HEALTH SECTOR REFORM PROGRAM

(UR-0133)

EXECUTIVE SUMMARY

Borrower and guarantor:	Republic of Uruguay	
Executing agency:	Planning and Budget Office, in coordination with the Ministry of Public Health	
Amount and source:	IDB (Ordinary Capital):	US$75 million
	Total:	US$75 million
Financial terms and conditions:	Amortization period:	20 years
	Disbursement period:	24 months
	Grace period:	5 years
	Interest rate:	variable
	Inspection and supervision:	1%
	Credit fee:	0.75%
	Currency:	U.S. dollars, under the Single Currency Facility

Objectives: The program will support the Uruguayan government in implementing a set of policy actions promoted by the Ministry of Public Health (MSP) to ensure the continuity of a gradual process of health sector reform aimed at resolving the sector's structural problems as part of a long-term vision. Specifically, the program will unify, integrate, and systematize the existing disperse body of regulations to create a basic set of shared ground rules and the foundations for a regulatory institutional framework that will foster the necessary strengthening of the public and private healthcare delivery systems and ensure complementarity between their efforts. This will create, over time, a competitive setting for service providers that will reduce costs and improve care quality while ensuring more equitable access to health services, especially for the more vulnerable population groups.

Description: This is a sector loan that will be carried out over a period of 24 months and disbursed in three tranches: the first for US$30 million, the second for US$20 million, and the third for US$25 million. The four areas of action are (see Annex II-1): (a) enhance the health system's regulatory

framework; (b) strengthen the private healthcare delivery subsystem; (c) strengthen the public healthcare delivery subsystem; and (d) strengthen the MSP's technical capacity.

Enhancement of the health system's regulatory framework. Uruguay's current regulatory framework for health care institutions is fragmented and spread out among a rather inoperative, disjointed set of regulations, and there is no specialized unit for regulation and oversight. As a result of the gaps left by an inadequate regulatory and institutional framework, supplementary insurance plans have surfaced that are using risk selection to assemble coverage portfolios that target the high-income end of the market and families with attractive size, age, and gender makeups, to the detriment of the rest of the health system institutions, which *are* regulated. The absence of a specialized regulatory body has made it impossible to conduct preventive monitoring, which could prevent financial crisis in a given healthcare institution from spreading and ultimately triggering a system-wide crisis.

The policy actions planned for this area will help to unify, integrate, systematize, and implement a shared set of regulatory guidelines and oversight arrangements aimed at safeguarding the medium- and long-term sustainability of all institutions in the Uruguayan health system (including the supplementary insurance plans). This will help to prevent unfair competition and risk selection by providing a minimum set of financial safeguards for the system, protecting users' rights, disseminating financial and statistical information on the system, and promoting a care model focused on health prevention and promotion. Support will also be provided for establishing, within the MSP's new organizational structure, a decision-making level with full responsibility for supervision and oversight of both public and private healthcare institutions.

The expected impacts of these actions are: (a) a climate of greater market transparency that will lead to cost reductions and better quality care; (b) a regulatory body that systematically monitors healthcare institutions and takes preventive oversight measures; and (c) protection for users' rights, ensuring the coverage and continuity of healthcare services (see paragraphs 2.3 through 2.7).

Strengthening of the private healthcare delivery subsystem. The healthcare institutions known as *instituciones de asistencia médica colectiva* (IAMCs) are private, not-for-profit organizations whose structure is not conducive to enhancing efficiency through sound management and cost control measures. Their executive staff is not affected directly and proportionately by the consequences of their management decisions, there is a lack of delimitation between the policy-setting function and the management function, and there are clear conflicts of interest at institutions where physicians are both

employer and employee. It is therefore not surprising that the private healthcare subsystem as represented by the IAMCs is in the throes of a severe financial crisis, with cumulative liabilities totaling around US$350 million; in fact, many of them have declared bankruptcy or have been the object of mergers and acquisitions, thus triggering a serious deterioration in the normal flow of care delivery to the population.

In this policy area, the program will lend support for the restructuring plans being formulated by the IAMCs with backing from sector authorities to resolve their current systemic financial deficit. The objective is to promote a more efficient management model, stabilize these institutions financially, and ensure the continuity of healthcare services for users on the basis of management agreements with the MSP, the Planning and Budget Office, and the Ministry for Economic Affairs and Finance, which will ensure the viability and long-term sustainability of these actions. Coupled with these restructuring plans, the program will also support the MSP's efforts to require IAMCs to adopt the model by-laws, which are essentially intended to separate policy-setting responsibilities from true management responsibilities, resolve conflicts of interest, and professionalize management.

The expected impact of these actions will be to restore the IAMCs to a sound financial footing, standardize care delivered to users, and bring about more efficient management of these institutions as a result of the new model by-laws (see paragraphs 2.8 through 2.12).

Strengthening of the public healthcare delivery subsystem. The main shortcomings of Uruguay's public healthcare subsystem can be traced to a budget that is set mainly on the basis of historical values for the entire network of public-sector establishments, guided by macroeconomic criteria and with few incentives for efficient management. The only cost-control mechanism that has been traditionally applied is overcentralized management of human and financial resources. Moreover, the Fondo Nacional de Recursos (FNR)—the government agency that funds higher-cost, more complex healthcare services—has been running an operating deficit and has liabilities of over US$70 million, owing to management inefficiencies and the cost-ineffectiveness of the services it finances.

Action in this policy area will support implementation of the modernization measures set forth in the recently approved 2000-2004 Five-year Budget Act, which empower the MSP to: (a) reorganize itself to separate out the functions of policy formulation and regulation (to remain under the MSP), financing (to be placed under the Government Health Services Administration [ASSE], and service delivery (to be assigned to specific service-delivery units); (b) authorize management agreements to bring private institutions in to manage public-sector service providers; (c) authorize the ASSE to

allocate budget funds to the network of public-sector service providers under management agreements that link budget allocations to performance, i.e., more and better healthcare services for the population; and (d) allow private institutions to be charged for the cost of healthcare services provided to their beneficiaries. Support will also be provided for the efforts of the ASSE's authorities to move forward with launching a system to identify and classify users who are served by the public network, in order to charge private healthcare institutions for this care. Another important action within this policy area will be support for the restructuring of the FNR to modernize its management.

The planned actions in this policy area are expected to make the public healthcare subsystem more efficient and promote a management model geared towards meeting the needs of users of the public network by focusing State resources on low-income groups as the preferred beneficiaries of its action. The FNR restructuring plan is expected to bring about management enhancements and pare back the fund's operating deficit and levels of indebtedness (see paragraphs 2.13 through 2.17).

Technical strengthening of the MSP. Support will be provided for the MSP's Strategic Technical Strengthening Plan (PEFT), with a focus on three key avenues of intervention: (i) studies on technical feasibility and political viability, which are crucial to sustaining the gradual process of reform towards the MSP's long-term vision for the healthcare system; (ii) design and implementation of a public information campaign to consult and inform public opinion in support of the modernization process; and (iii) technical consulting services for the MSP's line units responsible for implementing the agreed policy actions.

The PEFT is expected to generate the necessary inputs to consolidate and deepen the process of structural change and to strengthen the MSP's core technical and management levels in order to guide and lead modernization of the healthcare system (see paragraphs 2.18 through 2.22).

The Bank's country and sector strategy:

The Bank's strategy in Uruguay is geared principally towards supporting the government's development programs and policies for the period 2000-2004, which are aimed at achieving sustained GDP growth and greater social equity within a framework of macroeconomic stability. In operational terms, the Bank's strategy focuses on supporting: (i) initiatives to boost the competitiveness of national output regionally and internationally, and promote private investment on the strength of comparative advantages and modern technologies, with a view to fostering healthy competition and broader insertion in regional and international markets; (ii) deepening of the process of modernization of the State and

enhancing governability so as to reduce its burden on the economy, make it more efficient, streamline and focus its action, and reduce its impact on national output of goods and services; and (iii) efforts to enhance social well-being and equity by mainstreaming the most vulnerable groups into the development process and affording them a better quality of life.

Accordingly, supporting—through this program—the package of reforms being pursued by the MSP to improve overall management of the sector and foster more equitable access to healthcare services could have a direct impact on two of the strategic development thrusts that guide the Bank's action in Uruguay: modernization of the State and social well-being (see paragraph 1.46).

Poverty-targeting and social sector classification: This operation qualifies as a project that promotes social equity as described in the key objectives for the Bank's activity outlined in the report on the Eighth General Increase in Resources (document AB-1704). Under the guidelines set forth in that document and inasmuch as this is a fast-disbursing sector loan, the program cannot be classified as a poverty-targeted investment (PTI) (see paragraph 4.5).

Environmental and social review: As a sectoral operation, the program does not include financing for works or related management activities. Accordingly, it will not have an impact on the environment and it will not be necessary to take environmental protection measures during its preparation and execution (see paragraph 4.6).

Benefits: Most of the policy actions supported by the program share the same guiding principle, i.e., ensure more equitable access to health and more efficient management of the sector. As the health system's regulatory framework becomes more unified and integrated, with the concurrent strengthening and modernization of the management of its public and private subsystems, it will be possible to deliver more and better health services to the Uruguayan population and target public funds at those who need them most in terms of healthcare and social vulnerability (see paragraphs 4.8 through 4.11).

Risks: Owing to the complexity of transformations in a sector as sensitive as health, the main risk to the program is resistance from the health professionals' organization and its pressure to detain the process or modify it to benefit their specific interests. To mitigate this risk, there is consensus with the authorities as to the importance of maintaining and deepening dialogue with all relevant sector actors, while supporting the program with a public information campaign as a powerful tool to consult and inform the population and public opinion as to the true meaning of the modernizations, seeking to convert the

system's current and potential users into key allies of health sector reform. There are also some minor risks, associated mainly with the high turnover of sector authorities and technical teams, unsustainability of modernization actions, and the financial crisis of this sector in Uruguay; steps to mitigate these risks are outlined in the proposal (see paragraphs 4.12 through 4.15).

Special contractual clauses:

Release of each tranche will be subject to the borrower performing the following actions to the Bank's satisfaction: (i) maintain a macroeconomic environment consistent with the program objectives and the agreements reached with the International Monetary Fund; (ii) perform the policy actions agreed on for the respective tranche, as specified in chapter II and Annex II-1 hereto; (iii) maintain special accounts for the loan proceeds; and (iv) ensure that the MSP and its agencies that are participating in the program have the necessary resources to implement the policy actions agreed on for the three tranches (see paragraph. 3.10).

For the first disbursement, evidence is also to be presented of the following, as conditions precedent: (i) the interministerial committee, including its technical secretariat and the respective official representatives, has been established and is functional; (ii) the program execution agreement has been signed by the Planning and Budget Office and MSP, stipulating *inter alia* that the Technical Advisory Office on Social Policy and the International Project Coordination Office are the offices responsible for program execution in their respective spheres; and (iii) that the technical unit, with its technical team, has been set up under the International Project Coordination Office (see paragraph 3.11).

Exceptions to Bank policy:

None.

Procurement:

The proceeds from this Bank loan will be used to finance a project to support the borrower's national public sector, which includes the importation of eligible goods. The Bank's applicable sector-lending procedures will be followed, which do not require international competitive bidding.

I. FRAME OF REFERENCE

A. Recent macroeconomic situation

1.1 The Uruguayan economy enjoyed satisfactory growth and lower inflation over the past decade, coupled with progressive improvement in the situation of socially vulnerable population groups. The policy to control inflation succeeded in paring back the three-digit price hikes of 1990 to the single-digit level in 1998, using the exchange rate as the nominal anchor of the pricing system and exercising strict control over public finances. Fiscal policy management, a series of structural reforms stretching over two decades, opening of the economy, and a favorable external climate made it possible to post real GDP growth averaging 3.9% per annum during 1990-1998.

1.2 In 1999, however, the economy took a turn for the worse, as a result of deteriorating terms of trade (higher prices for imports, drop in prices for exports, and higher international interest rates), the financial crises in southeast Asia and Russia in 1998, devaluation of the *real* in Brazil, and the recession in Argentina. Real GDP fell 3.4%, the balance-of-payments deficit on current account grew, and the public sector deficit was pushed up by sharp drop in revenue. According to preliminary data from Uruguay's central bank, this recessionary trend continued during 2000, with GDP shrinking 1.5% and urban unemployment at 14%. The consolidated public-sector deficit for 2000 exceeded the target of 2.8% of GDP agreed upon with the International Monetary Fund (IMF), hovering at 3.7% as a result of the recession's impact on tax revenue.

1.3 With total public spending near 35% of GDP, Uruguay faces the problem of keeping its public finances balanced, especially in a scenario that calls for easing the fiscal burden on productive activities in order to make the economy more competitive. Moreover, with the economic cycle in a contractive phase, all sectors must seek work towards greater efficiency so as to prevent additional pressure on the public deficit, seeking to generate the greatest possible impact from available resources. Public spending for the social sectors rose from 21.6% of GDP in 1995 to 24% in 1999, mainly for social security and education, while health spending rose slightly—from 1.7% to 1.9%—over the same period. However, a key concern of the economic authorities is the growing share of health spending as a percentage of GDP, which rose from 6% at the end of the 1980s to 10% near the end of the 1990s.

1.4 The priority that the government attaches to preserving basic macroeconomic balance and stability has been translated into an economic program framed by an agreement with the IMF for a 22-month period running through December 2001 for US$197 million equivalent in special drawing rights. The economic program for 2001, which was approved by the IMF's Executive Board in late February and is currently being reviewed in light of the recent turbulence in the international economic setting, forecasts that the economy will begin to recover this year as the

measures to reduce fiscal and balance-of-payments disequilibria begin to have an effect and external competitiveness improves. Based on these assumptions and the preliminary revisions made by the authorities, GDP is expected to grow in 2001 by a possible 0.5% to 1%, the fiscal deficit will drop to around 2.6% of GDP, and inflation will hover in the range of 7% to 8%.

B. Uruguay's health system

1.5 Total health spending in Uruguay currently accounts for roughly 10% of GDP, equivalent in per capita terms to approximately US$700. According to the most recent report from the World Health Organization, Uruguay is in fourth place worldwide in terms of health spending as a percentage of GDP, but in 65th place in terms of health system performance, which gives cause for concern bearing in mind cross-country differences in spending levels. As will be seen in detail below, this situation is owed to a number of complex, interrelated structural causes, such as shortcomings of the regulatory framework, organizational and management problems of the financing model, and technical features of the care model.

1. Organization of the Uruguayan healthcare system

1.6 Uruguay's health system is organized around a complex, fragmented set of regulations and financing arrangements that involve various private-sector institutions of different types and several government agencies. In simplified terms, Uruguayans accede to health care services through two types of subsystems: a private one and a public one.

a. Private healthcare delivery subsystem

1.7 This subsystem essentially comprises the healthcare institutions known as *instituciones de asistencia médica colectiva* (IAMCs), which are private, not-for-profit associations that offer insurance and provide prepaid medical care. The IAMCs offer a single healthcare plan that is regulated by the Ministry of Public Health (MSP); they cover 45% of the population and administer 44% of the country's total health spending. They are financed in two ways: (i) through the social security system administered by Banco de Previsión Social, which only covers private-sector employees who are part of the formal economy; and (ii) people who voluntarily pay into the plan individually or on a group basis, consisting mainly of the families of workers who are covered by social security. The IAMCs make up a market that is competitive but relatively closed, since in practice they operate through one of two formats: as community-based group plans (e.g., Casa de Galicia and La Española) or as physicians' cooperatives.

1.8 The country's 48 IAMCs average 30,000 members in size, with only four having more than 50,000 members. These four are located in Montevideo and account for 45% of the total population covered by IAMCs; the main one is the IAMC

administered by the physicians' union. In Montevideo, there are a total of 16 IAMCs in operation, accounting for 67% of all IAMC members and operating in a competitive atmosphere, while 32 IAMCs operate outside Montevideo and offer coverage to the remaining 33%, with very limited competition since many *departamentos* are served by only one IAMC.

1.9 Over a decade ago, supplementary health plans (*seguros parciales*) were created in Uruguay. Although they represent a relatively small component of the private subsystem, these plans are significant in that they are for-profit concerns that offer voluntary health plans and operate in a competitive, open market that is not governed by specific regulations. They cover approximately 3% of the population and account for 10% of the country's overall expenditure on health.

b. Public healthcare delivery subsystem

1.10 Working through the Government Health Services Administration (ASSE), the public healthcare delivery subsystem operates a network of hospitals and health posts that provide medical care to 32% of the country's total population, mainly workers in the informal sector and low-income individuals who are not covered by the social security system.[1] In practice, however, it is the healthcare provider of last resort, serving individuals who are covered by IAMCs but who are unable to make the high copayments (fees paid directly by the user that are intended to help control overuse of services) for some services under the private subsystem. The ASSE network accounts for approximately 10% of total health spending in Uruguay; an additional 4% is channeled directly by the MSP to epidemiological surveillance and public health programs, e.g., large-scale vaccination campaigns and AIDS prevention and treatment programs. A family physician system is in its initial stages in the primary care sphere.

1.11 As a complement to these arrangements, the MSP and the Ministry for Economic Affairs and Finance (MEF), in collaboration with private-sector representatives, administer the Fondo Nacional de Recursos (FNR), a nongovernmental agency organized under public law that is responsible for providing funding, to all Uruguayans, for low-incidence illnesses that entail high costs. The FNR is funded through monthly contributions from IAMC plan members and a contribution made by the MEF for non-IAMC members. These medical services (e.g., dialysis, heart operations, transplants) are provided by the Institutos de Medicina Altamente Especializada (IMAE), and patients are free to choose where they go to receive this care. The FNR absorbs 7% of total health spending and its relationship with the IMAEs is calculated on a per-event basis for all costs incurred in each treatment.

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[1] Ten percent of the population is covered by the police, military, and government employees' health insurance plan; the remaining 10% are high-income individuals who do not have prepaid coverage but pay directly for healthcare services at the time they are administered. In spending terms, individual care and drugs account for 20%, while police, military, and government employee coverage account for 5%.

2. Analysis of structural problems

1.12 Uruguay's health system has operated relatively well as part of a long tradition of solidarity and public welfare that have been a hallmark of its institutions. It was a pioneering model in the region in that it separated the financing function from actual healthcare coverage and delivery in the social security sphere. This made it possible for the IAMCs, on an entirely volunteer basis, to be included early on so that they could provide coverage and medical care to private-sector workers in the formal economy. Over time, however, a number of structural problems became evident in the health system, as well as others that were specific to the private and public subsystems. The most recent—and worrisome—manifestation is the financial crisis that has beset the IAMCs. Precisely because of this crisis there is greater political will among sector authorities to implement a gradual process of change as part of a long-term approach to resolve the system's structural shortcomings and ensure long-term sustainability of its institutions.

a. Problems of the health system

1.13 **Inadequate regulatory framework and institutional structure.** One of the Uruguayan health system's most crucial problems is the absence of a regulatory framework that unifies and integrates a basic set of common regulations governing the operation of the system's institutions, coupled with the lack of a regulatory and oversight unit. Legislation exists, but it is dispersed among various bodies of regulations and is not very operational, since it is interpreted differently by the different actors involved. In some cases, regulations are inadequate. For instance, authorization needs to be given to the MSP unit that will regulate and oversee health institutions and clearly define their responsibilities (e.g., authorization and withdrawal of authorization for institutions to operate, application of fines and penalties, and dissemination of public information to ensure greater market transparency), specify the obligations of regulated institutions (e.g., have official authorization to operate, provide guarantees, and keep a minimum level of operating capital), and centralize the disperse body of consumer protection legislation (e.g., the right to bring claims and to seek settlement of disputes with health institutions).

1.14 The clearest reflection of this situation has been the appearance of the supplementary insurance plans (*seguros parciales*), which—given the inadequacies of the regulatory framework and institutional structure—are able to use risk selection to assemble coverage portfolios that target the high-income end of the market and families with attractive size, age, and gender makeups, to the detriment of the rest of the health system institutions, which *are* regulated. Moreover, the lack of an informed, responsible institutional structure capable of imparting timely remedial measures has allowed a serious financial crisis to spread throughout the IAMC system. Also lacking is a transparent and systematic flow of information that would enable citizens to select the best form of health coverage. Without

appropriate legislation to protect their rights, the system's users are the ones who have ended up paying the cost of these inefficiencies. IAMC plan members have seen both their monthly premiums and their copayments rise, under the specter of bankruptcies that could interrupt the normal flow of healthcare services and threaten the continuity of their healthcare coverage. The lack of appropriate user-protection legislation also has an impact on the quality of care received by patients under the public subsystem.

1.15 **Distortions in the hiring of health manpower.** Collective bargaining by the sector's medical and nonmedical personnel is centralized and heavily influenced by the State. Moreover, it is interesting to note that the main IAMC is administered by the physicians' union, which creates a serious conflict of interest since the physicians are acting simultaneously as employers and employees. Added to this is the lack of planning in the training of health professionals and the fact that university education is free; this, coupled with the lack of proper incentives for self-regulation of health professionals' work, has led to moonlighting and overspecialization by physicians, generating strong pressure to raise salaries and improve working conditions, a marked trend towards service differentiation, and induced demand for healthcare services.

1.16 This situation has had a major impact on the health system's productivity and on labor and nonlabor costs by producing a remuneration structure that is biased towards specialization (i.e., it discriminates against general practitioners) and characterized by a gradual decrease in per-hour professional workload per work position, which has led to moonlighting (2.9 positions held on average per physician). State involvement in collective bargaining helps to regulate the cost of the main factor of production, which—when taken together with the regulation of prices and copayments as described further on—limits competition and consequently the possibility for further cutting costs and improving care quality.

1.17 **Overspecialized care model.** Influenced by market distortions in the area of health human resources, the care model is biased toward curative and recuperative treatment, which promotes specialization and high technology, to the detriment of a more preventive and promotional approach that emphasizes primary health care. The most visible side of this structural problem are the current liabilities of the FNR (US$70 million) in covering, through the IMAEs, a series of complex, high-cost pathologies that have low incidence among the population. The incipient family-health model launched at the primary level in the public subsystem is encountering difficulties owing to the lack of adequate integration of these professionals with more complex levels of the service network, with the end result that efforts are being duplicated.

1.18 Given this trend towards overspecialization, IAMCs' costs grew at an annual rate of 6% in real terms during the 1990s and generated a chronic deficit, despite the cumulative increase of over 70% in plan fees and 200% in copayments over the

same period. As of this writing, the IAMCs' level of indebtedness stood at US$350 million (85% of which is short-term debt), equivalent to almost five months of revenue from the system. The FNR's expenses increased in real terms at an annual rate of 14% during the previous decade, owing mainly to the payment-per-treatment arrangement used by the FNR, which encourages growth in the number of services delivered by IMAEs.

1.19 **Financing model that does not balance contributions and risks.** The 8% wage tax that finances the health portion of social security covers only the worker and not his/her family, thus producing an imbalance between contribution and medical risk covered. This situation contrasts with the social security systems of other countries in the region, where at times even lower percentages of a worker's wages are used to finance health coverage of the entire family. In other words, under Uruguay's current social security system, the person at lowest risk (i.e., the worker) ultimately overpays for his health coverage, while coverage for the people who normally are at higher medical risk (family members, mainly children, women, and the elderly) is paid for out-of-pocket by voluntary plan members. Furthermore, the maximum fee that IAMCs may charge for health coverage is regulated, and voluntary plan members are required to pay a fixed premium regardless of their risk. Ceilings are also set for copayments.

1.20 The current financing arrangements have led some IAMCs to use somewhat less-than-transparent mechanisms in order to avoid covering higher-risk plan members (e.g., the elderly). Bearing in mind, too, the significant involvement of supplementary insurance plans (which are unregulated), the problems take on a profile that is both deeper and more structural, since there are strong incentives for voluntary IAMC members, who have higher incomes and are at less risk, to establish a separate market that is covered by the supplementary plans. Given the existing crisis and the impossibility of offsetting imbalances by increasing plan fees or copayments, the IAMCs are becoming more proactive in risk selection of their voluntary members. This, in turn, has triggered a trend towards market segmentation, since high-income, low-risk individuals may opt to seek coverage under the supplementary plans, while medium-income, medium-risk individuals would remain in the IAMCs, and low-income groups would be left with the public system as their only alternative.

1.21 Consequently, the high cost of equity is expressed in terms of the quality of care received by the various segments of the population. For instance, IAMCs have US$690 per capita to serve their plan members, while the ASSE has only US$233 per capita to care for its beneficiaries.

b. Specific problems of the private subsystem

1.22 The structure of the IAMCs is such that it does not promote efficiency improvements through sound management and cost control measures. Their

executive staff is not affected directly and proportionately by the consequences of their management decisions, and there is a lack of delimitation between the policy-setting function and the management function. Moreover, the IAMCs that operate as physicians' cooperatives do not receive cash contributions; members can work in any other institution; and remuneration is determined by collective bargaining with the unions, without considering the institution's operating costs or the risk of conflicts of interest created by physicians working simultaneously as employers and employees. The most direct impact of these problems on incentives is the chronic deficit of the IAMC system, which has led to the bankruptcy of several institutions and has left others in a very precarious situation, especially in Montevideo. There is also the issue of physicians feeling little identification with the institution's mandate, especially in the case of cooperatives and the main IAMC, which is managed by the physicians' union itself.

c. Specific problems of the public subsystem

1.23 The main problem of the public network is its highly centralized management, since the executive staff responsible for public health establishments are not the ones who administer the human resources, or the investments, or even the larger procurements: these decisions are all made at the central level, i.e., by the ASSE. In other words, the budget that they administer is set mainly on the basis of historical values for the entire network of public-sector establishments, guided by macroeconomic criteria to maintain the sector budget within the parameters agreed with the economic authorities.

1.24 Within such a rigid framework, there is limited management space for public health establishment executives, and no incentives for efficient administration. Usually, no provision has been made for monitoring these establishments' financial performance and there is virtually no management interest in promoting incentives for user satisfaction. Although the public subsystem's spending grew at a significantly slower pace during the past decade (3.9% per annum, on average, in real terms), compared with the increase in the private subsystem's spending as represented by the IAMCs (6%) in a context of relatively stable coverage levels, these efficiency shortcomings translated into poorer quality of care, which ultimately hurt the system's poorer beneficiaries, who were only able to have access to public health services.

3. Long-term vision of the reform process

1.25 In keeping with Uruguay's tradition, the current administration's health-sector reform strategy is built around a long-term vision and gradual implementation of specific reforms. The program presented here and the policy actions it supports are the first steps towards such a scenario of structural changes, as described below.

1.26 To broaden coverage of the population (especially the segments that are more vulnerable epidemiologically) without increasing expenditure (which could only be financed through pressure on public finances, labor costs, or family budgets), the authorities' long-term vision calls for organizing the sector on the basis of a unified, integrated regulatory framework. Defining a set of common ground rules for the entire system would foster a social security system that guarantees comprehensive coverage of health benefits for the entire population. From an implementation standpoint, insurance and service delivery would be managed by public and/or private institutions operating in a competitive setting that would promote efficient resource allocation and equitable coverage, building on a care model centered around health promotion and prevention.

1.27 The new arrangement will mean a different role for the State in the health sector, as part of the transition from a situation where the bulk of its work consists of administering the public service-provider network, to one in which the State focuses on the strategic functions of regulation and financing. Within this framework of structural definitions, the MSP will begin to assume greater "ownership" of its function of policy formulation and priority-setting in public health and, under a unifying and integrating approach, will take responsibility for the function of regulating both public and private providers of insurance and healthcare services. It is thus crucial to lay the foundations for a public-sector institutional structure to oversee the sector institutions that can mature into an independent regulatory and oversight unit for Uruguay's health system.

1.28 The second key challenge for the State will be to devise financing arrangements capable of guaranteeing that providers of insurance and healthcare services will have resources commensurate with the epidemiological risk of the covered population. Healthcare institutions will receive risk-differentiated payments calculated on the basis of such factors as gender and age, which will mean higher contributions from those more likely to incur major medical expenses (children, women, and the elderly). In other words, the financing arrangements must combine government resources targeted at the lowest-income population, social security coverage for the formal work force, and voluntary contributions from the more affluent population. Under this long-term scenario, the FNR could resort, as necessary, to reinsurance arrangements that would ensure the most cost-effective response to less-common but high-cost medical contingencies.[2]

1.29 Users, too, would play an active role by freely selecting the public or private institution that would provide them with coverage and healthcare services in a

[2] For example, the reinsurance function could mean that the FNR would cease to be simply a funder of high-complexity services and would assume a role of reinsurance vis-à-vis less-common but catastrophic medical events that, owing to their high cost, exceed the capacity of health institutions and their covered members to absorb the full expenditure generated, with a threshold amount being defined over which the FNR would be responsible for coverage.

competitive setting. Given the health sector's market imperfections and information asymmetries, there would also be the gradual addition of a body of standards and instruments to protect users' rights and greater transparency and equity in contractual relationships with healthcare institutions, as a responsibility of the Uruguayan health system's future, autonomous regulatory unit.

4. Recent advances towards modernization

1.30 The new sector authorities have launched a set of actions aimed at strengthening the public and private subsystems as part of a long-term vision. The recently approved 2000-2004 Five-year Budget Act provides legal backing for a package of important policy innovations in the public health sphere, including authorization for the MSP to carry out restructurings such as the new management models for the service-delivery units [*unidades prestadoras*] (UPs), organized as integrated healthcare networks. As a pilot initiative, the MSP has been empowered to enter into agreements with private institutions that offer healthcare services or have proven health management capacity to manage part or all of the administration of healthcare establishments. Furthermore, budget resources for service-delivery units attached to the ASSE are to be allocated on the basis of management agreements, including legal authorization for the ASSE to charge IAMCs for public healthcare services provided to IAMC plan members.

1.31 In the private subsystem, the MSP is promoting a restructuring of the IAMCs to make them financially stable and sustainable in the long term. As of this writing, audits have been conducted for all the IAMCs in Montevideo, and a full analysis has been done of their situation in economic/financial, technical/care delivery, and organizational/institutional terms, with an eye to evaluating objectively their current status and assessing their future sustainability as a basis for the restructuring plans that are expected to be launched soon, beginning with the IAMCs of Montevideo. These plans will adjust the IAMCs' organizational, technical, and administrative processes seeking to create an operating surplus that could be tapped to finance the loans that will support the restructuring process and put them on a sustainably sound economic and financial footing as a basis for their future management. Annex I-1 contains a summary of the restructuring strategy being pursued by the Uruguayan authorities to ensure successful evaluation of the restructuring plans, the prerequisite processes of absorption, merger, or liquidation, sources of available financing, guarantee mechanisms, risk coverage, and the associated incentives.[3]

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[3] According to the final consultant's report on the shared risk arrangements for financing the IAMC restructuring process, commissioned to support preparation of this project, the strategy devised by the Uruguayan authorities offers a solution to the IAMCs' financial problem and could effectively promote their successful restructuring, spreading risk appropriately between public and private funding sources. The technical design of the guarantee arrangements would minimize the risk for public funds and would mean that the State would have to assume a systemic risk—rather than individually with each IAMC—that would be subject essentially to the general trends in the country's economy.

1.32 As a reflection of the authorities' resolve and consensus-building capacity, the MSP and MEF organized a cross-sectoral commission with all the actors involved in the IAMC crisis (business associations, physicians' union, nonmedical staff, etc.) in order to reach agreement on a package of urgent measures for these institutions. The agreement, which was signed on 4 April 2001 by all the participants except the physicians' union, calls for a series of immediate actions to stabilize the IAMCs financially (mergers or liquidations, debt write-offs by suppliers, and other measures to cut operating costs related with the management and care models).

1.33 The cross-sectoral agreement firmed up the IAMC restructuring process with regard to acceptance of a new policy framework for the sector, adjustments that needed to be made in the IAMCs' management model, and necessary changes in the care model. Priority was assigned to health promotion and prevention and to defining clear commitments on the part of these institutions to increase client satisfaction (e.g., shorter waiting times for general and specialized care, and better coordination for timely hospital care in cases requiring this level of care).

1.34 Looking to the future, the 2000-2004 Five-year Budget Act assigned civil liability to IAMC executives for any harm or damage resulting directly or indirectly from the infraction of any law, bylaw, or regulation, or from poor performance caused by abuse of authority, fraud, or gross negligence. Mention should also be made of the initiative of the model bylaws for IAMCs, for which the authorities were recently able to secure approval; the objective is to separate out decision-making functions from management responsibilities, professionalize management, settle conflicts of interest for executive staff and managers, and create a more transparent space for decision-making and thus help to ensure the future economic viability of these institutions.

C. Experience and lessons learned

1.35 In the second half of the 1990s, the government embarked on a process of change in the public subsystem as part of a Bank-supported program to strengthen the social sectors (811/OC-UR). Under the program—which channeled US$12.5 million to health, mainly for institutional strengthening and infrastructure—, the authorities sought to take the first steps towards modernizing this sector, changing the care model, and enhancing service coverage and quality. The benefits were felt by the MSP's fledgling health promotion and prevention programs: coverage of regional health centers and posts was extended in terms of maternal and child care and family medicine, with emphasis on underprivileged groups. However, with regard to modernizing management at the MSP and ASSE, the impact was less noteworthy, essentially because efforts were fragmented and isolated, and actions lacked a common thrust towards a shared, long-term objective. This lesson has been reflected in the design of the present operation, especially in terms of enhancing the regulatory framework, strengthening the public healthcare delivery subsystem, and technical strengthening of the MSP.

1.36 As a complement to these efforts, the World Bank has been supporting the Health Sector Institutional Strengthening Project (FISS) since 1995. This initiative is intended to enhance the quality and efficiency of health services offered to the poor and uninsured populations by promoting decentralization of public services and strengthening the MSP's regulatory role. These actions, inasmuch as they have lacked a solid legal basis, have been generally ineffectual; in the case of the present project, however, they have the backing of the authority granted to the MSP under the 2000-2004 Budget Act. The initiative also supports efforts to improve public-sector management through the technical development of management agreements and the necessary information systems; these advances are consistent with the policy actions supported by the program at hand. The project also sought to expand the coverage of the IAMC system, but the crisis among these institutions has made it impossible to attain this specific objective.

1.37 Lastly, this program will incorporate the lessons learned under the social-security sector reform program (921/OC-UR) that the Bank approved for Uruguay in March 1996. This program has been fully executed and the completion report has been submitted. The present operation seeks to tap experience from the pension reform process that could be applicable to the health sector, particularly as regards the need to organize a public information campaign, to not require that legislation be passed as part of the policy action matrix, and to provide a proper level of executive coordination made up of the management staff of the agencies involved in the reform.

D. Program rationale

1.38 The Uruguayan health system has reached a deep and unsustainable level of crisis, as expressed in the high level of total health spending (10% of GDP), IAMC liabilities of around US$350 million, and growing user dissatisfaction with services. To a great extent, this can be attributed to the array of structural problems described above, namely an inadequate regulatory framework and institutional structure, distortions in the labor market and financing model, excessive bias towards overspecialization in the care model, and management shortcomings in the public and private subsystems. In an effort to address these structural hurdles in the health sector and as part of a long-term vision as the ideal scenario for gradually conducting the process of change, the MSP is implementing—with support from the economic authorities—a package of policy actions built around the legal basis provided mainly by the recently approved 2000-2004 Budget Act.

1.39 The program proposed herein (see Annex I-2 for an overview of the program's vision) will support these first steps to revamp the country's health system by enhancing the regulatory framework and setting up the respective oversight framework (attributes of the institutional structure for oversight, obligations of regulated institutions, and protection of users' rights). This is the backbone of the program in that it will promote greater market transparency and equity in

contractual relations between users and the health institutions, providing a solid foundation for the future sustainability of the country's health system. As a complement, the program will strengthen both the private healthcare delivery subsystem (e.g., restructuring plans to secure the financial stability of the IAMCs and ensure continuity in services to users, together with implementation of model bylaws to separate out the decision-making functions from those that are strictly administrative, settle conflicts of interest, and professionalize management) and the public healthcare delivery subsystem (e.g., separation of functions, restructuring of the MSP, management agreements between the ASSE and its service-delivery units, and management agreements with private institutions to manage public-sector establishments). These actions will prepare the two subsystems for keener competition and greater complementarity of efforts resulting from the new regulatory and institutional framework. Lastly, the technical strengthening to be provided under the program will ensure the continuity of these efforts by generating the body of studies needed to deepen the changes, providing a strong technical and management core within the MSP, and launching a public information campaign in order to consult and inform public opinion.

1.40 By the end of the program, the sector is expected to be in full transition towards the long-term view of health reform, displaying a scenario characterized by effective separation of the functions of regulation, insurance, service delivery, and reinsurance of the Uruguayan health system. From the standpoint of the regulation function, a comprehensive regulatory framework would be in place for the sector, defining clear ground rules for all participating health institutions and promoting market transparency and equity in contractual relationships between those institutions and users of their services. It is also expected that the MSP's General Directorate for Health (DIGESA), by way of its Health Services Division (DSS), will be fully exercising the regulatory function and will have generated a body of regulations to prevent recurrent financial crises in the health institutions (e.g., power to grant authorization to operate or to liquidate institutions, minimum level of operating capital, and executable guarantees), setting up the necessary information systems, launching programs to oversee health institutions in the field, disseminating information of public interest, and organizing a system for presenting claims and resolving users' disputes with the institutions.

1.41 As a result of the enhanced regulatory framework and institutional structure for oversight, the MSP would enjoy a broader space in health policy formulation and priority-setting for public health (in such areas as large-scale vaccination campaigns and AIDS prevention and treatment programs), which are its core strategic responsibilities in terms of guiding the health system in the long term. Even under such a scenario of transition as this, however, the MSP would maintain its central responsibility in the health-system financing model and would continue to be a key player in collective bargaining with health professionals and workers. Meeting these challenges calls for longer maturity and processing times, until the findings

are in from the technical and political feasibility studies that will be supported by the program's technical strengthening component.

1.42 As for the functions of health insurance and service delivery, the transition scenario would culminate with the IAMCs being strengthened organizationally and institutionally as a result of the restructuring plans, after re-establishing their economic-financial balance and normalizing the flow of services to users; they will also have complied with the requirements set forth in the new regulatory framework in terms of receiving authorization to operate, establishing guarantees, observing the mandatory minimum levels of operating capital to ensure their continuity, delivering financial and technical information to the DSS, and maintaining high standards of user satisfaction. The IAMCs are also expected to be stronger organizationally thanks to the implementation of the model bylaws, operating with a much more professional management, and experiencing a marked reduction in conflicts of interest. The institutions of the public subsystem are expected to have stronger management structures thanks to more modern organization, with incentives for user satisfaction and cost control under management agreements, and they will have begun on the path to complementing the private subsystem through management agreements to manage public health establishments.

1.43 With regard to the health system's reinsurance function, the target transition scenario is one wherein the FNR has adjusted and modernized its management and returned to a balanced operational and financial footing by strengthening its management bodies, following medical protocols for the treatment of highly complex pathologies and making adjustments to payment arrangements with service providers. These advances would place the FNR in a position, at program completion, to present an evaluation report on the various options for its modernization in order to provide the most cost-effective response to the less-common, low-cost medical contingencies.

1.44 Lastly, the users of the health system are also expected to enjoy a much better situation under this transition scenario, since they will be able to receive information on their rights and legislation will be in force to protect those rights, and they will be able to bring claims against health institutions that fail to honor their contracts or fail to provide care as stipulated in applicable legislation, with dispute settlement mechanisms in place as well.

E. Strategy of the Bank

1.45 The Bank's strategy in Uruguay is geared principally towards supporting the government's development programs and policies for the period 2000-2004, which are aimed at achieving sustained GDP growth and greater social equity within a framework of macroeconomic stability. In operational terms, the Bank's strategy focuses on supporting: (i) initiatives to boost the competitiveness of national output regionally and internationally, and promote private investment on the strength of

comparative advantages and modern technologies, with a view to fostering healthy competition and broader insertion in regional and international markets; (ii) deepening of the process of modernization of the State and enhancing governability so as to reduce its burden on the economy, make it more efficient, streamline and focus its action, and reduce its impact on national output of goods and services; and (iii) efforts to enhance social well-being and equity by mainstreaming the most vulnerable groups into the development process and affording them a better quality of life.

1.46 Accordingly, supporting—through this program—the package of reforms being pursued by the MSP to improve overall management of the sector could have a direct impact on two of the strategic development thrusts that guide the Bank's action in Uruguay. With regard to modernization of the State, important progress is clearly being promoted in the separation of functions within the health system with an eye to more efficient management: the MSP will exercise the functions of regulation, policy formulation, and priority-setting for public health, with the ASSE acting as administrator of public financing and management control; the service-delivery units, on the other hand, would be organized as integrated health networks and would offer healthcare services preferably to the low-income population. Inasmuch as health is one of the most sensitive social sectors for the population, supporting policy actions that seek to change gradually the ground rules under which the system operates could lead to significant improvement in the management of the various institutions as well as major advances in terms of user satisfaction. In this way, it would be possible to generate a significant impact on improving equity in access to quality healthcare, especially for the more vulnerable sectors of the population.

II. THE PROGRAM

A. Objectives[4]

2.1 The program's objective is to support the government in implementing a set of policy actions promoted by the Ministry of Public Health (MSP) to ensure the continuity of a gradual process of health sector reform aimed at resolving the sector's structural problems as part of a long-term vision. Specifically, it will unify, integrate, and systematize the existing disperse body of regulations to create a basic set of shared ground rules and the foundations for a regulatory institutional framework that will foster the necessary strengthening of the public and private healthcare delivery systems and ensure complementarity between their efforts. This will create, over time, a competitive setting for service providers that will reduce costs and improve care quality while ensuring more equitable access to health services, especially for the more vulnerable population groups.

B. Description

2.2 This is a sector loan that will be carried out over a 24-month period and disbursed in three tranches: the first one for US$30 million, the second for US$20 million, and the third for US$25 million. The four areas of action are (see Annex II-1): (a) enhance the health system's regulatory framework; (b) strengthen the private healthcare delivery subsystem; (c) strengthen the public healthcare delivery subsystem; and (d) strengthen the MSP's technical capacity.

2.3 **Enhancement of the health system's regulatory framework.** Given the lack of a shared set of ground rules for all health institutions, policy actions in this area will support the unification, integration, systematization, and implementation of a body of regulations and oversight mechanisms aimed at ensuring the medium- and long-term sustainability of all institutions in the Uruguayan health system (including the supplementary insurance plans). This will help to prevent unfair competition and risk selection, and it will guarantee the existence of a minimum set of financial safeguards for the system, protect users' rights, disseminate financial and statistical information, and promote the adoption of a care model that emphasizes health prevention and promotion. Support will also be provided for establishing, within the MSP's new organizational structure, a decision-making level with full responsibility for supervision and oversight of both public and private healthcare institutions.

2.4 In this policy area, disbursement of the *first tranche* will be subject to presentation, to the Bank's satisfaction, of evidence that: (a) the executive decree issuing regulations for and integrating the various existing regulatory frameworks has

[4] A schematic summary of the project's objectives and areas of action can be found in Annex I-2.

entered into effect, including general guidelines on: (i) the attributes of the MSP's General Directorate of Health (DIGESA) in order to regulate and oversee healthcare institutions, e.g., the power to grant or withdraw authorization to operate, request and disseminate the necessary information to fulfill its mandate, resolve users' complaints, apply fines and/or penalties, and oversee mergers, absorptions, and liquidations; (ii) the health institutions' obligation to secure authorization to operate from the oversight unit, establish guarantees, maintain minimum levels of operating capital, and comply with agreed levels of health coverage; and (iii) provisions on protection of users' rights, including the right to file complaints and receive information on their rights and guarantees in the area of health coverage; and (b) the executive decree, based on advice from the Executive Committee for State Reform (CEPRE), has entered into effect, including general guidelines for restructuring the public health subsystem and empowering the DIGESA, by way of the DSS, to assume regulatory and oversight authority over public and private health institutions that offer health coverage and/or service delivery.

2.5 For disbursement of the *second tranche*, evidence is to be presented to the Bank's satisfaction of the following: (a) the new regulations are in effect and being implemented in accordance with the general guidelines contained in the executive decree approved in the first tranche; (b) the MSP has allocated budgetary resources to the DSS to underpin its mandate; (c) the DSS has begun to operate as the regulatory and oversight unit for public and private health institutions that offer health coverage and/or service delivery, pursuant to the resolutions formalizing the authority conferred and presentation of the technical designs for: (i) the necessary information systems, (ii) implementation of the oversight and control programs, (iii) arrangements to resolve user complaints, and (iv) tools to publicize information of public interest and that make management of the institutions more transparent.

2.6 For disbursement of the *third tranche*, evidence is to be presented to the Bank's satisfaction of the following: (a) an evaluation report based on opinion studies that measure users' knowledge, perception, and degree of satisfaction with progress made in enhancing the regulatory framework and management of the new oversight unit, together with an action plan to fine-tune the regulatory framework; (b) a report on the DSS's management, including the impact produced by its resolutions and an evaluation of the implementation of: (i) the necessary information systems, (ii) the control and oversight programs, (iii) arrangements to resolve user complaints, and (iv) tools to publicize information of public interest and that make management of the institutions more transparent; and (c) a study evaluating the various options for enhancing the State's regulatory and oversight role in the health sector.

2.7 The expected impact of the actions supported by this component is to improve the financial and client-service performance of health institutions that offer coverage and/or health services delivery through systematic monitoring by the regulatory unit of the institutions' financial and accounting statements, disseminating early

warning indicators, making this information more transparent for the market, issuing instructions sufficiently in advance to remedy anomalies, or withdrawing authorization to operate for institutions at risk of bankruptcy. By strengthening the State's institutional capacity to exercise the functions of regulation and oversight in the health system, users' rights will receive more effective protection in conjunction with a transparent and systematic flow of information that increases their choices and proper safeguards for their guarantees and right to receive health coverage, and protects the continuity of care in the event an institution loses its authorization to operate.

2.8 **Strengthening of the private healthcare delivery subsystem.** In this policy area, the program will support the restructuring plans being formulated by the IAMCs, with backing from the sector authorities, to resolve the current systemic financial deficit. The objective is to promote a more efficient management model, re-establish the institutions' financial stability, strengthen them organizationally and institutionally, and ensure continuity of care for their users. This will be achieved through management agreements with the MSP, the Planning and Budget Office (OPP), and the MEF aimed at ensuring the viability and long-term sustainability of their actions. As a complement to these restructuring plans, the program will also support MSP efforts to require the IAMCs to adopt the model bylaws, which are intended essentially to separate out executive decision-making responsibility from strictly managerial responsibilities, resolve conflicts of interest, and professionalize management.

2.9 Within this policy area, disbursement of the *first tranche* will be subject to presentation, to the Bank's satisfaction, of: (a) a draft IAMC restructuring plan and a draft model for the management agreement to be signed with these institutions, including indicators of improvement in the following areas: economic/financial, (achievement of operational equilibrium and lower levels of indebtedness), technical/care delivery (normalization of health services provided to users and incentives for a care model focused on health promotion and prevention), and , and organizational/institutional (modernization of management and of information systems, coupled with training actions); and (b) the entry into force of the executive decree defining the new model bylaws for the IAMCs, which are to separate out executive decision-making responsibility from strictly managerial responsibilities, professionalize management, and resolve conflicts of interest.

2.10 For disbursement of the *second tranche*, evidence is to be presented, to the Bank's satisfaction, that: (a) the management agreements implementing the restructuring plans have been signed with at least 50% of the IAMCs in Montevideo or the equivalent of 40% of their user portfolio; and (b) the executive bodies of all institutions that have signed restructuring plans have adopted bylaws that, in the MSP's opinion, are substantially similar to the new model bylaws.

2.11 Disbursement of the *third tranche* will be subject to the presentation, to the Bank's satisfaction, of: (a) an evaluation report containing indicators of improvement in the economic/financial and technical/care-delivery status of IAMCs implementing restructuring plans, as well as the impact of the new model bylaws in terms of effective separation of functions at these institutions, the impact on professionalization of their management, and the specific impact of the provisions on conflicts of interest; (b) evidence that management agreements for the restructuring plans have been signed with IAMCs of Montevideo whose coverage represents at least the equivalent of 60% of the user portfolio, provided that their own bylaws adhere substantially to the provisions of the model bylaws; and (c) a work plan to extend adoption of the model bylaws and promote improvement of the economic/financial situation of all IAMCs throughout the country.

2.12 The expected impact of these actions will be to restore the IAMCs to a sound financial footing and standardize the care delivered to their beneficiaries, which has become irregular and in some cases has been deferred or suspended as a result of the crisis situation that has beset these institutions, especially in Montevideo. Similarly, management of the IAMCs is expected to become more efficient as a result of the adoption of the model bylaws.

2.13 **Strengthening of the public healthcare delivery subsystem.** In view of the chronic inefficiencies present in this subsystem, the actions for this policy area relate to the regulation and implementation of measures called for under the recently approved 2000-2004 Budget Act, which empower the MSP to: (a) reorganize itself to separate out the functions of policy formulation and regulation (to remain under the MSP), financing (to be placed under the Government Health Services Administration [ASSE]), and service delivery (to be assigned to specific service-delivery units), while promoting decentralization by transferring more attributes to the managing agencies; (b) authorize management agreements to bring private institutions in to manage public-sector service providers; (c) authorize the ASSE to allocate budget funds to the network of public-sector service providers under management agreements that link budget allocations to performance, i.e., more and better healthcare services for the population; and (d) allow private institutions to be charged for the cost of healthcare services provided to their beneficiaries. Support will also be provided for the efforts of the ASSE's authorities to move forward with launching a system to identify and classify users who are served by the public network, in order to charge private healthcare institutions for services provided to their beneficiaries by the public network. Another important action within this policy area will be support for the restructuring of the FNR to modernize its management.

2.14 For disbursement of the *first tranche*, the policy advances promoted by the MSP and approved under the 2000-2004 Budget Act will be acknowledged. In addition, evidence of the following is to be presented to the Bank's satisfaction: (a) the executive decree, based on advice from the Executive Committee for State Reform

(CEPRE), has entered into effect, including general guidelines for restructuring the MSP and the ASSE (including its service-delivery units), separating out the functions of policy formulation and regulation (to remain under the MSP), administration of financing and management control (to be placed under the ASSE), and service delivery (to be assigned to specific service-delivery units); (b) the model management agreement for allocating budget resources from the ASSE to the service-delivery units, promoting the adoption of a care model focused on health prevention and promotion; (c) the model agreements for full or partial management responsibility between the service-delivery units and healthcare institutions or other private organizations that demonstrate proven capacity for managing public establishments, and the areas and regions identified for their implementation; (d) the technical design of the user identification and classification system, together with an updated proposal for a mechanism for charging private institutions; and (e) the restructuring plan for the FNR, aimed at generating an operating surplus and allocating resources on a cost-effective basis by, for instance, following medical protocols for the treatment of high-complexity pathologies and making adjustments to payment arrangements for hiring healthcare services from service providers.

2.15 Disbursement of the *second tranche* will be subject to presentation, to the Bank's satisfaction, of: (a) a progress report detailing the activities of the MSP and ASSE under the new organizational structure of the public health subsystem, together with implementation of the new mid- and upper-level management structure in at least 40% of the service-delivery units; (b) evidence that management agreements are in force in at least 30% of the service-delivery units; (c) entry into force of the MSP resolution approving the total or partial management agreements to be signed by the service-delivery units and private institutions, stipulating the areas and regions where they are to be implemented; (d) evidence that the user identification system is up and running normally, together with the arrangements for charging private institutions, in at least 30% of the service-delivery units; and (e) a progress report on the following aspects of the FNR restructuring plan: economic/financial (operating equilibrium and lower levels of indebtedness) and technical/care-delivery (cost-effectiveness of services financed).

2.16 Disbursement of the *third tranche* will be subject to presentation, to the Bank's satisfaction, of: (a) an evaluation report on the status of the public subsystem's new organizational structure and extension of the new structure to 80% of the service-delivery units; (b) an evaluation report on the status of the management agreements in operation and their extension to 80% of the service-delivery units, (c) evidence of the implementation of total or partial management agreements between service-delivery units and private institutions in at least two public establishments in selected areas or regions; (d) an evaluation report on the user identification system and its arrangements for charging for services, extending coverage to at least 60% of the service-delivery units; and (e) an evaluation report on the FNR restructuring plan, together with an analysis of options for its modernization in order to provide

the most cost-effective response to the less-common, low-cost medical contingencies.

2.17 Taken together, the separation of functions, entry into force of the management agreements with public service-delivery units, establishment of management agreements with private institutions, and adoption of user identification systems and arrangements for charging the IAMCs for services are expected to make the public healthcare delivery subsystem more efficient and to promote management that is driven by user satisfaction in the public network of service providers, targeting the State's resources to the low-income population as the preferred beneficiaries of its action. Furthermore, the FNR restructuring plan is expected to enhance the agency's executive bodies and reduce its operating deficit and level of indebtedness.

2.18 **Technical strengthening of the MSP.** The program will support the MSP's Strategic Technical Strengthening Plan (PEFT), focusing on three key avenues of intervention: (i) studies on technical feasibility and political viability, which are crucial to sustaining the gradual process of de reforms towards the MSP's long-term vision for the healthcare system; (ii) design and implementation of a public information campaign to consult and inform public opinion in support of the modernization process; and (iii) technical consulting services for the MSP's line units responsible for implementing the agreed policy actions.

2.19 In this policy area, disbursement of the *first tranche* will be subject to presentation of the PEFT, which is to include: (a) the terms of reference for the studies on the health system financing model, the model for comprehensive healthcare networks, and the model for modernization of human resource management; (b) the design for the strategy and media plan for the public information campaign, including the design of a survey to evaluate its impact in terms of the public's support for the changes; (c) the terms of reference of the consulting services to support the MSP's line units, including criteria for the evaluation of those services.

2.20 Disbursement of the *second tranche* will be subject to presentation of a progress report showing that the PEFT has been launched through the commissioning of most of the strengthening actions and the key studies and external support for devising the communications strategy and media plan, together with the specialized consulting services to strengthen the MSP's line units.

2.21 Disbursement of the *third tranche* will be subject to presentation of the PEFT's outcomes, which should include: (a) final reports of the studies with the respective analyses of technical feasibility and political viability, including a work plan to disseminate the outcomes through seminars, workshops, and other activities; (b) a final evaluation report on the public information campaign and its impact in terms of public support achieved for the changes; and (c) a report evaluating the

consulting services to support the strengthening of the MSP's line units, including a work plan to ensure the continuity of these strengthening actions.

2.22 In terms of impact, the PEFT is expected to generate the necessary inputs to consolidate and deepen the process of transformations that are more structural and that require changes in laws, and also to consult and inform the Uruguayan population and public opinion to make them allies of the process of change, while strengthening the MSP's management and technical core to lead and conduct the modernization process.

C. Cost and size of the operation

2.23 The health sector reform program will channel US$75 million to the National Treasury, drawn on the Bank's Ordinary Capital resources. Since this is a sector loan, the resources are not linked to the execution of any specific component, but rather to comprehensive fulfillment—to the Bank's satisfaction—of the policy actions defined and agreed for the program. The operation's size is justified in terms of the resources needed to implement the package of policy actions to be promoted by the MSP, as well as in terms of the financial programming of external resources by the economic authorities (OPP and MEF).

III. PROGRAM EXECUTION

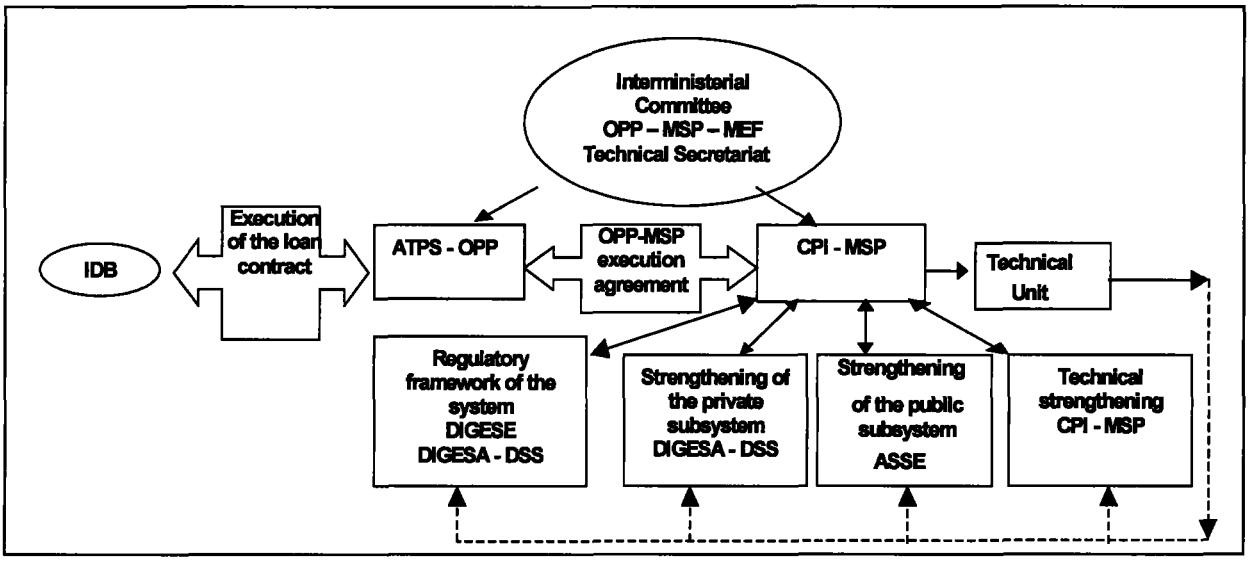
A. Borrower and executing agency

3.1 The borrower will be the Republic of Uruguay, and the executing agency will be the Planning and Budget Office (OPP), which is located in the Office of the President of the Republic. The Ministry of Public Health (MSP), as the sector's lead policy-setting agency, will provide technical support and will be responsible for implementing the proposed actions and reform measures.

B. Execution and administration

3.2 An execution structure will operate within the OPP whereunder executive responsibility and functions are concentrated in an interministerial committee made up of the Director of the OPP, the Minister of Economic Affairs and Finance, and the Minister of Public Health, who will chair the committee. The committee will have a technical secretariat comprised of representatives of each of the ministers, coordinated by the OPP representative. As the program's executing agency, the OPP will sign a technical execution agreement with the MSP to ensure proper implementation of the policy actions supported by the program. The OPP has appointed its Technical Advisory Office on Social Policy (ATPS-OPP) to administer and supervise the agreement; that office will also be responsible for coordinating the relationship with the Bank, and its coordinator will represent the OPP within the interministerial committee's technical secretariat. For purposes of this technical execution agreement, the MSP will appoint the International Project Coordination Office (CPI-MSP) to support, with cooperation from a specialized technical unit, the MSP's line units, e.g., the General Directorate for Health (DIGESA) and its Health Services Division (DSS), the General Directorate for Secretariat Affairs (DIGESE), and the General Directorate of ASSE, in their capacity as offices directly responsible for implementing the policy actions called for in the program in their respective areas of action. The following diagram provides a schematic representation of the program's execution structure.

Table III-1. Execution Structure



3.3 The interministerial committee will be responsible for strategic coordination of the policy actions called for in the program, specifically: (i) ensure an economic and health policy framework conducive to the timely and comprehensive implementation of the policy actions agreed upon for the first, second, and third tranches of the loan; (ii) approve strategic guidelines of the executive decrees and all instruments aimed at modernizing health sector management; (iii) approve the PEFT's strategic guidelines, specifically with regard to the information campaign and media plan, the planned technical studies to ensure the continuity of health sector reform, and the consulting services to strengthen a critical management core at the MSP; and (iv) define management guidelines for the OPP's Technical Advisory Office on Social Policy and the MSP's International Project Coordination Office, and monitor their respective performance.

3.4 The OPP's Technical Advisory Office on Social Policy (ATPS-OPP) will be the executive-level unit responsible for administration, technical monitoring, and general evaluation of the program. It will report the outcomes of its work directly to the interministerial committee and ensure coordination with the Bank, for which purpose it is to: (i) administer the technical execution agreement with the MSP in order to follow up on actions coordinated by the MSP's International Project Coordination Office and performed by the MSP's line institutions that are involved in the program, especially with regard to the implementation of agreed policy actions for release of the loan tranches; (ii) gather and present to the Bank the necessary information for authorizing disbursement of each tranche by securing and verifying the necessary information and documents that show that the policy actions agreed to in the loan contract have been performed; (iii) act as the government's principal technical interlocutor with the Bank; (iv) administer the fast-disbursing

funds in accordance with Bank rules on sector loans; (v) ensure the timely and proper implementation of actions to modernize the health sector and execution of the PEFT, especially with regard to the technical studies, the public information campaign, the training plan, and the consulting services to strengthen a critical management core at the MSP; (vi) track the quarterly monitoring and evaluation plan to ensure performance of the agreed policy actions for the second and third tranches; and (vii) prepare the necessary reports for Bank missions and a final program evaluation report.

3.5 Under the technical execution agreement to be signed by the OPP with the MSP, the OPP's Technical Advisory Office on Social Policy (ATPS-OPP) will have, for purposes of this program, a light, simple management structure made up of a general coordinator (who should be an economist, administrator, or engineer with experience managing projects financed by international organizations), a technical coordinator (who should be an economist with experience in the health sector), and an administrative coordinator (who should have professional management experience with administrative procedures of international agencies). This coordination unit will apply the experience gained and lessons learned from the execution of other Bank-financed programs in Uruguay (social-sector strengthening and social-security reform) for which the OPP was the executing agency.

3.6 To ensure performance of the policy actions agreed to in the loan contract and other responsibilities assumed as part of the task of coordination with the Bank, the technical execution agreement between the OPP and the MSP will stipulate such terms and conditions as to ensure the ATPS-OPP that disbursement authorizations will be processed in a timely manner by the Bank. Accordingly, the loan contract, the policy action matrix, and the quarterly monitoring and evaluation plan will be considered integral parts of the aforementioned technical execution agreement.

3.7 Lastly, the MSP's line ministries, coordinated by the International Project Coordination Office (CPI-MSP), will hold operating responsibility for performance of the technical execution agreement signed with the OPP. Accordingly, the CPI-MSP will have on staff a general program coordinator, who should be an administrator, economist, or engineer with experience in the public sector and with projects funded by international agencies. The DIGESE and DIGESA, by way of the DSS, will assume operating responsibility for policy actions to enhance the regulatory framework; the DIGESA, by way of the DSS, will be responsible for policy actions to strengthen the private subsystem; the ASSE for policy actions to strengthen the public subsystem; and the CPI-MSP itself will coordinate actions in the technical strengthening area. The International Project Coordination Office's technical unit will have a technical advisory role and will lend support to the Office and the MSP's specialized line units; accordingly, its staff should include administrators, economists, engineers, or health professionals with proven experience in public or private management in the health sector.

C. Execution period, amounts, and disbursement schedule

3.8 The program will be executed within a maximum period of 24 months, and the sector loan proceeds will be disbursed in three tranches: US$30 million for the first tranche, US$20 million for the second tranche, and US$25 million for the third tranche. This will ensure an adequate balance between the importance of the policy actions supported by this operation and the financial programming of the country's external resources.

3.9 The first disbursement is expected to take place when the policy actions agreed for that tranche have been implemented and approved to the Bank's satisfaction; this is expected to occur in the month following signature of the loan contract. The second tranche will be released upon performance and approval to the Bank's satisfaction of the respective policy actions, expected to occur approximately 12 months after signature of the loan contract. The third tranche will be released upon performance and approval to the Bank's satisfaction of the respective policy actions, expected to occur approximately 24 months after signature of the loan contract.

D. Conditions precedent for disbursements

3.10 Release of each tranche will be subject to the borrower performing the following actions to the Bank's satisfaction: (i) maintain a macroeconomic environment consistent with the program objectives and the agreements reached with the International Monetary Fund; (ii) perform the policy actions agreed on for the respective tranche, as specified in chapter II and Annex II-1 hereto; (iii) maintain special accounts for the loan proceeds; and (iv) ensure that the MSP and its agencies that are participating in the program have the necessary resources to implement the policy actions agreed on for the three tranches.

3.11 For the first disbursement, evidence is also to be presented of the following, as conditions precedent: (i) the interministerial committee, including its technical secretariat and the respective official representatives, has been established and is functional; (ii) the program execution agreement has been signed by the OPP and MSP, stipulating *inter alia* that the Technical Advisory Office on Social Policy and the International Project Coordination Office are the offices responsible for program execution in their respective spheres; and (iii) that the technical unit, with its technical team, has been set up under the International Project Coordination Office.

3.12 The borrower, by way of the executing agency, will be responsible for maintaining financial and accounting records on the use made of the loan proceeds and for preparing and submitting disbursement requests, making such documents available for inspection by the Bank and/or external audits, if need be. The borrower is to keep special accounts for managing the loan proceeds and will present the information on these accounts to the Bank prior to the first disbursement.

3.13 The project team will evaluate the information that is presented by the country as evidence of performance of the agreed policy actions and will draft the respective reports for the Bank's Management and Board of Executive Directors in order to request authorization for the disbursements in accordance with applicable policy.

E. Program monitoring and evaluation

3.14 Given the scope and complexity of this program, it has been agreed with the executing agency that the program will be monitored through a quarterly monitoring and evaluation plan that will help to ensure timely performance of the policy actions being supported, especially in terms of authorization for release of the second and third tranches. Moreover, the third-tranche policy actions call for a general review of all the processes under way; this will allow the country to conduct a quantitative and qualitative evaluation of the outcomes and overall impact of the reform. Annex III-1 presents the quarterly plan, which includes a set of indicators for measuring the program's impact upon completion of the implementation phase in the following areas: economic/financial, technical/care-delivery, and organizational/institutional.

3.15 Drawing on these outcomes and any additional information considered necessary, the Bank will conduct an ex post evaluation in order to assess to what degree the program objectives were attained. For the specific purposes of this evaluation, the borrower agrees to cooperate directly and through the executing agency by providing any information, data, and documents as well as any technical, logistical, or administrative support as may be requested.

F. Policy letter

3.16 The Bank is in agreement with the borrower on the policies outlined in the attached policy letter (Annex III-2). The letter summarizes the policies for the economy and for modernization of the State being pursued by the Government of Uruguay, and proposes specific health policy actions to enhance the regulatory framework and institutional structure, strengthen the private and public subsystems, and provide technical strengthening that will be supported by the program.

G. Procurement

3.17 The proceeds from this Bank loan will be used to finance a project to support the borrower's national public sector, which includes the importation of eligible goods. The Bank's applicable sector-lending procedures will be followed, which do not require international competitive bidding. Funds will be disbursed upon request submitted by the borrower and presentation of evidence that all the contractual conditions have been performed to the Bank's satisfaction.

H. Project Preparation and Execution Facility

3.18 The Bank financed program preparation activities through individual operation 1313/OC-UR in the amount of US$339,000, under credit line FAPEP/006-UR, which is available to the Republic of Uruguay. Accordingly, at the time of first disbursement, the Bank will draw on the proceeds of this loan to pay that amount plus the respective interest and credit fees to replenish up to the amount of US$339,000 under the credit line.

I. External audit

3.19 The Bank reserves the right to ask the borrower to provide financial reports on the use made of the loan proceeds, audited by independent auditors agreed to in advance by the Bank.

J. Inspection and supervision

3.20 The Bank will establish the inspection procedures it feels are necessary for purposes of satisfactory execution of this sector loan. To that end, the borrower will cooperate fully by providing all necessary assistance and information.

IV. VIABILITY AND RISKS

A. Viability

4.1 In view of the IAMCs' serious financial crisis (which is jeopardizing the continuity of healthcare services for the user population) and the deteriorating quality of services at public healthcare delivery establishments (which affects mainly the low-income sectors), the Government of Uruguay has indicated its firm political will to undertake a sweeping reform of the country's health system as reflected in the set of policy actions agreed within the framework of the present program. This political will is a guarantee for the operation's viability and has been assumed as a commitment not only by the MSP's authorities but also by the country's economic authorities as represented by the Planning and Budget Office and the Ministry of Economic Affairs and Finance.

4.2 This commitment by Uruguay's economic and health-sector authorities is embodied in the agreements reached on the arrangements for execution and administration of the program to ensure its institutional viability. Program execution has been designed in such a way that the policy-setting, executive, and administrative responsibilities (OPP) and the technical and operating responsibilities (MSP) are defined within their respective jurisdictions, thus creating an incentive for the OPP—as the agency responsible for overseeing the financial programming of external resources—to supervise performance of the policy actions by those with technical and operating responsibility to do so (MSP). At the same time, a virtuous circle is generated between the unit responsible for managing the country's budgetary resources and the sector unit responsible for carrying out modernization actions, in such a way that adequate availability of budgetary resources and timely financial programming will ensure the program's viability. Aware of the breadth of the challenges inherent in implementing the reforms, the MSP's authorities have included in the technical and operational structure responsible for the program the MSP's line agencies that are participating in the direct execution of policy actions, with support—through the PEFT—from specialized consulting services for these line units in order to ensure their effective involvement and also their commitment to the operation's success.

4.3 As for the program's political viability, it is worth noting the main conclusion of a report conducted on the stakeholders' positions as input for this operation's design. As an opportunity for change, the report concluded that the perception of crisis in the system, especially among the IAMCs, was very widespread among the main actors, and external factors (fee increases, higher copayments, or direct government subsidies) were not felt to be a solution. Politically, this is a very favorable context for promoting key modernization measures for which legal backing exists, especially bearing in mind that the current administration and sector authorities have only been in office for a year, so there is a potential planning horizon of three

years. Furthermore, the recent intersectoral commission agreement—signed by the MSP and MEF with the actors involved in the IAMC crisis—laid the foundations for the restructuring of the IAMCs in terms of acceptance of a new regulatory framework for the sector, necessary adjustments in their management model, and changes required in the care model, giving priority to health promotion and prevention, while defining clear commitments on the part of the IAMCs to enhance client satisfaction. Coupled with the agreement on the set of immediate measures to place the IAMCs back on a stable financial footing (mergers or liquidations, debt write-off by suppliers, and other actions to pare back operating costs), this will ensure a minimum framework of political viability for the success of the IAMC restructuring plans.

4.4 With regard to the program's economic viability, the 2000-2004 Five-year Budget Act grants both legal authorization and financial backing for the modernization measures being promoted. In addition, a more efficient health system (as a result of the program) could contribute significantly to stanching the upward spiral in health spending, thus easing pressure on the public deficit, labor costs, and family budgets. Even if the only achievement were to use the same resources spent by the system today (10% of GDP) to provide more and better healthcare services to the population, an important step will have been taken towards the objective of more efficient and modern health institution management, legitimizing these institutions' action vis-à-vis their beneficiaries and providing an important stimulus to the long-term economic sustainability of Uruguay's health system. In this regard, the findings of a simulation exercise prepared as part of the consulting services to support the Bank indicate that the policy actions supported by the program have significant potential to help attenuate the upward spiral in health spending, and could stabilize this spending at 10% of GDP by the middle of this decade. The projected savings of US$2,625 million (net present value) would ease future pressure on the public deficit, labor costs, and family budgets. This projection emerges from a comparison of a realistic reform scenario whose overall impact consists simply of keeping growth in health spending in line with the economic growth rate, and a non-reform scenario in which growth in health spending would remain higher than the economic growth rate posted over the past decade, meaning that by 2010 health spending would account for over 13% of GDP.

B. Social, environmental, and gender impact

4.5 This operation qualifies as a project that promotes social equity, as described in the key objectives for the Bank's activity set forth in the report on the Eighth General Increase in Resources (document AB-1704). In accordance with the report's guidelines and bearing in mind that this is a fast-disbursing sector loan, the program cannot be classified as a poverty-targeted investment (PTI). The project does not set any explicit performance indicators to measure poverty reduction or improvement of social equity. The rationale for classifying this project as promoting social equity lies in the fact that it will underpin health sector reform.

4.6 As a sector operation, this program does not call for the financing of works or related management activities. Accordingly, it will not have any impact on the environment and it will not be necessary to take environmental protection measures during its preparation and execution. The Committee on Environment and Social Impact considered this operation at its 16 February 2001 meeting.

4.7 From a gender standpoint, the study on the financing and reinsurance model included in the PEFT will explore mechanisms to ensure that workers' families can enjoy protection directly through the social security system rather than depend on voluntary contributions to health insurance coverage. Given the lower relative participation of women in the Uruguayan work force, this future measure could especially benefit mothers and their children.

C. Benefits

4.8 Most of the policy actions supported by the program share the common goal of making access to healthcare more equitable and sector management more efficient. As the regulatory framework of the country's health system becomes gradually more unified and integrated, and the management of its public and private subsystems becomes stronger and more modern, it will be possible to deliver more and better healthcare services to the population and target public funds to those who need them the most in terms of social and medical vulnerability.

4.9 Specifically, an enhanced regulatory framework and an institutional structure for oversight are the main benefit expected from the program, in that they will promote a common set of ground rules for all healthcare institutions in the health system and thus foster equity in contractual relationships with their beneficiaries and market transparency as a foundation for long-term sustainability. Strengthening the State's institutional capacity to exercise the functions of health system regulation and oversight will also ensure more effective protection for users' rights, thanks to a transparent and systematic flow of information that will broaden choices, safeguard their right to healthcare coverage, and ensure healthcare continuity in the event of liquidation of the institution. At the same time, it will be possible to head off recurrent financial crises in the health system through systematic monitoring by the regulatory unit of healthcare institutions' financial and accounting records, which will allow it to issue early-warning indicators, make this information more transparent for the market, issue instructions sufficiently in advance for measures to remedy anomalies, or withdraw authorization to operate from any institution at risk of bankruptcy.

4.10 The program will also have a beneficial impact on modernization of the State, inasmuch as it will support actions to foster an integrated regulatory framework for the Uruguayan health system, create an institutional structure responsible for this function, and strengthen management of the public subsystem by monitoring the restructuring of its main institutions (MSP, ASSE, service-delivery units, and

FNR). Given the organizational poverty that has been a traditional hallmark of the management of public institutions in the region's health sector, any effort to separate out functions and improve management will be welcome and will sow the seeds for a process of modernization that will gradually secure substantial improvements in the quality of services delivered to the user population.

4.11 Lastly, an additional, indirect benefit will be generated by using a quarterly monitoring and evaluation plan to monitor the agreed policy actions: it will allow the country authorities and the Bank to follow a critical path for implementing those actions, setting off warning lights in time for corrections to be made or progress accelerated in those that present possible delays. The program will also benefit from an evaluation of outcomes and outputs in terms of logical coherence of the actions programmed over time: the first tranche will support the establishment of a set of ground rules and the foundations for a minimum institutional structure for oversight; the second tranche will then launch a series of changes in the health system; and the third tranche will analyze the outcomes in order to assess the program's most direct impact, draw lessons from the experience, introduce adjustments, and deepen aspects that require more structural changes.

D. Risks

4.12 Owing to the complexity of transformations in a sector as sensitive as the health sector, the main risk to the program is resistance from organized interests of the sector players and their pressure to detain the process or modify it to benefit their specific interests. To mitigate this risk, there is consensus with the authorities as to the importance of maintaining and deepening dialogue with all relevant sector actors, while supporting the program with a public information campaign as a powerful tool to consult and inform the population and public opinion as to the true meaning of the modernization efforts, seeking to convert the system's current and potential users into key allies of health sector reform.

4.13 Another crucial problem when carrying out modernization efforts, especially in the health sector, is the high turnover of sector authorities and their teams of trusted advisors who stand at the technical helm of the process of change; this weakens the critical management capacity of the incoming authorities. To mitigate this risk, one of the PEFT's areas of priority focus is to invest in a technical and management core that could represent valuable human capital for the MSP and ensure, to the extent possible, that modernization efforts can be carried out independently of whether higher-level sector authorities remain in place or not.

4.14 A risk that is present in any process of modernization is the possible lack of continuity and long-term sustainability of the reform. In the case at hand, the backbone of the proposed changes lies in the policy actions to enhance the regulatory framework and institutions with an eye to creating a set of stable ground rules and institutional capacity to oversee regulated institutions as the foundation

for medium- and long-term sustainability of the country's health system. The PEFT also will make an important investment in knowledge generation, as witnessed by the set of studies which are considered key to consolidating and deepening the structural reforms required by the national health system in the long term. This investment will provide input for the analysis of the political feasibility and viability of future measures to be adopted by policy-makers in such key areas as the financing model, the care model, and modernization of labor relations in the sector.

4.15 Lastly, the current environment of financial crisis among the IAMCs is a specific risk for this program, especially in the present international economic scenario which could trigger a downturn in the country's general economic situation and undermine the likelihood of success for the modernization process embarked upon by the authorities. This risk is important in that it creates a perception on the part of these institutions that the government would be willing to use public funds to finance their restructuring without adopting a framework of economic, technical, and organizational conditions and without adequate financial safeguards. The risk will be mitigated by the government's public announcement that it would only offer loans to IAMCs that have adopted viable restructuring plans. IAMCs whose plans do not qualify must merge with or be absorbed by viable IAMCs, or be liquidated. Furthermore, the risk to the State is mitigated through the participation of private providers in the swap of liabilities for long-term bonds and since they will assume, together with the IAMCs, a large share of the associated risk. This is in addition to all the financial safeguards that have been designed to ensure adequate risk coverage for the Public Restructuring Fund (FRP), e.g., withholdings from contributions by members of the system administered by Banco de Previsión Social as payment guarantee, a technical reserve fund to cover possible noncompliance, debt pass-through arrangements for plan members, and partial disbursements subject to progress made with the restructuring plans. This will allow the financial risk to be shared by all the actors involved (State, IAMCs, and private-sector players), generating favorable incentives for a genuine, efficient restructuring of the IAMCs. Even so, it is crucial that the regulatory framework and institutional structure promoted by this program support the IAMC restructuring process from the very beginning, as a way to prevent, by means of new regulation and oversight tools, the recurrence of systemic financial crisis and thus the constant government bailouts and their consequent cost to taxpayers.

Strategy for restructuring the IAMCs

Evaluation of the restructuring plans

The Restructuring Plans will be evaluated by the Technical Unit of the MSP and by risk-rating institutions accredited by the Central Bank of Uruguay (Banco Central del Uruguay). The technical bodies of the MSP participating in the implementation of the Program will also evaluate each of the IAMCs in a dynamic analysis process in which the plan will be analyzed with the IAMC and its Consulting Firm. The Technical Unit will issue a pronouncement, which, together with the evaluations of the risk-rating institutions, will later be considered by an interministerial committee formed by the MSP, the MEF and the Office of Planning and Budget (Oficina de Planeamiento y Presupuesto, or OPP). This committee will approve or reject the respective restructuring plans.

Previous process of mergers, acquisitions and liquidations

The authorities are currently drafting procedural rules for mergers, acquisitions and liquidations for those IAMCs whose restructuring plans do not qualify and whose financial deficits **may** endanger the fulfillment of their health care obligations. This policy measure is crucial, since the resources to support the restructuring process will be assigned only to those IAMCs with real possibilities of improving their economic/financial, health care delivery, and organizational/institutional situations. The remaining IAMCs will need to look for different alternatives to achieve viability, including taking steps to merge with or be acquired by other institutions that qualify to receive financing, or otherwise cease operations with the appropriate safeguards to guarantee the continuity of health services to users.

In case of liquidation, a liquidation commission with wide administrative authority will oversee the enforcement of regulations and current agreements with respect to the redistribution of the pool of subscribers, liquidation of assets and payments to creditors. In the case of subscribers, health care continuity is temporarily ensured by ASSE while such subscribers wait for their final redistribution; whereas, in the case of payment of liabilities, the current regulations, which give priority to the cancellation of labor and social security debts, will apply.

Financing of restructuring plans

The IAMCs with approved restructuring plans will receive financial assistance from the Public Fund for Restructuring (Fondo Público de Reconversión, or FPR) through a loan contract (13.5 years and a variable market rate). This assistance will be channeled through a local financial institution. The total amount of resources managed by the FPR for the restructuring goals of the IAMCs of Montevideo will be US$ 70.8 million.

Given that the IAMCs have liabilities that approach US$ 350 million, the Uruguayan authorities have proposed a supplementary financial mechanism to support the capital structure reprogramming of these institutions. Through this mechanism, it will be possible to swap eligible liabilities (basically debts with providers) for fixed income bonds with a medium term (13.5 years, a grace period of one and a half years, and an annual interest rate of 6%). It is estimated that, through these mechanisms, US$113 million of the debt maintained by IAMCs of Montevideo with their private providers would be refinanced.

Guarantees of the financing allocated for the restructuring

With the object of generating incentives for a successful restructuring and of reducing the financial risk of the public resources provided through the FPR, the authorities consider putting into effect a set of guarantees, including: (i) the retention by the BPS of a percentage of the premiums it pays the IAMC for contracting medical care for its subscribers, in order to ensure payment of amortization and interest on the loans; (ii) the establishment of a technical reserve fund to solve eventual delays of the IAMCs in the compliance of their obligations; and (iii) the transfer of the debt owed to the FPR from an institution in the process of restructuring (but with a plan that may eventually fail and would have to be liquidated) to the rest of the IAMCs that continue in operation through the enrollment of subscribers ("transferable debt"), a situation that requires the participation in the restructuring process of all IAMCs that qualify, and allows the FPR to work with a systematic risk instead of the specific risk of each IAMC. In this case, the remaining debts of an IAMC that is going through restructuring and that will eventually cease operations are subject to the same liquidation procedures described earlier.

At the same time, it is anticipated that the resources of the FPR will be disbursed in fractions by brackets, in compliance with the commitments established by the IAMCs in their restructuring plans. The flow of credit to a particular institution may be stopped in case of breach and may require (even immediately) the accelerated payment of the credit disbursed to date, together with the application of the current regulations regarding mergers, acquisitions and liquidations.

The payment of the bonds will also be guaranteed by the retention by the BPS of part of the premiums paid by the subscribers, which will implement a system of automatic retention, so as to guarantee compliance in terms of the contributions to the private fund in charge of administering the supplementary financial mechanism. In this particular case, the Government will not offer any type of guarantee.

It is estimated that the retained premiums of the BPS would represent approximately 4% of the operational income of the IAMCs of Montevideo, which will have to consider this transfer of contributions in their restructuring plans when designing specific strategies for recovering their operational surpluses.

Strategy for restructuring the IAMCs

Risks coverage and incentives
The FPR (public funds) would assume only the systematic risk and not the specific risk of these institutions. Considering the guarantee mechanisms adopted, such risk would be practically null, since it would be affected only by an eventual generalized deterioration of the employment and economic conditions in the country that could mean a systematic failure in the restructuring process. Bondholders (private providers) would assume the specific risk of each IAMC, without there being any type of public guarantee for these instruments.
The swap mechanism of current liabilities with private suppliers for long-term bonds offers adequate incentives for a successful negotiation between the parties, since they introduce the possibility of swapping an accumulated short-term debt (essentially bad debt) for a future flow of payments (amortization plus interest payments) associated with the success of the restructuring plan promoted by the FPR, with the added perspective of an eventual secondary market for the anticipated liquidation of these bonds in case of a successful restructuring.
For private providers, it is difficult to refuse to support this restructuring process, because the risk of closing down the IAMCs leaves such creditors subject to the regulations that apply to liquidations, with scarce possibilities of recovering their loans. In some cases, private providers also participate in the ownership of the IAMCs, and this allows them to better assimilate the risks of the liquidation of these institutions and to decide their favorable support to the restructuring process.
Finally, this plan of shared risk between public and private financing sources for the restructuring process also introduces favorable incentives for a successful restructuring of the IAMCs themselves, since they risk their survival as institutions in case of an eventual liquidation, and their directors risk losing their institutional control and, in the case of institutions that are owned by health professionals, their own source of work.

SYNOPSIS OF THE HEALTH SECTOR REFORM PROGRAM IN URUGUAY

STRUCTURAL PROBLEMS

The structural problems of the Uruguayan health system can be summarized as follows:

1. Absence of a regulatory framework that unifies and integrates basic ground rules for all health institutions, together with the lack of an institution responsible for the regulation of the health system.
2. Current distortions in the organization of medical and non-medical resources (centralized collective bargaining and multiple employment of physicians).
3. Current model of care has a treatment and rehabilitation bias that favors specialization and high technology, to the detriment of a more preventive and promotional approach to health care.
4. Financing model generates an imbalance between contributions and covered risks.
5. IAMCs operate with a structure that is not very favorable to good management and cost containment (there is no separation between policy-setting and managerial functions, management is professionalized, and conflicts of interests have not been resolved).
6. Inefficiencies of the public health system (historical budgets, supply subsidy and mismanagement).

LONG-TERM VISION

The long-term vision of the authorities in the sector includes the following:

1. A health organization that ensures guaranteed and integral health care coverage for the entire Uruguayan population, based on common ground rules that stimulate efficiency and equity for all institutions.
2. A specialized and independent regulatory institution will carry out the regulation of the institutions that administer and provide health services.
3. The administration and provision of care will be managed by public and private institutions, operating in a competitive environment based on a model of care centered on the promotion of health and prevention of disease.
4. An integrated financing scheme that allows the definition of risk-adjusted payments, combining resources of the public budget targeted to the lowest income population, social security for the formal labor force, and voluntary contributions for the population at the highest socioeconomic level.
5. The National Resource Fund improvement would allow a response as cost-effective as possible to low-incidence and high-cost medical contingencies.
6. In this scenario, users will be able to play an active role since they will be able to choose freely the public or private institution that will provide them with coverage and care in a competitive context.

PROGRAM OBJECTIVES

A substantive set of policies will be supported to:

1. Improve the regulatory framework and institutions of the Uruguayan health system, promoting greater competition to generate reduction of costs and greater quality of health services.
2. Strengthen the private subsystem, by supporting the conversion of the IAMCs and the improvement of their organizational structures.
3. Strengthen the public health subsystem to modernize management, improve financial performance, stimulate health promotion and disease prevention as well as user satisfaction.
4. Strengthen the technical capacity of the MSP to follow up on the above actions and communicate changes, and also to generate technical feasibility and political viability studies to secure the future continuity of the modernizing efforts.

The objective is to overcome the structural flaws and to advance in a consistent and significant manner, within the execution timelines, towards the long-term vision for the health sector reform.

IMPACT

To the extent that the regulatory framework of the Uruguayan health system is unified and integrated, the management of its public and private subsystems will be strengthened, more and better health services can be delivered to the Uruguayan population, and public resources can be targeted to those who need it most from the point of view of their socioeconomic vulnerability.

Achieving greater efficiency in the Uruguayan health system can significantly contribute to attenuating the upward spiral of total expenditures on health, thus reducing pressures on the public deficit, labor costs, and household budgets.

ACTIONS OF POLICIES

FIRST TRANCHE	SECOND TRANCHE	THIRD TRANCHE
Approval of the Executive Orders that sustain and guide the set of modernizations promoted. Presentation of the models, plans and proposals to improve the management of the public and private health subsystems.	Application of the Executive Orders and launch of the models, plans and proposals to improve the management of the public and private health subsystems together with the establishment of progress goals.	Evaluation of the outcomes of the process of change, introduction of necessary improvements and extension of progress goals.

TRANSITION SCENARIO AT THE END OF THE PROGRAM

From the perspective of the basic functions and institutions of the health system, as well as from the perspective of users, the transition scenario expected at the end of the Program is characterized by:

1. An integral regulatory framework for the sector will be in force that defines the ground rules for all participating health care institutions, promoting market transparency and fairness in contractual relations between the institutions and the users of the services. It is also expected that the DSS of the MSP will be fully executing the regulatory function and will have generated the set of norms prescribed by regulations; established the necessary information systems; applied monitoring and enforcement programs for health institutions; disseminated public interest information; and created a system for the presentation of complaints and dispute settlement between users and institutions.

2. The MSP will have greater latitude for the formulation of health policies and the definition of public health priorities, attributions that are its strategic responsibilities, and that are essential for the conduction of the health system in the long term. However, in this transition phase the MSP will retain an important role in the financing model of the health system and will maintain a relevant participation in the collective bargaining with health professionals and administrators.

3. The strengthening of the IAMCs, which would regain their economic and financial balance and would normalize the provision of care to their user population, and which will have also adapted to the obligations established by the new regulatory framework in terms of registration, constitution of guarantees, and minimum operation capital that ensure their continuity, providing technical and financial information to the DSS and maintaining high standards of user satisfaction. In turn, it is expected that these institutions will have been strengthened organizationally by the enforcement of the model by-law, that they will find themselves operating with a much more professional management, and that conflicts of interest will have been significantly reduced.

4. The strengthening of the institutions of the public subsystem based on a more modern organizational structure, with incentives for user satisfaction and cost control based on performance agreements; the beginning of a complementary relationship with the private subsystem through management contracts for the administration of public health facilities.

5. The adaptation of the FNR and the modernization of its management, improving its operational and financial balance through the improvement of its administrative bodies, as well as introducing mechanisms for resource allocation according to cost-effectiveness criteria of the techniques for the different pathologies covered. Such advances would be the basis for the FNR to find itself in a position, at the end of the Program, to present an assessment plan of the different alternatives of its enhancement in order to give a cost-effective response to the medical contingencies of low-occurrence and high costs.

6. Finally, the users of the health system should have improved their situation considerably, since it is expected that they should be able to receive information regarding their rights and the regulations in force to protect those rights, and to have the ability to present complaints against the health institutions that do not comply with the regulations in force and to pursue operational mechanisms for disputes settlement.

HEALTH SECTOR REFORM PROGRAM
(UR-0133)
POLICY ACTION MATRIX

	Long-term vision	Program action	Impact	First tranche	Second tranche	Third
STABLE MACROECONOMIC ENVIRONMENT						
				Maintain consistency of macroeconomic environment agreed with IMF	Maintain consistency of macroeconomic environment agreed with IMF	Maintain co macroeconc environmen IMF
A. ENHANCEMENT OF THE HEALTH SYSTEM'S REGULATORY FRAMEWORK						
atory ucture that lows for bligations d service- ions o operate, f imum g capital, ner rights	Health protection legislation that integrates financing, guaranteed health coverage, institutional structure, care model, and organization of the health system, promoting competition, transparency, and equity in contractual relationships between beneficiaries and public and private insurance and service-delivery institutions Autonomous unit with functions of regulation, monitoring, and oversight of healthcare institutions	Approval of the decree unifying and integrating regulations that will apply to all healthcare institutions, promoting competition and protection of users' rights Implementation of a regulatory institutional framework responsible for regulation, monitoring, and oversight of healthcare institutions	Environment of greater market transparency in order to reduce costs and improve care quality Regulatory institutional framework provides systematic monitoring of financial statements of healthcare institutions, dissemination of early-warning indicators, and timely correction of anomalies Protection of users' rights, ensuring healthcare coverage and continuity of care	1. Issue of executive decree integrating various existing regulatory frameworks, identifying attributes for the regulatory unit, obligations of regulated institutions, and consumer protection regulations 2. Issue of executive decree empowering DIGESA, through the DSS, to act as regulatory and oversight institution	Evidence that work has begun to implement the new regulatory framework Evidence that the MSP has allocated the respective budgetary resources to the DSS and that the DSS has begun to operate by issuing resolutions	Evaluation users' perce rights and o knowledge regulatory u with a plan adjustments regulatory f Outcomes c managemer with option the State's r oversight ro health secto

	Long-term vision	Program action	Impact	First tranche	Second tranche	Third
B. STRENGTHENING OF THE PRIVATE HEALTHCARE DELIVERY SUBSYSTEM						
porate conducive encies d cost ve-level irectly impact of nt neration y ining, not ost tevideo nancial najor uring of service	IAMCs that are financially solvent, with professional management, and clear responsibilities for the executive level, with precise definition of incompatibilities and prohibitions for executives and managers The health system is operating in a competitive setting to ensure coverage and service delivery, with public and private institutions competing under the same set of ground rules that promote cost reduction and better quality in service delivery	Support for the restructuring plans to ensure financial stability of IAMCs and adoption of model bylaws to separate executive decision-making functions from management functions, professionalize management, and identify conflicts of interest for executives and managers	Remedying the financial imbalances of IAMCs and ensuring a steady flow of healthcare services to their beneficiaries Adoption of model bylaws to improve IAMCs' corporate structure as a basis for modernization of their management and long-term sustainability	1. Presentation of the model IAMC restructuring plan and model agreement to be signed 2. Issue of executive decree with new IAMC model bylaws	Signature of agreements implementing the restructuring plans with at least 50% of IAMCs in Montevideo, or the equivalent of 40% of the beneficiary portfolio Adoption of new model bylaws by all IAMCs engaged in restructuring plans	Expansion IAMC mana agreements equivalent beneficiary provided th adopted the bylaws Evaluation outcomes o plans and a model byla with work p participatio IAMCs in t
C. STRENGTHENING OF THE PUBLIC HEALTHCARE DELIVERY SUBSYSTEM						
ystem at is he basis a, and the ion sidizes	The public subsystem separates financial administration (ASSE) from service delivery (public healthcare firms) in a complementary framework with the private subsystem. The MSP keeps the roles of public health policy formulation and priority-setting	Separation of financing and service delivery functions in the public subsystem	More efficient and better care in the public subsystem, with management decentralized and geared towards user satisfaction and government resources targeted to the low-income sectors as the priority beneficiaries	1. Acknowledgement of the 2000-2004 Five-year Budget Act, which grants powers for modernization of the sector		

e	Long-term vision	Program action	Impact	First tranche	Second tranche	Third
ion in ncial gement te cost quality		Restructuring of the MSP, ASSE, and service-delivery units		2. Issue of executive decree containing general guidelines for restructuring of MSP, ASSE, and service-delivery units	Implementation of new public subsystem structure and implementation of new management structure at 40% of service-delivery units	Evaluation progress of and its exte of service-d
		Establishment of management agreements between ASSE and the service-delivery units, and between these units and private-sector players		3. Presentation of model management agreement for ASSE and service-delivery units, and for these units and private healthcare institutions	Management agreements in operation in at least 30% of service-delivery units. Issue of MSP resolution approving the model management agreement	Evaluation managemer and their ex 80% of serv units. Implementa managemer in at least t establishme
				4. Presentation of the design for the user identification and classification system at service-delivery units, together with updated arrangements for charging private institutions for public care provided to their beneficiaries	Identification system and charge-back arrangements in place at 30% of service-delivery units	Evaluation identificati charge-bac arrangemer their applic of service-d
rowth of e FNR are nd ot ost- The vent d by the growth in ervices IAEs	The Uruguayan health system has a reinsurance system for low-incidence, high-cost illnesses. The FNR only pays excess costs generated by uncommon medical catastrophes	Support for restructuring of the FNR to modernize its management	Reallocation of FNR resources to more cost-effective interventions, thus reducing operating deficits and levels of indebtedness	5. Presentation of the FNR management restructuring plan, including the use of medical protocols and adjustments to payment mechanisms	Progress reports on the FNR restructuring plan	Evaluation economic/f technical/ca outcomes o together wi of options t managemer

e	Long-term vision	Program action	Impact	First tranche	Second tranche	Third
D. TECHNICAL STRENGTHENING OF THE MSP						
of the ntering ange from ests of and the am needs ned	Structural transformations under way, atmosphere of favorable public opinion vis-à-vis the reforms, and management core strengthened	Formulation of key studies, launching of public information campaign, and support through consulting services	Continuity of structural reforms guaranteed, public-opinion support generated, and critical management core created within the MSP	1. Presentation of the PEFT containing terms of reference for key studies and consulting services, together with the public information campaign	Progress report containing evidence the most of the consulting services have been engaged to implement PEFT actions	Evaluation outcomes o work plan t continuity c

QUARTERLY MONITORING AND EVALUATION PLAN FOR THE HEALTH REFORM PROGRAM IN URUGUAY (UR-0133)

RESULTS	ACTIONS	INDICATOR	FIRST TRANCHE	I Q	II Q	III Q	SECOND TRANCHE	I Q	II Q	III Q
	AREA OF ENHANCEMENT OF THE REGULATORY FRAMEWORK									
ssment Report with perception on rights uties, and knowledge regulating institutions rt with Management sis to the *División de cios de Salud* (DSS). ncement Plan for the latory Framework.	1.1 Effect of Executive Order, which integrates various existing regulatory frameworks, setting forth the powers of the regulating entity, the obligations of the regulated institutions and the standards for consumer protection.	Executive Order in effect.								
	1.2 Effect of Executive Order enabling the DSS of the Ministry of Health (*Ministerio de Salud Pública, or* MSP) to act as regulatory and oversight body.	Executive Order in effect.								
	1.3 Organize the DSS with the minimum physical, human and financial resources to fulfill its regulating and controlling role, together with the annual budget plan.	DSS organized and with budget plan approved.								
	1.4 Issue general application resolutions with operating regulations on the regulating body's powers (i.e. to authorize and close registries, fines and penalties), obligations of health-care institutions (minimum capital, guarantees and information systems) together with protection of user rights (complaints and dispute settlement).	Resolutions issued and implemented.								
	1.5 Design of DSS information systems, of the control & oversight program, of the complaint and dispute settlement system and of user report card.	Designs made.								
	1.6 Run base-line opinion survey including user perception on regulatory framework and regulating entity.	Survey done.								
	1.7 Submit evidence that the Executive Order has begun to be applied.	Report with evidence submitted.								
	1.8 Submit evidence that the DSS is now in operation and that the MSP has allocated appropriate budgetary resources	Report with evidence submitted.								
	1.9 Launch of information systems at DSS; prepare oversight programs on health-care institutions and on the complaint settlement system.	Systems in operation.								
	1.10 Issue user rights report card, publish and distribute appropriately.	Report card published and distributed.								

RESULTS	ACTIONS	INDICATOR	FIRST TRANCHE	I Q	II Q	III Q	SECOND TRANCHE	I Q	II Q	III Q
	AREA OF ENHANCEMENT OF THE REGULATORY FRAMEWORK									
	1.11 Issue DSS Information Bulletins on subscribers' portfolio, user complaints, economic/ financial and health-service delivery matters regarding the health-care system.	Information Bulletins issued.								
	1.12 Apply second user opinion survey following the methodology of base-line survey and emphasis on results.	Survey done.								
	1.13 Assessment Report with user perception evaluation on rights and duties and knowledge about regulating entity, together with plan to make improvements to the regulatory framework.	Plan and Assessment Report submitted.								
	1.14 Evidence that the DSS's information, oversight, and user complaint and dispute settlement systems are working.	Report submitted.								
	1.15 DSS Management Analysis and Assessment Report on alternatives to improve the regulatory role of the State in the health sector.	Management analysis and Assessment Report submitted.								

RESULTS	ACTIONS	INDICATOR	FIRST TRANCHE	I Q	II Q	III Q	SECOND TRANCHE	I Q	II Q	III Q
	ENHANCEMENT AREA OF THE PRIVATE HEALTH-CARE SUB-SYSTEM									
sment Report on the cturing plans of the showing ement indicators on mic/ financial, health- elivery, and zational/ institutional ons. sment Report ning outcomes of the tandard By-Laws nentation. plan to extend effect ndard By-Laws to e all IAMCs.	2.1 Submit proposal of restructuring plans for the IAMCs and model standard agreement to be endorsed.	Plans and model agreement proposal submitted.								
	2.2 Inter-ministerial committee responsible for follow-up and assessment of restructuring plans in operation.	Committee Resolutions.								
	2.3 Effect of Executive Order with new IAMC Standard By-Laws.	Executive Order in effect.								
	2.4 Prepare and deliver guidelines to the IAMCs on the formulation of restructuring plans and the evaluation of this process.	Guidelines prepared and delivered.								
	2.5 Prepare operating regulations for the assessment of restructuring plans, its follow-up and monitoring, together with a work plan to extend the effect of the By-Laws to include all IAMCs.	Operating regulations and work plan prepared.								
	2.6 Receive proposals for restructuring plans; assessment by Committee, which will issue award resolution to accepted proposals and make recommendations to rejected proposals.	Proposals received, analyzed, awarded or rejected.								
	2.7 Sign agreements whereby restructuring plans are implemented with at least 50% of the IAMCs of Montevideo, or the equivalent of 40% of their portfolio of subscribers.	Management agreements signed.								
	2.8 Effect of new Standard By-Laws at all the IAMCs with restructuring plans.	Standard By-Laws in effect.								
	2.9 Monitoring and follow-up of approved restructuring plans, with an emphasis on economic/ financial, and health-care delivery commitments agreed upon.	Progress Report submitted.								
	2.10 Monitoring and follow-up of effect of Standard By-Laws on all IAMCs with restructuring plans.	Progress Report submitted.								
	2.11 Submit Report with evidence that the IAMCs of Montevideo have endorsed management agreements equivalent of at least 60% of IAMCs' subscribers, and requiring them to adhere to the Standard By-Laws.	Report submitted.								
	2.12 Submit Assessment Report on the outcomes of IAMC's restructuring plans and the implementation of Standard By-Laws, together with a Work Plan to extend its application to all the country's IAMCs.	Work Plan submitted.								

RESULTS	ACTIONS	INDICATOR	FIRST TRANCHE	I Q	II Q	III Q	SECOND TRANCHE	I Q	II Q	III Q	TH TR
	ENHANCEMENT AREA OF THE PRIVATE HEALTH-CARE SUB-SYSTEM										
sment Report on gress of the new zational structure of blic sub-system and ion of effect to e 80% of provision *Unidades doras*, UP). sment Report on nance Agreements tension of effect to e 80% of provision	3.1 Effect of Framework Decree of the Executive Power containing general guidelines for the restructuring of the MSP, ASSE and provision units.	Decree in effect.									
	3.2 Submit Model Performance Agreement between ASSE and provision unit.	Model submitted.									
	3.3 Submit Model Management Agreement between provision unit and private institutions.	Model submitted.									
	3.4 Submit User Identification and Categorization System together with proposed collection mechanisms.	Design and proposal submitted.									
ning of ement Agreements ast two public shments. sment Report on ntification System tension of its tion to 60% of on units.	3.5 Conduct workshops to promote modernization proposals among directors and officials of the MSP, ASSE and the provision units.	Workshops done.									
	3.6 Define bases and timetable for the negotiation of performance agreements with boards of provision units.	Negotiating bases prepared.									
	3.7 Identify facilities that qualify for management agreements with private institutions and prepare standard management agreement.	Facilities selected and agreement prepared.									
	3.8 Start pilot tests on the User Identification and Categorization System for implementation fine-tuning.	Tests performed.									
	3.9 Launch new organizational structure of the public sub-system and implement new management structure on 40% of provision units.	Evidence report submitted.									
	3.10 Performance agreements operating in at least 30% of provision units.	Progress report submitted.									
	3.11 Resolution by MSP approving standard management agreement with private institutions.	Resolution in effect.									
	3.12 Identify Users and have collection mechanisms operating at 30% of provision units.	Progress Report submitted.									
	3.13 Monitoring and follow-up of progress in organizational structure, user identification system and performance agreements agreed upon.	Progress Report submitted.									
	3.14 Define negotiation timetable and bases of management agreements with private institutions.	Bases and timetable prepared.									
	3.15 Submit assessment report on the progress of the new organizational structure of the public sub-system and extend effect to include 80% of the provision units.	Assessment Report submitted.									

ESULTS	ACTIONS	INDICATOR	FIRST TRANCHE	I Q	II Q	III Q	SECOND TRANCHE	I Q	II Q	III Q	TH TR
	ENHANCEMENT AREA OF THE PRIVATE HEALTH-CARE SUB-SYSTEM										
	3.16 Submit assessment report on performance agreements and extend effect thereof to 80% of provision units.	Assessment report submitted.									
	3.17 Submit assessment report on Identification System and extend application to 60% of provision units.	Assessment report submitted.									
	3.18 Launch of Management Agreements in at least two public facilities.	Progress report submitted.									
Assessment on alternatives to prove ement of the l Resource Fund *Nacional de os, or* FNR).	3.19 Submit adjustment plan for FNR management including improvement actions such as the use of clinical protocols and streamline of its payment mechanisms.	Plan submitted.									
	3.20 Prepare technical evaluation bases of the FNR management adjustment plan with an emphasis on economic/ financial and health-care delivery indicators.	Technical bases prepared.									
	3.21 Monitor and follow-up progress of FNR management adjustment plan (e.g. improvement of collegiate management body, protocol use, streamline of payment mechanisms).	Progress reports submitted.									
	3.22Progress report on launching of FNR adjustment plan.	Progress report submitted.									
	3.23 Monitor and evaluate advances in the preparation of an assessment report on the alternatives to improve management of the FNR.	Progress reports submitted.									
	3.24 Assessment report showing FNR's economic/ financial and health-care delivery outcomes, and analysis of alternatives to improve its management.	Assessment report submitted.									

RESULTS	ACTIONS	INDICATOR	FIRST TRANCHE	I Q	II Q	III Q	SECOND TRANCHE	I Q	II Q	III Q
	MSP TECHNICAL ENHANCEMENT AREA									
Reports of Studies on ng Model, Integrated Care Networks and Human rces Management lan for the disclosure ssemination of results n seminars, ops and other ational activities. sment report on campaign and results s of achieved public n support to changes sment report including from consultant s for e critical ement in terms of sionals hired and veness of activities ned.	4.1 Submit Technical Enhancement Strategic Plan (Plan Estratégico de Fortalecimiento Técnico, or PEFT), including the following annexes: a) Terms of reference for the studies. b) Design of media plan and strategy for media campaign. c) Terms of reference of supporting consulting to MSP line units.	PEFT submitted with annex detail.								
	4.2 Hire studies, media campaign and MSP line unit enhancement consultants.	Activities hired.								
	4.3 Launch of PEFT, with progress reports on studies, media campaign and MSP line unit enhancement consultants.	Progress reports submitted.								
	4.4 Follow-up and monitor progress of PEFT.	Progress reports submitted.								
	4.5 Submit PEFT assessment report including outcomes from studies, media campaign and MSP line unit enhancement consultants.	Assessment report submitted.								
	4.6 Submit work plan for the disclosure and dissemination of the studies' conclusions through seminars, workshops and other informational activities.	Work plan submitted.								

EVALUATION OF THE IMPACT OF THE PROGRAM

ECONOMIC-FINANCIAL IMPACT

EXPECTED IMPACT	BASE LINE (2000-2001)	PROGRAM COMPLETION (2003-2004)
positive net result for the period in IAMCs of Montevideo (total otal expenses)/ total income.	-6.6%	Larger than 0
lvency of IAMCs of Montevideo (total assets / total liabilities).	1.2	Larger than 1.2
uidity of IAMCs of Montevideo (current assets/ current liabilities)	0.4	Equal to or larger than 1
R debt (on December 31, 2000).	US$70 million	At least 50% reduction

HEALTH-CARE DELIVERY IMPACT

EXPECTED IMPACT	BASE LINE (2000-2001)	PROGRAM COMPLETION (2003-2004)
of pregnancies attracted during first 20 weeks.	IAMCs of Montevideo = 75% (Dec. 2000) ASSE Sub-system = Base 100 Dec. 2001	80% 20% improvement over base
eneral Medicine and Pediatric Visits/ Total Visits indicator.	IAMCs of Montevideo = Base 100 Dec. 2001 ASSE Sub-system= Base 100 Dec. 2001	10% improvement over base 10% improvement over base
atisfaction levels of users of the IAMC private sub-system as well as ub-system.	Base 100 Dec. 2001	20% improvement over base

ORGANIZATIONAL/ INSTITUTIONAL IMPACT

EXPECTED IMPACT	BASE LINE (2000-2001)	PROGRAM COMPLETION (2003-2004)
ercentage of IAMCs of Montevideo with separate policy-setting and functions.	10%	80%
ercentage of IAMCs of Montevideo with integral external audits.	40%	80%
ollection from private institutions users' fees at ASSE provision units.	Base 100 Dec. 2001	10% improvement over base
ercentage of public hospitals with cost centers.	0%	80%
ercentage of public hospitals with Service Quality Committee.	25%	80%

URUGUAY
POLICY LETTER
OF THE HEALTH SECTOR REFORM PROGRAM

Montevideo, July 2001

Mr. Enrique Iglesias
President
Inter-American Development Bank
Washington, D.C.

Dear Mr. Iglesias,

This policy letter presents an overview of the Reforms Program (Programa de Reformas) currently being implemented by the Government of Uruguay, and in particular, the objectives and specific actions being taken to further the modernizing transformations of the Uruguayan health system. To implement this reform, the Government of Uruguay requests the financial assistance of the Inter-American Development Bank.

I. ECONOMIC POLICY FRAMEWORK

The Uruguayan economy recorded satisfactory development during the 1990s, allowing a progressive improvement in the situation of the most socially vulnerable population groups. Through an austere administration of public finances, the inflation control policy was a success. The inflation rate was reduced from three-digits in 1990 to a single-digit in 1999. Structural economic reforms and a favorable external climate helped to overcome the stagnation of the 1980s and to reach an average 3% annual growth of the product per capita. In spite of these achievements, 1999 was a difficult year for Uruguay. The Uruguayan economy was affected by the successive international crises, the deterioration of the terms of trade, the increase in oil prices, the drought, and the uncertainties related to the presidential election. This set of factors explains the 3.4% decrease in the Gross Domestic Product (GDP) and the increase in the unemployment rate, which reached 11.4%. The recessionary trend continued during the year 2000, with a 1.5% further reduction in the GDP and an unemployment rate that reached 14%.

The main priority of the Government is to promote the sustainable recovery of economic activity while maintaining low inflation levels. Growth is a necessary condition to ensure unemployment absorption, the level of which currently exceeds socially tolerable limits. Economic policy measures are centered on keeping public finances under control, in order to reduce the debt ratio and thereby enhance the markets confidence. At the same time, the Government is considering an intensification of its reforms, aiming to increase both exports and private investments to promote growth. To consolidate the balance of public finances, the Government sent to the Parliament a five-year budget plan, based on expenditure containment as well as a change in the relation debt-GNP to be reached starting in the year 2003. The objective of the budgetary policy is to reduce the fiscal deficit from 3.7% to 2.6% of GDP by the end of 2001 and, at the same time, to decrease government spending (excluding interest payments) from 32.5% to 31.9% of GDP. The governing principle of the reforms is to put public and private businesses on equal

ground, by eliminating monopolies and establishing appropriate regulation to ensure a transparent market competition. Additionally, the Government intends to maintain an unrestricted regime of international payments and money transfers and to apply the reduction in trade tariffs agreed with MERCOSUR.

II. MODERNIZATION OF THE STATE

In 1995, Uruguay began an ambitious process of modernization of the State, which includes transformations in the social security system, education, the political system, public safety, public corporations and public administration. On the one hand, the reform of the State constitutes a factor that helps increase the competitiveness of the economy while generating a more favorable context to confront successfully the new scenario of greater trade and regional and international integration. On the other hand, the increased productivity of public management has a positive influence on the relationship between public spending and social well being.

The process of public management reform includes: (i) the structural reorganization of the central administrative bodies; (ii) the formulation of a strategic budget based on five-year management plans; (iii) the improvement of the State procurement systems; (iv) the alignment of the system of labor relations; (v) the enhancing of the administrative interface between the citizen and the State; and (vi) the implementation of a evaluation system of public management through a set of indicators of effectiveness, efficiency and quality of the services rendered to the user.

III. STRATEGIC FRAMEWORK OF HEALTH POLICIES

The authorities of the Ministry of Public Health (Ministerio de Salud Pública, or MSP) have explicitly stated that the MSP, as the governing entity of the health system, will promote and establish conditions for strengthening the public and private sectors, guiding them towards coordinated action in the development of policies and strategies that provide integral health care to the entire population of the country, within a framework of human development and financial sustainability of the institutions. The long-term vision of the MSP is the implementation of a health system that ensures universal and integral access to the whole population, as a function of the resources of the country. The role of the MSP is to carry out the modulation and articulation of the health system. A primary goal is to establish a model of care with emphasis in the first level (developing and prioritizing actions of prevention and promotion), in a stable and balanced health system with transparent rules and regulations. From common ground rules for the entire system—that contribute to a fair competition between entities—together with the transition from a highly specialized model of care towards a model centered on health promotion and disease prevention, it is possible to build an organization that ensures reduction in costs and satisfactory coverage and quality of care for the whole population. This approach will enable the quality of health care coverage to which the Uruguayan population has access to be consistent with the enormous effort made by society to finance the health system.

Within this strategy, the MSP intends to concentrate its efforts on policy formulation and the generation of an environment for complementary efforts between the public and private health institutions, within a context of regulated competition. In order to make this goal a reality, it is crucial to improve the performance of the MSP—which is responsible for regulating the

technical functioning of public as well as private institutions—by developing mechanisms so that users play an active role as controllers of the system. This initiative will be accompanied by a financial regime that will guarantee institutions resources consistent with the epidemiological risk of the covered individuals, a challenge that requires structuring a financial scheme in which are combined resources from the public budget targeted to the most vulnerable population, funds from the social security for the formal labor force, and voluntary contributions for the population with the highest socioeconomic level. Accordingly, the National Resource Fund (Fondo Nacional de Recursos, or FNR) will also improve its performance to allow a response as cost-effective as possible in dealing with low-incidence and high-cost medical contingencies.

According to this strategic vision for the medium and long term, the Health Care Reform Program represents an ambitious action plan. The Program includes a substantive number of policies that tackle the structural problems of the health sector, without disregarding the activation of instruments that will facilitate the transition.

The first core element of the Program includes the development of an integrated regulatory framework for the health sector, thereby eliminating current perverse incentives that erode the quality of services and adequate competition between the institutions. The goal is to establish an integrated normative framework that articulates the financing aspects, health care coverage, institutional model and organizational structure of the health system, thus promoting transparency and fairness in contractual relations between subscribers and health care institutions. The MSP intends to overcome the prevalent inequities in the health care market by promoting a higher level of efficiency and, in this manner, to sustain the effective protection of the rights of subscribers.

One of the central goals in establishing this integrated regulatory framework is to endow the regulatory authority with the necessary prerogatives to control and inspect all public and private institutions, whether such institutions provide collective medical care or partial insurance coverage. The above requires the generation of information and the establishment of authority for timely and sufficient inspection. The aim is to guarantee compliance with the regulations relating to the constitution of guarantees, minimal operating capital, and adequate medical-care delivery to subscribers by the regulated institutions.

To implement such actions, the Program will support the organizational restructuring process of the MSP, contemplating in the Direction General of Health (Dirección General de la Salud) the strengthening of the function of regulation and oversight of the public and private entities that operate at a national level through the Division of Health Services (División de Servicios de Salud), which will be created for this purpose. This Division will have the authority to certify and register private services, to apply fines and sanctions, and to regulate merger, acquisition and liquidation processes. It will also be responsible for controlling and inspecting the delivery of services by public and private providers, regarding medical-care aspects, the protection of users' rights, and the control and inspection of the proper use of resources.

The second core element of the Program is the strengthening of the private health care subsystem. The National Government, conscious of the seriousness of the crisis affecting the Institutions of Collective Medical Care (Instituciones de Asistencia Médica Colectiva, or IAMC)—especially those that operate in the Department of Montevideo (Departamento de Montevideo)— has defined a strategy based on improving management. Given the structural

character of the crisis suffered by these institutions, the Program encourages the adoption of changes in governance and management. For this purpose, a new model by-laws was defined which promotes management professionalization, separating policy-setting responsibilities from management functions and reaffirming civil liability of the directors for the acts of the institution during the term of their mandate. Assuming the need to introduce deep structural changes—which include, in many cases, the re-engineering of these institutions—the Program aims to foster a restructuring process based on the design and launch of reform actions aimed to secure their financial stability. This approach will be the base to guarantee adequate services for the population.

A third scope of action of the Program is the strengthening of the public health subsystem. The State Health Services Administration (Administración de Servicios de Salud del Estado, or ASSE) was originally developed based on a centralized management model which, together with a supply subsidization financing model, created an incentive structure that is not very sensitive to efficiency considerations. In this context, the Program will support the National Government in an effective separation of the planning, financing and regulation functions, on the one hand, from the health care delivery functions, on the other. In this way, the Program intends to advance the organizational restructuring of the MSP and the setting up of management agreements between the ASSE and the units rendering services. In a complementary fashion, it will be established an adequate framework of management interaction of public providers with the private sector through agreements that would allow the complementation of services.

The Program also includes reforms in the National Resource Fund (Fondo Nacional de Recursos, or FNR). The National Resource Fund is the instrument through which the country finances highly specialized medical-care for the entire population. The evolution of spending under the FNR shows notable increases that are not associated with the evolution of the epidemiological profile of the population, but rather with the increase in the number of services covered. The Program intends to support the Government in launching an upgrading plan conducive to improving the directive body of the FNR and its administrative and management processes, and oriented to rationalizing and controlling the use of resources and avoiding incentives that favor over provision of services. On this base, the Program will define strategic guidelines to design a system of incentives that generates opposite interests and regulates the demand.

The ambitious reform plan promoted by the National Government also requires support for strengthening technical expertise in critical areas of management of the MSP in order to generate studies, training activities, and communicational actions in support of the reform process. Among the studies needed, the following are considered to have strategic importance because of their implications as factors that may contribute to sustain the reform process in the future.

- Financing model of the Uruguayan health system. This study will identify the inconsistencies of the current financing regime and the harms it generates. Its main objective will be to facilitate a debate that stimulates consensus building around the need for introducing reforms and outlining the direction that these reforms should take.

- Model of integrated networks of health care delivery with a focus on health promotion and disease prevention. The design of this strategy will be accomplished by defining contents, operations, financing, expected results and impact. It will aim at developing sufficient

grounds to modify the health care profile prevalent in the public and private systems, and to incorporate in a systematic way promotional and preventive modalities.

- Model for the modernization of human resources management in the health sector. This study will examine reform alternatives based on the ground rules under which labor relations in the sector take place. Its objective is to stimulate a debate around the need to modernize styles of human resources management, aiming to promote alternatives to inadequate practices that have deep social and cultural roots.

Additionally, the Program will also include the support through consulting services and training to strengthen the operating capacity of the line departments of the MSP in charge of carrying-out the policies agreed upon within the scope of the Program. Another fundamental line of support consists of the introduction of a public information campaign in order to consult and inform public opinion, as well as the principal actors in the sector, about the progress of the health sector reform process.

In summary, the Health Sector Reform Program aims at confronting simultaneously the structural and operational problems of the private sector; at decentralizing the management of health care services that integrate the network of public hospitals dependent on the ASSE; and at incorporating new mechanisms of policy formulation, management and control for the National Resource Fund (FNR). In order to achieve these goals, it is important to adapt the structures of the MSP relating to the recovery of its governing role within the health system and the strengthening of the normative, regulatory, evaluation and oversight functions of public and private agents, all with a view toward improving the quality of services and a greater satisfaction of public and private users.

IV. IMPACT OF THE PROGRAM

The Government is taking the necessary measures to overcome the difficult economic and social situation that the country is facing. One component of particular relevance within the Government plan, which supports the present Program, is the promotion of policies that allow substantial improvements in the population health care coverage, especially for the most vulnerable groups. To the extent the regulatory framework of the Uruguayan health system is unified and integrated—while the management of its public and private subsystems is strengthened and modernized—it will be possible to provide the Uruguayan population with more and better health services with a priority criterion of equity.

In addition, achieving greater efficiency can contribute significantly to attenuating the upward spiral of total expenditures on health, thus reducing pressures on the public deficit, labor costs and household budgets. Very conservative economic projections suggest that the impact of the Program, in the short run, will translate into a deceleration of this upward tendency in spending. The important thing is that with the same resources available at present it will be possible to offer greater and better health care coverage. In this way, an important step will have been taken towards the objective of efficiency and the modernization of the management of health institutions, thus legitimizing its actions to its subscribers and reaching an important momentum for the long term sustainability of the Uruguayan health system.

The reforms contemplated by the Program are innovative, ambitious and complex. Moreover, because they will be applied in a social sector as sensitive as the health sector, they naturally imply a confrontation with inertias and vested interests of actors with power. In this sense, the most important risk the Program faces is associated with the potential objections it may generate. It is foreseeable that the implementation of changes will activate corporate pressures devised to stop the process or to accommodate it in favor of corporate interests to the detriment of the population as a whole. To lower this risk, it is the Government's decision to maintain and deepen the dialog with all the actors involved, while the Program supports these efforts with a public information campaign focused on consulting and informing the population about the true significance of the changes. It is hoped that in this transforming role the National Government will have as its principal allies the current and potential users of the system.

V. SUPPORT OF THE INTER-AMERICAN DEVELOPMENT BANK

The above overview demonstrates the importance and depth of the reform that the National Government of Uruguay intends to undertake in the health sector, and its articulation with the rest of the agenda of public policies the country is promoting. Within this framework, the financial and technical assistance of the Inter-American Development Bank constitutes a support of fundamental importance so that these structural reforms are correctly implemented.

Sincerely,

Dr. Luis Fraschini
Minister of Public Health

Cr. Alberto Bensión
Minister of Economy and Finance

Cr. Ariel Davrieux
Director of the Office of Planning and Budget

PROPOSED RESOLUTION

URUGUAY. LOAN /OC-UR TO THE REPUBLICA ORIENTAL DEL URUGUAY
Health Sector Reform Program

The Board of Executive Directors

RESOLVES:

That the President of the Bank, or such representative as he shall designate, is authorized, in the name and on behalf of the Bank, to enter into such contract or contracts as may be necessary with the República Oriental del Uruguay, as Borrower, for the purpose of granting it a financing to cooperate in the execution of a Health Sector Reform Program. Such financing will be for the amount of up to seventy five million dollars of the United States of America (US$75.000.000), which are part of the Single Currency Facility of the Ordinary Capital resources of the Bank, and will be subject to the "Special Contractual Conditions" and the "Financial Terms and Conditions" of the Executive Summary of the Loan Proposal.