projects ranged from highly satisfactory in Estonia to moderately satisfactory in Romania and moderately unsatisfactory in Hungary (Table 2). But beyond the specific project activities, what role did the projects play in health sector? The health projects in Estonia, Hungary and Romania shared many objectives and characteristics, but the evolution of health reform dialogue and the degree of commitment differed in the three countries. Estonia has been among the most advanced reformers in the region both economically and within its health sector, while Romania has lagged on both fronts. Hungary has progressed in economic reform and is positioning itself for accession to the European Union, but it has made slow progress in reforming its health sector.

Table 3. Health and Health System Trends in Estonia, Hungary, and Romania

	Estonia		*Hungary*		*Romania*		*ECA*	
	1990	***1999/00***	***1990***	***1999/00***	***1990***	***1999/00***	***1990***	***1999/00***
Population (millions)	1.5	1.4	10.4	10.0	23.2	22.5		
GDP per capita (constant 1995 US$)	4487	3952	4858	5151	1531	1290	2710	2134
Gov't Health expenditure as % GDP	2.13	4.66*	5.9	7.5*	2.82	2.6*		5.3*
Infant mortality (per 1000 births)	12.4	9.5	14.8	8.4	26.9	19.8	27.7	20.8
Life expectancy at birth (years)								
Female	74.6	76.1	73.7	75.1	73.1	73.4	73.7	73.4
Male	64.6	65.3	65.1	66.3	66.6	65.7	65.3	64.3

Source: World Bank Statistical and Information Management and Analysis (SIMA)
* Data from 1997.
Note: The ECA regional data may underestimate actual mortality, since some countries report only deaths in hospitals.

Romania—Strengthening Capacity and Consensus in a Slow Reformer

13. Health indicators in Romania were on a par with the rest of Europe in the 1960s, but declined in relative and absolute terms in the years leading up to and following the fall of the Ceaucescu regime in late 1989. This reflected a growing burden of noncommunicable disease, as well as severe deterioration in health service during the latter years of communism. Despite initial optimism for both health and economic reform after the fall of communism, lack of progress in economic reform contributed to economic stagnation, and the government showed limited commitment to health reforms through the mid-1990s. Following a change of government in 1996, Romania enacted several significant health reforms, including establishment of compulsory national health insurance; decentralization of service delivery to the district level; increased hospital autonomy; and the establishment of family doctors as private practitioners (Vladescu and others 2000). These reforms are still at early stages, however, and have not yet led to significant improvements in health services or health indicators (World Bank 1999). The MOH and health insurance funds have yet to fully adapt to their new roles. Although infant and maternal mortality have begun to decline, Romania remains one of the few countries in Eastern Europe that has not experienced an improvement in adult life expectancy (Table 3).

14. The experience of the Romania Health Services Rehabilitation Project illustrates the challenges of supporting sector reform in a country with relatively weak institutions and an unstable macroeconomic environment. The project was designed and approved less than two years after the fall of communism, at a time of severe crisis in the health sector. It sought to rehabilitate basic health infrastructure and respond to emergency shortages in the health system (mainly drugs and equipment), while laying the groundwork for structural reforms. In retrospect, the project was too large ($150 million loan) and too complex—nine components (see Table 1)—for local implementation capacity. Romanians were unfamiliar with Bank procedures, especially procurement rules, and conflicts between Bank and government procedures contributed to delays.

15. The project was restructured following a mid-term review in 1995, but the government refused the request a reduction in the loan amount. The Bank subsequently adopted a two track strategy: engaging in a broad policy dialogue with stakeholders on sector reforms, while also seeking to resolve implementation bottlenecks and fully disburse project funds. While the reform activities eventually proved influential, the outcome of most of the project's physical investments were mixed—with the exception of support for maternal and child health. And monitoring and evaluation was inadequate to assess impact on service quality, access, or health outcomes. Continued weaknesses in sub-sector policies undermined some investments (e.g, lack of an essentia l drugs policy), while inadequate complementary investments in training or capacity building reduced the impact of others (emergency medical services, rural health centers).

16. Until the change of government in 1996, the MOH demonstrated either indifference or resistance to reform activities, but persistent pressure from the Bank, together with support from stakeholders outside the MOH, permitted some progress in reform components (including a 1993 sector study,[6] district decentralization pilots, and the successful establishment of a health management institute). These had limited sector impact initially, but significantly influenced the reforms implemented following the change of government in 1996. To further build consensus for reform, the Bank supported a study on health sector financing, a participatory sector review (InterHealth Institute 1998), and developed a Bank sector strategy for Romania (World Bank 1999). These studies and the accompanying stakeholder discussions influenced the government's sector strategy, and led to modifications in insurance legislation (see below). Government changed again in 2000, but has adopted most elements of the previous government's health strategy. Implementation of the strategy remains the fundamental challenge, however. A follow-on Health Sector Reform project support further reforms and investments.[7]

Estonia—Support for an Advanced Reformer

17. Although formerly part of the Soviet Union, Estonia is unusual in many respects, including its small size, ethnic homogeneity, and geographical and social proximity to Scandinavian. Since independence in 1991, successive governments have maintained macroeconomic discipline and

6. The 1993 sector study was carried out by a consulting firm from the United Kingdom, and called for creation of a national health insurance fund, increased hospital autonomy, establishment of general practice doctors as private practitioners, and improved accreditation (Kings Fund College 1993). The government never formally responded to the study, but the reforms ultimately adopted in the late 1990s followed many of its recommendations.

7. The Romania Health Sector Reform Project of US$112 million, supported by a World Bank loan of $60 million, was approved in 2000. The six-year Adaptable Program Loan in two phases seeks to further strengthen health reforms while supporting additional investments, especially for district hospitals and emergency medical services. The project retains a strong focus on infrastructure and is not providing direct project support for strengthening health insurance—the European Union has emerged as primary donor for insurance. But the project seeks to combine investments with support for systemic reforms (for example, piloting an integrated approach to emergency services).

established an effective civil service. Estonian health reforms have been driven by a group of enlightened health professionals—both in academia and government—who began developing a strategic vision for health reform prior to independence. Soon after independence, the new government quickly enacted wide-ranging health legislation, including establishment of national health insurance (1991), and decentralization of responsibility for service provision to the district level (1994). The need for increased technical and management capacity, further refinements in the policy and legislative framework, as well as improved equipment and infrastructure, soon became apparent, however. When legislation stalled in Parliament, the government continued to advanced reforms through ministerial decrees (Jesse 2000).

18. Estonia has made progress in strengthening primary care and prevention, improving the health insurance system, and strengthening human resources throughout the system. The establishment of family medicine as a recognized specialty was carefully planned and sequenced—both technically and politically (see below). Estonia's population-level health indicators have improved over the past decade, reflecting improvements in living standards as well as the health system, but life expectancy is still below that of Western Europe (Table 3). Although the government passed a tobacco control law in 2000—one of the first in the former Soviet Union—tobacco consumption has increased among women and youth.

19. The Estonia Health Project originated in 1993 (after the initial launch of health reforms) with a request from the Minister of Health for Bank support in financing the construction of a new medical school.[8] Although the Bank was initially reluctant to finance medical education, the request led to an intensive dialogue with the government regarding the sector reform program and priorities. The result was a project (approved in 1995) that provided a wide range of technical and investment support for the design and implementation of the government's reform program. The project provided support to reorient health services to emphasize health promotion, disease prevention, and family medicine; restructure health care financing; and develop human resources, including through support for modern public health training, pre-clinical medical training, and continuing education for doctors, administrators, and other health personnel. Most of the $20 million loan went to support the construction of a new medical school building—a highly popular investment—but the project design effectively integrated a wide range of reform and capacity-building activities.[9] In effect, the project became an overall framework for the government's reform program.

20. Government commitment was strong throughout, and all major objectives were met or exceeded. The project successfully supported improvements in primary care, strengthened health promotion, and improved provider training and protocols.[10] Monitoring and evaluation arrangements were inadequate to fully assess the impact of investments, but project activities are

8. The old school was more than 100 years old and had had few updates and little rehabilitation since.

9. These included strengthening the School of Public Health; allocating 0.5 percent of health insurance revenues to finance community health promotion projects; refinements in the organizational and legislative framework for health insurance; and strengthening in-service training capacity for health managers and providers.

10. The Estonia experience raises the question: given Estonia's relatively better starting point, did the involvement of the Bank add value? And if so, did the benefits outweigh the opportunity costs to the Bank, especially for work in poorer and less-advanced countries? The OED evaluation answers "yes" to both questions. Estonians report that the project preparation and supervision process provided valuable discipline in designing the reform program, as well as in implementing a major public investment program (under the Soviet system those responsibilities had been centralized in Moscow). Bank staff were valued for their international perspectives, including assistance in identifying appropriate international consultants to help with the details of policy and legislative development. Moveover, the Estonian experience with family doctor reforms, and the current effort to restructure the hospital sector, has provided an opportunity for joint learning between the Bank and Estonian partners, which is of wider value to other countries in the region that are at earlier stages of reform.

likely to improve health outcomes in the medium to long-term. A follow-on project is currently being prepared, which seeks to support the implementation of the hospital master plan, establish a framework for private sector investment in hospitals, and further strengthen health promotion.

Hungary—Advanced Economic Reformer, but Limited Health Reform

21. Hungary has been successful in economic reform, but successive governments have given limited priority to the health sector. Despite having more doctors per capita than the regional average, health indicators are worse than expected for Hungary's income level, reflecting a neglect of primary care and limited attention to prevention of noncommunicable disease. Frequent changes in government, including in 1994 and 1998, have made it difficult for the Ministry of Health to develop a coherent strategy for reform. As a result, health reforms have been piecemeal, enacted in response to economic constraints or pressure from interest groups, rather than following an overarching strategy. The first health reforms—establishment of national health insurance and legalization of private practice—were initiated prior to the first democratic election in 1990. The elected post-communist government devolved ownership of hospitals and clinics from central to local government. Subsequent governments have implemented additional reforms, including privatizing family doctors, a shift toward paying hospitals on a per case basis rather than fee-for-service, and a 15 percent reduction in hospital bed capacity. But health spending continues to emphasize curative care, and the payment system still rewards overtreatment and hospital-base care. Thus cost escalation continues to threaten the sustainability of the health insurance system (Gaal and others 1999).

22. The Hungary Health Services and Management Project sought to improve the health status of the Hungarian population and to support the government's program of health sector restructuring. The project had two components. The health services development component was meant to "restructure the health sector to focus on more effective interventions" and consisted of two subcomponents—public health and disease prevention, and institutional care. The policymaking and management component was intended to strengthen the institutional capacity of the health sector and had subcomponents on public health and management training, management support systems, and project management. Despite being the Bank's first project in the Hungary health sector, it was as complex, with 29 separate activity clusters in the original design. Project design was primarily driven by consultants, contributing to low government ownership. And project objectives were stated very generally, contributing to a lack of focus during implementation. The project was restructured twice, first at mid-term review in 1996, and again following the election of a new government in 1998. But the new government cancelled most of the remaining project activities, and has not requested further lending. Despite several successful project components—including establishment of training schools for public health and health management (see below), and a successful health information system pilot (Box 4)—most of the project investments had limited sector impact, and the sustainability of many individual investments is uncertain.[11]

11. The Bank will maintain some engagement in the country through World Bank Institute courses at the health management institute. But the Hungary experience raises questions as to whether and to what the Bank should seek to maintain policy dialogue in countries that have either "graduated" from Bank assistance, or chosen not to borrower.

3. Design and Implementation of Key Health Reforms

23. Despite differences among countries, the health sector reform agenda has been remarkably similar across the region. This section discusses experience with implementation of three key reforms: national health insurance, strengthening of family medicine and privatization of general practitioners; and strengthening health promotion and public health programs.[12] The reform agenda is much broader, of course, including pharmaceutical reforms, accreditation for hospitals and providers, improving treatment protocols, and hospital reforms. But some common lessons emerge regarding the process of reform, including:

- The implementation experience and outcome of similar reforms have varied depending on economic, institutional, and political context, including the level of consensus for and commitment to reforms, and national capacity for design and implementation of reforms.
- Attention to optimal sequencing of reforms (politically and technically) is important, as is ensuring adequate support for training and capacity development to allow organizations and providers to adapt to new roles.
- Monitoring and evaluation is essential to informing the reform process, but has not been given adequate priority by governments, the Bank, or international partners.

Health Insurance Reforms —Great Expectations, Mixed Results

24. Most countries in ECA have established some form of national health insurance, financed through a compulsory payroll tax. Whereas central governments previously both financed and provided health services, the reforms established national (and sometimes regional or district) health insurance agencies, and gave them responsibility for purchasing curative services from both public and (newly legalized) private providers. The reforms were expected both to increase resources available to health (through the payroll tax), and to serve as a catalyst for further system reforms, including improving system efficiency. The reform commanded wide support, but for different reasons: ministries of finance, for example, hoped for increased efficiency and cost control, while doctors expected higher salaries.

25. In most countries, the results generally have not lived up to expectations (World Bank 2000). While solving some problems, national health insurance has created others—including cost escalation (Hungary, Croatia)—as well as new demands for legislation and regulatory and administrative capacity. While earmarked taxes have helped protect resources for health, revenues typically have fallen below initial projections, due to economic recession and weaknesses in tax collection systems. Shifting purchasing responsibilities to health insurance funds has contributed to reforms in payment systems. For example, paying hospitals on a per case basis (Diagnostic Related Groups) rather than bed days has helped reduce length of stay in Hungary—but admissions increased, so total occupancy rates were not affected (Kroneman and Nagy 2001). Payment reforms may require various enabling factors to achieve results, including adequate management capacity, information flows, provider autonomy, and quality assurance systems. The prevalence of informal payments also undercut efforts to improve incentives through payment reforms (Lewis 2000). Moreover, introduction of health insurance has not led to significant restructuring in the hospital sector, which continues to consume a disproportionate share of resources (Croatia, Estonia, Hungary, Romania). Experience suggests that complementary supply-side interventions may be

12. In this paper, the term "health promotion" refers to activities that seek to influence health behaviors, whereas "public health" encompass a broader set of disciplines including epidemiology, environment health, and so on. "Primary health care" refers to outpatient care delivered in a non-hospital setting, typically by family doctors or nurses.

necessary to restructure and downsize hospital services—as in the current efforts to implement a "hospital master plan in Estonia (Box 1)—but are politically difficult.

26. Implementation and outcomes have varied, however, depending on country circumstances. Some countries, such as Estonia, Hungary, and the Czech Republic, have structural characteristics that increase the likelihood of successful introduction of health insurance, including relatively higher per capita income, and a large percentage of the population living in urban areas and working in the formal sector (Ensor and Thompson 1997). But cost containment and the economic burden created by health and social insurance taxes (totally 44 percent in Hungary) have emerged as major challenges. In countries with less developed regulatory systems, a large percentage of unemployed or self-employed workers, and weak tax collection systems (Romania, Albania), establishing and sustaining compulsory national health insurance is more difficult (Belli 2000).

27. What role has the Bank played? The Bank had limited influence on the political decision to establish national health insurance. Many countries decided to establish national health insurance by the early 1990s (Estonia, Hungary), prior to Bank involvement in the sector. Elsewhere (Romania), governments adopted the reforms despite Bank concerns regarding financial sustainability and implementation capacity. Instead, Bank dialogue has typically focused on encouraging refinements in the system (with respect to payment systems, equity, cost containment, risk pooling), and project investments have sought to strengthen health insurance management systems and capacity.[13] Due in part to the Bank's ambivalence towards compulsory national health insurance, its advice was sometimes inconsistent within or among countries. And sector dialogue was not always adequately coordinated with macroeconomic dialogue by the Bank or IMF (for example, with regard to tax policy or risk pooling mechanisms).

28. ***Estonia's*** experience has been among the most successful in ECA. The government established national health insurance in 1991, financed through a 13 percent wage tax.[14] (Jesse 2000). The initial insurance law established semi-autonomous funds in each county (district). But during project design and subsequent dialogue, the Bank raised concerns regarding the size of risk pools and the limited administrative capacity of the local funds. This appears to have influenced the government's decision in 2000 to consolidate them into a unitary Central Health Insurance Agency. The Estonia Health Project supported staff training at the national and district levels, 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. The fund is now 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. Payment for family doctors (see below) is based on a mix of capitation and fee for service, and contracts with hospitals are capped. But due to overcapacity in the

13. In Hungary, however, the Bank has played a relatively marginal role in health insurance and financing, except indirectly through project support for the Health Services Management Institute (see below). In a reversal of earlier reforms (following the 1998 change in government), the Ministry of Finance in Hungary assumed control over the health insurance fund, in hopes of encouraging greater cost containment. In Croatia, the project supported strengthening of information systems for the insurance agency, including establishment of a magnetic card system to help track each insured client.

14. 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.

hospital sector, this has led to a situation where the same number of hospitals each receive less money. A National Hospital Master Plan is expected to contribute to downsizing (Box 1).

Box 1. Restructuring the Hospital Sector in Estonia—The National Hospital Master Plan

Designers of the Estonia Health Project recognized that changing payment systems would not be sufficient to reduce the excessive capacity in the hospital sector. As a result, the loan agreement for the Project called for the development of a National Hospital Master Plan (NHMP)—a systematic review and rationalization of the Estonian hospital sector. Project design assumed that the plan would be completed in the first years of the project. In practice, it was not completed until just prior to project closing—reflecting both the technical difficulty and political sensitivity of restructuring the hospital sector, even in a relatively advanced reformer.

Prior to development of the Master Plan, Estonia 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 (Jesse 2000). The restructuring proposed by the National Hospital Master Plan are more fundamental, however—including closure or conversion of large hospitals—and thus more politically contentious.

A Swedish consortium provided technical assistance to prepare the Master Plan, and implementation is being financed from both the state budget and from grant allocated for preparation of the second World Bank loan. Despite initial delays, the Master Plan was completed in April 2000, and was approved by the Government of Estonia (GOE) in May 2000. The Master Plan will be a central part of the GOE's ongoing reform/refinancing program, guiding further reduction of hospital capacity and optimization of facility use. Its implementation—including efforts to create a framework for private sector capital investments in hospitals—will be a central focus of the Bank's follow-on project.

29. The ***Romania*** experience points to some of the challenges posed by health insurance reform where the institutional and economic context is less than ideal. The 1997 health insurance law, which came into force in 1999, established a national health insurance fund and 41 district funds, paid for through an earmarked 14 percent wage tax. The reforms are still recent and remain fragile. Real health spending increased by 25 percent in 1999—permitting increased allocations to primary care—but pressures from increasing hospital and drug costs reversed these gains in 2000 (Vladescu and Radulescu 2001). The national and district health insurance funds still have limited expertise with contracting and designing appropriate payment systems, and ambiguities in the legal framework creates uncertainties about the relative roles of the MOH and the health insurance funds. The financial sustainability of the new health insurance system faces a number of risks, in light of the relatively small proportion of formal sector workers, high rates of tax evasion, rapid escalation of pharmaceutical costs, and an inefficient hospital sector that consumes a disproportionate share of sector resources (World Bank 1999; Vladescu and others 2000). With nearly half the population in rural areas, the rural poor, whose sources of income are from farming or self employment, could be negatively affected if the insurance funds refuse to reimburse those who are not formally employed.

30. The Bank sought—with mixed success—to influence the process through analytic work and policy dialogue. Its advice evolved over time. The project sponsored a 1993 sector study, which called for the establishment of national health insurance, but offered few caveats regarding feasibility or adapting the model to the Romanian context (Kings College Fund 1993). While social insurance had little support in the MOH initially (the government never formally responded to recommendations from this study), social insurance commanded growing support with Parliament. By the mid-1990s, Bank began to regularly raise concerns in its policy dialogue regarding the viability and advisability of national health insurance for Romania, but the political momentum was already established. The project also supported a study on health sector financing

(1998), carried out by the Health Insurance Commission of Australia. This was initially intended to assess *whether* the government should establish national health insurance, but Parliament passed a health insurance law before the study was launched. The study instead focused on assessing policy options under health insurance. It is specifically credited with raising the problem of equity among the various district health insurance funds, which led Parliament to amend the law to allow up to 25 percent of funds to be transferred to poor districts. This represents a significant policy contribution. In practice, however, the reallocation formula is not transparent, and has benefited districts on the basis of revenue shortfalls, rather than equity criteria. Although the Bank's current project does not provide direct support to the national or district health insurance funds (the European Union has taken the lead in this area), the Bank has sought to maintain engagement in these issues through its macroeconomic and sector dialogue.

31. While health insurance reforms in ECA have introduced an important new player into the reform process, important questions remain. For example:

- Do the benefits of compulsory national insurance outweigh the opportunity cost of establishing these new institutions, particularly in low capacity settings (Belli 2000)?
- Even if compulsory national health insurance is not ideal, how can countries that have made a political commitment to national health insurance best adapt to this system?
- Should governments introduce competition among public and private insurance providers—along with the even greater regulatory burden required by this approach (Kornai and Eggleston 2001)?
- Should payroll taxes continue to be the primary source of revenue for national health insurance—given their potential to increase labor costs and tax evasion? If not, what mix of revenue sources might reduce negative side effects for the economy?

Countries themselves will make these decisions, but increasing knowledge and advising client governments on such questions is an important priority for the Bank and its partners.

Strengthening Family Medicine —Sequencing Reforms and Capacity Building

32. During the communist era, health systems and health financing were biased toward expensive secondary and tertiary inpatient hospital care. Primary care was underfinanced and relatively neglected. Most outpatient care was provided by specialists in outpatient polyclinics, or in rural health centers. After hours, patients relied on national ambulance services to provide primary care (such that over 90 percent of ambulance visits were for primary care in Romania). General practice doctors were relatively few, received only basic medical training, and had little professional prestige.

33. As a result, countries throughout the region have either piloted or implemented reforms to establish family medicine as a distinct specialty, and to employ family doctor as private or independent practitioners, paid on a per patient (capitation) basis, sometime with additional fees-for-service (Kersnik 2001). Modeled in part on the general practice reforms in the U.K. and Europe, governments in Estonia, Hungary, and Romania (among others) have adopted elements of this approach, and the projects in Estonia, Kyrgyz Republic, and Romania provided support.[15] The reforms had multiple objectives, including improving the integration of care for patients,

15. In Hungary, the government has piloted family doctor schemes, and everyone is assigned a primary care doctor. But in practice, most patients visit specialists directly without consulting their family doctor. In Kyrgyz Republic, the project helped train 1,400 doctors and 900 nurses in family medicine, with 90 certified as family medicine trainers.

reducing referrals and bed days at the secondary and tertiary levels, giving patients greater choice of providers, and increasing of the incentives for primary care providers to relocate to underserved areas. Not surprisingly, reforms have had varied success in meeting these multiple objectives.

34. In ***Estonia***, these reforms were carefully planned and implemented over a 10-year period—driven by a core group of progressive medical faculty. Particular attention was given to establishing family medicine as an accepted medical specialty. A Department of Family Medicine was established at the University of Tartu in 1991, which initiated a re-training program for family doctors, and the specialty was officially recognized in 1993. The Health Project supported strengthening and expansion of the training program. Thus critical mass of well-trained family doctors (650 of the 800 needed nationally) was established before primary care reform was launched in 1997[16], increasing public acceptance and the credibility of the reforms. By the late-1990s, the professional association for family medicine was the largest among all medical specialties, and played a key role in promoting reforms. Reforms proceeded more slowly in the capital (Tallinn), where polyclinics (outpatient clinics established during the Soviet era that are staffed by specialists) are politically influential, but a project-sponsored pilot scheme helped increase acceptance. The impact on referral behavior was initially limited,[17] but the "gatekeeper" function of family doctors is being strengthened through a phased approach to enforcing referral payment rules by the national health insurance fund. Public opinion surveys have found high levels of public satisfaction with the family doctor reforms. Studies suggest family doctors are providing more integrated care, and that the level of services they provide, based on key indicators such as child vaccination rates, is equal to that of pediatricians (Kalda and others 2000; Maaroos 2000).[18]

35. The Estonia Health project provided direct support for strengthening the Department of Family Medicine at the University of Tartu; facilitating international contacts; sponsoring international accreditation of the family medicine department (which helped increase its professional credibility); and supporting family medicine pilots in Tallinn. The family medicine reforms would have proceeded without project support, but the project allowed them to proceed more quickly, and achieve greater credibility, than they might have otherwise.

36. In ***Romania***, the 1997 health insurance law also established family doctors as a distinct specialty, paid through a mix of fixed payments per patient (capitation) and fee-for-service (30 percent). The reforms were intended to strengthen access to and quality of primary health care, improve client responsiveness through competition among GPs, and reduce reliance on specialists and hospital care by giving GPs a "gatekeeper" function. The design and implementation of general practice reforms were consistent with recommendations in the project-sponsored 1993 sector study. A project-sponsored pilot scheme (in eight districts of the country's 40 districts)

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16. A draft Family Practice Law was prepared in 1994/95, and subsequently revised as a more comprehensive Law of Primary Care. The revised law was never presented to Parliament, however. As a result, primary care reform was enacted by ministerial decree in 1997. To ensure adequate funding for primary care, the national health insurance fund earmarked 16 percent of the health services budget for primary care and helped refine the payment system (Jesse 2000).

17. 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 (Maaroos 2000).

18. 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 1988. 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 (Maaroos 2000; Kalda and others 2000; Jesse 2000).

tested output-based contracts for the provision of primary services (see Box 2). The pilots provided valuable experience that helped refine the subsequent legislation, and helped build support for the reform. But the reforms were implemented nationally before the majority of doctors (formerly pediatricians or adult doctors) received training in their new roles—integrated family care as well as managing private practices.

37. The Romania reforms create the potential for improved primary care—and there are anecdotal reports of improved client orientation by family doctors. But they have not yet significantly reduced use of hospital services, or induced doctors to relocate to underserved areas (Vladescu and Radulescu 2001). Slow progress in other reforms and structural constraints create additional risks. First, although financing for primary health care increased in the first year of implementation, cost overruns in the hospital sector have squeezed financing for primary care and prevention. This was a major problem in 2000, resulting in wide press coverage of inadequate funding for drugs and underpayment for family doctors. Second, the national and district health insurance funds have limited capacity to monitor the amount and quality of services billed by providers (Vladescu and Radulsecu 2001). Third, although the Health Services Rehabilitation Project supported equipment and upgrading for nearly 200 rural health clinics, it currently is unclear whether the upgraded infrastructure is owned by the government or the doctors. Responsibility for maintenance also remains unclear.[19] Finally, while the current approach to primary care has the potential to succeed in urban areas, nearly half of the populace lives in rural areas, and many are not covered by formal insurance.[20]

38. The contrasting Estonia and Romania experiences point to several lessons.

- First, changes in employment and payment system should be accompanied or preceded by intensive training for family doctors, to allow them to adapt to their new roles, and to increase credibility for reforms among patients and the medical profession.

- Second, general practice reforms should be implemented in phases, with the "gatekeeper" function the last to implement (after credibility is established).

- Third, the success of reforms depends not only an establishing appropriate incentives in the payment system (World Bank 2000), but also on developing adequate capacity within the purchasing authority for regulation and monitoring of general practitioners, and effective mechanisms to protect budgetary allocations for primary care.

- Finally, privatization of general practice requires clarification in the regulatory framework for primary care, including clarifying ownership of primary care facilities (usually previously owned by government), employment for nurses, and accreditation for private practitioners.

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19. The government has expressed unwillingness to directly support further equipment for family doctors, since they are now private practitioners, and doctors are reluctant to invest their own resources unless ownership is clarified. A supplementary "practice allowance" was to help cover these costs, but was reduced significantly in 2000. In addition, nurses are still employed by government, so doctors have limited control over their performance.

20. Encouraging group practice-particularly in urban areas-holds promise for addressing a number of issues, including pooled use of equipment and administrative assistance, and improved coverage for after-hours care, which could in turn help reduce reliance on emergency services for primary health care. But group practice remains rare, and is less viable in rural areas.

Box 2. The Romania Pilot Decentralization Program—Contracting With Family Doctors

The Romania project sponsored a pilot decentralization program in eight of Romania's 40 districts (covering 4 million people) that tested new payment mechanisms for primary care doctors. The plan for piloting was received enthusiastically by district staff, and generally welcomed by doctors, but had only lukewarm support initially from MOH. It is notable that the pilots took place at all. The government had previously resisted piloting, particularly experimentation with private sector approaches to service delivery, and the pilots were only able to proceed in 1994 once Parliament passed specific legislation authorizing them. District health authorities established contracts with doctors, ending their status as hospital employees. The contracts specified primary care services to be covered (which continued to be free), and patients were allowed to choose their family doctor. Family doctors were expected to enroll between 1500 and 2500 patients each (Vladescu and Radulescu 2001).

An evaluation of preliminary pilot experience was carried out in 1995 as a condition for extending the Bank project (Jenkins and others 1995). This was too early for an effective evaluation but provided some preliminary findings. After two years, 86 percent of the population was covered by family doctors, with eight percent higher coverage in urban areas. Few patients changed doctors, but surveys indicated that family doctors had become more client oriented. The output of family doctors increased, providing 21 percent more consultations and 40 percent more home visits, and 87 percent provided emergency coverage that night or weekends. Doctors' incomes increase by 15 percent on average, and there was some evidence of declines in informal payments (although these were already relatively low for primary care). There was no effect on hospital admissions, however, and no evidence regarding the impact on key coverage indicators (such as vaccination rates) or health outcomes.

The pilots continued until 1997, when they were discontinued by the new government. While the pilots would have benefited from further evaluation, national and district staff involved in the pilots played key roles in developing subsequent reform regulations, and a number of adjustments were made as a result of pilot experience. These included greater specificity in the contracts regarding doctors' responsibility for primary care, adding a "practice allowance" to the capitation payments for doctors to help cover capital and recurrent expenditure, doubling capitation payments for family doctors practicing in remote or low-income areas, and permitting doctors to charge for vaccinations to children not on their "lists." (Vladescu and Radulescu 2001).

Strengthening Health Promotion—Slow Progress

39. Despite the importance of improving health behaviors and prevent disease, most ECA countries have made slow progress in establishing health promotion programs. Following the transition from communism, few countries had skills or appropriate institutional homes for health promotion—either inside and outside government (McKee and Jacobson 2000). And few countries have tobacco control laws or effective prevention programs, even though smoking is the main contributor to morbidity and mortality in ECA (WHO 1997). In the early 1990s particularly, governments were mostly focussing on addressing problems in their curative health systems, and gave limited attention to health promotion. Moreover, while the previous systems placed a strong emphasis on vaccination and environmental health, few policymakers or providers were trained in "modern" health promotion approaches.

40. Changing health behaviors requires an integrated approach, targeting both individual knowledge and behavior, as well as the socio-economic context. Effective health promotion efforts typically combining information, education, and communication (IEC) campaigns to increase individual awareness, complemented by efforts to strengthen laws, regulations, and "sin taxes" to discourage unhealthy behaviors (restricting tobacco advertising and public smoking) and encourage healthy lifestyles (proper diets, use of seat belts) (IUHPE 2000). Implementing such an approach, however, requires progress on several fronts, including establishing an appropriate institutional framework for the financing and delivery of health promotion activities; building necessary skills

and organizational capacity; ensuring sustainable financing for public health (which often receives low political priority); and drafting and passing necessary legislation (which may encounter stiff political opposition). The institutional challenges are significant: a multi-faceted approach is required to establish new organizations, help existing ones adapt to new roles, strike an appropriate balance between "top-down" national programs and "bottom-up" community initiatives. Given the specialized skills required for health promotion, experience in ECA and elsewhere suggests that contracting with NGOs and private sector organizations can play an important role (Godinho 1998).

41. Most of the completed projects included components to strengthen prevention and health promotion activities (including Croatia, Estonia, Hungary, and Romania), and project design documents and sector analysis emphasized the importance of strengthening modern public health approaches and behavior change interventions. Specific project-sponsored activities have included support for establishment of schools or departments of public health (Estonia, Hungary) and national centers for health promotion (Romania, Estonia); efforts to create funds to finance local health promotion activities (see Box 3); support for training of national and district-level staff and health education materials (Estonia, Hungary, Romania), media campaigns (Croatia); and efforts to reorient the existing sanitary-epidemiology agencies toward addressing prevention of non-communicable diseases (Hungary, Estonia).[21] The Bank also sought to maintain dialogue regarding the importance of health promotion during supervision missions, and to encourage the development of health promotion strategies (Croatia, Estonia, Hungary, Romania). But with the exception of Estonia and Croatia, the overall outcome of health promotion components were unsatisfactory—due to weak government commitment and the lack of a clear national framework for health promotion. Yet a few component activities were successful, and the health promotion agenda was more advanced than it would have been without the projects.

42. In ***Romania***, the project design allocated $5 million for investments in building capacity for public health and health promotion, as well as support for development of a national health promotion strategy. This component was unsuccessful overall. The project helped establish a National Center for Health Promotion and Education (a "covenant" in the loan agreement), financed training for a few national staff, several district-level workshops, education materials, and equipment for national and district health promotion offices. Substantial training and technical assistance resources went unused and were reallocated to other activities at the mid-term review. The MOH showed relatively little interest in health promotion through most of the project, and the government was slow to develop a coherent framework for health promotion activities. Although the Bank sought to emphasize the importance of health promotion in its policy dialogue, its willingness to shift project funds toward hardware investments sent a mixed signal. The project spent half the originally planned amount, or about 1 percent of total project costs. Monitoring focused on component outputs rather than impact on behavior. Project design anticipated the creation of a demand-driven health promotion fund, but this was never established (Box 3). The Center for Health Promotion has sought to advocate changes in legislation, but tobacco legislation has yet to pass Parliament. But while the impact and profile have been relatively limited, it is greater than would have occurred without the project and Bank involvement.

43. The ***Hungary*** project allocated over $30 million for a wide range of public health and health promotion activities, but less than half of the planned amount was spent—some of it inefficiently. Attempts to strengthen the National Public Health and Medical Officer's Service and broaden its approach to public health were unsuccessful, largely due to resistance from leadership

21. 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.

and staff.[22] Similarly, the health promotion and primary disease prevention activities largely failed to achieve stated objectives. For example, a pilot program to encourage community-based prevention activities in a single community (based on a successful program in Kerala, Finland) did not result in any measurable impact, and was weakly supervised, despite expenditures of nearly $2 million. But some project activities were successfully implemented and are likely to be sustained. The project sponsored the establishment of a School of Public Health at Debrecen University, which is playing a key role in training and is likely to be relevant to future government restructuring/reform efforts. Some project activities are continuing to varying degrees, including a national cancer registration and countrywide extension of secondary prevention efforts; the introduction of a more modern school health curriculum; and dissemination of information on tobacco control to policymakers, professionals, and the general public. The government has drafted a national tobacco law, but it has not yet passed Parliament. Although the government did not develop a health promotion strategy during the project, some project emphases, experiences and approaches have been incorporated into the recently drafted National Public Health Programme for 2001–2010.[23]

44. The ***Estonia*** project financed a number of specific activities, which helped develop a strategic framework health promotion, strengthen capacity, and increase financing. First, the project catalyzed the successful introduction of an innovative Health Promotion Fund, financed through earmarking of 0.5 percent of health insurance revenues (see Box 3). Second, the project supported the establishment and strengthening of a Department of Public Health at the medical school at the University of Tartu in Estonia. The Department is providing both pre-service training to medical doctors in public health, and also advanced training and research in public health and health promotion.[24] Third, the project supported various health promotion activities (implemented by the MOH) in four identified priority areas associated with the largest disease and disability burden in Estonia: smoking reduction, cardiovascular disease prevention, injury prevention, and women's health/family planning (to reduce high abortion levels). Finally, the project supported the consolidation (from 700–800 physicians to 400) and redirecting of the Health Protection Service from its narrow "sanitarian" role in Soviet times into a modern public health service.[25] Estonia has

22. The project's largely unsuccessful attempt to foster reorientation of the government's National Public Health and Medical Officer's Service toward greater emphasis on prevention of non-communicable disease may be beginning to bear fruit, however. Some 15–20 staff have been trained at the School of Public Health, and prevention of major noncommunicable causes of premature morbidity and mortality has been incorporated into the new National Public Health Programme for 2001–2010.

23. At the time of the OED Review, the National Public Health Programme, 2001–2010 did not have an implementation plan or budget attached, so the extent to which the project may have a lasting or continuing influence on this program remains uncertain.

24. In Estonia, the Department of Public Health has a prominent and visible place within the "Biomedicum"—the new undergraduate medical school constructed with project funds—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, reflected 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 (with project support). 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 higher taxation on cigarettes.

25. 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.

also been a leader in passing health promotion legislation, including a Public Health Law (1995), restrictions on tobacco advertising and a comprehensive tobacco law that restricts smoking in public places (2000). The Estonia project provided technical support and advice for these activities, and Bank staff and consultants provided informal advice on legislation.

Box 3. Establishing Health Promotion Funds to Finance Community Projects

All three projects attempted to create health promotion funds, which were to provide grants on a competitive basis to communities and nongovernmental organizations (NGOs) engaged in local health promotion activities. For example, the Hungary Project sought to establish a "Close the Gap Committee," consisting of national and international experts, whose function was to review proposed new initiatives in health promotion and disease prevention and to recommend which should be funded. But these components were cancelled in both Romania and Hungary without disbursing any funds, due both to a lack of government commitment, as well as a reluctance to use loan funds for grants.

In contrast, the Estonia Health project supported 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. The government agreed to establish this fund during project design. A 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. Annual conferences provided opportunities to share experiences, and to designate "best projects."

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. For these reasons, under the Second Health Project, the government plans to consolidate efforts in order to achieve national scale as it confronts major current or future public health problems, including 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.

45. Several key messages emerge from this experience.

- First, changing long-established patterns of individual and social behavior is a long-term process, as is building institutional capacity and national commitment for health promotion—particularly given the low starting point of most ECA countries.
- Second, the Bank can contribute to building capacity and consensus for health promotion through policy dialogue (with MOHs, ministries of finance, and nongovernmental stakeholders), and through targeted project support. But these activities require consistent attention during project design and supervision, despite the modest size of investments. Interventions can be scaled up, including through larger project investments, once consensus has emerged.
- Third, monitoring and evaluation of health behaviors was weak in all completed projects—and in most countries—both in terms of tracking behavior trends at the national level (which typically require survey instruments), and evaluations of the effectiveness of specific health promotion interventions. Projects tended to set unrealistic targets for changes in health indicators for chronic diseases (cancer, heart disease); intermediate behavioral indicators are more appropriate (smoking prevalence).

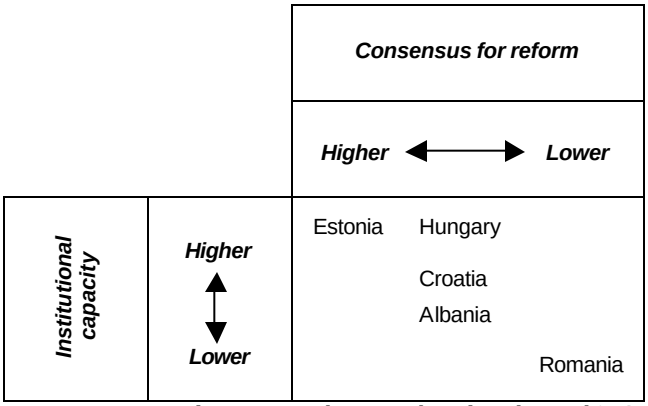
4. Determinants of Successful Support for Reform

46. Country project experience demonstrates that Bank lending and policy advice can influence sector policies, both in an advanced reformer (Estonia) and in a slower reformer (Romania). But the Bank cannot determine reform outcomes. What broad lessons emerge regarding Bank support for reform in these differing contexts? This section highlights six dimensions of successful support for reform: adapting reforms, project design, and policy advice to the country context; building consensus for reforms among stakeholders; strengthening capacity for design and implementation of reforms; "packaging" capital investments with capacity building and institutional reforms; establishing effective partnerships; and improving monitoring and evaluation of reform outcomes.

Adapting Reforms and Project Design to the Country Context

47. Country experience demonstrates that the Bank's overall strategy, instrument mix, and project design must be matched to the political and sectoral context of the country—especially the degree of consensus for reform, and the capacity for design and implementation of projects and reforms programs.[26] Figure one provides a framework—albeit oversimplified—for thinking about the role of projects and dialogue in these differing contexts. In Estonia, the government and health community developed a strategic vision for reform prior to project design, and the economic and governance context was conducive to effective project and policy implementation. In Romania, commitment and consensus for reform were lacking until the final years of the project, and implementation capacity was generally weak. The situation in Hungary was mixed; despite some steps toward reform: there was no national strategy, and while there are many trained individuals in the country, the Ministry of Health experienced difficulties in implementation and project coordination.

Figure 1. Consensus and Capacity for Reform



Note: Institutional capacity rankings are based on the Bank's Country Policy and Institutional Assessment (CPIA) ratings.

48. The challenge for the Bank is to match overall strategy and project design to existing borrower commitment and institutional capacity, while seeking to strengthen commitment, consensus, and capacity in the medium to long term. Similar lessons apply to reforms. For example, there was a widespread consensus in favor of compulsory national health insurance throughout the region, but the reforms have strained implementation capacity in many countries.

26. Institutional capacity denotes not just the number of trained individuals in a country, but the effectiveness with which public and private sector organizations make use of human and financial resources.

Conversely, consensus for hospital and downsizing or tobacco control legislation has generally been low. Several lessons and implications follow from this analysis.

- *Reforms and projects are more effective when incorporated into a coherent strategy*

49. A health reform strategy requires development of sufficient consensus among sector stakeholders regarding the objectives and implementation of health reform. A strategy without adequate consensus is unlikely to be implemented. The Estonia experience illustrates that when borrowers that have a strategic vision for health reform, the Bank can provide technical and financial support for the detailed design and implementation reforms, and loan agreements can provide discipline to keep reforms on track. But in Hungary and Romania, the lack of a government strategy contributed to a lack of coherence among project activities and subcomponents. Project experience suggests that if consensus for reform has yet to emerge—as was the case in Romania and Hungary—the Bank should focus on policy dialogue, capacity building, and *limited* investment activities for which there are clear local "champions," to help test new approaches, and leverage sector reforms. In both Romania and Hungary, a more modest approach might not have significantly improved the pace and quality of reform, but it would have focused Bank efforts and avoided inefficient use of staff time and loan resources.

- *Project complexity, and structural reforms, should be adapted to local capacity*

50. The importance of avoiding excessive project complexity—a characteristic of many first generation projects—is now widely recognized (Johnston and Stout 1999), and reflected in subsequent ECA project designs. For example, the Albania project design limited project size and the number of components to avoid excessive complexity. Yet health reform is inherently complex and demanding. The experience of the ECA projects suggests that the key factor is not just complexity (the number of project activities and agencies involved), but adapting necessary project complexity to borrower capacity and commitment. The Estonia project was complex, yet was integrated into an overall sector strategy, and was well implemented by a capable and committed borrower. The Hungary and Romania projects were both complex but lacked coherence, and taxed the implementation and coordination capacity of the borrower. The projects therefore often seemed to be a series of disparate, uncoordinated activities, and proved difficult to supervise and implement.[27] Similarly, some structural reforms—such as establishing national health insurance—place significant demands on government implementation and regulatory capacity. The design and sequencing of reforms should be adapted to the institutional context, together with sustained efforts to build capacity.

- *Ownership and commitment often vary—among stakeholders, project components, and reforms*

51. Not surprisingly, the most important determinant of outcome for the completed projects was the commitment of the borrower to project (or subcomponent) objectives and to health sector reform in general. But the experience of the projects also shows that ownership has multiple dimensions, and can vary among subcomponents within a project, among different stakeholders, and over time—especially after changes in government.[28] This highlights the importance of:

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27. In Estonia, a high-level project coordinating committee met regularly to ensure coherence of project activities; multiple attempts were made to establish such committees (or to at least hold regular meetings of subcomponent managers) in Hungary, and during the initial years of the Romania project, with limited success.

28. At least four dimension of ownership can be identified, including the degree of intellectual consensus between Bank and borrower regarding strategic and technical priorities; the degree of high-level political support for project

assessing ownership and the degree of consensus among diverse stakeholders; seeking to identify and target support to local "champions" both inside and outside of government; and attempting to strengthen ownership and consensus through dialogue with government officials, parliaments, and other stakeholders.

Building Consensus for Reform—Through Lending and Policy Dialogue

52. While the Bank cannot play a central role in building political coalitions for health sector reform, it can support the wider process of building consensus for reform through policy dialogue, sector analysis, pilot projects, and monitoring and evaluation activities.

- *Engaging stakeholders, including opposition leaders, during project design and policy dialogue is often essential.*

53. The Bank's effectiveness in influencing policy requires dialogue and engagement with a wide variety of stakeholders, including central government (ministries of health and finance), local government, health professionals, Parliament and opposition parties, NGOs, and civil society. Ministers of health and governments often change several times during the life of a project.[29] Changes in political leadership should thus be *assumed* during project design, rather than seen as a "risk." In Estonia, the government changed soon after the first health project was approved in 1995. But because the Bank had regularly consulted with the new health minister—formerly the head of the Social Committee in Parliament—and established a broad constituency in the medical community, the new government strongly endorsed the project. In Hungary, the Bank team did a good job in renewing government ownership during a mid-term project restructuring, but neither the health team nor the Bank's country office sufficiently engaged opposition leaders in the dialogue. Thus, when a new government came to power, it cancelled many of redesigned project activities and decided not to extend the project or request additional lending. In Romania, in light of MOH resistance to reforms during the first several years of project implementation, the Bank decided to use a project extension and preparation of a follow-on sector reform project to stimulate a wider dialogue among stakeholders regarding sector reform. The reasoning was that momentum for reform was likely to originate outside of the MOH (often through medical doctors in Parliament)—this strategy was vindicated when a new government came to power, more sympathetic to reform.

- *Sector analysis can improve understanding and stimulate debate regarding reforms*

54. Bank-financed studies and policy advice were generally respected among government officials, academics, and the donor community. Their influence on policy, however, depended on political timing; the degree of local stakeholder involvement and dissemination of findings; and the capacity and willingness of policymakers to absorb recommendations and translate them into effective legislation.[30] Sector analysis can be formal (published) or informal (background studies

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objectives; the "locus of development" of project design (e.g., whether driven by local staff or external consultants); and the degree of stakeholder support for project objectives and subcomponents (Johnson and Wasty 1993).

29. During the Hungary project's six-year implementation period there were three changes of government (with six ministers of health, four chief medical officers, and three heads of the PMU).

30. In Albania, for example, several technical studies were completed rapidly in the final year of the project, but the MOH did not have sufficient opportunity to internalize recommendations. The general findings regarding the impact of sector analysis are consistent with recent Bank-wide reviews of economic and sector work by OED and Bank management (Johnston 2001).

or memos). The Estonia experience suggests that when governments have a clear national strategy, informal policy notes and dialogue can help shape the technical design of government policies and reforms. If health ministries lack commitment or clear strategy (early years of Romania project), formal sector analysis can stimulate stakeholder debate and build consensus for reform. Although Bank staff are generally aware of the political dynamics in the sector, none of the projects were preceded by formal stakeholder analysis. More formal analysis might help put political dimensions more explicitly "on the table" in strategy discussions within the Bank and with client counterparts (Reich and Cooper 1996).

- *Pilot projects can test and refine proposed reforms – if well-designed and evaluated*

55. Pilot projects can be an effective means to test new approaches to health financing or service delivery and to facilitate "learning by doing" and the "internalization" of lessons. But pilots can also be used to delay action or to provide a pretext for policy decisions that have already been made. The district pilots sponsored by the Romania project influenced primary health care reforms, but the evaluation was completed after just one year—too early for an effective evaluation (Box 2). In contrast, a community-based prevention pilot project in Hungary was weakly supervised and never evaluated—and had no visible impact on health or national policies. Thus, the impact of pilots depends on effective design, supervision, and evaluation to feed findings into the policy process.

- *Conditionality can strengthen the hand of reformers*

56. Project conditions are most effective when used strategically by reformers to provide discipline for a reform program or to enact or "lock in" changes that are supported by a consensus of stakeholders. Conditionality cannot force governments to take actions they oppose for policy or political reasons (Haggard and Kaufman 1992; Johnston 2001). For example, a project "covenant" in Estonia led the government to agree to contribute half of one percent of health insurance proceeds to a health promotion fund. The Bank engaged in a sustained dialogue regarding the importance of health promotion before and after agreement to this covenant, however, and key stakeholders within government and the medical community supported the idea. At least two key covenants were not fulfilled until the final year of the project: establishing a planning unit in the Ministry of Social Affairs; and conducting a study on hospital restructuring (see Box 3). These were implemented only after several years of sustained dialogue. The conditions were useful, therefore, but not sufficient to achieve change; in this case the Bank's emphasis on dialogue rather than strict compliance proved more effective.

57. Project conditions can provide critical support for reformers even when government ownership is lacking. In Romania, project conditions led to the establishment—and survival—of the health management institute, a reproductive health unit in the MOH, and the national center for health promotion, despite resistance and occasional opposition from the ministry leadership during the initial years of the Romania project. The entities created by the project became important internal constituencies for reforms and for strengthening key technical areas. Yet the Romania experience also illustrates that the Bank should avoid using conditions to micromanage the borrower, such as the project covenant requiring six staff in the MOH reproductive health unit; regular scolding by the Bank on this issue generated resentment and unnecessary tension. Conditions also must be clearly specified in legal agreements, otherwise, they are difficult to enforce.

Strengthening Local Capacity to Analyze and Implement Reforms

58. As noted above, capacity constraints in ECA health sectors differ from those of many less-developed countries. There is often an adequate supply—or even oversupply—of trained medical personnel, but a shortage of critical skills (in policy analysis, health management, health promotion, family medicine, and project design and implementation) and distorted incentives for individual and organizational performance. The reform process has created the need to establish new organizations, such as health insurance funds, and reorient existing ones, such as ministries of health and health protection agencies. The situation requires a good diagnosis of key capacity constraints and multiple strategies and approaches, including strengthened local capacity for research and training; direct sponsorship of local or international training; establishing accreditation mechanisms to improve the quality and credibility of training, and support for strengthening and reorienting specific organizations.

- *Bank support for training and capacity building was consistently among the most successful of the project-sponsored activities.*

59. In each of the completed projects, project ICRs and the OED evaluations concluded that Bank support for training and local capacity building was among the most successful of the project-sponsored activities—even though it typically represented a small percentage of total project costs (less than 2 percent of total project costs in Romania, for example). It was not always successful—training and technical assistance programs were sometime poorly designed or implemented—but when done well, the contributions were significant. Yet there was generally little evaluative evidence regarding the impact of training on provider behavior or system performance. So it is difficult to assess the cost-effectiveness of training support, or to draw conclusions regarding the relative impact of various types of training and capacity building (e.g., training providers in new protocols compared to strengthening management skills).

- *Support for establishment and accreditation of health management institute, departments of public health and family medicine has helped increase the credibility of these "new" disciplines, built national capacity, and strengthened constituencies for reform.*

60. Projects supported the establishment or strengthening of health management and policy institutes Hungary and Romania, and departments of public health in Estonia and Hungary. Project support helped increase the credibility of these "new" disciplines, built national capacity in skills critical for reform, and strengthened constituencies for sector reform. The successful establishment of these institutes/departments was hardly inevitable, however. First, strong local leadership was necessary, and careful design and support during supervision—including ensuring transparent selection of local faculty for international training and the transition from international technical assistance to local leadership. Second, because ministries of health sometimes sought to marginalize or undermine these new entities (Hungary, Romania), it was important for Bank staff to maintain direct contact during project supervisions (rather than relying on project management units) (HSMTC 2000). Third, linkages with prestigious international institutions and establishing national or international accreditation (e.g., for the department of family medicine in Estonia) helped both improve training quality and increase acceptance in the medical community.

61. The influence of these institutes on the wider system and health reform process has varied, however, depending on the receptivity of health policymakers to technical advice; the strength of linkages between the institute, government, and academia; the retention of trainees in the government and job market for trainees in wider health system; and the ability of the institutes

to develop a strategic policy research agenda. Although all the institutes continue to operate, train local staff, and contribute to policy research, none has a substantial core budget beyond immediate salary costs, so each faces the challenge of balancing project funding (mostly from donors) with the need to establish a strategic research agenda.

- *Establishing in-service training programs can help increase skills among managers and providers, and assist in organizational reform.*

62. Projects in Estonia and Albania successfully established programs for in-service training of health managers and providers. The Albania experience represents a good example of adapting a training program to a weak institutional context. In response to difficulties retaining skilled trainers on civil service salaries, the training program hired trainers on contract. Several lessons emerged. First, ensuring the quality and relevance of training is critical. Regularly assessing the quality and impact of training, including through accreditation programs, is necessary. Second, hospital managers and physicians sometimes had difficulty attending short-course, due to professional demands. Adapting trainings to their schedules is important. Third, to promote changes in organizational and management practices, an increased emphasis on team approaches—rather than only individual, short-term courses—may be necessary, especially if a project is trying to change organizational behavior. Finally, overseas training—either short-term or for degree programs—can have a significant impact on the skills and thinking of trainees, but can be a conduit for patronage and "tourism" if not designed and monitored carefully. For example, the Romania project spent nearly $1 million on short-term overseas training courses for government officials, but with limited impact.

- *Reforming existing organizations is a difficult and long-term process*

63. Changes in the policy framework and structure of the health sector, while difficult, have tended to progress more quickly than the ability of organizations to respond effectively to their new roles (for example, health insurance reforms in Romania). The Bank and donors have tended to underestimate the time required and overestimate the difficulty of achieving organizational change. Establishing new organizations (health management institutes, schools of public health), while challenging, has been less difficult than reorienting existing organizations (MOHs, epidemiology-sanitary agencies).

- T*he training needs generated by reforms often outstrips available training capacity.*

64. Despite contributions from the Bank and other donors, the training needs generated by health reforms exceed current training capacity and donor contributions, especially in less-developed countries. In Romania, neither GPs nor staff of the health insurance funds created by the national health insurance bill received sufficient training to help them adapt to their new roles. Also, hospital reforms have created new demands on hospital managers, but few have adequate skills.

- *The capacity of health planning or policy units influences government ability to design reforms and absorb policy advice*

65. The transition from communism resulted in a reaction against central planning, although to varying degrees in each of the countries. But economic transition and health reforms have increased the need for strategic planning and capacity for policy analysis, needs that have increased as ministries of health have taken on new roles. In Estonia, establishing a "policy unit" in the Ministry of Social Affairs was a project covenant, but the ministry initially resisted because "policy" was seen as the realm of politicians and Parliament. The Bank continued to raise the

issue in project dialogue, and a compromise was reach to establish a relatively small unit, which is taking on a growing role in strategic planning and policy analysis. But despite efforts through the project and policy dialogue, Romania has yet to establish a strong planning unit, despite an increased supply of trained health policy professionals. This is due to difficulties in retaining skilled staff in the MOH (due to poor terms of service), and unclear commitment by the ministry to such a unit. As a result, absorptive capacity for policy recommendations and strategy development remains constrained.

"Packaging" Investments with Capacity Building and Institutional Reform

- *Tensions may emerge between strategic priorities for the sector and borrower demands for loan funds*

66. Many borrowers—especially ministries of health—place a higher priority on improving equipment and infrastructure than on investments in capacity or institutional strengthening (Romania, Hungary). Borrowers also are often reluctant to use loan financing to support technical assistance and training when grant financing is available for these activities (from the European Union and bilateral donors). In addition, since the Bank is able to mobilize considerably more resources than other donors, Bank assistance is often sought for "big-ticket" items such as infrastructure and equipment. Finally, borrowers may be either reluctant or uninterested in addressing certain issues (for example, corruption or discrimination against Roma). Internal Bank incentives can encourage an emphasis on lending and disbursements, thus reinforcing some of the above tendencies. This partly explains the continued emphasis on capital investments in Bank projects—even when the main constraints to sector performance lie elsewhere. The Bank has generally tried to deflect requests for sophisticated medical equipment, but has sometimes acquiesced (for example, support for CT scanners in Hungary, or equipping an *in-vitro* fertilization laboratory in Romania).

- *Capital investments can complement and reinforce the reform process, if used properly...*

67. Project design is the outcome of a negotiating process with borrowers—including both ministries of finance and health—reflecting the need for compromise while also maintaining a focus on core objectives. The Bank's development effectiveness thus depends on effectively "packaging" investments in equipment and infrastructure, often high on the list of priorities for borrowers, with lending and nonlending support for capacity building, and policy and institutional reforms. This "packaging" has several dimensions. First, from a political perspective, including popular investments can help increase support for and ownership of reform. In Estonia, the popularity of new medical school constructed with project funds was credited in part with the survival of the project through several changes in government. Second, project design provides an opportunity to build-in reforms, capacity building, and other activities that increase returns from project investments. For example, maternity equipment financed by the Romania project was effectively linked to support for training of hospital maternity teams (financed by USAID). This *combination* of badly needed equipment and training appears to have contributed to a reduction in perinatal mortality. Third, project covenants or conditions can be used to encourage policy changes (see above). Finally, the design of a project may also integrate new rules and incentives for the allocation of investment resources, which could have a wider influence on sector incentives. Examples include transfer of knowledge in international competitive bidding, or establishing a competitive mechanism to qualify for hospitals to quality for information system investments in Hungary (Box 4).

- *…But the contribution of physical investments to reform and institutional change was frequently disappointing.*

68. Efforts to "bundle" investments with policy change or institutional reform can also backfire, for three major reasons. First, once project implementation is underway, borrowers may choose to implement only their preferred investment activities. The completed and ongoing projects in Romania also point to a tension between facilitating implementation—which suggest front-loading large procurement packages but weakens subsequent leverage—versus phasing procurement over time, which increases the risk of delay, but may improve policy leverage. Second, project designers may underestimate the political and institutional difficulty of proposed reform—and provide inadequate support for implementation. Third, given the excess capacity and shortage of recurrent funds in many ECA health sectors, capital investments can contribute to further burdens on recurrent financing—particularly when expectations for downsizing prove overoptimistic.

69. The completed projects provided direct support for investments in equipment and infrastructure for rural primary health care facilities (Albania, Croatia, Romania, and Turkey), secondary hospitals (Albania, Hungary, Croatia), emergency medical equipment (Romania), and pharmaceuticals (Romania, Albania). In Romania, the Bank did a good job of building a few key reform activities into overall project design, but most of the investment components were only weakly linked to reforms—thus, for example, despite more than $60 million expenditures for pharmaceutical procurement, the project had little success in promoting critical pharmaceutical sector reforms. Similarly, the outcome of capital investments to upgrade or rehabilitate infrastructure were mixed. The Romanian project supported upgrades to nearly 200 rural health centers, in the hope that the investments would improve the quality of care and attract doctors to underserved areas. While the investments contributed to improve to quality of care when a qualified and committed team of providers were already in place, the investments alone were inadequate to attract doctors to underserved areas, and much of the equipment and facilities are underutilized. The Albanian project successfully rehabilitated nearly 99 rural health centers, improving working conditions, but was not successful in achieving the original objective of simultaneously closing down marginal centers and reallocating staff. The Albania ICR concluded that project design underestimated both the technical difficulty and political resistance to restructuring.[31]

Establishing Effective Partnerships

70. Effective partnerships with other international agencies or local organizations were important both to improving the outcome of specific investment activities and to improving the coherence of donor programs. But the extent and quality of such partnerships varied.

- *Project investment activities were more likely to be successful when carried out in partnership with other donors, nongovernmental organizations, or research institutes.*

71. As noted earlier, the impact of infrastructure and equipment investments often depends on complementary technical assistance and capacity building, but governments are reluctant to borrow for technical assistance and prefer to finance these activities through grants (for example, from the European Union or bilateral donors). Moreover, other international or local organizations may have a comparative advantage in technical areas or capacity building. Thus in

31. Similarly, the Croatia ICR concluded that: "The provision of equipment and training alone is insufficient to shift the health system emphasis to primary care in the absence of other changes within the health system." The current Croatia project seeks to promote system reforms, but in response to requests from the government, project investments focus on equipment for secondary and tertiary hospitals.

Romania, for example, complementary training and technical assistance financed by USAID was critical to the success of the maternal and child health components. And project investments in ambulances and emergency medical equipment had significantly greater impact on the performance of emergency services in the six districts where Swiss cooperation provided support for strengthening dispatch systems and the quality of emergency care. Technical support from WHO (e.g., for tuberculosis programs) was essential to strengthening these programs. "Twinning" arrangements between local research or training institutes and similar institutes in industrialized countries facilitated knowledge transfer without creating undue dependence on expatriate assistance (Albania, Estonia, Romania).

- *Donor assistance is more effective when part of a coherent policy and financing framework.*

72. Bank projects can serve as frameworks for coordination of donor assistance, as in Estonia and to some extent in Romania. But in Romania at least—and perhaps other more donor-dependent ECA countries—lack of donor coordination was cited by stakeholders as a concern. At the project level, lack of coordination can lead to overlapping or competing programs, or to over-investment in infrastructure and equipment relative to available recurrent budgets. Aid coordination is most effective when led by the borrower (Eriksson 1999). In Estonia, for example, established a strong framework for aid coordination, with the recently established planning unit taking responsibility for donor coordination. But such a framework has yet to be established in Romania. Finally, while a diversity of views can be useful, conflicting donor advice can be counterproductive. Thus donors themselves are an important constituency in building consensus for reform

Monitoring and Evaluation of Reforms

- *Monitoring and evaluation was inadequate for each of the completed projects.*

73. For each of the completed projects, both the ICRs and OED reviews concluded that monitoring and evaluation was inadequate—in large part because the Bank and its borrowers gave inadequate attention to M&E. This has been a major shortcoming, since the catalytic effect of project lending often depends on demonstrating the effectiveness of particular approaches to policymakers and the public. Similarly, despite stated intentions to address the needs of the poor, none of the projects successfully monitored and disaggregated outcomes for the poor. These weaknesses in monitoring and evaluation are not unique to Bank-financed projects, but reflect a wider neglect of M&E by both governments and donors (Grielen and others 1999). But the consequence is that, despite over a decade of experience with health reform, there is little evidence regarding the impact of specific reforms on system performance or health outcomes (Belli 2000).[32]

74. While all the completed projects incorporated (or retrofitted) some performance indicators, monitoring and evaluation focused on immediate project outputs or on health outcomes, without enough attention to intermediate indicators (such as service utilization,

32. "…One is surprised to see how little evidence is available on the output of reform. It seems that, with a few exceptions, very limited resources and attention has been devoted to gather more precise measurements of the outputs of the reform process that could make possible rigorous evaluations.... this negative conclusion... points at a key factor for future reforms. Interventions ought to be designed and implemented so that they can be more rigorously evaluated, either by phasing in changes progressively or, in the more ideal settings, through setting up randomized experiments." (Belli 2000).

vaccination coverage, or smoking rates), or an evaluative framework that could help assess the project's impact. The projects generally lacked baselines and indicators to link project outputs with intermediate indicators of health service quality and access.

- *Weaknesses in project monitoring and evaluation reflects broader weaknesses in the collection and analysis of health service and financial information at the country level.*

75. Although most countries have some form of health information systems, these data rarely are collected and analyzed in a way that helps guide policy. Projects have sought to strengthen the systems, with variable success (Box 4). Moreover, monitoring health behaviors, and the impact of health promotion interventions, requires household or individual surveys, as well as targeted research. These can be implemented by academic or research institutes but require government support and engagement. Recently designed projects are required to include a "logical framework" specifying indicators for outputs, immediate outcomes, and ultimate objectives. But establishing baselines and ensuring the collection, timely analysis, and use of data for decision-making continues to be a challenge.

Box 4. Strengthening Health Information Systems—Contrasting Experiences in Hungary and Romania

Several projects have sought to strengthen routine health information systems, but with varied results. The Hungary project supported the introduction of an integrated, management-supporting management information system designed to control costs and improve organizational decision-making into one-sixth of all Hungarian hospitals. The hospitals were selected in an open and transparent competition—apparently a new approach in Hungary—in which each hospital had to develop a health information plan. "Winning" hospitals had their management information systems upgraded and received technical assistance in order to begin basing their management decisions on cost and utilization data. The implementing agency for this component was a local firm that had a high level of expertise, and involved hospital managers and staff in system design. Although the current government cancelled plans to scale up the system nationwide, 75 percent of all hospitals report that they are making use of the information plans developed under the project.

In Romania, despite an escalation of costs from a planned $3.1 million to nearly $20 million, this component failed to establish a working health information system. After several years of delays, the component was rapidly implemented in the final years of the project, driven primarily by consultants and a small number of technocrats, with little consultation with end-users and limited technical oversight by government or the Bank. The software (SAP) and systems chosen were inappropriate and largely unworkable at the facility level, and for the most part are not being used. The component did little to improve the use of information and decision-making, except in an initial pilot district. Some of the hardware may be salvageable, but a new approach with more user-friendly software will be necessary. This failure not only represents a significant waste of resources, but also means that a major bottleneck to improving system performance—improved collection, analysis, and use of health information for management and decisionmaking—remains unresolved.

5. Recommendations

76. The Bank has internalized many of the lessons from its early experience in the region (Staines 1999). First, the importance of avoiding excess of complexity is widely recognized, and with the exception of Russia, few health loans approved since 1995 exceed $50 million. Second, the Bank is increasingly making use of new lending instruments—including Adaptable Program Loans, and Learning and Innovation Loans—to provide more flexible support for the long-term and uncertain process of sector reform. Third, the Bank has sought to strengthen requirements for project monitoring and evaluation. Study findings suggest several recommendations, however.

Further strengthen monitoring and evaluation of projects and sector reforms

77. Strengthening monitoring evaluation will require action on several fronts. First, at the project level, the primary challenge is ensuring that M&E plans are implemented. This requires (i) developing a clear strategy as to how quantitative indicators and qualitative data will be collected, analyzed, and used for improving project performance—and specifying the respective roles of the government, Bank, and other partners; (ii) allocating adequate staff budget and time for M&E during project preparation and supervision; (iii) ensuring baseline surveys are completed prior to project effectiveness, or very soon thereafter; and (iv) and ensuring Bank staff and managers regularly review and discuss with country clients evidence of progress toward development objectives. Strengthening project M&E should not generate a bias toward projects that show prompt and quantifiable results, however, to the neglect of policy dialogue and capacity building efforts for which the impact may be slower to materialize and more difficult to quantify.

78. Second, while improving project-level evaluation is important, the more critical challenge is to improve the analysis and use of information—including facility based data, surveys of health behaviors, and financial data—to improve policy and resource allocation decisions at the national, district, and facility level in client countries. Substantial data are often collected, but may be fragmented among the MOH, individual facilities, central statistics offices, and national health insurance funds. Developing the capacity and culture for evidence-based policy making will be a long-term process, however. The Bank can contribute through project-specific investments (while avoiding an exclusive focus on hardware) and through policy dialogue with government and partners to help develop a coherent national monitoring framework. Third, the Bank and its partners should select a limited number of priority health reforms to be the subject of rigorous impact evaluations—either in specific countries, or comparatively across several countries (for example, the impact of provider payment reforms). Impact evaluations are time and resource intensive, require careful design and sophisticated expertise, and are a public good that borrowers may not wish to finance through loan funds. Thus the Bank and partners could seek to identify internal or external funds to finance such evaluations, and to contract with academic or research institutions (both international and in the ECA region) to carry them out.

Strengthen analytic work on how to adapt reforms to local circumstances

79. Many of the reforms being adopted throughout the ECA region are based on earlier reforms in Western Europe. But there is relatively little research and evidence regarding the extent to which these reforms are appropriate to the very different institutional and political context in many of these countries. As countries such as Estonia and Hungary "graduate" from Bank lending, the Bank's lending portfolio will increasingly consist of slower reformers such as Romania and the Central Asian republics. In establishing priorities for country and regional analytic work, the Bank could give greater attention to both comparative analysis of specific reforms across different countries, and to assessing the suitability of specific reforms in a given

country. The retrospective study being currently undertaken by ECA health staff is an important step in this direction.

Increase focus on neglected priorities, including health promotion, informal payments, and equity

80. First, despite some progress, the Bank needs to give greater emphasis to health promotion activities—including reducing tobacco and alcohol consumption, nutrition, and accident prevention—in its lending and policy dialogue at both the sectoral and macroeconomic levels. While health promotion still tends not to be a top government priority, the climate and potential for progress is clearly better than a decade ago. Second, although Bank sector analysis has highlighted the problems of informal payments, the Bank has had limited success in addressing the issue in the context of project. The Bank could make greater use of its convening role at the country level to encourage dialogue and consensus regarding how to address the problem, and selectively pilot and evaluate interventions to reduce informal payments. Third, although the Bank is giving greater attention in policy dialogue to issues of poverty and equity in access to health services, these issues received limited attention in the completed portfolio. Priorities developing disaggregated monitoring of health outcomes and service access for the poor and ethnic minorities; analytic work to assess the equity implications of policy reforms; and ensuring that project interventions are prioritized and evaluated according to their poverty impact.

Continue to experiment with new lending instruments

81. Although most health projects in ECA are standard investment loans, Adaptable Program Loans (APLs) and Learning and Innovation Loans (LILs) are increasingly common. No programmatic loans—for example, sector adjustment loans (SECALs)—have yet been approved, although one is under discussion in Estonia. This review did not assess the extent to which the Bank has successfully integrated health sector concerns into macroeconomic adjustment operations, but macroeconomic and public sector reform operations are increasingly including health-related conditions. Experience suggests that adjustment conditionality alone is inadequate to implement complex social sector reforms (Nelson 1999). But experimentation with these instruments—particularly in combination with support for building capacity and consensus—may be appropriate.

82. This evaluation and other recent OED evaluations suggest several issues for consideration, however. First, development effectiveness appears to depend on the complementarity among various lending and nonlending instruments (Battaile 2001). Adjustment lending may be more effective at addressing specific policy constraints—particularly those requiring attention from finance ministries—but investment lending or technical assistance may still be necessary to overcome capacity or institutional bottlenecks. Second, although no APLs have been evaluated, key challenges may include identifying appropriate "triggers" for each phases (e.g., targets that are achievable but not focussed simply on inputs or outputs), and ensuring an adequate focus on development outcomes over the course of the six to nine year implementation period. Third, because piloting new approaches can be time and resource intensive, LILs need to accompanied by adequate budget for design and supervision, and should be adequately evaluated before scaling up.

Further strengthen partnerships with donors, nongovernmental organizations, and research institutes in the region.

83. Partnerships can improve the efficiency of development assistance, but depend on frameworks that specify each partner's role and accountability. In the absence of efficient specialization, coordination, and motivation, partnerships can lead to overload and stress (Picciotto 1998). The Bank has made progress in developing and strengthening partnerships at the

regional and country level, but experience suggests several priorities. First, at the country level, the Bank should assess where it should focus its staff time and resources, and what activities it can leave to other partners. A particular challenge is to seek ways to remain engaged in dialogue on key policies (for example, health insurance and health financing) even it is not provided direct project support. Second, the Bank and donors can help build government capacity for aid coordination, including through strengthening planning and coordination units and assisting in the development of medium term expenditure plans that incorporate both donor and government resources. Where government commitment to or capacity for aid coordination is relatively weak, the Bank could take a more proactive in strengthening donor coordination—both for investments and policy dialogue. Third, the Bank should continue to strengthen links with research, academic, and nongovernmental organizations in the region, and to facilitate interactions among local organizations and international counterparts. Finally, while this study did not explicitly evaluate the Bank's regional partnerships (such as the European Observatory for Health Reform), study findings suggest that such partnerships may be an effective mean to generate and disseminate knowledge regarding health and health reform in the region. The costs and benefits of all such regional partnerships should be carefully assessed, however, as well as their alignment with the ECA regional health strategy.

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Annex A. Current and Completed ECA Health Projects

Country	Proj ID (LEN)		Date, Approval	IBRD/IDA Amt
Albania	**P045312**	**HEALTH RECOVERY**	**5/12/1998**	17.0
Albania	**P008253**	**HEALTH SERVS REHAB**	**11/8/1994**	12.4
Armenia	**P050140**	**HEALTH**	**7/29/1997**	10.0
Bosnia-Herzegovina	**P044523**	**BASIC HEALTH**	**5/4/1999**	10.0
Bosnia-Herzegovina	**P044522**	**ESSNTL HOSP SERV**	**12/13/1996**	15.0
Bosnia-Herzegovina	**P044424**	**WAR VICTIMS**	**6/28/1996**	5.0
Bulgaria	**P055157**	**HEALTH SECT REF**	**6/22/2000**	63.3
Bulgaria	**P008318**	**HEALTH SECT RESTRUCT**	**4/9/1996**	26.0
Croatia	**P039450**	**HEALTH**	**2/14/1995**	40.0
Croatia	**P051273**	**HEALTH SYSTEM**	**10/5/1999**	29.0
Estonia	**P008402**	**HEALTH**	**1/19/1995**	18.0
Georgia	**P008414**	**HEALTH I**	**4/25/1996**	14.0
Hungary	**P008484**	**HEALTH SERVS & MGMT**	**4/20/1993**	91.0
Kazakhstan	**P046499**	**HEALTH RESTRUCTURING**	**4/8/1999**	42.5
Kyrgyz Republic	**P008523**	**HEALTH**	**5/14/1996**	18.5
Latvia	**P058520**	**HEALTH**	**11/12/1998**	12.0
Lithuania	**P035780**	**HEALTH**	**11/30/1999**	21.2
Macedonia, former Yugoslav Republic of	**P036089**	**HEALTH SECT TRANSTN**	**6/20/1996**	16.9
Poland	**P008587**	**HEALTH**	**5/7/1992**	130.0
Romania	**P008797**	**HEALTH SECTOR REFORM**	**6/27/2000**	40.0
Romania	**P008759**	**HEALTH SERV REHAB**	**10/1/1991**	150.0
Russian Federation	**P008814**	**HEALTH REFORM PILOT**	**6/5/1997**	66.0
Russian Federation	**P038571**	**MED EQUIP**	**6/4/1996**	270.0
Slovenia	**P051418**	**HEALTH SECTOR MANAGEMENT**	**1/20/2000**	9.5
Tajikistan	**P049894**	**PRIM HEALTH CARE**	**3/7/2000**	5.4
Turkey	**P009076**	**HEALTH II**	**9/22/1994**	150.0
Turkey	**P009095**	**PRIM HEALTH CARE SER**	**6/24/1997**	14.5
Uzbekistan	**P009125**	**HEALTH I**	**9/22/1998**	30.0
Total Commitments				**1,327.2**

Annex B: Stakeholder views and additional project findings

The following sections provide some additional background on stakeholder perspectives on the Bank's work, as well as more detailed lessons regarding project design and implementation.

Strengths and Weaknesses of Bank's Work—Stakeholder Perspectives

The OED project reviews in Estonia, Hungary, and Romania included a confidential questionnaire that was completed by about a dozen stakeholders in each country, including representatives of government, nongovernmental organizations, and academia. In addition to rating the strengths and weaknesses of each project, the respondents were asked to describe three strengths and three weaknesses of the Bank's work in their country. The most common responses are summarized below—though not all were mentioned by stakeholders in each of the three countries.

Strengths

- The Bank is valued for its international perspective—including beyond the ECA region—and its ability to identify appropriate international expertise
- Good strategic overview of the sector
- Ability to mobilize resources
- Leverage *vis-à-vis* other donors, both for additional financing and for coordination

Weaknesses

- The Bank sometimes focuses too much on hardware investments
- Bank procurement rules can be cumbersome
- Turnover of Bank supervision teams can undermine continuity
- Despite international expertise, some international staff or consultants lacked adequate understanding of local conditions
- Despite contributions to donor coordination, the Bank needs to play an even greater role

Lessons on Project Design and Implementation

Clarity and realism of objectives: OED rates project outcomes against stated project objectives. Vague or unrealistic objectives therefore result in lack of focus and unsatisfactory project outcome ratings. The objectives for the Hungary project were vague, stating that the project would contribute to improved health for the country, even though project activities were unlikely to change population-level outcomes within the lifetime of the project investments. The Estonia project objectives were more succinct and focused, and more relevant to the core challenges facing the health sector, which both helped keep the project on track and made it easier to evaluate project accomplishments. None of the projects had put in place a strong monitoring framework, however, which would have allowed tracking progress and the project's contribution to overall sector outcomes.

Effectiveness of project implementation: The Estonia project was well implemented, but Romania encountered myriad implementation challenges—some of which were eventually overcome. Several issues merit discussion. First, lack of familiarity with Bank procedures initially created bottlenecks in all three countries. Second, staff turnover—a consequence both of relatively lower salaries in the public sector and changes of government—negatively affected project implementation, especially in Hungary and Romania. Third, the wider institutional environment

affected project implementation but was difficult to address by health staff alone. In Romania, for example, major bottlenecks to project implementation included chronic shortages of counterpart financing, and government tax and auditing regulations that made it difficult to hire technical assistance. Fourth, project management units were useful in moving implementation forward, but the effect on ownership and capacity building varied. The PMU undermined ownership in Hungary, while in Estonia, the head of the PMU was regular staff in the Ministry of Social Affairs, but project-related procurement, financial management, and logistics were contracted out to a private firm.

Bank performance: Although borrower performance is the more important determinant of project outcome, Bank performance matters too. OED rated Bank performance as highly satisfactory in Estonia; it was rated satisfactory in both Hungary and Romania, but with a number of caveats. Key issues included the quality of technical analysis and advice provided by the Bank, during both project design and supervision; attention to borrower ownership and to the political dimensions of the health sector; the continuity of supervision teams; and maintaining a focus on outcomes during supervision, not just procurement or disbursement. Project experience suggests that in more advanced reformers, such as Estonia, the Bank's traditional approach to supervision—with two missions per year to review progress—may be appropriate. In countries such as Romania, however, a stronger local presence may be necessary both to deal with various implementation difficulties and to sustain dialogue with local stakeholders.