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PROJECT PERFORMANCE ASSESSMENT REPORT

ROMANIA

HEALTH SERVICES REHABILITATION PROJECT
(LOAN 3409)

February 27, 2002

Sector and Thematic Evaluation Group
Operations Evaluation Department

Currency Equivalents (annual averages)

Currency Unit = Leu

1 Leu = US$ 0.0000472
US$ 1 = Lei 21,182.50

Abbreviations and Acronyms

HIS	Health information system
ICR	Implementation Completion Report
GMP	Good Manufacturing Practice
GOR	Government of Romania
GP	General practitioner
MOH	Ministry of Health
MTR	Midterm review
NGO	Nongovernmental organization
OED	Operations Evaluation Department
PPAR	Project Performance Assessment Report
SAR	Staff Appraisal Report
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WHO	World Health Organization

Fiscal Year

January 1—December 31

Director-General, Operations Evaluation	:	Mr. Robert Picciotto
Director, Operations Evaluation Department	:	Mr. Gregory K. Ingram
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The World Bank
Washington, D.C. 20433
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Office of the Director-General
Operations Evaluation

February 27, 2002

MEMORANDUM TO THE EXECUTIVE DIRECTORS AND THE PRESIDENT

SUBJECT: Project Performance Assessment Report on Romania
Health Services Rehabilitation Project (Loan 3409)

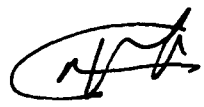
Attached is the Project Performance Assessment Report prepared by the Operations Evaluation Department (OED) on the Romania Health Services Rehabilitation Project. The project was the first Bank-supported project in the health sector in Romania, and one of the first health projects it supported in the Europe and Central Asia Region. Total project cost was initially estimated at US$207.5 million, with an IBRD loan of US$150 million. The final cost was US$224.5 million, with an IBRD loan of $149 million, and a government contribution of $75.6 million. The project was approved on October 1, 1991, and closed three years later than planned, on June 30, 1999, after four extensions. Following a midterm review in 1994, some activities were dropped, others added, and several expanded substantially, but project objectives remained unchanged.

The objectives of the project were (i) to rehabilitate and upgrade the primary health care delivery system, which was collapsing for want of equipment, spare parts, drugs, medical supplies, and transfer of knowledge to health providers; and (ii) to support the first steps of a major restructuring of health sector financing and management to ensure a sustainable and cost-effective health-care system in the medium-term. The project originally had nine components, a complex design that proved challenging to implement, particularly in light of the government's lack of experience in implementing a Bank-funded project. Project implementation encountered many bottlenecks in the first two years but subsequently improved. Initial optimism about the prospects for health sector reform proved unfounded: the Ministry of Health showed limited commitment to reform until a change of government in 1996. Rather than reduce the size of the loan following the midterm review, the Bank approved a reallocation of funds to activities that would disburse rapidly, even when the institutional framework necessary to effectively use these investments was lacking—contributing to inefficient use of loan resources. Following the change in government, however, the Bank refocused on engaging government and a wide range of stakeholders in an intensive dialogue on sector reform and national health strategy development. This dialogue—together with sector analysis, district pilots, and capacity building sponsored earlier in the project—positively influenced health reform legislation and the government's health strategy. These reforms create the potential for improvements in health system performance and efficiency, but significant progress in policy refinement and capacity building are needed to realize that potential.

The project made important contributions to rehabilitating health system equipment and infrastructure and to initiating sector reforms. But rating this project is difficult because of the need to give an aggregate rating to a project with many components and activities, the most successful of which represented a minority of project costs. Substantial portions of project resources were not used effectively or efficiently due to inadequate planning—particularly to ensure complementarity between investments in "hardware" and "software"—and an excessive focus on disbursements during much of implementation. Judging outcome by aggregating the success of individual components—weighted by cost—would suggest an overall rating of moderately unsatisfactory. But the project's reform and capacity building components, together with intensive dialogue in the latter years, have influenced policies and strategies beyond the confines of the project, despite a difficult political and institutional context. Notwithstanding the poor performance of some project components, this assessment thus rates overall outcome as moderately satisfactory, compared to a satisfactory rating in the Implementation Completion Report (ICR).

Institutional development is rated modest, consistent with the ICR. Some key investments are likely to be sustained, although sustainability prospects for several of the largest (in dollar terms) project components will depend on further consolidation of reforms and adequate financing for recurrent costs. Most of the reforms initiated with project support are being continued by the new government, however. Sustainability thus is rated as likely, consistent with the ICR rating. Bank performance and Borrower performance are both rated satisfactory as in the ICR.

Experience with the project confirms a number of well-established OED lessons, including the need to match project design with borrower implementation capacity and avoid excessive complexity, and the need to focus Bank supervision on achieving development outcomes rather than maximizing disbursements. Several other findings of broader relevance emerged. First, the impact of health sector investments—particularly for facilities, equipment, and other "hardware"—depends crucially on complementary investments in training, and on parallel policy and institutional reforms. Second, in promoting health sector reform, a mixed strategy incorporating sector analyses, pilot projects, long-term local capacity development, and policy dialogue may not yield immediate results—particularly when government commitment to reform is low—but may prove influential subsequently when the political or policy context changes. Third, while reform may be necessary, reforms that are partially enacted or inadequately implemented risk falling short of objectives or being discredited. Finally, Bank support can help strengthen and sustain preventive and health promotion programs—which are often low priorities for governments—but without continued supervision attention and policy dialogue, these programs are likely to be neglected in favor of curative and hardware interventions. A follow-on project is providing support for several key components of the government's reform strategy, in partnership with other international agencies.



Attachment

OED Mission: Enhancing development effectiveness through excellence and independence in evaluation.

About this Report

The Operations Evaluation Department assesses the programs and activities of the World Bank for two purposes: first, to ensure the integrity of the Bank's self-evaluation process and to verify that the Bank's work is producing the expected results, and second, to help develop improved directions, policies, and procedures through the dissemination of lessons drawn from experience. As part of this work, OED annually assesses about 25 percent of the Bank's lending operations. Assessments are conducted one to seven years after a project has closed. In selecting operations for assessment, preference is given to those that are innovative, large, or complex; those that are relevant to upcoming country evaluations; those for which Executive Directors or Bank management have requested assessments; and those that are likely to generate important lessons. The projects, topics, and analytical approaches selected for assessment support larger evaluation studies.

A Project Performance Assessment Report (PPAR) is based on a review of the Implementation Completion Report (a self-evaluation by the responsible Bank department) and field work conducted by OED. To prepare PPARs, OED staff examine project files and other documents, interview operational staff, and in most cases visit the borrowing country for onsite discussions with project staff and beneficiaries. The PPAR thereby seeks to validate and augment the information provided in the ICR, as well as examine issues of special interest to broader OED studies.

Each PPAR is subject to a peer review process and OED management approval. Once cleared internally, the PPAR is reviewed by the responsible Bank department and amended as necessary. The completed PPAR is then sent to the borrower for review; the borrowers' comments are incorporated into the document that is sent to the Bank's Board. When an assessment report is released to the Board, it is also widely distributed within the Bank and to concerned authorities in member countries.

About the OED Rating System

The time-tested evaluation methods used by OED are suited to the broad range of the World Bank's work. The methods offer both rigor and a necessary level of flexibility to adapt to lending instrument, project design, or sectoral approach. OED evaluators all apply the same basic method to arrive at their project ratings. Following is the definition and rating scale used for each evaluation criterion (complete definitions and descriptions of factors considered are available on the OED website: http://wbln1023.worldbank.org/oed/oeddoclib.nsf/

Relevance of Objectives: The extent to which the project's objectives are consistent with the country's current development priorities and with current Bank country and sectoral assistance strategies and corporate goals (expressed in Poverty Reduction Strategy Papers, Country Assistance Strategies, Sector Strategy Papers, Operational Policies). *Possible ratings:* High, Substantial, Modest, Negligible.

Efficacy: The extent to which the project's objectives were achieved, or expected to be achieved, taking into account their relative importance. *Possible ratings:* High, Substantial, Modest, Negligible.

Efficiency: The extent to which the project achieved, or is expected to achieve, a return higher than the opportunity cost of capital and benefits at least cost compared to alternatives. *Possible ratings:* High, Substantial, Modest, Negligible.

Sustainability: The resilience to risk of net benefits flows over time. *Possible ratings:* Highly Likely, Likely, Unlikely, Highly Unlikely, Not Evaluable.

Institutional Development Impact: The extent to which a project improves the ability of a country or region to make more efficient, equitable and sustainable use of its human, financial, and natural resources through: (a) better definition, stability, transparency, enforceability, and predictability of institutional arrangements and/or (b) better alignment of the mission and capacity of an organization with its mandate, which derives from these institutional arrangements. Institutional Development Impact includes both intended and unintended effects of a project. *Possible ratings:* High, Substantial, Modest, Negligible.

Outcome: The extent to which the project's major relevant objectives were achieved, or are expected to be achieved, efficiently. *Possible ratings:* Highly Satisfactory, Satisfactory, Moderately Satisfactory, Moderately Unsatisfactory, Unsatisfactory, Highly Unsatisfactory.

Bank Performance: The extent to which services provided by the Bank ensured quality at entry and supported implementation through appropriate supervision (including ensuring adequate transition arrangements for regular operation of the project). *Possible ratings:* Highly Satisfactory, Satisfactory, Unsatisfactory, Highly Unsatisfactory.

Borrower Performance: The extent to which the borrower assumed ownership and responsibility to ensure quality of preparation and implementation, and complied with covenants and agreements, towards the achievement of development objectives and sustainability. Possible ratings: Highly Satisfactory, Satisfactory, Unsatisfactory, Highly Unsatisfactory.

Contents

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

Principal Ratings

	PPAR	*ICR*
Outcome	Moderately satisfactory	Satisfactory
Sustainability	Likely	Likely
Institutional Development	Modest	Modest
Borrower Performance	Satisfactory	Satisfactory
Bank Performance	Satisfactory	Satisfactory

Key Staff Responsible

Project	*Task Manager/Leader*	*Division Chief/ Sector Director*	*Country Director*
Appraisal	Julian Schweitzer	Ralph Harbison	R. Cheetham
Completion	Richard Florescu	Armin Fidler	Andrew N. Vorkink

Preface

This is a Project Performance Assessment Report (PPAR) for the Romania Health Service Rehabilitation Project. The project supported investments and commodities to help rehabilitate the health sector after years of neglect, and supported the first steps of health sector restructuring. The project was financed through IBRD Loan 3409 for US$150 million; it was approved in October 1991 and closed in June 1999 with all but $1 million of loan funds disbursed.

This assessment report is based on information gathered by an Operations Evaluation Department mission to Romania in May 2001. The mission team also reviewed completed health projects in Hungary and Estonia, which are the subject of separate reports. The mission reviewed the performance of the project and interviewed government officials, Bank and donor field staff, academics, and staff of nongovernmental organizations. Documentary sources include the project's Implementation Completion Report, the Staff Appraisal Report (SAR), independent audit reports, and project files. In addition, a dozen individuals including directors of project components, NGO representatives, and others involved in project implementation answered a confidential questionnaire, and met at the end of the mission to discuss its findings. These findings have also informed this report. This report also benefited from background evaluation reports and stakeholder workshops, which were organized as part of the Intensive Learning ICR undertaken for this project.

The author gratefully acknowledges all those who made time for interviews and provided documents and information, including officials at the Ministry of Health, the Institute of Health Services Management, the National Health Insurance Fund, the Center for Health Statistics and Computing, the Institute of Mother and Child Care, P. Sarbu Maternity Hospital, Polizu Maternity Hospital, the Institute of Lung Diseases, the Cantacuzino Institute, the National Center for Health Promotion, the Romanian College of Physicians, the Ministry of Finance, donor partners, nongovernmental organizations, and World Bank staff. The author also gratefully acknowledges the support from staff in the Project Management Unit, who coordinated the mission and arranged interviews.

Following standard OED procedures, copies of the draft PPAR were sent to the relevant government officials and agencies for their review and comments. A number of observations were made, which have been incorporated into the PPAR as Annex C.

BACKGROUND AND SECTOR CONTEXT

1. Although health status in Romania was on par with the rest of Europe in the 1960s, it declined in relative and absolute terms, with a marked worsening of health status, in the years leading up to and following the political transition that started in 1989. Currently, most premature mortality is from noncommunicable diseases—particularly those attributable to smoking, alcohol consumption, and poor dietary habits—but communicable diseases remain common, with the rising incidence of tuberculosis a particular cause for concern. Although abortion rates have declined from their very high levels following the transition, they remain high, and the use of modern contraceptives, while increasing, is still not widespread. Infant and maternal mortality may have begun to decline in recent years (investments from this project may have contributed, see below), but infant mortality remains three times higher than in Western Europe. Life expectancy at birth in Romania is five years lower than in Western Europe, primarily the result of high adult mortality among men. The high rates of smoking and alcohol consumption among men remain unchanged, and tobacco use is increasing among women and youth due to aggressive marketing by tobacco companies (WHO 2000). Moreover, the percentage of the population in absolute poverty is among the highest in Europe, as is the percentage of the population living in rural areas (45 percent).

2. Romania has been a relatively slow reformer, both in its macroeconomy and within its health system, in part because of conflicting stakeholder interests and a lack of consensus among major political parties regarding the scope and pace of reforms. A number of factors outside the health sector have affected sector performance in general and project implementation in particular. Limited progress in economic reform has contributed to slow or negative growth, minimal progress in poverty reduction, and constraints on resources available for health. A large informal sector and weak tax enforcement have hindered revenue collection, both for general government taxes and for the recently established health insurance fund. Civil service salaries are low relative to the private sector. Those trained with project and donor funds tend not to stay long in government service. Low wages for providers, together with weak enforcement mechanisms, have contributed to the widespread practice of under-the-table payments for health providers. Systemic delays in the government's planning and budget cycles creates uncertainty regarding the availability and flow of funds, which has exacerbated problems with the timely provision of counterpart financing.

3. As in many transition countries, the Romanian health system was highly centralized, with excess hospital capacity, limited focus on primary care and prevention, and little client responsiveness. The entire system suffered from extreme neglect during the latter years of communism. Despite initial optimism, health reform stalled during the mid-1990s—the government was interested in physical investments in the health sector, but showed limited commitment to major reforms.[1] Following a change of government in 1996, Romania enacted several significant health reforms, which have sought to shift the health system from the Soviet model of centralized government financing and delivery of services to a more decentralized and pluralistic approach.

4. The major elements of the reform program are similar to those being undertaken in many other Eastern European countries and are modeled after health systems in Western Europe. Key reforms enacted by Parliament have included establishment of a national health insurance fund

1. Proposals to establish a national health insurance scheme, paid for with a dedicated wage tax, did attract support both within Parliament and among some senior MOH officials. The latter appeared to have viewed this initially as a means to obtain additional resources for the health system, rather than to improve efficiency or promote wider reforms in service delivery.

and 41 district funds, paid for through an earmarked wage tax; decentralization of service delivery; increased hospital autonomy; and the establishment of general practice doctors (GPs) as independent practitioners, paid on a mixed capitation and fee-for-service basis. The insurance law was approved in 1997 and came into full force in 1999. As discussed further below, Bank-sponsored sector analysis, pilot projects, and dialogue influenced these reforms, although not all recommendations were adopted. Government changed again in 2000, but has adopted most elements of the previous government's health sector reform strategy. While still in their early stages, reforms remain fragile, and have not yet led to significant improvements in health system quality, efficiency, or public satisfaction. The government's strategy recognizes the need for further development of regulations and policies, improved incentives, and significant capacity building at all levels of the system (GOR 2001). Implementing this agenda represents a significant challenge, however—technically, institutionally, and politically.

PROJECT OBJECTIVES AND COMPONENTS

5. The Romania Health Services Rehabilitation Project was designed and approved in 1991, soon after the fall of the totalitarian communist regime in 1989. The project objectives were: (i) to rehabilitate and upgrade the primary health care delivery system, which was collapsing for want of equipment, spare parts, drugs, medical supplies and transfer of knowledge to health providers; and (ii) to support the first steps of a major restructuring of health sector financing and management to ensure sustainable and cost-effective health-care system in the medium-term. Total project cost was initially estimated at US$207.5 million, with an IBRD loan of US$150 million. The final project cost was US$224.5 million, with an IBRD loan of $149 million. The project originally was planned for four and a half years, but closed in June 1999, after four extensions.

6. The project originally had nine components, which sought to: (a) upgrade rural dispensaries; (b) improve reproductive health; (c) train health practitioners; (d) procure and distribute drugs and consumables; (e) improve the management of emergencies; (f) promote health and people's participation; (g) develop a national health strategy, and conduct a pilot decentralization in selected districts (*judets*); (h) develop a health information system (HIS); and (i) support the establishment of an Institute of Health Services and Management. During implementation, a number of components were adjusted, a few canceled, and others added. The nurse training subcomponent was canceled,[2] a planned Health Promotion Fund was never established, and expenditures on contraceptives were well below appraisal estimates. Savings were used to support selected national health programs (tuberculosis and HIV/AIDS), and to increase the size of other project components (particularly emergency medical services and health management information systems).

PROJECT DESIGN AND IMPLEMENTATION

7. At the time of project design, the health system and the economy were in severe crisis, but there was a high degree of optimism regarding the future pace of economic and social reform. The project was prepared relatively quickly—in less than a year—and sought to respond both to emergency shortages in the health system (mainly drugs and equipment), while laying the groundwork for subsequent structural reforms. The large loan size and multiple project components may have seemed appropriate at the time, particularly given the dire situation in the

2. Strengthening nurse training was identified as a sector priority during project preparation. A project covenant required a transfer of responsibility for nurse training from the Ministry of Education to the Ministry of Health. This transfer never took place, so the component was canceled.

health sector. But many of the problems were institutional, and not resolvable by the injection of resources. The project was too large and complex for local implementation capacity. It was the first health project in the Europe and Central Asia Region (ECA), and one of the first Bank projects in Romania after a long lapse in lending. Romanians were unfamiliar with Bank procedures, particularly procurement rules, and conflicts between Bank and government procedures contributed to delays.[3] Frequent turnover of government officials, both political and civil service, hindered implementation. During the seven years of project implementation, there were ten ministers, twice as many deputy ministers, and high turnover of the Minister of Health (MOH) staff. Periodic turnover of the Bank's project team also undermined continuity, particularly given the high turnover on the government's side. In retrospect, despite the "emergency" situation, the original loan size should have been smaller, with a more phased approach to investment activities (to allow problems to be identified and resolved) and greater linkages between hardware investments and complementary technical support (either from the Bank or other donors).

8. While the MOH leadership during project design appeared committed to both the reform and rehabilitation aspects of project, a new minister,[4] who was opposed to most sector reforms, took over soon after project approval. Project implementation was slow in the two years before the midterm review—a consequence of weak capacity, lack of familiarity with Bank procedures, and weak government commitment. While a few components progressed, the MOH leadership showed limited interest in addressing implementation bottlenecks—for example, resisting Bank requests to hire additional project staff and technical advisors to assist with procurement—and demonstrated little commitment to the project's reform components. By the midterm review, the project had disbursed $34 million (22 percent) of the total loan of $150 million, of which $25 million was for emergency pharmaceutical procurements through UNICEF.

9. The Bank emphasized reform activities in its policy dialogue and official communications during the initial phase of implementation.[5] Indeed, progress on reform might have stalled—and the reform components killed—without Bank support and pressure. The proposal for piloting new approaches to health financing and service delivery generated enthusiasm at the district level, but the MOH initially provided little support. Similarly, the newly established health management institute had strong local leadership and an enthusiastic cadre of young professionals but was perceived as a threat by some in the MOH, thus, it was initially marginalized from MOH strategy and policy decisions. A Bank-financed sector review was completed in 1993, but the MOH did not formally respond to its recommendations. The government's 1993 "white paper" was prepared with little input from the health management institute and did not adequately address the major challenges facing the health system.

10. The midterm review rated project progress unsatisfactory. The Bank expressed strong disappointment with the slow progress and weak commitment displayed by MOH, and suggested

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3. For example, Romanian tax laws made it difficult to hire international consultants, and the national Court of Accounts regularly rejected payment requests for international consultants and contractors, leading to delays or cancellation of planned technical assistance.

4. The new minister was the former personal physician to Nicolae Ceausescu—an indication that many from the previous regime retained positions of power after the 1989 transition.

5. During the earlier years of implementation, Bank aide memoires highlighted a variety of policy issues—despite the MOH's limited receptivity to such advice—and occasionally included annexes with more detailed discussions of specific issues. In the year following the MTR, broader policy dialogue appears to have dropped off in favor of a focus on implementing specific project components—including some of the reform components. The team leader in this period was not a sector specialist, which may have also contributed to a focus on implementation. Staff at the resident mission played a growing role in operational support, but had more limited engagement in policy dialogue until the latter years of the project.

that the loan size exceeded the government's implementation capacity and should be reduced. Project component managers rarely met jointly, and few had a clear concept of the project's overall objectives. The Bank also emphasized that without a strengthened strategic and policy framework, further investments in areas such as pharmaceuticals and emergency medical equipment were unlikely to result in much development impact. The Ministry of Finance agreed to apply pressure on the MOH to improve implementation, but refused to request cancellation of any loan amount. Bank staff investigated whether unilateral cancellation of part of the loan might be possible, but concluded that this would have been very difficult without a request the borrower.

11. Following the midterm review (MTR), the Bank named an implementation specialist as task manager, increased the involvement of its country office in project supervision, and agreed to a reprogramming of $20 million. The government put pressure on the MOH to improve project implementation. Implementation performance subsequently improved, as long-standing bottlenecks were addressed. The decision to restructure the loan was fully appropriate, in principle. Yet in the year following the MTR, the Bank focused primarily on increasing disbursements, rather than maximizing development impact. The Bank agreed to reallocate project funds to activities that would disburse quickly[6]—including pharmaceuticals and emergency medical equipment—even though the MOH made only nominal efforts to comply with the policy conditions laid out in the MTR. Despite the increased focus on implementation of project activities, the government's overall commitment to reform remained weak, and counterpart funding to cover recurrent costs for new equipment remained scarce.[7]

12. In late 1995, the government requested the first extension of the loan. This led to an active debate among the Bank project team and management as to whether to cancel the project or extend. A high-level mission—which included the Bank's regional sector manager and the head of the Bank's HNP Sector Board—visited Romania in late-1995. The mission concluded that the Bank should grant the extension, but use the additional time not just to complete project activities, but also to engage the government and stakeholders in a broad debate regarding health sector reforms and strategy. This dialogue was to form the basis for a follow-on sector reform project. In practice, the Bank appears to have followed a two track strategy: engaging in a broad policy dialogue on sector reforms, while also seeking to complete agreed activities and fully disburse project funds.

13. Implementation of investment activities generally improved in the final years of the project with increased capacity and stability in the project management unit, but insufficient procurement staff in the PMU continued to be a problem. A threatened misprocurement for two large packages (ambulances and a management information system) in 1997 caused additional delays and further extensions of project closing. Efforts to rapidly implement the HIS component after these delays contributed to the eventual failure of this component. The Bank's flexibility in reprogramming project resources during the four project extensions was appreciated by government counterparts, particularly the addition of support for TB programs (in partnership with WHO). But it also led to financing of some items that were outside the project's original

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6. This rationale is stated explicitly in internal Bank correspondence and in communications with the MOH.

7. Given government's refusal to consider canceling part of the loan amount, a more appropriate strategy for the Bank might have been to: (i) continue to require that minimal policy and institutional arrangements should be in place to ensure effective use of investments—as agreed upon during the MTR—before resuming disbursements on specific subcomponents (e.g., for pharmaceuticals); (ii) to the extent possible, provide support to help the government meet those minimum requirements (e.g., establishing an essential drugs policy); and (iii) if there were little progress, reduce or cancel nonperforming components at time of project closing, prior to approving a project extension. Important activities that had suffered delays for reasons outside of MOH's control could also be rolled into a subsequent loan, rather than rushed to completion prior to project closing.

objectives (such as in vitro fertilization equipment), and to an excessive focus by the Bank and MOH on fully disbursing the original loan amount. The four loan extensions represented the major opportunities for reducing the loan amount, but in each case the Bank agreed to government requests not to reduce the loan. In retrospect, a reduction in the loan—possibly accompanied by shifting key incomplete activities into the new loan—would have reduce inefficient use of loan funds, and possibly prevented the failure of the HIS component. Changing sector policy framework also complicated some of the investment components. The project was designed for a centralized system, and had to adapt to a more pluralistic health insurance system.

14. With the change in government in 1996, the earlier efforts in sector reform began to pay dividends, as ideas put forward in the 1993 sector review, or tested in the district pilot projects, found their way into the new health reform legislation. The change in government coincided with the Bank's efforts to engage a wide range of stakeholders in dialogue regarding sector reforms, using supervision and loan resources from this project together with a project preparation resources for a follow-on health sector reform project. A study on health financing was financed through this project in 1998, while a project preparation grant facility supported a wide-ranging sector study, which established working groups consisting of international and local experts, and representatives of key stakeholders. Based these consultations and studies, the Bank produced a health sector strategy paper in 1999. This strategy and the preceding dialogue and sector work informed the government's own health strategy (see below), and the Health Sector Reform Project was approved in 2000. The new government has endorsed the objectives of the current Bank project.

15. In general, implementation of the various components varied depending on the quality and commitment of counterpart agencies, as well as on the presence of parallel financing from other donor partners, particularly for training and technical support. Coordination between the Bank and donors was *ad hoc* in the early years but subsequently improved. Bilateral and multilateral donors provided critical cofinancing for several components—WHO and USAID for reproductive and child health, the Swiss for emergency services—and the Bank was perceived as being more consultative in the latter years of the project. Overall donor coordination in the sector has been relatively weak, however, both in coordinating specific investment activities and in ensuring a degree of coherence in policy dialogue.[8] The government still is not sufficiently active in aid coordination at the strategic or operational level.

Rehabilitating the Primary Care Delivery System

16. In the final years of the totalitarian communist regime, the government made almost no capital investments in the health sector. The economic free-fall that followed the transition deepened the crisis. The project clearly contributed to improving health infrastructure and equipment that suffered from the crisis, particularly in contrast to the desperate situation at project design. But the effect on service delivery and quality was mixed. With some notable exceptions—particularly reproductive and child health—activities focused too much on physical investments and not enough on the technical assistance, training, and institutional reforms needed to ensure impact from those investments. Where complementary inputs were in place, supported by an adequate institutional environment, measurable improvements in service quality and client

8. Inconsistencies in policy dialogue stem from at least two factors: (i) the differing levels of technical capacity among various donors, particularly at the local level (the Bank is seen to be relatively strong technically, whereas some donors have a limited technical presence); (ii) differing approaches among donors to key sector issues, including national health insurance. For example, despite endorsement of national health insurance in early sector work, the Bank emphasized potential risks in subsequent policy dialogue, while the EU and European donors tended to support these reforms.

satisfaction occurred. But substantial portions of the investments financed under this objective are underused, used inefficiently, or not used at all. Moreover, the lack of monitoring data makes it difficult to assess the impact of most of the expenditures financed under this objective—including improved service access for the poor.

17. The emphasis on emergency rehabilitation was understandable given the context. And despite the initial implementation obstacles, the project gave the MOH valuable experience in implementing a complex investment activity. But while the country was clearly experiencing a health care crisis, the "emergency" characterization contributed to an emphasis on injecting a large amount of resources, despite fundamental institutional issues that could not be addressed through investments alone. Moreover, the decision by the Bank and government after the MTR to focus on maximizing disbursements, even after it became clear that conditions for making effective use of those investments were not in place, resulted in the wastage of valuable resources. Policy conditions should not be used to micromanage, but project experience illustrates the long-standing lesson that the Bank should reduce or defer lending unless basic policy and institutional conditions are put in place—particularly as the project timeframe lengthened and the country moved out of its initial crisis situation.

18. Although some sectors of the Romanian economy have been slow to privatize, the rapid privatization of some health sub-sectors (including pharmaceuticals and dentistry) was not anticipated in project design. This contributed to difficulties in implementation and reduced the impact of the project's public sector investments. Recent or planned policy reforms—such as efforts to strengthen incentives for doctors to serve in rural areas, or to permit transfer of some public assets to private providers—could enhance the future return of some project investments, but it is still too early to tell.

19. ***Upgrade Rural Dispensaries.*** The project sought to upgrade 419 rural health dispensaries, many of which were dilapidated and had limited equipment. Infrastructure and equipment investments were centrally planned, however, with little input from end-users, and the MOH had limited capacity for supervising widely dispersed investment activities. Based on an evaluation prepared for the ICR,[9] the outcome was mixed. Much of the equipment purchased (e.g., analyzers, radiology) was too sophisticated for rural clinics.[10] Local governments were responsible for clinic rehabilitation, and the work was frequently delayed—in part owing to a lack of counterpart financing—and often of poor quality. As a result, many of the upgraded clinics are underutilized, and much of the equipment is rarely used. Some of the more sophisticated equipment has been transferred to local hospitals, however. Many of the clinics are still without running water. The upgrades were intended to attract doctors to rural areas; while investments in doctor housing may have made a modest contribution to staff retention, other factors predominated in this decision. Rather, when a motivated team was in place, service quality and patient satisfaction were substantially improved; if not, the equipment was underused and often deteriorating.[11] Clients generally had a positive perception of the upgraded facilities: sixty percent of clients and rehabilitated dispensaries reported that service quality was "very good,"

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9. The evaluation team visited two rehabilitated dispensaries and one non-rehabilitated dispensary in each of nine districts. They administered a standard survey to clients at the facilities, undertook unstructured interviews with health staff, and surveyed available equipment. This evaluation report summarizes the data from the client surveys, but could not secure quantitative data on the extent and quality of the actual rehabilitation or the percentage of facilities with trained medical staff (Institute of Health Management 2000).

10. Some of the equipment was financed through EU-PHARE, but is associated with this project. The initial equipment procurements were initiated in the early years of the project, even though the clinic rehabilitations were not complete.

11. According to the PMU, the most recent survey of all 419 dispensaries was conducted in 1998, covering staffing and activity in 1997. At that time, seven dispensaries out of the 419 had no physician.

compared to 36 percent in non-rehabilitated dispensaries. But providers were more negative. Many doctors interviewed said that because of the poor quality of the work and inefficient use of scarce resources, the effect was demoralizing rather than motivating.

20. Recent reforms in payments for general practice doctors—making them independent practitioners—could help strengthen incentives for doctors to practice in rural areas. But ownership of rural clinic equipment and responsibility for maintenance remains unclear. The government has expressed unwillingness to directly support further equipment for GPs, since they are now independent practitioners, and GPs are reluctant to invest their own resources unless ownership is clarified. The project also financed dental equipment for 140 clinics (increased after the MTR from the planned 40 clinics). Dentistry privatized rapidly, however, so this equipment is mostly unused.

21. ***Improve Reproductive and Child Health.*** This was the most successful of the rehabilitation components, in large part because of the close coordination between hardware investments financed by the project and complementary support from donors and NGOs. The project equipped 50 maternal and neonatal units throughout country and the Mother and Child Protection Institute (the national maternity referral hospital), which previously lacked even rudimentary delivery, examination, and neonatology equipment. These investments were supplied in parallel with training for medical teams in delivery wards (provided by USAID, WHO, and NGOs.)[12] Based on visits by the OED mission to two maternity hospitals, medical staff highly value the equipment and training, and the equipment is fully in use. Infant mortality declined during the life of the project, as did maternal mortality.[13] Although infant mortality has multiple causes, the declines appear to be mostly the result of decreases in neonatal mortality, which is sensitive to the quality of medical care during and following delivery. Thus, the equipment and associated training appears to have contributed to declines in neonatal mortality—a view endorsed by Romanian pediatricians and obstetricians. Anecdotal evidence suggests that improved equipment and training may also have contributed to reduced maternal mortality.

22. Immediately following the transition in 1989, the government legalized abortion and established the country's first network of 100 family planning clinics. The project further expanded the family planning network to 230 clinics, supported the establishment of 11 reproductive health referral centers, and established a reproductive health unit within the Ministry of Health.[14] Contraceptive prevalence rates have doubled since the early 1990s, although they are still relatively low. The family planning clinics have made a modest contribution to this progress, but currently provide only 9 percent of modern contraceptives—behind private retail sales and public hospitals (Serbanescu and others 2000). The family planning clinics are mostly urban, but

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12. This parallel financing was not incorporated in the original project design. The component made little progress up to the midterm review. At that time, WHO was reviewing maternal and child health. The recommendations emerging from the review strengthened the policy framework for the component, and helped mobilize complementary cofinancing. Faculty at the Maternal and Child Institute and other maternity hospitals were strong champions for this component, ensuring ownership.

13. According to the ICR, infant mortality is reported to have dropped from 27 per 1000 live births in 1990 to 19 per 1000 in 1998. Facility-based data on infant mortality tend to understate the declines, however, in part because a significant portion of premature babies that would not have been counted as live births in the early 1990s are now considered so. The acquisition of ventilators in particular has allowed survival for many premature babies that would have died previously—although they still remain at higher risk for mortality than full-term babies.

14. The establishment of this unit was a project covenant, which specified that the unit should have six full-time staff. The staffing and capacity of this unit varied over the years, but Bank supervision focused somewhat narrowly on fulfilling the requirement for six staff. While the Bank could have strengthened the enforcement of other project covenants, this represented unnecessary micromanagement.

disproportionately serve the poor.[15] The project originally allocated $12 million for contraceptive procurement (using UNFPA as international procurement agent). Initial shipments encountered delays but helped improve availability. Most of these funds were subsequently reallocated, however, when private sector provision expanded rapidly and other donor funds became available. In the final year of the project, excess funds were allocated for neonatal intensive care equipment, and to equip an in-vitro fertilization laboratory at a government maternity hospital.[16]

23. ***Procure and Distribute Drugs and Consumables.*** This component was designed as an emergency response to address the critical shortages of drugs and supplies during the first two years of the project. Originally estimated at $93 million, it ultimately disbursed $77 million—or a third of total project costs—most of this after the MTR. Lack of data makes it difficult to assess the extent to which drugs purchased through the project were used effectively. The component disbursed $25 million in the first two years, which helped alleviate the initial, severe shortages. But procurement and distribution encountered a variety of delays and bottlenecks, reducing the impact on availability at the facility level. The use of UNICEF as procurement agent was intended to speed the process, but it initially contributed to delays and bottlenecks. A rapid and weakly regulated privatization in the pharmaceutical sector increased drug availability nationwide more quickly than anticipated (although mostly for higher-cost, non-generic drugs). Drugs procured through international competitive bidding cost half the appraisal estimate, a significant cost saving compared to the cost of drugs procured locally. But government pricing policies created a disincentive for retailers to sell the lower-cost drugs procured through the project.[17]

24. The midterm review emphasized that drug procurement had "very mixed results"—due to inadequate tracking and distribution, inappropriate pricing, and lack of a policy framework for the pharmaceutical sector. The Bank thus called for suspending further financing of drug imports. Following the MTR, however, the Bank resumed pharmaceutical procurements based only on the submission by MOH of an essential drugs list that applied only to the project, despite an absence of wider pharmaceutical sector reforms. Project-financed drug procurement continued until 1996, well after it was justifiable purely on an "emergency" basis.[18] While the Bank sought to sustain dialogue on pharmaceutical reform[19]—particularly the importance of cost control and developing

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15. Before the transition, modern contraception was banned, and illegal abortions were the primary mode of family planning. When abortion was legalized after independence, the number of abortions skyrocketed, to nearly 1 million in 1990. Abortion has begun to decline (to about 260,000 in 1998), as has mortality due to abortion, but both are still very high by international standards. Maternal deaths due to obstetric risk dropped from 263 in 1989 to 96 in 1998; an estimated half of the initial decline was due to legalization of abortion, but subsequent improvements in equipment and delivery practice appear to have contributed. Prevalence of modern contraception among married women 15-49 increased from 14 percent in 1993 to 30 percent in 1999 (Serbanescu and others 2000).

16. The facility is functioning, and the bulletin board in the laboratory features dozens of pictures of happy parents with their newborns. The mission was told that patients make a copayment of about $1,000, compared to $3,000 in the private sector. Although infertility is doubtless a significant issue given the high abortion rate, in vitro fertilization equipment falls outside the original primary health care objectives of the project.

17. Private pharmacies and hospital received lower markups for drugs purchased through the project (usually for high-cost, nongeneric drugs), leading some drugs to expire. The MOH eventually had to require hospitals to purchase drugs procured through the project.

18. Staff from the MOH Pharmaceutical Department and the National Drug Agency acknowledged the difficulties with this component, but had a generally more positive view of its outcome. For example, they report that following the MTR, procurements were targeted on essential drugs that were not being adequately provided by the private sector.

19. The project sponsored a 1993 study on restructuring the local pharmaceutical industry, but neither the MOH nor the Bank appeared to follow up on the recommendations. Several Aide Memoires contain detailed discussion of policy issues in the pharmaceutical sector, and the Bank sponsored a 1995 pharmaceutical sector review (Cohen 1995). The MOH initially showed little commitment to reform, however, which was resisted by a variety of vested interests. WHO and EU/PHARE are currently taking a lead role in policy dialogue for the subsector.

an essential drugs policy—the Bank's willingness to continue to finance drug procurement despite progress on basic reforms sent a mixed message.

25. Recent years have seen modest progress in strengthening pharmaceutical policies, with WHO and EU/PHARE taking a leading role in dialogue and technical assistance. But inadequate regulation and an ineffective essential drugs policy has contributed to rapid escalation of drug costs, which is threatening the financial sustainability of the new health insurance system. The local pharmaceutical industry complained about Bank-financed drugs flooding local markets, but has resisted establishment of an essential drugs policies or other regulations that would help control the rapidly escalating costs of drugs. Instituting reforms and price controls is more difficult now that private pharmacists and pharmaceutical multinationals are influential politically.

26. The project also provided equipment and training to upgrade the national Drug Control Institute, which increased its capacity to monitor drug quality; financed equipment to help protect the blood supply; and financed equipment for vaccine production and animal breeding facilities at the Cantacuzino Institute in Bucharest. The OED mission visited the institute, which now satisfies most of the national requirements for several childhood vaccines. Revenues from vaccine sales and related activities are now sufficient to cover salaries and other recurrent expenses for the institute. The institute has not yet received full Good Manufacturing Practice (GMP) certification for vaccine production, however, so it is unable to export.[20]

27. ***Improve Management of Emergencies.*** The project purchased modern ambulances and emergency equipment for district and municipal hospital emergency rooms (including 250 ambulances), and provided emergency equipment for 96 rural health centers. This component made limited progress up to the MTR; the Bank stated that the component would be significantly scaled back unless the MOH developed a comprehensive plan to improve the efficiency and effectiveness of emergency services. Despite only nominal efforts to produce such a plan, this component instead was expanded significantly after the MTR, with a final cost of $58 million ($25 million from loan funds), compared to an appraisal estimate of $9 million.

28. Most of the modern ambulances currently in use in Romania were purchased through the project. The use of emergency room equipment, and effectiveness of emergency services, varies among districts, depending on the presence of emergency doctors and extent of staff training. The impact of project investments was higher in the six districts where the Swiss supported training for emergency teams and establishment of dispatch systems.[21] In most districts, monitoring data was inadequate to assess the degree to which ambulances are being used properly, and there is no evidence as to whether project investments actually contributed to improved health outcomes. The ICR evaluation and stakeholders interviewed by OED asserted that most of the project-financed ambulances are being used for emergencies, but anecdotal evidence suggest occasional

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20. The production for pertussis vaccine is partially GMP compliant. For measles, BCG, and influenza vaccines the GMP compliant equipment exists—thanks to project financing—but the buildings are not yet GMP compliant. The animal breeding facility—which produces "germ free" animals for vaccine testing—is fully GMP compliant.

21. This parallel financing was arranged soon after the MTR, but the project procured equipment for all districts, even though only a few were receiving essential complementary assistance. The OED mission visited an ambulance center in Bucharest that had received vehicles and equipment through the project, and support for training and a computerized dispatch system through the Swiss. The dispatch system is fully functional, and the director emphasized the critical importance of this system for effective use of the vehicles and equipment. The project-funded "C" class ambulances are reserved for emergency cases, with less well-equipped "A" and "B" class ambulances dispatched for primary care. The system is not yet integrated with police, fire, or other emergency rescue operations, however.

use for non-medical transport in some districts.[22] Moreover, the project was not effective in using these extensive investments to leverage institutional reforms in ambulance services, many of which remain highly inefficient. According to a study sponsored for the ICR, project investments did not improve response time for emergencies in most districts, resulting in a high number of emergency patients found dead on arrival. Ambulance fleets remain too large—over 90 percent of the fleets are unequipped or used mostly for transport—and continue mostly to provide primary care, a legacy of the previous health system. The proposal to equip rural health centers with emergency equipment (not in the project design) was approved with limited technical evaluation, and most of this equipment is underutilized, due to lack of trained staff. The follow-on Bank-financed project is seeking to establish integrated emergency response teams in selected pilot districts.

29. ***TB and HIV/AIDS Control.*** This component, added in the final years of the project, was designed by Romanian specialists with support from WHO, the World Bank, and NGOs. The project financed lab equipment for tuberculosis and HIV/AIDS, and was well coordinated with programmatic support from WHO and NGOs. Despite progress in strengthening TB programs, Romania currently has the highest TB notification rates in Europe, and TB incidence continues to increase. This may be in part due to improved case detection, but TB cure rates and success rates remain relatively low, indicating continued shortcomings in staff training, equipment, and case follow up.[23]

Support for Health System Restructuring

30. To "support the first steps of health sector restructuring," the project financed a number of activities, including studies, decentralization pilots, a health management institute, an HIS, and a center for health promotion. In retrospect, the project design—and the international community more generally—was optimistic regarding the pace and scope of reforms. Yet the underlying strategy—to support a mix of technical inputs, experimentation, and local capacity building—was appropriate, particularly in light of the long-term nature of the reform process in Romania. While the sector studies, district pilots, and management institute did not have an immediate impact, they contributed to policy discussions and influenced the reforms implemented when a new government took power in 1996. Bank policy dialogue and sector studies in the latter years of the project also contributed to the development of the government's health sector strategy, the main elements of which remain unchanged in the current government's strategy documents (GOR 2001). The project made only limited progress in reorienting the health system to focus on prevention and health promotion, however, and the failure of the HIS component means that inadequate information remains a significant constraint to improved system efficiency and quality. Monitoring and evaluation remains weak throughout the system, making it difficult to assess what works, what doesn't, and to establish priorities for strengthening performance.

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22. According to the evaluation prepared for the ICR, only three to five districts were able to provide adequate data on ambulance utilization. In these, the ambulances were rarely if ever used for simple transport or home visits, and only one in ten trips were for minor emergencies. These districts likely have the best managed fleets, however, so use for home visits or non-emergency transport is probably higher in other districts, as is underuse due to lack of trained emergency medical staff.

23. According to WHO, the TB treatment success rate is currently 78 percent. The government is currently piloting direct by observed treatment (DOTS) with support from WHO, and hopes to achieve nationwide DOTS coverage by 2005. Staff at the Institute for Lung Diseases note that lack of transport has constrained follow-up. The ambulance services previously provided free transportation to GPs for house visits, but now that GPs are privatized, they are not able to use public ambulances.

31. A constraint throughout the project has been the limited capacity for strategic planning and sector analysis within the MOH. Relations with the health management institute have improved, and the MOH is receptive to external technical advice. But establishing and sustaining a strong planning and strategy unit in the MOH would contribute to government's capacity to absorb technical inputs and guide the implementation of health reform.

32. The new government's health strategy documents have endorsed most of the elements of the previous government's strategy, and reflects many of the issues emphasized in Bank-sponsored sector studies and dialogue. This includes revising the legislative framework; improving strategic planning in the MOH; delimiting the roles of professional associations; strengthening health promotion; strengthening the insurance collection and payment system; and rationalizing health infrastructure (GOR 2001). The current strategy documents focus on broad strategic objectives, however, rather than the specific reforms and implementation challenges that are necessary to achieve those objectives, and have not yet been translated into a prioritized expenditure program. The reform program is broad and ambitious, highlighting the need for strengthened capacity at both the strategic and implementation levels.

33. ***Developing a National Health Strategy.*** This component financed several studies of the Romanian health system. It also intended to provide technical assistance to support the development of the government's own strategy, but only a small portion of planned technical assistance was used. Bottlenecks to the use of technical assistance were a factor, as was a general lack of interest by MOH leadership in the early years of the project.

34. In 1992/93, the project financed a draft strategy paper entitled "A Healthy Future," which was the first major review of the Romanian health sector following the transition (King's Fund College, 1993).[24] Led by a team of consultants from the United Kingdom, working jointly with staff from the Institute of Health Management, the study provided analysis and a range of recommendations for health sector reform.[25] As noted above, the government did not formally respond to the study. But the report served as a framework for subsequent discussions of sector reforms, and a number of elements were eventually adopted, including making GPs independent contractors, and establishing social health insurance in 1997 (the latter likely would have occurred regardless of study recommendations). Although the study team consulted widely in preparing its report, the recommendations they made mirrored the health reforms adopted in the United Kingdom and elsewhere in Western Europe, without sufficient adaptation to the Romanian context.

35. A study on health sector financing (1998), carried out by the Health Insurance Commission of Australia, was initially intended to assess *whether* the government should establish national health insurance.[26] Although plans for the study were initiated in 1996, slow action by MOH resulted in a two-year delay. As such, Parliament passed a health insurance law before the study was launched, so it instead focused on assessing policy options under health

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24. The study was carried out by a team of foreign consultants—coordinated by King's Fund College, London, and Nuffield Institute for Health Services, Leeds—and the National Institute for Health Services and Management.

25. These included establishing a national health insurance fund, increasing hospital autonomy, establishing general practice doctors as private practitioners, reorienting the system to focus on health promotion and prevention, and strengthening accreditation for hospitals and providers.

26. The King's Fund College study had recommended social health insurance, paid through dedicated wage taxes, and similar insurance arrangements. Based on the European model, these were being established in neighboring transition countries. By the mid-to late-1990s, the Bank became concerned about the financial sustainability of the social health insurance model in Romania, but by that time the political momentum for social insurance had already been established.

insurance. The study was of high technical quality and developed a health financing model for Romania.[27] 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.

36. In addition to these technical inputs, the change in government created an opening for a more consultative approach to health sector reform. The project preparation grant financed technical working groups of technical specialists and stakeholders, coordinated by the InterHealth Institute of Maryland. These consultations and the *Romania Health Sector Reform Report* (InterHealth 1998) influenced elements of the government's 1999 health sector reform strategy. The report is stronger in identifying sector constraints than in recommending specific measures to address them, however, and did not place its recommendations with a comprehensive financing framework.[28]

37. ***Pilot Decentralization Program.*** The project sponsored in eight selected districts a pilot decentralization program that, among other activities, tested new payment mechanisms for primary care doctors. As noted above, 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. After an extended planning period, the first four district pilots were launched in 1994. An evaluation of preliminary pilot experience was carried out in 1995 (Jenkins and others 1995).[29] This was too early for an effective evaluation but provided some preliminary findings, and led to the addition of four districts, with support from the British Council. 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—for example, adding a "practice allowance" to the capitation payments for doctors (Vladuscu and Radulescu 2001).

38. ***Establish an Institute of Health Services and Management.*** Although it consumed a relatively small proportion of project costs, this was one of the most successful components. Plans to establish the school were well thought through, including the choice of international partner institutes,[30] training of the initial cadre of 12 young, motivated faculty, and the transition from external technical assistance to local staff. Before the project, few Romanians were trained in modern health policy and management. The institute has now become a center for such research and training, and is developing a cadre of skilled health policy and management professionals. During the mid-1990s, when the health reform process was stalled, the institute became an "island" for new thinking about the health system. Subsequent governments have shown greater interest in policy advice and recommendations. But influence has been somewhat

27. Although the team provided training for local staff in the use of the computer model for exploring policy options, it does not appear to be in use currently.

28. For example, the government appears to have adopted the InterHealth study's upper range estimate of total physical investment needs of the sector, without sufficiently considering fiscal implications or tradeoffs with other priority programs. In its comments on the PPAR, the government argues that these investments are necessary (Annex C).

29. The Bank required that the MOH evaluate the pilots as a condition of the first loan extension.

30. The consortium included the London School of Hygiene and Tropical Medicine, University of Montreal, and New York University.

constrained because few trainees stay long in government service, making it more difficult for government to absorb technical advice. Most of the faculty and trainees who have left have remained active in the health sector, however. Although the institute has emerged as a partner in most donor-sponsored health studies, the lack of core funding for policy research has contributed to a project-driven approach, making it difficult to establish strategic research priorities. The school is not licensed to grant degrees, and there is a gap between training capacity of the institute and the vast management training needs of health system. As part of its medium-term strategy, the Institute is considering becoming a school of public health, which will allow it to grant degrees.

39. Despite these challenges, the contributions of the institute stand in contrast to the short-term overseas training courses that the project financed for about 180 professionals, mostly government officials, some near retirement. Selection criteria were not transparent, and the expenditure appears to have had little impact on policy or management capacity.[31]

40. ***Health Information Systems.*** 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 the initial pilot district. Some of the hardware may be salvageable, but a new approach with much more user-friendly software will be necessary. It is unclear if resources are currently available, however, to develop and implement such a system. 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. Improving the quality and availability of information on service provision and cost is essential to further development of health reform—including improving the payment system and rationalizing service delivery.

41. ***Health Promotion and People's Participation.*** This component was unsuccessful relative to its original objectives and the critical need for improved health promotion in Romania. The project helped establish a National Center for Health Promotion and Education, 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 MTR. The MOH showed relatively little interest in health promotion through most of the project, and 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. 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 due to government resistance to using loan funds to finance grants. Thus, the goal of promoting people's participation in health promotion was not achieved. But while the impact and profile have been relatively limited thus far, it is greater than would have occurred without the project and Bank involvement. The National Center for Health Promotion has emerged as the coordinator for

31. Correspondence in project files suggests that senior MOH officials resented that the initial cadre of faculty sent for overseas training were young and selected on a merit basis, to the exclusion of party loyalists. Following the midterm review, the Bank approved overseas short-term training in response to MOH recommendations with relatively little oversight, partly in the hope that oversees exposure might increase receptivity to reform, but the high cost of this training/tourism also helped "improve" the project's disbursement record.

Romania's health promotion network, and receives direct funding from the state budget. Further expanding prevention and promotion programs will be critical, however, to reducing or stabilizing the growing burden of noninfectious diseases.

RATINGS

Relevance

42. Project relevance is rated **substantial** overall. The project design was consistent with the Bank's country strategy and with the government's stated objectives for the health sector. The project design was too large and complex, but it tried to "do the right things," given the time and context. Rehabilitation investments would have been more relevant if they had been more consistently coordinated with technical assistance and key institutional reforms—or scaled back if conditions for effective use of investment resources were not yet in place. The project pursued a multifaceted approach to encouraging sector reform—combining sector analysis, pilot projects, and strengthening local capacity for management and policy analysis—which was appropriate given the long-term nature of health sector reform. While the MOH showed limited interest in the reform components for the first years of implementation, the reform components became highly relevant subsequently.

Efficacy

43. The project's overall efficacy is rated as **substantial.** Performance varied considerably among the components varied considerably (see Annex B). In relation to major objectives, the first objective—to rehabilitate and upgrade the primary health care delivery system—was only partially achieved, for reasons discussed above. The project clearly contributed, however, toward "supporting the first steps of a major restructuring of health sector financing and management...," as stated in the second objective. It remains uncertain whether these reforms will "...ensure a sustainable and cost-effective health-care system in the medium term." The reforms have created the potential for achieving this objective, but further progress is needed on a wide range of reforms, capacity building, health promotion, and other activities to achieve this result. The political and institutional environment in Romania following the transition was particularly challenging, however, and health sector reform is a slow and contentious process even in advanced economies. The efficacy rating thus reflects the greater importance accorded to the project's contributions to the national reform process.

Efficiency

44. The project's efficiency was only **modest.** Some components were efficiently implemented, including maternal and child health, health reform activities, and establishing the school of health management. Yet the bulk of project expenditures were not efficiently used. Some of the rural health clinics, laboratory and emergency equipment, and ambulances purchased through the project are being put to efficient use, but many are underutilized for lack of adequate planning and complementary inputs. While project-financed pharmaceuticals procurements resulted in cost savings relative to previous prices, the total cost appears to have well exceeded the net benefit in terms of the overall quality, availability, and efficiency of pharmaceuticals nationally. Finally, the $20 million spent on the health information system was a particularly inefficient use of scare resources, in light of the limited impact of these investments.

Outcome

45. The project's outcome is rated **moderately satisfactory**, compared to the satisfactory rating in the ICR.[32] Despite the mixed outcomes of investment activities, the project contributed to progress with respect to both major objectives, despite a difficult institutional context. This represents an upgrade from the original OED evaluation summary rating of moderately unsatisfactory, based on a desk review of the ICR. Specific PPAR findings that contribute to this more positive assessment include: (i) confirmation of the project's contribution to sector reforms; (ii) a more positive assessment of some project components, based on field visits (particularly for the reproductive health component); and (iii) the generally positive views of stakeholders toward the project's overall contributions, despite a variety of shortcomings. With regard to the latter, in a confidential survey given by OED to a dozen Romanian counterparts in government, NGOs, and research institutions, most agreed or somewhat agreed that "the project achieved its major objectives," and none disagreed.[33]

Institutional Development Impact

46. Institutional development impact is rated **modest**, consistent with the ICR.[34] The project made a substantial contribution to strengthening capacity for health management and policy analysis through the establishment of a Health Management Institute, and the PMU gained experience in managing a complex investment operation. The staff and trainees from the institute and the PMU have benefited the overall health system, but the impact on the MOH itself has been more limited. The project also contributed to a number of institutional reforms, which may improve the health sector's effectiveness and efficiency, though it is still early to judge impact. The project's rehabilitation components—including pharmaceuticals, emergency medical services, rural health centers, and health information systems—emphasized physical investments without sufficient attention to the need for technical assistance, training, and institutional reforms. On average, respondents to the stakeholder survey only "somewhat agreed" that "the project enhanced national capacity to plan, manage and evaluate health programs;" three respondents disagreed with this statement. Most agreed or somewhat agreed that the project had contributed to strengthening the legislative and regulatory framework for the health sector, with two dissents.

Sustainability

47. Sustainability prospects vary considerably among components, and even within components—and the lack of data makes it difficult to judge the extent to which various project investments are at risk. For example, the maternal health investments are likely to be sustained, while sustainability prospects for dispensaries and emergency medical equipment depend on continued reforms and the adequacy of recurrent expenditures. The pharmaceuticals and other commodities procured under the project were initially intended as emergency injections of critical inputs; they were not intended to be sustainable as such. The slow progress in strengthening pharmaceutical policies and regulations represents a long-term risk to sustainability of these

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32. ICRs have a three-point rating scale for project outcome (highly satisfactory, satisfactory, and unsatisfactory). The OED rating of moderately satisfactory is consistent with the text of the ICR. According to OED project evaluation guidelines, the moderately satisfactory rating is consistent with ratings of substantial for project relevance, modest for efficiency, and substantial for efficacy.

33. Two respondents strongly agreed, three agreed, and five "somewhat agreed." Two respondents "neither agreed nor disagreed." Respondents from the MOH/government tended to be more positive than those outside of government.

34. The borrower disagrees with this rating, and suggests that a rating of substantial would be more appropriate in light of progress made in reforms (Annex C).

investments. Risks to future project benefits include availability of recurrent financing to sustain investments and continued uncertainties about the sustainability of sector financing—particularly to contain escalating and drug and hospital costs. Most of the reforms initiated with project support are being continued by the new government, and the new government's health sector strategy calls for continued reforms and capacity building measures that could enhance the sustainability of both the investment and reform contributions of the project.[35] Most stakeholders surveyed either agreed or somewhat agreed that the project's contributions were likely to be sustained. Despite these caveats, sustainability is rated **likely**, consistent the ICR.

Bank Performance

48. Bank performance is rated satisfactory, but with several shortcomings, compared to a satisfactory rating in the ICR. The Bank's project design appropriately sought to address both immediate rehabilitation and to initiate structural reforms. The combination of crisis conditions in the health sector and high expectations for reforms following the collapse of communism led to an overly complex design and undue optimism regarding the pace of reforms. Project supervision sought to improve implementation performance and sustain policy dialogue, but was undermined by staff turnover. Following the MTR, the Bank shifted supervision responsibility to the field and gave increased attention to project implementation, which facilitated completion of project activities. But Bank management and project supervision gave too much emphasis to disbursement and completion of planned outputs, particularly in the years following the MTR, rather than intended impact. The Bank also sought to sustain dialogue on reform during a difficult period, and responded well when a change in government created new openings for reform. The stakeholder survey revealed a generally positive assessment of Bank performance in design and supervision.[36] Concerns expressed included staff turnover; lack of local knowledge by some international consultants; inadequate donor coordination; and the cumbersome nature of some Bank rules and procedures.

Borrower Performance

49. Borrower performance is also rated **satisfactory**. Performance during project preparation was satisfactory, but borrower performance in project implementation and sector reform subsequently deteriorated as a result of high turnover and weak commitment at the political level. Project implementation improved in the year following the MTR, but commitment to policy reform remained weak. The government's weak commitment to health promotion was a particular concern, as was the greater emphasis placed on physical investments rather than rationalizing and strengthening service delivery. Government took significant steps to implement health sector reform in the latter years of the project, however. The initial OED evaluation summary rated borrower performance as unsatisfactory. The PPAR rating gives greater weight to progress on policy and project implementation in the project's final years.

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35. As noted in the borrower's comments (Annex C), the government has recently initiated several policy changes that may enhance prospects for sustainability. These include plans to transfer ownership of clinic facilities and equipment to family doctors, and further training for family doctors. Incentives in the family doctor contracts to locate to underserved areas may improve utilization of project-financed investments in rural clinics.

36. For example, nearly all respondents agreed or strongly agreed that Bank staff have been technically well-qualified and brought valuable international experience, and that effective and regular supervision has been carried out by the Bank.

FUTURE DIRECTIONS

50. The health reforms of the past few years have fundamentally altered the framework for health services in Romania, but players have yet to fully adapt to their new roles. The Ministry of Health has become the lead agency for regulation, standard-setting, quality assurance, monitoring and evaluation of the health system, but does not yet have the capacity to fully carry out these roles. It also retains responsibility for capital investments, with the risk that focus on the latter will crowd out attention to policy issues. The health insurance houses have taken responsibility for financing curative care, but capacity and experience are limited, and the incentives, structure, and functions of the health insurance system remain to be clarified. Hospitals have greater autonomy, but few trained managers. The reforms thus create opportunities for improving quality and efficiency, but substantial progress in capacity building and policy development is necessary to realize this potential. Moreover, the reforms create additional risks, particularly related to financial sustainability, the functioning of the primary care and referral system, and access to health service for the rural poor.

51. After several years of preparation and extensive consultation, the Bank approved a Health Sector Reform Project in 2000. The project is a six-year adaptable program loan in two phases. It seeks to further strengthen health reforms while supporting additional investments, particularly for district hospitals and emergency medical services.[37] The project preparation process itself made a substantial contribution to stakeholder dialogue. Project design sought to incorporate lessons from the earlier project, including seeking to avoid excessive complexity, and giving strengthening attention to health promotion and monitoring and evaluation. The project retains a strong focus on infrastructure, however, although it seeks to build in support for systemic reforms (for example, piloting an integrated approach to emergency services). In response to government request (and to reduce project complexity), the project does not provide direct support to strengthen health financing and the newly established national and district health insurance funds; instead, 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, however, including through a Public Expenditure Review (currently underway), as well as inclusion of health sector issues in an ongoing social sector development loan.

52. In moving forward, the experience with the first project highlights several specific challenges facing the health system.

53. ***Health Financing and Sustainability.*** 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. To address these risks, parallel action will be necessary on a variety of fronts. First, the payment system will need to be further refined to better align provider incentives with desired quality and efficiency objectives. This will require technical support and capacity building in the health insurers. Second, the "separation of purchasing from provision" is unlikely, on its own, to result in substantial efficiency gains or rationalizing of the hospital system. The insurance houses do not currently have the regulatory authority or political clout to force significant rationalizations in hospitals. Hospital downsizing and restructuring will be necessary, although politically

37. Specific components for the first 3-year phase include: (i) planning and regulation of health-care delivery systems; (ii) district hospitals: essential upgrade and integration; (iii) primary care development; (iv) emergency medical services; (v) public health and disease control; (vi) project coordination and management. Total project cost (both phases) is $112 million, with an IBRD loan of $60 million—$40 million for the first phase. Triggers to move to the second phase focus on: (i) satisfactory legal and regulatory frameworks for investment and publicly financed health-care providers; and completion of rational plans for future investment and physical and human resources.

challenging to implement. Third, the capacity and governance structure of health insurers will need to be strengthened. While the Bank was initially opposed to proposals for electing the boards for health insurance houses, the current system of appointment by the government has led to administrative instability and politicization of senior positions.

54. ***Clarifying the Legal Framework.*** Despite the passage of key legislation, a number of aspects of the legal and regulatory framework remain to be clarified. Most important is to clarify the relative roles and relations of the health insurance funds and the Ministry of Health—which still owns most secondary and tertiary facilities. Accountability for health insurance revenues also needs to be clarified, given that the MOH has asserted control over "surplus" revenues to help close the government's chronic fiscal deficit. Clarification is also necessary regarding the ownership of rural health centers and related equipment, given that these are now staffed by GPs. The government's strategy highlights the need for progress in this area; drafting and passing effective legislation will require both technical and political skill, however.

55. ***Primary Health Care.*** Establishing general practice as a distinct specialty, paid through a mix of capitation (70 percent) and fee-for-service was intended to strengthen primary service delivery, improve client responsiveness through competition among GPs, and improve the referral system through giving GPs a "gatekeeper" function. These reforms were tested initially through the district pilots and have now been implemented nationwide. Importance policy changes were introduced as a result of the pilot, including establishment of a "practice allowance" and up to double the capitation allowance for family doctors working in underserved areas.

56. The reforms create the potential for more client-responsive primary care, but also create additional risks. First, the major risk is that financing for primary care and prevention through the health insurance funds is being "squeezed" as a result of cost overruns in the hospital sector. This was a major problem in 2000, resulting in wide press coverage of inadequate funding for drugs, and underpayment for GPs.[38] Left unresolved, this could threaten the credibility of the reforms. Second, most GPs are former pediatricians or adult medicine specialists with little additional training to help them adapt either to their new roles as family doctors or to the new demands of running a private practice. Some training is being provided through NGOs and other donors, but it is inadequate.[39] Third, the reforms may have initially weakened the referral system by separating primary care from hospitals. Further policy development and training is necessary to strengthen referral and clarify new roles. Fourth, financing equipment and other capital investments for general practitioners remains an unresolved issue. A supplementary "practice allowance" was to help cover these costs but has since been reduced significantly. Fifth, 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. While the current approach to primary care has the potential to succeed in urban areas, it may prove inadequate for rural primary health care. Nearly half of the populace lives in rural areas, where "competition" among general practice doctors is unlikely to bring about quality improvements, since there is limited choice of

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38. Allocations to primary health care increased by about 30 percent when national insurance was first introduced in 1998. The government had set a target of 11 percent of the health insurance proceeds to be allocated to primary health care, but actual expenditures were only about 9 percent in 1999, and slightly above 9 percent in 2000. Certain districts had significant shortfalls in primary care allocations, however, resulting in underpayment for GPs and negative press coverage. Comparative data on GP salaries were not available, but appeared to have increased somewhat since the reforms, but with increased variation among providers – depending on location, the number of patients, etc.

39. In the borrower comments (Annex C), the government notes recent initiatives to address these constraints, including: (i) allocating at least 9 percent of the health insurance budget to primary care; and (ii) a six-month retraining program for family doctors that had not yet received formal accreditation as GPs.

alternative providers. Capitation payments create some incentive for providers to locate to rural areas, and the government's strategy calls for further strengthening such incentives.

57. ***Equity***. Access to and quality of health services in Romania remain inequitable among geographic areas, among income groups, and for ethnic minorities. Several concerns deserve highlighting. First, because most of the rural population is engaged in subsistence agriculture, many rural households are at risk of losing access to health services if the health insurance funds begin enforcing insurance card requirements. This would further reduce the incentives for GPs to work in rural areas and significantly undermine equity. Second, the practice of informal payments for doctor remains widespread; this distorts provider incentives and constitutes a significant burden on the poor (Lewis 2000). Neither the ongoing Bank project nor current government strategy documents propose a comprehensive approach to address this entrenched problem. Third, a transparent criteria for redistributing health insurance income among districts needs to be established and consistently implemented. This issue is highlighted in the government's strategy paper, and the government states that it is planning amendments to the health insurance law to establish a more transparent distribution formula (Annex C).

58. ***Health Promotion.*** Recent reforms create a significant opportunity for the MOH to take a leadership role on health promotion and prevention. The current project is providing support for development of a national health promotion strategy, health behavior surveys, as well as technical assistance and training at the national and district levels. Building on the modest progress under the first project, the challenge is to establish a comprehensive approach to health promotion, which incorporates traditional health education activities with strengthened regulations (including for tobacco, alcohol, and accident prevention), and increased community participation. For example, tobacco control legislation has been developed, but has not yet passed Parliament. Improving monitoring and evaluation on the causes of ill health—and wide dissemination of findings among decision makers and the public—will be important to building support for health promotion.

59. ***Pharmaceuticals.*** With support from WHO and other partners, the government has taken steps to improve the policy framework for the pharmaceutical sector. But effective cost controls have yet to be implemented—both in terms of establishing an essential drugs policy and strengthening incentives in the reimbursement system to promote cost containment. Continued cost escalation could threaten the financial sustainability of social health insurance and undermine equity—as poor patients are forced to pay for high-cost drugs or go without. Various vested interests oppose these reforms, however. The Bank is not currently providing financing for pharmaceutical policy development, but should seek to remain engaged in policy dialogue—and could discuss with the government the possibility of incorporating key pharmaceutical sector reforms into future programmatic lending at the national or sector levels.

60. ***Health Information, Monitoring, and Evaluation.*** The current Health Reform Project includes a set of indicators for each component, and efforts to collect baseline data are currently underway.[40] The more critical challenge, however, 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. Substantial data are available on mortality, morbidity, and service utilization. But due in part to the failure of the HIS component, these information are not systematically analyzed or used by

40. The PMU is expected to submit a report by January 2002 giving baseline values (from 2000) for key project indicators, as well as 2001 data where available. These data will have to be collected from a variety of sources, including routine health surveillance data (e.g., incidence of TB, STIs, or accidents), specific surveys (e.g., for tobacco consumption or sexual behavior), as well as financial and administrative information.

national or local policymakers in decisionmaking. The recently created Health Insurance Funds are beginning to collect and analyze data on costs and expenditure trends, but progress is needed to use the information to refine the payment system and improve efficiency of resource allocation. Future efforts to strengthen both health and financial collection, however, should focus first on addressing the organizational requirements and incentives for strengthening HIS, before making substantial investments in hardware and software.[41] Finally, a key priority is to improve the quality and frequency of data on health behaviors—which invariable must be collected by surveys—as well as studies on the effectiveness of specific program interventions in achieving behavior change. Such surveys and studies could be carried out by academic or research organizations, but need to have standardized designs and stable funding to allow tracking of trends and to inform the policy process.

FINDINGS AND LESSONS

61. The project reaffirms several long-standing OED lessons (Johnston and Stout 1999), including the need to match project design with borrower implementation capacity and avoid excessive complexity, and the need to focus Bank supervision on achieving development outcomes rather than maximizing disbursements. Other key findings of broader relevance are as follows:

- The impact of health sector investments—particularly for facilities, equipment, and other "hardware"—depends crucially on complementary investments in training, and on parallel policy and institutional reforms. The project provides examples where this was done well (maternal and reproductive health) and where it was done less well or poorly (the health information system, emergency medical services, rural health centers). A more phased approach, with a smaller loan size, would have allowed the Bank to more effectively "package" investments with technical assistance, policy dialogue, and targeted conditions, such that they leverage wider institutional reforms. This is the intention behind the use of an Adaptable Program Loan for the current health reform project.

- Health system reform is a nonlinear process, and the Bank is only one of many players. Project experience suggests that a mixed strategy incorporating sector analyses, pilot projects, long-term local capacity development, and policy dialogue may not yield immediate results—particularly when government commitment to reform is low—but may prove influential subsequently when the political or policy context changes. The impact of these activities on the policy process, however, depends on the technical quality; the extent of local involvement in the design, implementation, and evaluation; and government's capacity to absorb technical advice.

- While reform may be necessary, reforms that are partially enacted or inadequately implemented risk falling short of objectives and/or being discredited. For example, the recent reforms to establish GPs as independent practitioners could be undermined by a lack of training for GPs and shortfalls in funding for primary care through the recently established health insurance system. In addition, the "separation of purchasing from provision" of health services, through the establishment of a Health Insurance Fund is unlikely to lead to fundamental restructuring or efficiency gains in service provision without parallel (and politically difficult) efforts to rationalize and restructure service delivery.

41. For example, a successful HIS component in Hungary required hospitals to develop an information strategy in order to quality for project investments. Even hospitals that did not benefit from project funding are still using the plans.

- Bank support can help strengthen and sustain preventive and health promotion programs—which are often low priorities for governments—but without continued supervision attention and policy dialogue, these programs are likely to be neglected in favor of curative and hardware interventions.

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Annex A. Basic Data

ROMANIA—HEALTH REHABILITATION PROJECT (LOAN-3409)

Key Project Data

	Appraisal estimate	*Actual or current estimate*	*Actual as % of appraisal estimate*
Total project costs (US$)	207.5	224.53	108.2
Loan amount (US$)	150	149.03	99.3
Cancellation (US$)		0.97	
Date physical components completed: June 30, 1999			

Project Dates

Steps in project cycle	*Original*	*Actual*
Approval		October 1, 1991
Signing/Agreement		October 7, 1991
+Effectiveness	January 7, 1992	January 1, 1992
Closing	June 30, 1996	June 30, 1999

Staff Inputs (staff weeks)

Stage of project cycle	*Actual/Latest Estimate*	
	Weeks[a]	*US$*[b]
Identification/Preparation + Appraisal/Negotiations		452.376
Supervision		1,109.209
ICR	18	45.769
Total		1,607.623

a. Staff weeks not available for years prior to 1999; 22.7 staff weeks supervision recorded in 1999.
b. Totals include Trust Fund financing of US$3,315

Annex A

Mission Data

Stage of project cycle	Date (month/year)	Specializations represented	Performance Ratings	
			Implementation Status	Development Objectives
Identification/Preparation		1 health specialist (team leader), 1 public health specialist, 1 pharmaceuticals specialist, 1 health economist, 1 family planning expert, 1 senior implementation specialist, 1 operations officer		
Appraisal/Negotiation		1 health specialist (team leader), 2 public health specialists, 1 pharmaceuticals specialist, 1 health economist, 1 family planning expert (UNFPA representative), 1 senior implementation specialist, 1 operations officer, 1 administrative assistant		
Supervision Core team (10 supervisions)		1 public health specialist (program team leader), 1 health finance/management specialist, 1 health information systems specialist, 1 medical equipment specialist, 1 program assistant, 1 operations officer (task team leader), 1 operations analyst		
MTR	03/1994	1 senior implementation specialist 1 PAS 1 HNP specialist (mission leader), 1 senior implementation specialist and PAS, 1 pharmaceutical specialist, 1 program assistant, 1 health policy specialist, 1 health promotion specialist, 1 operations officer	U	U
ICR	02/2000	1 health economist (program team leader) 1 public health specialist, 1 peer reviewer from HNP thematic group, 2 support staff with medical and health management qualifications, 1 operations officer (task team leader) 1 health information systems expert, 1 health services management expert (+input from other staff of Institute of Health Services Management and Surveyors)	S	S

Annex B. Ratings by Major Objectives and Components

(H=High, SU=Substantial, M=Modest, N=Negligible, NA=Not Applicable)

Development Objectives:		*ICR*	*PPAR*
(i) rehabilitate and upgrade the primary health care delivery system which is collapsing through want of equipment, spare parts, drugs, medical supplies and transfer of knowledge to health providers;		*M*	*M*
(ii) support the first steps of a major restructuring of health sector financing and management to ensure a sustainable and cost-effective health care system in the medium term.		*M*	*SU*
Outputs of Components:	***% of project cost***	***ICR***	***PPAR***
A. Rural Dispensaries	10	M	M
B. Reproductive Health	11	M	SU
C. Training (component cancelled)	0	NA	NA
D. Drugs & Consumables	34	M	M
E. Mgmt of Emergencies	26	M	M
F. Health Promotion	1	M	M
G. Health Reform Strategy	1	SU	SU
H. Health Mgmt Information System	11	N	N
I. Health Mgmt School	1	SU	SU
J. TB Control + HIV/AIDS	3	M	M
K. Project Management		M	M

Annex C

Ministerul Sănătății si Familiei
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Mr. Alain Barbu
Sector and Thematic Evaluation Group
Operations Evaluation Department
The World Bank

January 28, 2002
Bucharest

Dear Mr. Barbu,

Re: Romania Health Services Rehabilitation Project (Loan 3409)
Project Performance Assessment report

Thank you for asking our opinion on the *Project Performance Assessment Report- Romania Health Services Rehabilitation Project.*

After a thoughtful reading of the document, we consider it as a very accurate description and analysis of the first loan for the health sector in Romania. It shows a deep understanding of the reform process in the health sector in Romania, including its successes and weaknesses, and the present challenges we have to deal with.

Although we agree with the accuracy of the report in generally, we have some comments that might be taken into consideration for the final report:

1. You could consider the GPs as independent practitioners rather then private practitioners (page 2, page7). Unlike the pharmacists and the dentists who have almost 100% private practices, the GPs are functioning mainly in public spaces, given to them under MoH regulations. The GPs do not own the facilities and they are reimbursed almost 100% from public funds, i.e. the Health Insurance Funds.
2. Pct. 38: "Establishing of the Institute of Health Services management": The last sentence concerning "the recently proposed merger with the school of public health at the University of Bucharest.." is not accurate. We do collaborate in some of our training programs both with

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the University of Medicine and Pharmacy "Carol Davila" Bucharest (Department of Public Health) and with the University of Bucharest-Faculty of Sociology, but we will not merge with any of them in the near future. Even more, we are licensed by MoH to grant certificates for our continuing education training programs, which are also credited by the College of Physicians. We have presently under work a mid-term strategy to become a school of public health, in order to be able to grant degrees as well. This strategy includes collaborating, but not merging with the universities mentioned above.

3. Pct. 41:"Health Promotion and People's Participation"- We would also add to this chapter the fact that even the original project's objectives were not entirely achieved, the National Center for Health Promotion and Education is a sustainable outcome of the project, being the methodological forum for the health promotion country network and the coordinator of the national program for health promotion and health education, program substantially funded yearly from the state budget through MoH.
4. Pct. 56:"Equity"- The statement "Fourth, minority ethnic groups, particularly the Roma, are often marginalized or excluded from care" is no evidence based and we consider it is no truth in it as a general remark concerning minority ethnic groups. The Rroma population in particular is a category with some specific features in their quality as health services consumers: a high percentage of this population is neither insured nor registered with a GPs. They are however high consumers of public health services, mainly tertiary health services, while they are not interested in prevention or primary health care. The next phrase, "Different approaches may be needed, ...but this not appear to be a political priority at present" is no longer actual, different strategies concerning the poor and marginalized groups being on the Government agenda, including the health sector.

Thank you again for asking our comments and opinion on this document.

Yours sincerely,

Dr. Bogdan Martian
Director

Annex C

ROMÂNIA
MINISTERUL SĂNĂTĂŢII ŞI FAMILIEI
CABINETUL MINISTRULUI

Nr. DB 991 Data 1.02.20

To: Mr. Alain Barbu,
Manager
Sector and Thematic Evaluation Group
Operations Evaluation Department

Dear Mr.Barbu:

Re: Romania Health Services Rehabilitation project (loan 3409 RO)

Thank you very much for the deep analyses of the Health Services Rehabilitation Project (HSRP)

The Ministry of Health and Family considers your report a very professional point of view on a long and huge effort of the Ministry of Health and the World Bank. I had the opportunity to lead the implementation of the project for a period in 1996 and to participate through the ministry' staff at your experts evaluation in 2001.

We would like to point some aspects:
- the evaluation methodology is very updated and probably is applied to the last generation of projects designed from the beginning to answer to some mandatory requirements;
- The HSRP was an "emergency program" designed to respond to the needs of a system in a deep crisis. Any evaluation of the background emphasized lack of human and physical resources, knowledge, excess of centralization, no possibility for local initiative, which reflected in the implementation performance.
- It was the first and biggest and most complex program for health in the region.

The political context of the country, the instability, frequent changes or inconsecvencies of the policy during transition which reflected also at the level of the Ministry of Health risen lots of difficulties for the implementation. The teams involved in the management and implementation

of the project had to face lack of specialized staff, counterpart funds, legislation constrains (especially Court of Accounts) and sometimes lack of flexibility from the Bank side.

In spite of these aspects the development of the project objectives are very significant. Both the rehabilitation of primary care and the restructuring of the system were achieved. Comparing to the system of 1991 the health system in 1999 (end of the project implementation) was decentralized, financed through health insurance, focused on the family physicians, which have personal contracts with the HIH and looking for different mechanism to control the cost and quality of the services. For all these changes the HSRP had the catalyst role, generating or supporting the main decisions in the heath system (evaluation of the system and proposing the main direction of the reform, experimenting the capitation and fee for services in the primary health care, the issuing the health financing model, the improving of the primary and emergencies care, improving the quality of the vaccines and drugs, etc.

In this context we think that the borrower performance should be reformulated and rated higher.

On the sustainability of the system we have a slight different opinion.
The primary health care is still a key element of the heath strategy. The family doctors received through contracts without taxes the cabinet and sometimes the equipment (depending on the level of training and interest). The budget practice and the salary of the doctor are significant higher comparing with the old state salary. The Ministry is preparing a set of regulation in order to attribute the equipment to the doctors. The ambulatory (specialized) care cabinets are also contracting individually. A training program started last year (organized by the MOHF) in order to assure for all the family doctors in the country the requested level of competence. Annually the primary care is receiving a special percentage of the health insurance fund to cover all the needs. This year is agreed 9%.

Emergency care is also improved, confirmed by the quality indicators and is supported by the new ongoing World Bank project which creates integrated emergency teams (doctors, nurses, firefighters).

Another aspect for debate is the institutional development, which we think is substantial. There are other institutions with an improved capacity for health

management and policies as result of the project activities. The MOH staff involved in the project management and implementation benefited of training or external assistance. They are working now in different departments of MOHF and participate actively at the decisions of changes. The institutional development support was continued by other agency as PHARE and also by the present World Bank project (component planing and regulation of the system). The team of the PCU is trained in the old project and successfully manages the new one. An important indicator of the capacity of the ministry to develop health policy is the fact that, in the last years the MOHF's reform strategy is based on the World Bank documents strategy and continuous is improving. Other institution like Institute for Drug Control financed by the project became the National Agency for Drug and is aligned to other similar European institution. Cantacuzino Institute is producing some vaccines at GMP standards and is looking for international co-operation.

The equity of the provision of the health services is an objective of the strategy of the MOHF. In order to assure the continuity of care, new requirements of the frame contract are asking to the family doctors to organize themselves in group practice. Also the contract is asking that they have on their list the non-assured and risk groups like Roma, unemployed, etc. The vaccination, emergency care, surveillance and treatment of TB are free. For the TB control are involved the local authority and police. The doctors working in areas with Roma population are receiving a doubled salary. Taking into consideration the above measures, the remark with the Roma population has to be interpreted in fact like positive discrimination. In Romania, there are no discriminated groups, by laws. We do have some problems with the Roma population, because sometimes their behaviour is self exclusive of the society. But Romania has very important progresses on these issues. Two partnership agreements between the leaders of Roma, NGOs and Ministry was signed the last year in order to control all the aspects linked to health, education. Especially on health the progress is notable. The partnership supported the creation of a new profession: mediator for medical care in order to facilitate the access of the Roma population and to improve their healthy behavior. This profession has been included in the official list of occupations in Romania. Starting with this year it will be financed nation wide. Due to this success the Romania was asking by OSCE to prepare a guideline for this new profession.

Also for the equity reasons, the MOHF is preparing new amendments to the Health Insurance Law for a transparent system of redistribution among districts.

We understand and we agree that the Bank is always focused on a balance between the disbursement and impact. We also agree that institutional development is a major factor for improvement. We also think that in the context of the Romanian system the improvement of the technology was critically important. Is well recognized that the technology improves the quality of the heath services. The investment in medical equipment was modest within the HSRP comparing to the needs and addressed only to the rural health centers and emergency care. The report of the InterHeath on the physical assets in 1998 reflected that the major part of the medical equipment and other assets were obsolete and dangerous for the population and medical staff. In this conditions we can not speak about quality of care.
In conclusion the investment was not a waste, even in the situation when the initial destination (RHC) was changed. This change was made to improve the utilization rate of the equipment (at the level of ambulatory centers and hospitals). The lesson learned with the health information system is also important.

We would like to underline that during the implementation of the project a major change of financing of the system has been implemented. The HSRP was designed for a centralized system and had to adapt to a health insurance one. Judging retrospectively, this required more assessment, flexibility and coordination both from the Ministry and the Bank' side.

Hope that you would find valid our comments and helps you to better understand the general context and the impact of the HSRP at the present time.

Best regards,

Dr. Daniela Bartos
Minister of Health and Family

cc: Mr. Richard Florescu; Mr. Tim Johnson