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The World Bank

Report No:ICR0000305

IMPLEMENTATION COMPLETION AND RESULTS REPORT
(IDA-34080 JPN-52808 NETH-24413 SIDA-29833)

ON A

CREDIT

IN THE AMOUNT OF SDR7.6 MILLION
(US$10 MILLION EQUIVALENT)

TO THE

REPUBLIC OF MOLDOVA

FOR A

HEALTH INVESTMENT FUND PROJECT

May 1st, 2007

Human Development Sector Unit
Europe and Central Asia Region

CURRENCY EQUIVALENTS

(Exchange Rate Effective 11/10/2006)

Currency Unit = Leu
MDL 1.00 = US$ 0.0759
US$ 1.00 = MDL 13.18

FISCAL YEAR
January 1 - December 31

ABBREVIATIONS AND ACRONYMS

CAS	Country Assistance Strategy
ECA	Europe and Central Asia
EGPRSP	Economic Growth and Poverty Reduction Strategy Paper
DO	Development Objective
GOM	Government of Moldova
HIC	Health Insurance Company
HIF	Health Investment Fund
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome
IDA	International Development Association
M&E	Monitoring and Evaluation
MOF	Ministry of Finance
MOH	Ministry of Health
PAD	Project Appraisal Document
PCU	Project Coordination Unit
POM	Project Operation Manual
PSRA	Public Sector Reform Adjustment
RM	Republic of Moldova
SIDA	Swedish International Development Agency
UNAIDS	United Nations AIDS Programme
UNICEF	United Nations Children's Fund
UNDP	United Nations Development Programme
WHO	World Health Organization

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COUNTRY
Health Investment Fund Project

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A. Basic Information			
Country:	Moldova	Project Name:	Health Investment Fund Project
Project ID:	P051174	L/C/TF Number(s):	IDA-34080,JPN-52808,NETH-24413,SIDA-29833
ICR Date:	04/23/2007	ICR Type:	Core ICR
Lending Instrument:	SIL	Borrower:	REPUBLIC OF MOLDOVA
Original Total Commitment:	XDR 7.6M	Disbursed Amount:	XDR 7.5M
Environmental Category: C			
Implementing Agencies: Ministry of Health and Social Protection			
Cofinanciers and Other External Partners: Government of Netherlands			

B. Key Dates				
Process	**Date**	**Process**	**Original Date**	**Revised / Actual Date(s)**
Concept Review:	12/15/1999	Effectiveness:	07/04/2001	07/04/2001
Appraisal:	05/02/2000	Restructuring(s):		
Approval:	08/22/2000	Mid-term Review:		01/15/2004
		Closing:	11/30/2005	12/30/2006

C. Ratings Summary	
C.1 Performance Rating by ICR	
Outcomes:	Satisfactory
Risk to Development Outcome:	Moderate
Bank Performance:	Satisfactory
Borrower Performance:	Satisfactory

C.2 Detailed Ratings of Bank and Borrower Performance (by ICR)			
Bank	**Ratings**	**Borrower**	**Ratings**
Quality at Entry:	Satisfactory	Government:	Satisfactory
Quality of Supervision:	Satisfactory	Implementing Agency/Agencies:	Highly Satisfactory
Overall Bank Performance:	Satisfactory	**Overall Borrower Performance:**	Satisfactory

C.3 Quality at Entry and Implementation Performance Indicators			
Implementation Performance	**Indicators**	**QAG Assessments (if any)**	**Rating**
Potential Problem Project at any time (Yes/No):	Yes	Quality at Entry (QEA):	None
Problem Project at any time (Yes/No):	No	Quality of Supervision (QSA):	Yes
DO rating before Closing/Inactive status:	Satisfactory		

D. Sector and Theme Codes		
	Original	**Actual**
Sector Code (as % of total Bank financing)		
Central government administration	5	5
Health	95	95
Theme Code (Primary/Secondary)		
Access to urban services and housing	Secondary	Secondary
Health system performance	Primary	Primary
Other communicable diseases	Secondary	Secondary
Population and reproductive health	Secondary	Secondary
Rural services and infrastructure	Primary	Primary

E. Bank Staff		
Positions	**At ICR**	**At Approval**
Vice President:	Shigeo Katsu	Johannes F. Linn
Country Director:	Paul G. Bermingham	Roger W. Grawe
Sector Manager:	Armin H. Fidler	Armin H. Fidler
Project Team Leader:	Maris Jesse	Joana Godinho
ICR Team Leader:	Maris Jesse	
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F. Results Framework Analysis

Project Development Objectives (from Project Appraisal Document**)**

The Health Investment Fund (HIF) Project aims to improve the health status of the Moldovan population, and to increase the quality and efficiency of the public health sector, by improving access to essential services for the poor. The project also includes

support to strategic work, aiming at controlling the TB and HIV/AIDS epidemics. Specific objectives of the project are:

(i) Guarantee universal access to a minimum package of health services;
(ii) Modernize emergency services and primary health care;
(iii) Reduce excess capacity in the health sector;
(iv) Strengthen health sector institutional capacity; and
(v) Support the development of TB and AIDS Strategies.

Revised Project Development Objectives (as approved by original approving authority)

(a) PDO Indicator(s)

Indicator	Baseline Value	Original Target Values (from approval documents)	Formally Revised Target Values	Actual Value Achieved at Completion or Target Years
Indicator 1 :	About 35% of all public health expenditures should be allocated to primary care, the total budget should never be less than 450 million Lei			
Value quantitative or Qualitative)	21%	35%		27.6 %
Date achieved	12/31/2000	11/30/2005		12/30/2006
Comments (incl. % achievement)	% achievement is 79%. About 450 million Lei was allocated to health budget.			
Indicator 2 :	Legislation defining a minimum package of health services			
Value quantitative or Qualitative)	package undefined	Package defined in legislation		Minimum package defined in 2004, expanded in 2005 and 2006. Public information available in all health centers.
Date achieved	08/30/2001	11/30/2005		12/30/2006
Comments (incl. % achievement)	The Government has approved the Unique Program stipulating the medical services provided to the insured free of charge. The list of medical services provided to the non-insured was also defined.			
Indicator 3 :	Health care providers receive public funds on contractual basis to provide services included in the basic package			
Value quantitative or Qualitative)	No contractual arrangement	Health care providers receive public funds on contractual basis		Starting on January 1st, 2004, HIC contracted with the heath care providers at the Raion level.

Date achieved	08/30/2001	11/30/2005		12/30/2006
Comments (incl. % achievement)	Primary health care centers received funds from the Raion hospitals.			
Indicator 4 :	Patients do not pay fees for services included in the basic health package			
Value quantitative or Qualitative)	Patients pay user fees	No user fees for services included in basic health package		Patients do not have to pay fees for services that were included in the basic health package.
Date achieved	08/30/2001	11/30/2005		01/01/2004
Comments (incl. % achievement)	100% achievement			
Indicator 5 :	New population-based resource allocation mechanism implemented by December, 2001			
Value quantitative or Qualitative)	No populatoin based resource allocation mechanism	Population based resource allocation mechanism implemented		The mechanism was implemented first in 2003 within health insurance and this mechanism is under modernization and experimentation in one District.
Date achieved	12/30/2005	11/30/2005		12/30/2006
Comments (incl. % achievement)				
Indicator 6 :	Approval by Government of the Health Sector Restructuring Plan and the timely execution in accordance with the time bound action plan.			
Value quantitative or Qualitative)	N/A	Approval by the government and timely execution		Government approved and executed several health restructuring plans
Date achieved	08/30/2001	11/30/2005		12/30/2006
Comments (incl. % achievement)	Important steps have been undertaken with respect to hospital sector downsizing, development of primary and emergency care, implementation of Compulsory health insurance and approval of Chisinau hospital restructuring plan.			
Indicator 7 :	Number of acute hospital beds per 10 000 population			
Value quantitative or Qualitative)	62.8	10% reduction		56.8
Date achieved	12/31/2000	11/30/2005		12/31/2005
Comments (incl. % achievement)	100% achievement			

Indicator 8 :	At least 75% of general practice office (270)operating providing the basic package of PHC by the end of the project			
Value quantitative or Qualitative)	N/A	270		343 PHC centers equipped and 100 PHC centers refurbished under HIF
Date achieved	08/30/2000	11/30/2005		12/30/2006
Comments (incl. % achievement)	127% achievement			
Indicator 9 :	25% decrease in fatality rate in emergency cases since the beginning of the project			
Value quantitative or Qualitative)	10.2 per 100,000 inhabitants	7.65 per 100, 000 inhabitants (25% reduction)		8.9 per 100, 000 inhabitants
Date achieved	12/31/2000	11/30/2005		12/31/2005
Comments (incl. % achievement)	84% achievement. The indicator is not defined clearly. There was some confusion of the definition of "emergency cases", ie, whether it is only limited to surgery related case.			
Indicator 10 :	Referral to secondary and tertiary care limited to 20%			
Value quantitative or Qualitative)	36.5% (weight of FD in the structure of total outpatient care)	20%		Not available
Date achieved	12/30/2000	11/30/2005		12/30/2006
Comments (incl. % achievement)	Relevant data for calculating this indicator was not collected properly.			
Indicator 11 :	(Increased) access of population, especially youth , to upgraded services			
Value quantitative or Qualitative)	N/A	N/A		N/A
Date achieved				
Comments (incl. % achievement)	This indicator was not precisely defined and is not measurable			
Indicator 12 :	Improved user satisfaction at those facilities supported by the project			
Value quantitative or Qualitative)	N/A	Improved user satisfaction		Improved user satisfaction
Date achieved	12/31/2000	11/30/2005		12/30/2006
Comments (incl. % achievement)	The focus group sessions with rural and urban patients were carried out during the Project Assessment. The study showed improved user satisfaction at PHC that have benefited from investment under HIF.			
Indicator 13 :	Health Services Capacity limited to 1 general practitioner per 1500 population			
Value quantitative or Qualitative)	1GP/2377 population	1GP /1500 population		1 GP/1770

Date achieved	12/31/2000	11/30/2005		12/31/2005
Comments (incl. % achievement)	88% achieved.			
Indicator 14 :	At least 750 physicians and 1500 nurses initiate training in by the end of the project			
Value quantitative or Qualitative)	N/A	750 physicians and 1,500 nurses		748 GPs trained and 1474 nurses trained
Date achieved		11/30/2005		08/30/2006
Comments (incl. % achievement)	98% achievement			
Indicator 15 :	At least 20 senior staff from the MOH and Judet Health Authorities are trained in health management			
Value quantitative or Qualitative)	N/A	20		300
Date achieved		11/30/2005		12/30/2006
Comments (incl. % achievement)	300 managers trained in health management.			
Indicator 16 :	At least 2 students obtain public health and health care management training abroad			
Value quantitative or Qualitative)	N/A	At least 2		15
Date achieved		11/30/2005		12/30/2006
Comments (incl. % achievement)	15 students obtained a Master degree in Public Health abroad.			
Indicator 17 :	Clinical protocols for perinatal and obstetric care, integrated management of childhood, illness (IMCI), STIs, TB, Diabetes, hypertension, and breast and cervical cancer, developed and in use by training programs, by December 2001			
Value quantitative or Qualitative)	No protocols	Protocols developed		evidence-based guidelines and standard treatment protocols have been developed
Date achieved	12/30/2000	12/30/2001		12/30/2006
Comments (incl. % achievement)	Evidence-based guidelines and standard treatment protocols have been developed with support of UNICEF and WHO and introduced in the training curricula. The protocols include: antenatal care, delivery, newborn and post-partum care, immunization, TB, etc.			
Indicator 18 :	Approval by the Government of updated TB and AIDS strategies by December 2001			
Value quantitative or	N/A	Approval of strategy by		Strategy 2001-2005 was approved on

Qualitative)		government		June 18, 2001. Strategy 2006-2010 was approved on September 5, 2005.
Date achieved		12/31/2001		06/18/2001
Comments (incl. % achievement)				

(b) Intermediate Outcome Indicator(s)

Indicator	Baseline Value	Original Target Values (from approval documents)	Formally Revised Target Values	Actual Value Achieved at Completion or Target Years
Indicator 1 :	Health care providers become financially autonomous entities according to the agreed plan			
Value (quantitative or Qualitative)	N/A	Health care providers become financially autonomous		Health care providers at the Raion level (Raion hospitals) become financially autonomous as Raion hospitals contract with HIC.
Date achieved		11/30/2005		12/30/2006
Comments (incl. % achievement)	Though Raion hospitals became financially autonomous, primary health care centers within each Raion had not achieve financial autonomy. PHC centers receive their budget from Raion hospitals.			
Indicator 2 :	Acceptance of health sector reforms by the majority of population, patients, providers and politicians			
Value (quantitative or Qualitative)	N/A	Acceptance of health sector reforms		General acceptance of health sector reform
Date achieved		11/30/2005		12/30/2006
Comments (incl. % achievement)	Number of people who consider that Moldova should adopt a system that is functional everywhere has increased by 13%.			

G. Ratings of Project Performance in ISRs

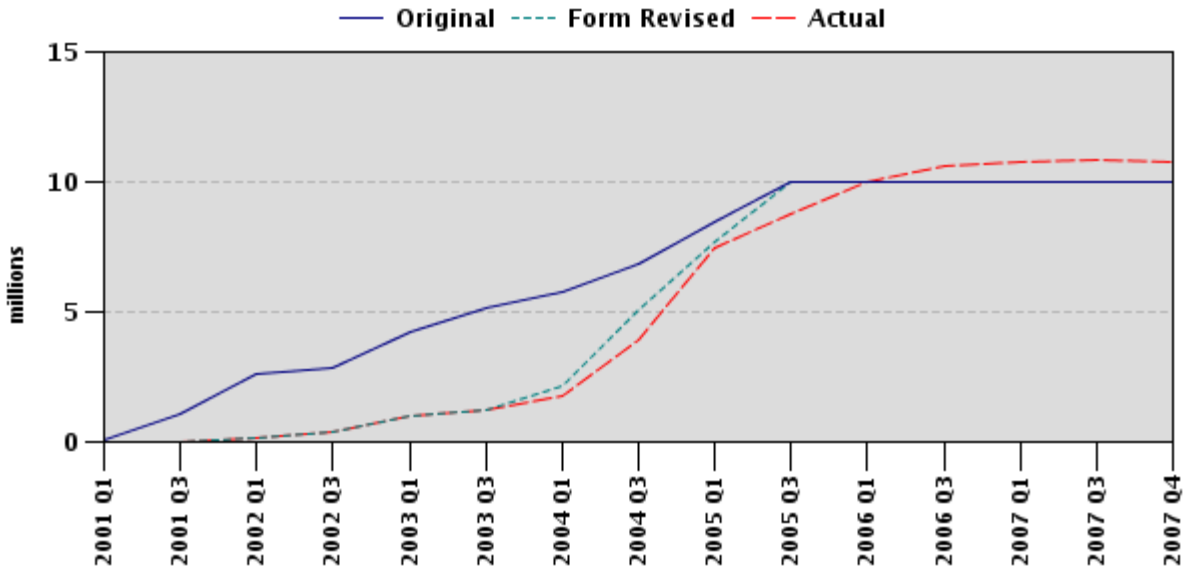
No.	Date ISR Archived	DO	IP	Actual Disbursements (USD millions)
1	09/13/2000	Satisfactory	Satisfactory	0.00
2	06/20/2001	Satisfactory	Satisfactory	0.30
3	12/26/2001	Satisfactory	Satisfactory	0.45
4	06/25/2002	Satisfactory	Satisfactory	1.47

5	12/16/2002	Satisfactory	Satisfactory	2.59
6	01/28/2003	Satisfactory	Satisfactory	2.59
7	07/31/2003	Satisfactory	Satisfactory	3.80
8	10/17/2003	Satisfactory	Satisfactory	4.12
9	02/27/2004	Satisfactory	Satisfactory	7.02
10	07/06/2004	Satisfactory	Satisfactory	10.80
11	12/16/2004	Satisfactory	Satisfactory	12.82
12	05/03/2005	Satisfactory	Satisfactory	13.12
13	10/12/2005	Satisfactory	Satisfactory	15.20
14	03/20/2006	Satisfactory	Satisfactory	18.74
15	12/29/2006	Satisfactory	Satisfactory	21.67

H. Restructuring (if any)

Not Applicable

I. Disbursement Profile



1. Project Context, Development Objectives and Design

(this section is descriptive, taken from other documents, e.g., PAD/ISR, not evaluative)

1.1 Context at Appraisal

(brief summary of country and sector background, rationale for Bank assistance)

The economic crisis in Moldova in 1990s had a marked impact on the health system. Since 1990, GDP declined by about 60 percent which led to a drastic decline in public expenditures. Health expenditures declined by about 62 percent from 1993 to 2000. In 1999 alone, the health budget was reduced by 35%. From 1996 to 2000, budgetary resources available for health care declined to about US$10 per capita per year. Out-of-pocket spending increased to complement the decline of public health expenditures, raising the total health expenditures to around US$20 per capita per year in the year of 2000.

Moldova inherited an excessive network of health facilities, which was very costly to maintain. In 1998, there were about 6.42 hospitals, 1,123 hospital beds and about 363 physicians per 100,000 population compared to EU average of 3.27 hospitals, 659.6 hospital beds and 299.5 physicians per 100,000 population. The distribution of heath care resources was highly skewed towards the large tertiary level hospitals, the regional hospitals and the sectoral hospitals, which consumed over 70 percent of all health spending.

The very low level of public expenditures, coupled with enormous and unnecessary infrastructure, had led to a situation where most resources were spent on utilities, arrears, and salaries. There was little money available to maintain or strengthen the essential preventive care, emergency care, and the provision of essential pharmaceuticals. As a result, the health system offered poor quality services because of limited resources and out-dated practices. Evidence-based protocols of care for such problems as tuberculosis, sexually-transmitted diseases, AIDS, hypertension, diabetes, and mental diseases were not in use. Even if those protocols were in use, in most cases pharmaceuticals would not be available or would be too expensive for patients to be able to afford them.

Moldova's health status had markedly declined from 1990 to 2000. Life expectancy had decreased from 68.64 years in 1990 to 67.75 years in 2000, and the incidence of some infectious diseases had gone up, especially the incidence of TB and HIV/AIDS. In the late 1990s, the incidence of TB in Moldova increased dramatically, especially in prisons (more than 300 new cases/year). The number of cases of HIV/AIDs was relatively low in Moldova (408 cases in 1998), but it had increased tenfold in just two years. This poor health status was due to the deterioration of the economic situation, and the consequent deterioration of the social and physical environment; to lifestyle characterized by poor diet and high consumption of alcohol and smoking; and to the deterioration of the health services. For those members of the population that could not pay for health services, both at primary care level and for hospital services, the deterioration of the health system had resulted in deepening poverty and substantial decline in the quality of life.

A comprehensive and complex health care reform was needed. In the Country Assistance Strategy (CAS) of January 1999, the Bank and the Government identified the critical need to reverse the ongoing decline in health indicators and gave high priority to health reform. The Government and the Bank agreed on a comprehensive program of health sector reform and much of the policy content of the health reform program would be pursued under a Public Sector

Reform Adjustment operation (PSRC). However, given the severe circumstance of the health sector, the Bank continued working with the Government on the design of the HIF project. Moldova would benefit from both the financial and technical assistance that the World Bank could provide, especially with World Bank's capacity to assist the government with the design and implementation of a nationwide project focusing on most important health sector issues.

1.2 Original Project Development Objectives (PDO) and Key Indicators (*as approved*)

The Health Investment Fund (HIF) project aimed to improve the health status of the Moldovan population, and to increase the quality and efficiency of the public health sector, by improving access to essential services for the poor. The project also included support for strategic work, aiming at controlling the TB and HIV/AIDS epidemics.

Specific objectives of the project were: (i) guarantee universal access to a minimum package of health services; (ii) modernize emergency services and primary health care; (iii) reduce excess capacity in the health sector; (iv)strengthen health sector institutional capacity; and (v) support the development of TB and AIDS Strategies.

Project objectives were to be measured by the following key indicators, as presented in the main text of the PAD[1]:

(i) At least 75 percent of the funds disbursed as follows: from the first tranche by December 2001; from the second tranche by December 2003; and from the third tranche by December 2005;
(ii) At least 75 percent of general practice centers (270) operating in the country and providing the basic package of PHC by the end of the project;
(iii) Approval by Government of health sector restructuring plan by December 2001, and timely execution according to time-bound action plan;
(iv) Health services capacity limited to 1 general practitioner/1,500 population;
(v) At least 750 physicians and 1,500 nurses initiate training in general practice by the end of the project;
(vi) At least 20 senior staff from the Ministry of Health and Judet Health Authorities are trained in health management by the end of the project;
(vii) Clinical protocols for perinatal and obstetric care, integrated management of childhood illnesses (IMCI), STIs, TB, diabetes, hypertension, and breast and cervical cancer, developed and in use by training programs and general practice centers, by December 2001;
(viii) Increased access of population, especially youth, to upgraded services, as compared with baseline results;
(ix) Improved user satisfaction at those facilities supported by the project, as compared with baseline results;

[1] The indicators listed in the result framework were based on the indicators listed in Annex1 in the PAD. Annex1 listed 18 outcome indicators and 13 output indicators. 18 outcome indicators include all 10 performance indicators. Since 11 output indicators were virtually the same as the outcome indicators, only two output indicators were listed in the result framework.

(x) Approval by the Government of updated TB and HIV/Strategies developed with project support, and in close cooperation with WHO and UNAIDS, by December 2001.

1.3 Revised PDO (as approved by original approving authority) and Key Indicators, and reasons/justification

The project objectives and key indicators were not revised during the implementation.

1.4 Main Beneficiaries,
(original and revised, briefly describe the "primary target group" identified in the PAD and as captured in the PDO, as well as any other individuals and organizations expected to benefit from the project)

The main beneficiaries as defined in the PAD were the entire population of Moldova. The poor, women and children were expected to particularly benefit from the increased access to the basic package of care, and from the adoption of new quality standards in emergency care, primary and secondary health care.

Other individuals/institutions that were expected to benefit from the project (though not explicitly identified in the PAD) included staff from MOH and Health Insurance Company, physicians, nurses, and hospital management teams who participated in the trainings. In addition, beneficiaries included family centers that received medical equipment and/or refurbishment from the HIF, hospitals which received surgery and emergency care equipment and/or ambulances.

1.5 Original Components (*as approved***)**

The HIF had three components with a total cost of US$ 20 Million:

Component I – Policy Development and Institutional Strengthening of MOH (US$ 1.67 million total estimated project cost) aimed at assisting the Government in the development of health policies and providing support to the MOHSP through financing the development of health reform strategy, key policy and respective legislation. This component had three sub-components. The first was **health policy development**, supporting the development of the legal framework for the health sector reform, including (i) health care financing (sources and resource allocation); (ii) basic package of health care services; (iii) provider-payer split; (iv) user charges; (v) human resources; and (vi) TB and AIDS strategies. The second sub-component was **Communication of Health Sector Reform,** financing public communication campaigns to inform stakeholders about the sector reforms. The third sub-component was **Management and Technical Training Program,** including (i) training of physicians, nurses and other staff associated with the provision of the basic package of health care; and (ii) training of managers at Central, Judet and health care facility levels.

Component II – Health Investment Fund (US$ 17.72 million total estimated project cost) aimed to establish the HIF, with the primary aim to sponsor changes through demonstration of improvements in access, quality and efficiency of health services at all levels of the system. This component was to mainly finance regional restructuring proposals, including the development of emergency services and development of primary health care based on general practitioners (physicians and nurses). This component had two sub-components. The first sub-component was **Emergency and Primary Health Care,** to provide funding on a competitive basis to the

Municipality of Chisinau and Judets for primary health care and emergency services. The second sub-component was **Hospital Refurbishment,** to make limited investments on key hospital refurbishments up to US$300,000 per facility.

Component III – **Project Management and Evaluatio**n (US $0.61 million total estimated project cost) financed project management, including procurement and financial management and project evaluations. This component had two sub-components. The first one was **Project Management,** which was to support the establishment and operation of a project coordination unit. The second was **Project Evaluation,** aimed to provide financing for monitoring and evaluation at different stage of the projects.

1.6 Revised Components

The components were not revised during implementation.

1.7 Other significant changes
(in design, scope and scale, implementation arrangements and schedule, and funding allocations)

The closing date was extended twice. The first extension was from November 30th, 2005 to August 30th, 2006 mainly due to initial delay by one year on Credit effectiveness caused by elections. The second extension was granted from August 30th to December 30th 2006 to ensure effective completion of activities that were being financed with additional funding which had become available because of currency fluctuations between the SDR and the US$.

2. Key Factors Affecting Implementation and Outcomes

2.1 Project Preparation, Design and Quality at Entry
(including whether lessons of earlier operations were taken into account, risks and their mitigations identified, and adequacy of participatory processes, as applicable)

There was no formal quality at entry review. However, based on the review at the ICR stage, the Quality at Entry was satisfactory based on the following facts:

During the project preparation, the team analyzed the country and sector's background, the need for the project, lessons learned from other ECA countries and related projects in Moldova financed by the Bank and/or other development agencies (including completed, ongoing and planned projects). The team also analyzed the adequacy of borrower's commitment and ownership of the project. In addition, the team identified specific risks associated with the operation and further defined risk mitigation measures.

The design of the projects was consistent with the development objectives and the need of the population and government. A participatory approach had been pursued with beneficiaries and other stakeholders, including consultation of patients, professionals, health organizations, local and international organizations and partnership with the Municipality of Chisinau and the (former) Central Judet Health Authority. Other alternative designs were identified and briefly analyzed but were rejected for various reasons. These designs included pilot project (rejected because of the overall collapse of the health care system at that time), downsizing without investing in emergency services and primary health care (rejected because of the possible negative impact on population health), and investment in emergency services and primary care

without downsizing (rejected because of consequent financial burden to the health system). The design of the project was innovative as it supported the establishment of the Health Investment Fund to create a competitive mechanism to allocate resources among the Municipality of Chisinau and Judet Health Authorities and, to a lesser extent, hospitals. The HIF was also designed to be disbursed in three phrases and each phrase was associated with a set of triggers that were linked to the national health policy reform, which had facilitated the national health policy reform. There were some weaknesses in the M&E design, which is discussed in detail in section 2.3.

2.2 Implementation

(including any project changes/restructuring, mid-term review, Project at Risk status, and actions taken, as applicable)

The project was the first health sector project supported by the Bank in Moldova. It comprised an ambitious reform package that was implemented well in a challenging environment. Despite numerous government reshuffles, including 4 different ministers of health and the merger of health and social protection under one ministry, the commitment by the government was maintained through the entire implementation period.

As noted earlier, the project had an initial delay as a result of late credit effectiveness (11 months after Board approval). However, after the project was effective, its implementation progressed well and Moldova made considerable progress in healthcare reform. Despite good project performance, which was supported by strong guidance from the Bank team in the context of a challenging environment, the Quality Assurance Group rated supervision as moderately satisfactory. Two main comments were: (1) a part of the project objective was to improve access to essential services for the poor, but this objective was not attained and the team failed to pay sufficient attention to it; (2) the M&E framework contained too many indicators and was not amended during project supervision. The ICR mission, however, found that the access by the poor was improved based on the following statistics. A representative population survey (2005) found that in the second year of the health reform, 30% of the rural population (having more poor than the urban population) considered that access to health services had increased, as compared to 18.4% of urban residents; increased access was mainly mentioned by people over 55 years, people in the age of needing health care more frequently. These achievements were, at least partly related to the Bank team's efforts to increase the awareness and commitment of the government to expand health insurance coverage through policy dialogue, Aide-Memories, management letters, and more extensive analysis of health insurance coverage in the Moldova Health Policy Note. From the supply side: (i) civil works were undertaken in 100 health centers, which were mostly in rural areas; (ii) 100% of GPs were provided with portable medical equipment kits; (iii) lab equipment for PHC were provided in all raions, covering 85% of all PHC facilities; (iv) ambulances were procured and distributed to raion hospitals and the Chisinau municipality. QAG argued that "relatively little attention appeared to have been paid to the issues of access to health services by the poor except for the dialogue on health insurance". But in fact, health insurance is the most important instrument to increase access for the poor from the demand side. Regarding the second comment, the ICR agrees that the M&E framework had too many indicators and no action was taken during supervision to improve the M&E framework. Detailed evaluation regarding M&E is discussed in section 2.3.

During the mid-term review (January 15-30, 2004), several risk factors were identified regarding the health insurance financial sustainability: (i) Financial risk. A large share of health insurance funds was from the State budget to cover the segment of the population unable to contribute to

the health insurance; (ii) Administrative risk. The legal independence of the HIC was a necessary condition for the HIC to properly function as a health services contracting and purchasing agency; (iii) Political risk. The success of HIC needed the commitment of the government to support and sustain the HIC. To address these risks, the Moldovan government, with the consultation of technical experts, established clear rules regarding the legal status, fiduciary management, reporting requirement, oversight and auditing of the HIC. The State budget for those who could not contribute to the health insurance through payroll taxes has been sustained for the past three years and there are no foreseen risks of inadequate state budget allocation to those who can not contribute.

The Mid-term review identified another risk factor related to the primary healthcare sector due to administrative changes in the healthcare organizational system in Moldova following law 123/2003. Under this structure, PHCs no longer operated as separate legal entities and the Chief Doctor at the Raion Hospital was responsible for the budget to the PHCs. Following successful dialogue on this issue by the Bank team with the Government, MOH agreed to ensure adequate budget allocation to the PHCs by requiring hospitals to provide sub-accounts for the PHCs. Chief doctors were required to comply with MOH budgeting norms to allocate 35% of resources to PHC, 15% to emergency services, and 50% for hospital services.

One facilitating factor that is noteworthy is that when the government decided to implement the national health insurance policy, the Bank team was able to quickly mobilize a PHRD grant to help its implementation, including financing services from a health insurance expert who provided long-term advice to the HIC, MOH and MOF. In addition, the Bank team worked closely with WHO experts to guide implementation of health financing resources.

2.3 Monitoring and Evaluation (M&E) Design, Implementation and Utilization

The PAD has a very detailed list of indicators and these were monitored in the course of implementation. Most indicators provide a good indication of the progress of the project as listed in the result framework in the datasheet. However, in terms of the design of M&E framework, the project set up ten key performance indicators in the main text of the PAD and 18 outcomes indicators and 13 output indicators in Annex1. (i) There was repetition among the indicators as 11 output indicators were virtually the same as some of the outcome indicators.; (ii) One of the key performance indicators was “increased access of population, especially youth, to upgraded services”, which is not clear enough to be measurable; (iii) some indicators were not collected property, such as “referral to secondary and tertiary care limited to 20%”. Despite these weaknesses, the Bank team had not revised the M&E framework during the course of supervision.

In terms of project monitoring, the project supported and strengthened the work of the Center of Public Health and Management (the Center) to collect data on a broad range of indicators, including those key performance indicators and to analyze the data. The Center sent the data to the PCU and the PCU then sent the monitoring and progress reports to the World Bank on a quarterly basis. The Center collected data from the raion level. The head of the Center was well trained and the process of data-collection was reasonable. Status of implementation of key monitoring indicators (as defined in the PAD) was reviewed systematically and reported upon after each supervision mission and included in the supervision package.

There is high likelihood of sustainability of M&E arrangements. Over the course of the project, the capacity of the Center had been improved. The MOH involved the Center in almost every

meeting in the preparation and pre-appraisal meetings for the new Health Services and Social Assistance Project, showing the evidence that the high level decision makers relied more on data to make decisions.

2.4 Safeguard and Fiduciary Compliance
(focusing on issues and their resolution, as applicable)

During implementation, there was full safeguard and fiduciary compliance. No adverse environmental impacts were associated with the rehabilitation of the health facilities supported under the project.

2.5 Post-completion Operation/Next Phase
(including transition arrangement to post-completion operation of investments financed by present operation, Operation & Maintenance arrangements, sustaining reforms and institutional capacity, and next phase/follow-up operation, if applicable)

The government developed the 2004-2006 Economic Growth and Poverty Reduction Strategy Paper (EGPRSP). EGPRSP with one program targeting health care services rendered through the mandatory health insurance system. Reform actions were specified including consolidation of healthcare staff capacity at the national and regional level, development of an M&E system to track outcomes, and ensuring the transparency of management of the National Health Insurance Company's management. To support implementation of the government's strong vision to continue strengthening the health care system in Moldova, a World Bank team is working with MOH to design a new project "Health Services and Social Assistance", which is scheduled to be prosecuted in June, 2007. The proposed project has two health-related components. The first deals with further strengthening of the primary health care system and the second with hospitals restructuring.

3. Assessment of Outcomes

3.1 Relevance of Objectives, Design and Implementation
(to current country and global priorities, and Bank assistance strategy)

The objective, design and implementation of the HIF remained relevant and consistent with Moldova's current development priorities in the health sector and with current Bank country and sectoral assistance strategies and corporate goals. The achieved outcomes are consistent with the Government's strategy of strengthening the primary health care network, improving resources allocation, restructuring health provider networks and developing the institutional capacity at different levels to better meet population health needs and improve the efficiency and effectiveness of the health delivery system. They also reflect the critical need identified in the Bank's Country Assistance Strategy (2004) to continue the healthcare reform in the direction to remove excessive health infrastructure, strengthening primary health care, increase access to essential health services, especially the poor. The development objectives are consistent with the Millennium Development Goals in the health sector.

3.2 Achievement of Project Development Objectives
(including brief discussion of causal linkages between outputs and outcomes, with details on outputs in Annex 2)

The project has achieved its development objectives in a satisfactory way as demonstrated through the accomplishment of most targets set out in outcome and output indicators in the result framework. There are five specific project objectives, which are discussed in detail with a couple of applicable indicators.

(i) Guarantee universal access to a minimum package of health services:

This objective was achieved in a satisfactory way. Legislation was passed to guarantee a universal access to a minimum package of health services, and patients do not have to pay user fees for the services covered in the package. Communication activities supported by the project helped increase public awareness and understanding of the scheme of health insurance.

PDO indicators:

Legislation defining a minimum package of health services. This indicator was fulfilled in a satisfactory way. Health Insurance was launched nationwide on January 1st 2004 and was expanded in 2005 and 2006. The fundamental structure of the financing system, based on national pooling of funds financed from both payroll taxes and general revenues and managed by the HIC, had gone generally well. With the help from the project, the Government approved the Unique program stipulating the medical services provided to the insured free of charge. The list of medical services provided to the non-insured included: services provided under National Programs, life endangering emergencies and primary care provided by FD, including clinical examination and recommendations to the secondary and tertiary care for further investigations and treatment.

Patients do not pay fees for services included in the basic health package. This indicator was fulfilled in a satisfactory way. Patients do not have to pay fees for services included in the basic health benefit package.

(ii) Modernize emergency services and primary health care:

This objective was achieved in a satisfactory way. HIF helped financing refurbishment of 100 Primary Health Centers across the country. The project financed the training of 748 physicians, about 1500 nurses and 300 health managers. Under the project, 2089 portable kits were procured and distributed to all family doctors. The condition of primary health centers were improved by procurement and distribution of medical and laboratory equipments. The number of family doctors increased from 1285 in 1998 to 2096 in 2004, which was from 2951 population/family doctor in 1998 to 1713 population/family doctor. Anecdotal evidences show that the increase in the number of family doctors was partly due to the improved working conditions funded by the HIF project. The emergency care was strengthened by procurement and distribution of 75 ambulances and 5 sets of communication and informational systems and other necessary medical equipments. The investment increased the quality of health care services.

PDO indicators:

At least 750 physicians and 1500 nurses initiate training in by the end of the project. This indicator was fulfilled in a satisfactory way. 750 physicians and 1500 nurses were trained by the end of the project. The training of family doctors and nurses by the University of Medicine and Pharmaceutics “N. Testimitanu” contracted by the PCU was launched in 2003. The trainees were mainly from medical facilities that benefited from HIF investments in medical equipment and civil works. The main purpose of the course was to upgrade the skills of PHC medical staff

through: (i) unification of specialists' knowledge of PHC; (ii) training of family doctors and nurses on the early diagnostics and rational behaviors of the most frequent and important diseases in Moldova; (iii) training on the utilization of medical equipment delivered under the HIF project, and upgrading their practical skills; (iv) promotion of team work among PHC staffs; (v) promotion of PHC staff' collaboration with specialists from hospital sector by stressing the limits of competence and criteria for patients' referral to specialized and/or hospital care; (vi) promotion of holistic approach to the patient and to the practice based on the principles of family practice and nursing.

All the trainees had been subjected to a pre- and post-training testing on practical skills and theoretical knowledge. According to the test results, the course contributed to a 225% improvement of the FDs' theoretical skills and to 66% improvement of their practical skills. Evaluation of course's effectiveness for nurses showed 107% improvement in theoretical skills and 53% improvement in practical skills of the trainees.

Clinical protocols for perinatal and obstetric care, integrated management of childhood, illness (IMCI), STIs, TB, Diabetes, hypertension, and breast and cervical cancer, developed and in use by training programs, by December 2001. This indicator was fulfilled in a moderately satisfactory way. One of the major requirements to improve the quality of medical care was the development and use of standard approaches to medical interventions and introduction of evidence-based clinical guidelines/treatment protocols. In this context development of standard clinical protocols was identified by MoHSP as one of the priority issues to be addressed by the project. Evidence-based guidelines and standard treatment protocols were developed with support of UNICEF and WHO and introduced in the training curricula. The protocols included: antenatal care, delivery, newborn and post-partum care, immunization, Tuberculosis, care of children under 5 etc. Development of protocols and standards was a continuous process. By June 30, 2006, 11 guidelines in 10 disease areas and 17 protocols in 5 disease areas had been developed by expert groups. Many other protocols and guidelines were in various stages of development.

(iii) Reduce excess capacity in the health sector:

The objective was achieved in a satisfactory way. Many rural hospitals with the capacity of 50 to 100 beds were closed or converted to primary health centers. Chisinau Municipal Children Hospital No. 2 was closed. Chisinau Narcological Dispensary was merged with the Republic Narcological Dispensary and more than 200 ancillary facilities were closed. The number of hospitals decreased from 276 in 1998 to 116 in 2005, that is, 6.42 hospitals per 100,000 population in 1998 to 3.23 hospitals per 100,000 population in 2005. The number of hospital beds was reduced from 48,261 in 1998 to 22,961 in 2005, which was 112.3 bed/10,000 population in 1998 to 63.9 bed/10,000 population in 2005[2]. The number of *acute* hospital beds was reduced from 62.8 per 10,000 population in 2000 to 56.8 per 10,000 population in 2005. The closure or merging of hospitals increases the efficiency of the health care delivery in Moldova as anecdotal evidence shows that more care is provided at the primary health care level instead of secondary or tertiary level.

PDO indicator:

[2] Data from WHO European Database.

10% reduction in Number of acute hospital beds per 10 000 population. This indicator was fulfilled in a satisfactory way. The number of acute hospital beds per 10,000 population was 62.8 in 2000, and reduced by 10% to 56.8 per 10,000 population in 2005.

(iv) Strengthen health sector institutional capacity:

This objective was achieved in a satisfactory way. The capacity of MOH in designing and leading national policies was improved, as shown in the vision and commitment of the government in the movement of strengthening primary health care and reducing excessive health infrastructures. The staff members of the MOH expressed that they had learned a lot by working with the World Bank and other donors, such as procurement and M&E. The trainings of physicians, nurses and health managers, the strengthening of health information systems in the HIC, the equipping of medical and laboratory equipment at different levels of health institutions, improved the capacity of the health sector.

The project also supported the MOH to have a Health System Optimization Plan. The objective of the plan was to optimize the use of resources and improve the efficiency and effectiveness of hospital services in Chisinau, by evaluating the secondary and tertiary care facilities in Chisinau Municipality, identifying the gaps and developing a detailed time-based implementation strategy for each of the actions outlined. The project also supported the MOH to have a Human Resource Plan with the objective to restructure the human resources in the sector and to optimize the use of resources. Finally, the project supported MOH to have an Architectural and Engineering Assessments of physical changes needed for hospital consolidation and restructuring to prepare for further hospital consolidation and the accompanying hospital equipment management plan to match the architectural and engineering assessments of physical changes.

PDO indicator:

At least 20 senior staff from the MOH and Judet Health Authorities were trained in health management. The indicator was fulfilled in a highly satisfactory way. 300 senior staffs from MOH and Judet Health Authorities were trained, which was critical as the implementation of the health restructuring program required increased capacity of healthcare managers both within health services delivery system and the MOH. The nationwide training of 300 health managers was designed to upgrade the trainees' management capacities, especially in the context of the implementation of health insurance. The training curricula included a variety of aspects of health management, including general management, strategic planning, health economics and financial management, and quality control. The trainees came with different background: 49 percent of the trainees were from primary care, 31 percent from hospital care, 4 percent from emergency care services and 16 percent from preventive medicine.

(v) Support the development of TB and AIDS Strategies:

This objective was achieved in a satisfactory way. TB and AIDS Strategies were developed and approved in June 2001. The implementation had started under several grants arranged with Bank assistance including GFATM grant of $5.2 million for TB/AIDS; SIDA/Sweden Grant of $0.5 million for TB/AIDS; $0.1 million from $10 million Dutch Grant under the HIF project; and $5.5 million IDA grant. New strategy for period 2006-2010 was approved in September 2005.

PDO indicator:

Approval by the Government of updated TB and AIDS strategies by December 2001. This indicator was achieved in a satisfactory way. TB/AIDS Strategy 2001-2005 was approved on June 18, 2001. TB/AIDs Strategy 2006-2010 was approved on September 5,2005.

In summary, the project objectives were achieved. The project increased the quality of public health sector by modernizing emergency services and primary health care, including civil works, investment in medical equipments, training of family doctors, nurses and health care mangers. The project improved the efficiency of health care services in terms of reducing excess capacity in the health sector, especially in terms of number of hospitals and hospital beds. The program also strengthened the primary health cares, which was proved by the international literature as a more cost-effective way to provide preventive care. The project improved access to essential services for the poor by establishing the national health insurance policy and by guaranteeing access to a minimum package of health services. The project also supported the strategic work, aiming at controlling the TB and HIV/AIDS epidemics.

3.3 Efficiency
(Net Present Value/Economic Rate of Return, cost effectiveness, e.g., unit rate norms, least cost, and comparisons; and Financial Rate of Return)

During project preparation, cost-effectiveness analyses were carried out. The results of the study indicated a present value of net benefits, after investment and recurrent costs, of almost $10 million and an internal rate of return (IRR) of 39%. No overall IRR or net present value calculations were carried out at the end of the project because the calculations rely too much on assumptions, especially for indirect benefits. In addition, it is hard to attribute the indirect benefits solely to the project. For example, it assumed that infant mortality would be reduced by 20% and the actual reduction in infant mortality rate (at national level) was 33% (from 18.54 per 1000 live birth in 1999 to 12.42 per 1000 live birth in 2005[3]). However, the reduced mortality rate is an outcome of many factors including investment in primary health care.

Nonetheless, it could be argued that the cost-effectiveness of the project was high. International literature has documented the high cost-effectiveness of primary health care. Research shows that the cost of delivering medical care, and especially preventive care, through primary health care is low relative to delivery through hospitals or through specialists. Research also shows that delivery by primary care physicians is associated with low use of diagnostic tests, less referrals to secondary services, and less prescriptions, relative to other models of service delivery, all with no significant difference in patient satisfaction[4]

3.4 Justification of Overall Outcome Rating
(combining relevance, achievement of PDOs, and efficiency)
Rating: Satisfactory

[3] Data from WHO European Database.

[4] Dale J et al. Cost effectiveness of treating primary care patients in accident and emergency: a comparison between general practitioners, senior house officers and registrars. BMJ, 1996, 312:1340-1344; Murphy AW et al. Randomized controlled trial of general practitioner versus usual medical care in an urban accident and emergency department: process, outcome and comparative cost. BMJ, 1996 312:1135-1142 and. Ward P, Huddy J, Hargreaves S. Primary care in London: an evaluation of general practitioners.

Given the high relevance of PDOs, the overall achievement of the PDOs, and the likely high cost-effectiveness of the project, ICR rates the overall outcome as satisfactory.

3.5 Overarching Themes, Other Outcomes and Impacts
(if any, where not previously covered or to amplify discussion above)
(a) Poverty Impacts, Gender Aspects, and Social Development

Access to health care by low income group was improved. More importantly, quality and evidence-based services were rendered to the poor through the rehabilitation and provision of equipment of health facilities in rural areas as outlined under section 3.2.

The communication activities supported through the project concentrated on informing the public about the reform and focused on areas of interest such as access to services and health insurance, public opinion surveys (which is seldom carried out under projects) attest to the increased consumer satisfaction for the improved services and the role that health insurance was playing in the development of the sector.

(b) Institutional Change/Strengthening
(particularly with reference to impacts on longer-term capacity and institutional development)

Capacity building was at the core of the project. The numerous training activities supported through the project to upgrade technical, clinical and management skills of physicians, nurses, health managers and staffs of the MOH were instrumental not only in strengthening the performance of the sector, particularly PHC, but also in raising the morale of health staff. The project trained 748 physicians and about 1500 nurses in family medicine. It trained 300 health managers (well above the original target). Training for the senior staff was conducted in and outside the country. Several staff of the Ministry had the opportunity to attend international conferences, to make contacts with counterparts in other countries and to be exposed to international experiences with implementation of health reform in general and particularly health insurance and hospital automation. Training was also provided for the development of clinical protocols and guidelines. Technical assistance and training was provided thanks to an implementation PHRD to guide the early stages of implementation of health insurance. Technical assistance and training was also provided in hospital restructuring, development of a human resource strategy, etc.

A Moldova-based Flagship Course on health sector reform and sustainable financing was conducted in Chisinau from June 28 to July 3, 2004. Forty health sector staff participated in the training and got exposed to health sector reform experiences in Europe and Central Asia as well as to the successful and unsuccessful experiences from countries in other regions. All these trainings and courses broadened the knowledge of the senior staff and improved the capacity of the MOH.

(c) Other Unintended Outcomes and Impacts (positive or negative)

The project has contributed to the development of an efficient procurement system in the MOH, and especially the introduction of streamlined procedures for procuring medical equipment and supplies. The project paid particular attention to communication activities. These activities helped increase public awareness and generate positive attitudes for health reform and better understanding of health insurance.

The PCU had done an outstanding job in coordinating and implementing the HIF project (please see details in section 5.2(b)).With the support from the Bank, the capacity of PCU had been built up in the areas of procurement and financial management. The PCU had become the core implementation agency not only for the HIF project, but also the IDA financed HIV/AIDS project, Global Fund grant for HIV and TBC projects and Council of Europe Bank financed Blood Security Project

3.6 Summary of Findings of Beneficiary Survey and/or Stakeholder Workshops
(optional for Core ICR, required for ILI, details in annexes)

Beneficiary Surveys

HIF financed a **Public Opinion Research**, consisting of the design and implementation of a research strategy to provide quantitative and qualitative data on public perceptions of the health sector reform in Moldova. The research was designed to examine both existing state of public opinions on the health care reform and how people would react to various messages concerning the reform. The survey found that the level of population's awareness of the reform increased by 16% and the number of people acknowledging that improvements in Moldova's health sector can only be achieved through implementation of a health reform increased by 13%. For details on survey results see Annex 5.

4. Assessment of Risk to Development Outcome
Rating: Moderate

The risk to development outcome is rated **moderate** based on the following:

First, the sustainability of the achievement of the development objectives and further healthcare reforms depend to a large extent on the ownership and capacity of MOH. The current MOH is highly committed to the healthcare reform agenda and has been working with the World Bank and other donors extensively. The possibility of change of the leadership and key senior staff in the Ministry would hamper the healthcare reforms in terms of strengthening primary health care networks and downsizing hospitals.

Second, the HIF project was successfully implemented by the PCU, which was physically outside of the MOH and managed by a PCU director, who reported to the Minister. With the closure of the project and following closure of the PCU, MOH has greater responsibility to sustain the outcomes. The capacity of MOH has been improved during the project, but the capacity still needs to be strengthened. Some factors are outside the control of the project, such as relatively low salaries in the public sector, which makes it hard to attract and maintain highly competent staff.

Third, the average age of family doctors in Moldova is around 50. With the aging of physicians and limited supply of family doctors in rural areas, the primary care network may face a great shortage of supply of doctors.

Fourth, currently primary health centers are incorporated into the Raion health services with hospitals and have little financial autonomy, which raises the barriers for the primary health centers to better serve patients.

However, some of the risk factors identified above can be mitigated by the follow-up project (Health Services and Social Assistance Project), which is going to the Board by the end of this fiscal year. The objective of this project is to further support the Government's program to increase equity in access to quality and efficient health and social assistance services for the Moldovan population in line with the MTEF for 2007-09. Under the continuous dialogue between the World Bank and the government, MOH officials are to be provided with further trainings and capacity building. Primary health care network is going to be further strengthened by various means.

5. Assessment of Bank and Borrower Performance

(relating to design, implementation and outcome issues)

5.1 Bank Performance

(a) Bank Performance in Ensuring Quality at Entry

(i.e., performance through lending phase)

Rating: Satisfactory

Bank performance in ensuring quality of entry is **satisfactory** based on: (i) the consistency of the project objectives with the priorities identified by the Government, and the CAS (1999), in which the Bank and the government identified the critical need to reverse the ongoing decline in health indicators, and gave high priority to health reform; (ii) the adequacy of the project design given the needs of the health sector at the time of the project preparation; (iii) conditions established for the disbursement of the HIF to ensure adequate policy changes; (iv)the realism of needs assumptions, implementation arrangements, system priorities which were in line with the situation in the country; (v) A sound analysis of the project alternatives and the reasons for rejection and consideration of potential risks and appropriate measures to mitigate them.

The overall project result framework could be improved given the current standard. However, the project has profited from the thorough preparation based on the solid understanding of the main sector issues, the sound background analysis and careful and accomplishable project design. Therefore, the quality at entry is rated as satisfactory.

(b) Quality of Supervision

(including of fiduciary and safeguards policies)

Rating: Satisfactory

The project was closely supervised by a team of Bank specialists and consultants all through its implementation. Supervision missions took place at least twice a year. Only one "virtual supervision" was conducted through a video conference, while all other supervisions were conducted in country including field visits to project sites. The Bank supervision team changed leadership twice but there was overlapping between the former leadership and the new leadership so the transition was smooth. The Bank closely monitored the progress of the project and identified new issues and actions to be taken. The quality of the mid-term review was satisfactory. Risks to meeting development objectives were identified and mitigation measures were agreed upon and implemented. The Bank also used supervision opportunities to engage the Government on health insurance issues, especially with the new Ministerial leadership due to the changes in Government. The writeups in ISRs and AMs were candid and clear. Each supervision mission organized a workshop with the participation of management and staff of the MOH and other central ministries as well as international partners such as WHO and UNICEF. Frequently, the

supervision team also participated in press conferences organized by MOH to inform the media of progress under the project, including successes and challenges.

Despite numerous Government reshuffles, the Bank has enjoyed a trusting relationship with the Government at all levels of the system because: (i) the team was always proactive and ready to provide options to resolve complex issues as they arose, and (ii) the team ensured continuous communication between the Borrower and the Bank before, during and in between missions. The supervision team followed the original result framework and reported the indicators regularly. But the supervision team could have done a better job by improving the M&E framework. Considering the overall satisfactory performance of the Bank supervision team, especially in the context of the country's circumstances, the ICR rates the quality of supervision as satisfactory.

(c) Justification of Rating for Overall Bank Performance
Rating: Satisfactory

The Bank, to a large extent, ensured the quality at entry and supported the implementation through appropriate supervision work. The Bank also ensured adequate transition arrangements, including the writing of detailed handover notes to guide the new TTL. The result framework could have been improved, but considering the overall performance, the ICR rates the Bank's performance as satisfactory.

5.2 Borrower Performance
(a) Government Performance
Rating: Satisfactory

The Government's performance in preparation and implementation is assessed as satisfactory. There was close cooperation at the time of preparation between the Government and the Bank. The government was actively engaged during project preparation and provided the necessary political leadership and technical expertise. Despite the political changes, each Government supported the objectives and implementation of the Project. Commitment and ownership by the Government, especially the Ministry of Health was apparent at all stages of project despite numerous government reshuffles.

(b) Implementing Agency or Agencies Performance
Rating: Highly Satisfactory

Ministry of Health	Highly Satisfactory

The performance of the MOH is rated satisfactory due to political commitment and support towards the preparation and implementation of the HIF project and the health sector reforms in general. It is relevant to note that the Ministry of Health and Ministry of Social Protection were separated at the appraisal stage, but merged during the last year of the project implementation. The ministries have separated again since the credit closed.

The project was managed by the PCU. The PCU was established as a legal entity reporting to the MOH and the MOF. The PCU developed a Project Operational Manual to ensure the quality of the operation. In the course of implementation, the PCU involved hospitals and health care centers to get their inputs about the conditions of facilities and the request for improvement. The funds were then allocated to facilities based on need and priority and through competitive procedures as part of the HIF operations. The PCU employed a key procurement specialist and a

financial management specialist, who had training abroad. Over the course of implementation, the ministers changed 4 times, however, the continuity of the PCU ensured that there were no delays in implementation. The PCU engaged the government in the project by consulting with the Ministers, senior staffs and main specialists. In terms of monitoring and evaluation, the PCU closely worked with the Center of Public Health and Management to get the key indicators and sent the Bank progress reports. The PCU also hired an independent consultant to conduct the mid-term evaluation and end of the project evaluations. Given the overall performance of the PCU, especially under the circumstances of leadership changes in the MOH and the World Bank Team, the ICR rates the performance of the PCU highly satisfactory.

(c) Justification of Rating for Overall Borrower Performance
Rating: Satisfactory

Overall Borrower's performance is rated satisfactory.

6. Lessons Learned
(both project-specific and of wide general application)

This project provides the following lessons:

First, the Bank team was able to mobilize financial resources to engage and leverage the government to achieve the overall objectives. When the government initiated the national health insurance policy, the Bank team was able to quickly mobilize a PHRD grant to help the implementation of national insurance policy, which on the one hand facilitated the implementation and on the other hand built more trust with the counterparts.

Second, the projects designed disbursement triggers on the credit and grant. The triggers were linked to the overall healthcare restructuring and reform objectives, which provided relatively strong incentives to the government to pursue the overall objectives of the project.

Third, close coordination with development partners to ensure coherence and complementarity of activities is critical. Establishing strong working relationship with development partners, especially WHO and UNICEF, was key to ensuring coherent advice related to health financing and clinical protocols.

Fourth, stakeholders' involvement throughout project implementation is crucial. Local empowerment for planning and implementing locally developed plans to compete for HIF funding resulted in greater ownership, commitment and transparency.

Fifth, communication, information dissemination, and capacity building played a significant role in the successful implementation of any project and this project was no exception.

Sixth, a focus on identifying problems and seeking solutions as a coherent, collaborative Bank-client team is important for achieving results. The Bank team's role in creating an atmosphere of trust and partnership was paramount for effective implementation and achieving the desired results.

Seventh, other projects had benefited from the PCU established originally for the HIF project. The HIF project built up to a large extent enhancing the capacity of the PCU, especially in terms

of procurement and financial management, which facilitated the management and coordination of other projects financed by IDA and other international agencies.

Lastly, the indicators need to be measurable, reliable and reflect development objectives. There should be a clear distinction between output indicators and outcome indicators. The specified indicators need to be consistent across the PAD and ISRs. In addition, the project could benefit from a focused impact evaluation design to provide more scientific evidence on to what extent national policy and the improvement in primary health care centers made differences in access and utilization of health services[5].

7. Comments on Issues Raised by Borrower/Implementing Agencies/Partners

(a) Borrower/implementing agencies

(b) Cofinanciers

(c) Other partners and stakeholders
(e.g. NGOs/private sector/civil society)

[5] The project had a national policy change in 2004 with the implementation of the national health insurance. There were variations in the primary health centers in terms of the extent of the refurbishment and the equipping with medical devices. These exogenous variations could be exploited with pre-post household level data collection to provide more scientific evidence on to what extent national policy and the improvement in primary health care centers made differences in access and utilization of health services.

Annex 1. Project Costs and Financing

(a) Project Cost by Component (in USD Million equivalent)

Components	Appraisal Estimate (USD millions)	Actual/Latest Estimate (USD millions)	Percentage of Appraisal
I. POLICY DEVELOPMENT AND INSTITUTIONAL STRENGTHENING OF THE MOH	1.61	2.5	155%
II. HEALTH INVESTMENT FUND	16.12	17.4	102%[6]
III. PROJECT MANAGEMENT AND EVALUATION	0.57	0.6	105%
Total Baseline Cost	18.30		
Physical Contingencies	0.00		
Price Contingencies	0.70		
Total Project Costs	19.00	20.5	
Project Preparation Fund	1.00	0.00	
Front-end fee IBRD	0.00	0.00	
Total Financing Required	**20.00**	**20.5**	**102.5%**

(b) Financing

Source of Funds	Type of Cofinancing	Appraisal Estimate (USD millions)	Actual/Latest Estimate (USD millions)	Percentage of Appraisal
Borrower		1.6		
NETHERLANDS, Govt. of THE (Except for MOFA/Min of Dev. Coop		8.4[7]	10.0	119%
International Development Association (IDA)		10.0	10.5	105%

[6] 102% was calculated based on 17.4/(16.12 + 1 million US$ PPF).

[7] The original amount of 8.4 Million US$ was the estimated amount in PAD (dated July 24, 2000). The final legal agreement (April 11, 2001) stated the amount of financing was 10 Million US$.

Annex 2. Outputs by Component

This section aims at providing separate evaluations and ratings of achievements by component. Information on project outputs that are closely related to key project indicators and commented in the main body of ICR is not repeated. The section rather summarizes outputs by component in the table format, as listed below.

Component	Planned outputs/activities at Appraisal	Actual output/activities at ICR	Comments
Component I. Health Policy Development and Institutional Strengthening of the MOH (US$ 2.5 Million total actual cost). **(a) Health Policy Development**	Supporting the development of the legal framework for the health sector reform, including (i) health care financing (financing sources and resource allocation); (ii) basic package of health care services; (iii) provider-payer split; (iv) user charges; (v) human resources plan; (vi) TB and AIDS strategies.	(i) Population-based resource allocation was applied within Health Insurance Company. Health care is financed by the payroll tax and state budget. (ii) A minimum package of health services was approved by the Government. (iii) Health Insurance Company was established. (iv) Patients do not have to pay fees for services included in the basic health benefit package (v) Human resources plan was carried out. (vi) TB and AIDS Strategies were developed and approved in June 2001	The project assisted the MOH to develop a human resource plan with clear definition of required staff levels, skills, and training requirements for the entire health sector. The objective of the plan is to restructure the human resources in the sector to improve efficiency and effectiveness of health services and to optimize the use of resources. The minimum package was defined in 2004 and then expanded in 2005 and 2006. Though patients do not have to pay fees for services included in the basic health benefit package they need to pay fees for services out of the scope of the basic packages. **Satisfactory**
(b)Communication of Health Sector Reform	(i)Communication campaigns were organized to inform stakeholders about the sector reform; (ii)The media expertise to be provided to the MoH.	(i) A two-phase Public Awareness Campaign was implemented. (ii) The consultants worked in building local capacity to ensure continuity and further improvements of MOH's communication efforts in support of health sector reform.	A two-phase Public Awareness Campaign was implemented since March 2002 with support from the project. The first phase aimed at assessing the population's and stakeholders' attitudes towards the health sector and their preparedness to support health reform. The second was geared to

			identifying changes in attitudes following the campaign. **Satisfactory**
(c) Management and Technical Training Program	(i) training of physicians, nurses and other staff associated with the provision of the basic package of health care; (ii)training of managers at Central, Judet and health care facility levels.	(i) 748 physicians and 1474 nurses were trained under the GP program. (ii) 300 health managers were trained	The training programs were contracted by the PCU and the training had effectively improved the theoretical base and practical skills of GPs and nurses who had received the training. The number of health managers who participated in the training was well beyond the original target. **Satisfactory**
Component II. Health Investment Fund (US$ 17.4 Million total actual cost) **(a) Emergency and Primary Health Care**	Providing funding on a competitive basis to the Municipality of Chisinau and Judets for primary health care and emergency services.	Funding was provided to the Municipality of Chisinau and Judets for PHC and emergency services.	**Satisfactory** Please refer to note 1 below for details
(b) Hospital Refurbishment	Making limited investments on key hospital refurbishments up to US$300,000 per facility.	Investment was made to key hospitals.	**Satisfactory** Please refer to note 2 below for details
Component III – Project Management and Evaluation (US$ 0.6 Million total actual cost) (a) **Project Management**	Establish a project coordination unit to manage and coordinate the health project.	The PCU was established as a legal entity reporting to the MOH and the MOF.	The PCU successfully managed the project despite the changes of the government and Bank TTLs. **Satisfactory**
(b) Project Evaluation	Provide financing for monitoring and evaluation at different stage of the projects.	The project was evaluated at the mid-term and at the end.	A couple of indicators were not collected properly. **Moderately Satisfactory**

Note1: Investment in Emergency and Primary Health Care Centers can be summarized as follows:

- **Procurement of 2089 portable kits** for family doctors, covering 100% of family doctors currently activating in PHC facilities.
- **Procurement of 606 sets of basic medical equipment**, distributed to 343 PHC facilities, covering over 85% of all PHC facilities from the republic. 1 set includes circa 30 items (ocular tonometer set, electrocardiograph, neurological set, scales for adults and children, gynecologic chair, table for examination of newborn, oxygen unit, ultrasound stethoscope etc.), for patient's primary examination and diagnostics.
- **Procurement of 35 small sets of complex medical equipment**, distributed to all raional Centers of Family Doctors;
- **Procurement of 40 large sets of complex medical equipment** (1 set includes: 1 ultrasound, 1 fibrogastroscope and 1 colposcope), distributed to the raional Centers of Family Doctors and 5 Territorial Medical Associations from Chisinau Municipality;
- **Procurement of 93 sets of basic laboratory equipment** (1 set includes 1 microscope binocular, 1 hemoglobinometer, 1 biochemical analyzer, 1 chronometer, 1 set of semiautomatic droppers), distributed to the rural PHC facilities.
- **Procurement of 44 sets of complex laboratory equipment** (1 set includes 1 microscope binocular, 1 hemoglobinometer, 1 biochemical analyzer, 1 hematological analyzer, 1 chronometer, 1 set of semiautomatic droppers). Through these 2 last procurements, the PCU has endowed over 34% of PHC facilities from the republic with modern lab equipment.
- **Procurement of informational sets** for the PHC service from all raions (1 package includes 2 computers, 2 printers, 1 fax machine, 1 copier, accessories and consumables).
- **Physical rehabilitation of 100 PHC facilities** throughout the republic (25% of all PHC facilities).
- **Procurement of 75 ambulances for the republic's Emergency Care System.**
- **Procurement of 5 sets of communication and informational systems** for the Emergency Care System from Chisinau Municipality and for the 4 zonal emergency stations of the republic. This activity was aimed to increase the overall efficiency of the service at its all stages, starting with the accessibility of the 903 service for the population, emergency call processing and direction from the place of accident or illness and ending with hospitalization or definitive solving of the emergency case, involvement of police, fire service, and, eventually, other specialized services needed to solve the case.
- **Procurement of training equipment for the Medical College and the Emergency Training Center** (anatomic maps and simulators).

Note 2: Investments in hospital care financed under the Project can be summarized as follows:

- **Procurement of medical equipment for the emergency rooms** of all raional hospitals and Emergency Center from Chisinau Municipality (37 sets). 1 set included: 1 electrocardiograph with 6-12 channels, 1 portable regulator-suction unit, 1 portable illuminator, 1 portable cardiomonitor, 1 device for artificial ventilation, 1 non-automatic wheelchair, 1 otoscope-ophthalmoscope, 1 oxygen unit for adult and child, 1 laryngoscope with blades for adult and child.
- **Procurement of medical equipment for the operating theatres** of all raional hospitals (35 sets). 1 set included: 1 surgery table, 1 device for artificial ventilation and anesthesia,

1 surgery lamp, 1 stationary suction unit, 1 coagulator, 1 cardiomonitor, 1 defibrillator, 1 laryngoscope with blades for adult and child.

- **Procurement of medical and training equipment for laparoscopic surgery and urology division of the republican hospital.** This included the following items: (i) 2 sets of medical equipment for laparoscopic surgery (destination: Emergency Center from Chisinau and abdominal Surgery Division from the Republican Hospital), (ii) 1 pelvitrainer for medical staff training on laparoscopic surgery (destination: Medical University), (iii) 1 ultrasonic lithotriptor (Urology division from the republican hospital) and (iv) 1 ultrasound system with integrated doppler system, transducers and printer (Urology division from the republican hospital).
- **Procurement of medical equipment for the neurosurgery division** of the Emergency Hospital from Chisinau Municipality.
- **Procurement of medical equipment for the ORL division** of the Republican Hospital for Children “E. Gotaga”, from Chisinau Municipality.
- **Procurement of medical equipment for endoscopic and laparoscopic surgery,** for medical (Emergency Hospital) and training purposes

Annex 3. Economic and Financial Analysis

(including assumptions in the analysis)

During project preparation, cost-effectiveness analyses were carried out. The results of the study indicated a present value of net benefits, after investment and recurrent costs, of almost $10 million and an internal rate of return (IRR) of 39%. No overall IRR or net present value calculations were carried out at the end of the project because the calculations rely too much on assumptions, especially for indirect benefits. In addition, it is hard to attribute the indirect benefits solely to the project.

Annex 4. Bank Lending and Implementation Support/Supervision Processes

(a) Task Team members

Names	Title	Unit	Responsibility/ Specialty
Lending			
Joana Godinho	Sr. Health Spec.	ECSHD (LCSHH)	Task Team Leader
Neil Parison	Economist		Team member
Denham Pole			Team member
Slavian Gutu	Communications Specialist		Team member
Christian Hurtado	Project Management		Team member
Imre Holo	Economist		Team member
Eszter Kovacs	Procurement Officer	ECSPS	Team member
Hiran Herat	Financial Management Specialist,	LOAG1	Team member
Jennifer Manghinang	Program Assistant	ECSHD	Team member
Zoe Kolovu,	Counsel	LEGOP	Team member
Jan Pakulski	Sr. Social Development & Civil Society Specialist	ECSSD	Team member
Ala Pinzari	Operations Analyst	ECSHD	Team member
Rose-May Brea Colon	Budget Officer		Team member
Supervision/ICR			
Bogdan Constantin Constantinescu	Sr Financial Management Spec.	ECSPS	Team member
James Cercone	Consultant		Team member
Richard Gargrave	Sr Procurement Spec.	ECSPS	Procurement Specialist
Joana Godinho	Sr. Health Spec.	ECSHD (LCSHH)	Task Team Leader
Betty Hanan	Sr. Operations Officer	ECSHD	Task Team Leader
Anna Goodman	Program Assistant	ECSHD	Program assistant
Nedim Jaganjac	Consultant	ECSSD	Team member
Xiaohui Hou	Young Professional	YPP	Team member
Maris Jesse	Sr Health Spec.	ECSHD	Task Team Leader
Vitaly Kazakov	Financial Management Specialist	ECSPS	Financial Management Specialist
Antonio C. Lim	Operations Officer	ECSHD	Team member
Rekha Menon	Senior Economist	ECSHD	Team member
Ala Pinzari	Operations Officer	ECSHD	Team member
Tamara Ursu	Program Assistant	ECCMD	Program assistant
Anna L Wielogorska	Sr Procurement Spec.	ECSPS	Procurement Specialist

(b) Staff Time and Cost

Stage of Project Cycle	Staff Time and Cost (Bank Budget Only)	
	No. of staff weeks	USD Thousands (including travel and consultant costs)
Lending		
FY98		13.62
FY99		147.63
FY00	62	197.17
FY01	20	35.60
FY02		0.00
FY03		0.00
FY04		0.00
FY05		0.00
FY06		0.00
FY07		0.00
Total:	82	394.02
Supervision/ICR		
FY98		0.00
FY99		0.00
FY00		0.00
FY01	26	63.82
FY02	41	100.29
FY03	21	91.34
FY04	21	101.94
FY05	13	70.11
FY06	18	69.23
FY07	7	24.72
Total:	147	521.45

Annex 5. Beneficiary Survey Results

(if any)

HIF financed a **Public Opinion Research** in 2002 and 2003, consisting of the design and implementation of a research strategy with a view to providing quantitative and qualitative data on public perceptions of the health sector reform in Moldova. The research was meant to examine both existing state of public opinion and how people would react to various messages concerning the reform. In particular, the research was expected to probe the general public as well as specific target groups assessment of the existing situation in the health sector and their preparedness to support various measures to be introduced under the HIF Project. The research included: (i) conducting two nation wide surveys; (ii) conducting 9 focus groups sessions with various stakeholders that are likely to develop distinct attitudes towards the reform.

The main findings of the research can be summarized as follows (comparative analysis of the 1st and 2nd surveys):

- The level of population's awareness of the reform increased by 16%.
- The number of people acknowledging that improvements in Moldova's health sector can only be achieved through implementation of a health reform increased by 13%.
- The quote of opponents to closure of small and inefficient hospitals decreased by 9%.
- Respondents had improved their opinions about the institution of family doctors. A large part of the surveyed residents (55%) had benefited from the services, which encouraged a positive opinion about this innovation.
- Slight improvements with respect to the emergency service: fewer respondents (23%) complained about the shortage of medications and instruments at emergency services.
- The percentage of respondents who called for emergency assistance had decreased since the last survey (52% in 2002 and 45% in 2003).
- Informal payments (including cash and in-kind) were offered to doctors as often as before (52% of respondents in both surveys), although the number of people who would prefer to pay only official charges had increased considerably (41% of respondents in 2002 and 51% of respondents in 2003).
- There were fewer people (22%) who favored the reinstatement of the Soviet system.
- An increasing number of people accepted the existence of various types of medical institutions, including the private ones. The population was getting used to the need to pay for certain medical services. The number of people who prefer to pay legal fees had increased by 10%.

Annex 6. Stakeholder Workshop Report and Results
(if any)

Annex 7. Summary of Borrower's ICR and/or Comments on Draft ICR

Background and objectives

1. The objective of the evaluation has been to consider three questions:
    - If the problem to be solved with the project still exists in the same terms as originally presented
    - If the impact on the beneficiaries and the environment have been relevant
    - If the programming execution of the process has been effective

2. In 1999 the situation in Moldova was dramatic. After almost 10 years of transition, health and economic indicators were both poor and worsening. In the intervening period great improvements have been made although health status in the country is still poor (average life expectancy 68), the economy weak and incomes low (average US$720/Capita) when compared to EU countries.[8] But life expectancy has stabilized and great improvements have been made in terms of key indicators such as infant and mortality rates. Infectious disease rates will need to be monitored closely.

3. The current situation is therefore still difficult but more stable. Considerable long-term challenges exist to improve the health status of the population but the situation is no longer one of crisis.

4. In terms of public health care enterprise(s), the HIF project provided a lifeline. Roughly equivalent to the annual turnover of the MOH in 2000, the importance of the project to the survival of public health care enterprise(s) cannot be underestimated. As the bulk of the population, and certainly those in the rural areas, depend on publicly provided services for their health and social care needs, the scope and ambition of the project was considerable.

5. The strategy of the project was to refocus the public health care (Shemashko) system from specialist care, provided through a vast, degraded and unaffordable network of hospitals; to relatively more cost-effective General Practice and ambulatory care. While General Practice (which came to be called ‘Family Medicine’) is widely practiced and accepted in Western Europe, and had been piloted in Moldova as early as 1993, it was still not recognized as a medical specialty in Moldova in 2000. Family Medicine was seen as a viable means to provide universal access to essential services.

Methodology and data collection

6. The approach taken was to develop a list of questions based on a matrix linking the project and its activities to the background to and implementation of the health sector reform. The matrix resulted in 7 groups of questions. The evaluation questions can also be clearly linked to the key indicators as specified in the Project Appraisal Document.

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[8] CSPPHHCM 2005 and the Official Website of the Government of Moldova.

The question matrix was used to guide data collection using both qualitative and quantitative techniques and data sources. These guiding questions were further broken down or reformulated where relevant in terms of evaluation method or stakeholder, data source.

7. During the evaluation, the team was faced with a number of challenges and risks:
   - The short period for the evaluation
   - Availability problems for some key stakeholders due to vacations and moves to new positions (particularly outside the country)

   Despite these challenges the team managed to visit 10 of 35 Raions. Those interviewed were open and frank. Structured interviews were also held with more than 30 key stakeholders.

Project implementation

8. Family medicine is now an established concept in Moldova. The HIF project has played a key role in this achievement. The project has renovated 100 of 430 need facilities, provided equipment in 360 of these facilities, established retraining courses and facilities, and provided re-training to 750 of approximately 2500 needed physicians, and 1500 nurses.

9. These achievements were realized despite 4 changes in Minister and a reorganization of public administration from Judets (11) to Raions (35) that fundamentally changed the original planning base for investments and led to considerable repetition in work and delays.

10. In terms of down sizing the hospital sector bed capacity reduced from 106 to 58 per 10,000 between 1998 and 2004. The major gains were made early in the project. The project aimed to stimulate restructuring in the hospital sector by linking the availability of funds to invest in primary care facilities to restructuring targets. Managerially, this 'competitive mechanism' failed to recognize that the upsides and downsides fell to different parties, and undermined its own efforts to stimulate planning and project management capacity at peripheral levels by adjusting the value of funding to investment projects planned by a coefficient linked to a score based primarily on restructuring targets; with no consideration as to how this might have affected the implementability of the original plan made. The need for continued down-sizing and reengineering in the public hospital sector is well appreciated by Moldova and a second phase of planning is underway. The focus now is re-engineering, i.e. not only down scaling but also up-grading the remainder. External funding agencies might also consider how restructuring pain in the hospitals market might also be alleviated in the hospital market to support a difficult managerial process.

11. In the event, planning of investments became relatively informal, certainly in terms of infrastructure projects, but the HIF Project management proved highly effective and flexible in leveraging funding at local levels to maximize results on individual sites.A great success of the project as an Investment Fund has been its ability to use available funding to leverage additional finance for infrastructure – "if you pay for the cosmetic work I will pay for the roof" – while this has happened somewhat informally, planning and contract formalisation (both at site and network level) would certainly need to improve for bigger capital projects, it shows great potential. The project limited itself to local public funding but a greater deal of

finance is available in the private sector and from doctors themselves. Ownership issues with respect to the assets would then arise, and subsequently how public services might be contracted from public-private facilities but the problems are not insurmountable and examples exist both within Moldova and Internationally.

12. Almost all stakeholders agree that there is no turning back from Family Medicine, but the path has not always been smooth. Numerous trade-offs exist. The project itself illustrates how the concept must compete with other needs and requirements. For example, US$4 million was spent on ambulances that may have resulted in patients by-passing Family Medicine. Spent on Family Medicine, for example, approximately 75% of facilities could have been upgraded and no by-pass risk would have been created.

13. While the training courses have been well received retraining existing cadres in only 4 weeks to take on an increasingly medical role, i.e. that of Family Medicine has limitations. The Medical University itself is now carrying the baton forward through compulsory Continuous Medical Education, but as the medical knowledge of Family Doctors deepens and widens this is likely to have knock on effects for the social work these same people did and still do. Interviews and site visits illustrated that while some Family Doctors feel comfortable with, for example, rectal touché, others clearly do not, and have a strong preference for their community work and/or mid-wife/pediatrics functions. The fact that Family Doctors have to fulfill all these functions is putting them under an increasing strain of responsibilities; and associated administration. In rural areas Family Doctors can be responsible for the social and medical needs of up to 6000 people.

14. Increasing responsibilities and poor terms of conditions are making Family Medicine, particularly in rural areas, a very unattractive proposition for young doctors. The medium to long-term sustainability of the achievements of the project are now threatened by a new problem, instead of accelerating, the replacement of retrained older cadres with young and fully trained Family Doctors is actually decelerating.

Project Impact

15. The impact of the project went beyond its immediate activities. It is of course difficult to precisely correlate project activities to policy and management changes in the public health care sector but the financial size of the project relative to state budget would suggest, and stakeholder interviews confirmed, that the project created strong incentives. The use of targets, linked to disbursement to the project was the prime link. The targets related to:
    - Inputs and process: the level of funding and the organization of financing within the public health care network
    - Outputs: universal access to an essential services package

16. A significant increase in public funding to public health care providers has been achieved. Increased public funding, in part financed by an earmarked 4% payroll tax, under a Compulsory National Health Insurance Scheme introduced on January 1, 2004. The introduction of compulsory insurance under a national Health Insurance Company finally lead to a key indicator level of 35% of public health care expenditure (not less that MDL 430

million) being spent on primary care. The Medium Term Expenditure Framework would seem to indicate that this increased level of funding to the public health sector is secure in the medium term.

17. The National Health Insurance Company provides cover to its beneficiaries for an essential service package (*programul unic*). The essential package is also free at the point of use. Both Key Performance Indicators. While registered coverage is not universal the eligibility criteria for the non-formally employed mean that key target groups amongst the young, mothers and the elderly are covered and access to essential services amongst these groups has improved significantly.

18. The National Health Insurance Company estimated that approximately 25% of the population, principally amongst the un- and informally employed, are uninsured. A challenge will be to make insurance products which are attractive to these people. Indeed as private predominantly out-of-pocket expenditure still accounts for a large, potentially even the bulk of health care expenditures (but no reliable data exist), there is also the challenge of making health insurance products which will be attractive to the formally employed. This might include changing the scope of medical products and services covered under the *programul unic*

19. The scope of the essential service package is subject to much discussion. While benefits could always be increased it is clear that there will be trade-offs first between, for example, the ability of the central government to raise a compulsory levy, the scope of the package and the level of co-payment on the package. Benefits under the package are frequently seen as only relevant to those who have no other choices.

20. Despite the tangible benefits of the free essential service package, particularly for vulnerable groups, the price has been a growing pressure on providers and medical professionals. Doctors particularly feel 'unprotected'. Blame frequently focuses on the HIC. In the decade prior to reform patients had grown used to paying out-of-pocket for services. The project financed an intensive campaign around the free essential service package. As insured's demanded these rights, chaotic scenes in clinics and hospitals ensued.

21. If a number of critical targets under the project had been pursued falling (formal and informal) incomes for physicians and other medical staff could have been compensated by increased income as providers:
    - became financially independent
    - where directly contracted for services

    Unfortunately, while these goals may have been achieved *de jure*, *de facto* they were not achieved. Instead at the beginning of 2004 primary and hospital providers were fused at a Raional level to form integrated health care providers under unified Raion Chief Physician management. Physicians and staff have remained salaried civil servants, and secondary incomes came under pressure as patients demand free care.

22. The medium to long-term consequences of these events is now becoming clear. The medical profession – and family medicine in rural areas in particular – is no longer a viable career option for the highly educated people needed. The profession of Family Medicine in

particular is in danger of imploding and with it, in the medium to long-term, so to will Family Medicine in Moldova.

23. In principle the problem is not only financial. If, as officially stated is the case, each insured person is worth a capitation fee of MDL.90 the average allocation to a Family Doctor under the essential package is approximately MDL.140,000 for a list of 1,500 patients. Where is the money going? On drugs? On maintaining still large infrastructure? The discussion cannot be de-linked from that of transparent priority setting in the essential package.

24. After almost 15 years of constant change, reform exhaustion is apparent at all levels. A slogan that kept emerging at all levels throughout the evaluation, however, was ‘we can’t turn back, so let’s move forward’. The creation of the HIC, while much improvement is needed, creates an institutional structure in which difficult choices can be made more managerial, than political. If however the MOH is to move to a more coordinating role a primary challenge for the MOH will be to free itself of the burden and potential conflict of interest in managing a large number of (republican) facilities including the bulk of significant public hospitals (and, indirectly, emergency services).

25. This brings us back to a number of key conclusions from the Health Investment Fund project experience. Restructuring is as much a question of management as policy, particularly in a national health care enterprise (or system/ network of). A basic textbook lesson in management is to delegate/ equate authority with responsibility. Secondly, management motivation can be linked to the goals you want to achieve. The HIF Project experience has demonstrated that there are managers willing and able to mobilize and leverage additional funding if they feel they will profit from the venture. The importance of the private sector to both patients and physicians would suggest normalizing these transactions will be fundamental to the health of the sector itself.

26. What applied to investing in Family Medicine under the Health Investment Fund Project will apply in equal measure to investing in the Centre of Excellence hospitals. Motivated and engaged physicians and medical staff are the prime pre-requisite to access to services, whether essential or otherwise. Achieving this is becoming urgent.

Annex 8. Comments of Cofinanciers and Other Partners/Stakeholders

Annex 9. List of Supporting Documents

1. Mission BTOs, Aide Memoires, ISRs, Office Memoramdum
2. Country Assistance Strategy (1999) (Report No. 18896-MD)
3. Country Assistance Strategy (2004) (Report No. 28556-MD)
4. Credit Agreement CREDIT NUMBER 3408 MD
5. Dutch Grant for the Health Investment Fund Project Grant Number TF024413
6. Swedish Grant for Health Investment Fund Project Grant No. TF029833
7. Swedish Grant for Health Investment Fund Project Grant No. TF029833
8. Japanese Grant for the Implementation of the Health Investment Fund Project Grant TF052808
9. Japanese Grant for the Implementation of the Health Investment Fund Project Grant TF052808 -- Amendment to the Letter Agreement
10. Letter to Govt re Notification to the Borrower of Closing Date
11. Moldova Health Sector Reform Project, Project Operational Manuel POM, April 2000
12. Poverty Assessment (1999)
13. Ministry of Health, Republic of Moldova, National Program of Tuberculosis Control in the Republic of Moldova for 2001-2005, Chisinau, 2000
14. Ministry of Health of the Republic of Moldova Project Coordination and Implementation and Monitoring Unit. Health Investment Fund Project. Mid-term Project Evaluation Study. December, 2003
15. End of Project Evaluation. Health Investment Fund Project, Moldova. Final Report, December 2006
16. QAG: Moldova Health Investment Fund: SMU comments
17. Project Appraisal Document (2000) (Report No. 20292-MD)
18. Health Investment Fund, Progress Report. Project Coordination Implementation and Monitoring Unit.
19. Report on the evaluation of the social-information situation in focus groups. Report based on focus group interview. By Moldova Modern Center for Public Opinion Research. Chisinau, 2002
20. Project Operation Manual. Moldova Health Sector Reform Project. Project Coordination Implementation and Monitoring Unit, Moldova. April, 2000.

MAP

I N S E R T

M A P

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