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Report No: 28395-RO

PROJECT APPRAISAL DOCUMENT

ON A

PROPOSED LOAN

IN THE AMOUNT OF EURO 65.1 MILLION
(US$80 MILLION EQUIVALENT)

TO

ROMANIA

FOR A

HEALTH SECTOR REFORM PROJECT
IN SUPPORT OF THE SECOND PHASE OF THE HEALTH SECTOR REFORM PROGRAM

November 17, 2004

Human Development Sector Unit
Europe and Central Asia Region

CURRENCY EQUIVALENTS

(Exchange Rate Effective September 30, 2004)

Currency Unit	=	Romanian Lei
1 Leu	=	US$ 0.000033418
1 EURO	=	US$ 1.23065
US$ 1	=	Lei 33,418

FISCAL YEAR

January 1 – December 31

ABBREVIATIONS AND ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
ALOS	Average Length of Stay
APL	Adaptable Program Loan
CAD	Computer Aided Dispatch
CAS	Country Assistance Strategy
CDF	Comprehensive Development Framework
CEE	Central and Eastern Europe
CFAA	Country Financial Accountability Assessment
CPAR	Country Procurement Assessment Report
DFID	Department for International Development (United Kingdom)
DPHA	District Public Health Authority
DRG	Diagnostic Related Group
ECA	Europe and Central Asia
EIB	European Investment Bank
EMP	Environmental Management Plan
EU	European Union
ER	Emergency Room
FMR	Financial Monitoring Report
FMS	Financial Management System
GDP	Gross Domestic Product
GFATM	Global Funds to Fight Aids, Tuberculosis and Malaria
GOR	Government of Romania
GP	General Practitioner
HIH	Health Insurance House
HIV	Human Immunodeficiency Virus
IBRD	International Bank for Reconstruction and Development
IEC	Information Educ. Communication
IFI	International Financial Institution
ILO	International Labor Organization
IMCI	Integrated Management of Childhood Illnesses
IMR	Infant Mortality Rate
M&E	Monitoring and Evaluation
MOF	Ministry of Finance
MOH	Ministry of Health
MPHC	Multipurpose Health Centers
NHA	National Health Accounts
NHIH	National Health Insurance House
NICARE	Northern Ireland Dept of Health, Social Services and Public Safety – Business Unit
OED	Operations Evaluations Department
PAL	Programmatic Adjustment Loan
PHARE	EU Assistance for CEE Countries
PHRD	Population and Human Resources Development (Japanese Grant)
PFM	Public Financial Management
PIC	Project Investment Costs
PMU	Project Management Unit
PHC	Primary Health Care
PPIBL	Private & Public Sector Institutional Building Loan
SA	Special Account
IMCI	Integrated Management of Childhood Illnesses
SAP	Automated Accounting System
SDC	Swiss Development & Cooperation Agency
SOE	Statement of Expenditures
TA	Technical Assistance
TB	Tuberculosis
TOR	Terms of Reference
UNAIDS	Joint United Nations Program on HIV/AIDs
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WDR	World Development Report
WHO	World Health Organization

Vice President:	Shigeo Katsu
Country Director:	Anand K. Seth
Sector Director:	Charles C. Griffin
Sector Manager:	Armin H. Fidler
Task Team Leader:	Dominic S. Haazen

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ROMANIA
HEALTH SECTOR REFORM II

CONTENTS

ROMANIA

HEALTH SECTOR REFORM II

PROJECT APPRAISAL DOCUMENT

EUROPE AND CENTRAL ASIA

ECSHD

Date: November 17, 2004	Team Leader: Dominic S. Haazen
Country Director: Anand K. Seth	Sectors: Health (100 percent)
Sector Manager/Director: Charles C. Griffin	Themes: Health system performance (P)
Project ID: P078971	Environmental screening category: Partial Assessment
Lending Instrument: Adaptable Program Loan	Safeguard screening category:

Project Financing Data

[X] Loan [ ] Credit [ ] Grant [ ] Guarantee | Other:

For Loans/Credits/Others:
Total Bank financing (US$m.): 80.00
Proposed terms: VSL

Financing Plan (US$m)

Source	Local	Foreign	Total
BORROWER	44.77	0.00	44.77
INTERNATIONAL BANK FOR RECONSTRUCTION AND DEVELOPMENT	5.06	74.94	80.00
EC: EUROPEAN INVESTMENT BANK	54.43	27.29	81.72
Total:	104.26	102.23	206.49

Borrower:
Ministry of Public Finance
17, Apolodor St.
Bucharest
Romania
Tel: (+40-21) 410 34 00; 410 11 89 Fax: (+40-21) 312 16 30

Responsible Agency:
Ministry of Health
Str. Ministerului Nr. 1-3
Bucharest
Romania
70109
Tel: +40 1 314 1526 Fax: +40 4 312 4916
acarmen@ms.ro

Estimated disbursements (Bank FY/US$m)					
FY	5	6	7	8	9
Annual	3.04	19.51	28.00	22.00	7.45
Cumulative	3.04	22.55	50.55	72.55	80.00

Project implementation period: Start May 31, 2005 End: June 30, 2009
Expected effectiveness date: May 31, 2005
Expected closing date: December 31, 2009

Does the project depart from the CAS in content or other significant respects? ***Ref. PAD A.3***	[ ]Yes [X] No
Does the project require any exceptions from Bank policies? ***Ref. PAD D.7***	[ ]Yes [X] No
Have these been approved by Bank management?	[ ]Yes [X] No
Is approval for any policy exception sought from the Board?	[ ]Yes [X] No
Does the project include any critical risks rated "substantial" or "high"? ***Ref. PAD C.5***	[X]Yes [ ] No
Does the project meet the Regional criteria for readiness for implementation? ***Ref. PAD D.7***	[ ]Yes [X] No

Project development objective ***Ref. PAD B.2, Technical Annex 3***
The project will have the following objective: provide more accessible services, of increased quality and with improved health outcomes for those requiring maternity and newborn care, emergency medical care and rural primary health care.

Project description *[one-sentence summary of each component]* ***Ref. PAD B.3.a, Technical Annex 4***
1. Support rationalization and improvements to the system of maternity and neonatal care.
2. Develop and implement integrated ambulance dispatch capability, and upgrade hospital emergency areas.
3. Improve the accessibility and quality of basic medical services in rural and small urban areas, and support two of the most important activities included in the Primary Care Strategy recently approved by the Government: Multipurpose Health Centers, and credit/lease lines for family doctors.
4. Support the development of National Health Accounts and the preparation of proposals for rationalization and service development projects.
5. Project management.

Which safeguard policies are triggered, if any? ***Ref. PAD D.6, Technical Annex 10***
Environmental Assessment (OP?BP?GP 4.01), Category B

Significant, non-standard conditions, **if any**, for:
Ref. PAD C.7
Board presentation: None
Loan/credit effectiveness: None

Covenants applicable to project implementation:

Disbursement Condition: The Operational Manual, satisfactory to the Bank, has been approved by the Borrower, and an Administration Agreement has been executed between MOH and a respective Sub-loan Service Provider with respect to a Sub-loan Fund for which the Borrower has requested a withdrawal from the Loan Account.

Implementation Conditions:

1. PMU to be maintained throughout the Project with qualified staff and adequate resources.
2. No later than May 31, 2005, establish a unit in each of the eight District Public Health Directorates, to support the PMU in implementation of Project activities at the local level.
3. No later than May 31, 2005, establish Project Steering Committees for each Part of the Project.
4. No later than September 30, 2005, establish an Evaluation Committee within MOH for appraising and selecting eligible Sub-projects and Beneficiaries in accordance with the Operations Manual.
5. Select Sub-loan Service Providers in accordance with the eligibility criteria and procedures set forth in the Operations Manual and in accordance with the provisions of Section III.A of Schedule 4.
6. Authorize each selected Sub-loan Service Provider to establish a revolving fund for provision of Sub-loans under Part C.2 of the Project, which fund shall be replenished through withdrawals from the Loan Account from time to time, in accordance with the terms and procedures set forth in the Operations Manual.
7. Enter into an Administration Agreement with each Sub-loan Service Provider, under terms and conditions set forth in the Operations Manual and which shall have been approved by the Bank.
8. Cause each Sub-loan Service Provider to provide Sub-loans to selected Beneficiaries on the basis of a Sub-loan agreement between the Sub-loan Services Provider and a Beneficiary, on terms and conditions set forth in the Operations Manual.
9. Not amend, abrogate or terminate any provisions of the Operations Manual without the Bank's prior agreement.
10. Ensure that measures to carrying out of the Environmental Management Plan are taken in a timely manner.
11. Maintain policies and procedures adequate to facilitate monitoring and evaluation.
12. A mid-term evaluation report to be prepared by the borrower by March 31, 2007.
13. Mid-term review to be completed no later than June 30, 2007.

A. STRATEGIC CONTEXT AND RATIONALE

1. Country and sector issues

Country Overview:

Romania is a lower middle-income country with GNI per capita of US$2,260 and a population of 21.7 million. It is the second largest country in Central and Eastern Europe, and is larger than 19 of the 25 current members of the European Union (EU). Since 2000, the new Government has implemented macroeconomic policies which are supportive of growth. A disciplined fiscal policy, which complemented a tight monetary policy, and was augmented by strong advances on structural reforms, led to improved financial discipline in the enterprise sector, and has placed public finances and the financial system on much firmer footing.

This resulted in robust GDP growth for four consecutive years – 5.3 percent in 2001, 4.3 percent in 2002, 4.9 percent in 2003 and expected to be over 6 percent in 2004. In addition, inflation and interest rates have declined steadily, the fiscal deficit has been brought under control, foreign exchange reserves have increased to historic highs, and the external balance is comfortable. Export growth has remained vigorous, fuelled by private investment and the competitive depreciation in real terms of the currency against Euro (3.7 percent in 2003). The competitiveness of the enterprise sector has been boosted by productivity gains. Romania is now a visible and attractive destination for international investors as a result of better sovereign ratings and improved access to international capital markets.

Key issues in the Health Sector and Government Strategy:

In 1997, Romania began to enact key reforms in the health sector, aimed at shifting the health system from the model of centralized government financing and delivery of services to a more decentralized and pluralistic approach. The main change was the establishment of a compulsory health insurance fund, paid for through an earmarked wage tax and contracting services from public and private providers. The ongoing program supported by the World Bank in the health sector was based on a reform strategy elaborated by the Government in 1997-1998 and outlined in the 1999 Letter of Sector Development Strategy, which identified the following key issues:

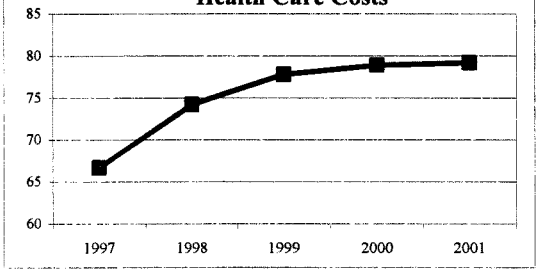
- weaknesses in governance of the system and the legislative framework;
- shortcomings in the efficiency, equity and transparency of sector financing;
- inefficient use of physical capacity and human resources in health care delivery;
- critical infrastructure deficiencies resulting from inadequate maintenance and investment;
- mismatch between population health needs and health services distribution and priorities;
- consumer dissatisfaction with the health services.

Substantial progress has been made on this agenda, and a clear sector strategy is in place for addressing the remaining reform needs. In the area of **governance**, there have been major revisions of the health insurance law to strengthen accountability of the insurance fund, increases in the role of local authorities in ownership and accountability of health care provider units, new organizational forms for physicians' offices, regulation of public-private partnerships, a new law

on hospital organization, and development of planning capacity at both the Ministry of Health (MOH) and local level. Although much of this activity has been undertaken by the Ministry itself, there has also been assistance from DFID (UK Department for International Development), and APL1 (Phase 1 of the present program). The remaining agenda includes further improvements to the legal framework for the organization of providers, developing and implementing governance and management arrangements for hospitals conducive to greater efficiency, and development of a modern health services accreditation body and adequate quality management monitoring systems. The Government is actively taking the lead in these reforms, although the PAL (Programmatic Adjustment Loan) process is providing key support and technical assistance.

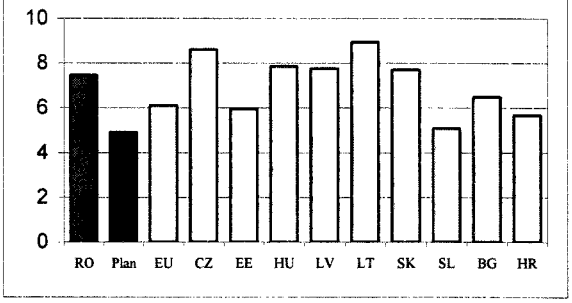
In terms of the **efficiency, equity and transparency of health sector financing**, there has been an increase in public funding for the health sector, capacity building for health insurance, and piloting of new case-based payment mechanisms for hospitals. Again, the Government has taken the lead in this, although USAID and Phare have also provide important assistance. Figure 1 shows the progress in the area of public financing for health services through the end of 2001. The remaining agenda includes increasing the resources allocated for primary care services, ambulatory care, and hospital day surgery; rolling out new payment mechanisms for hospitals; containing the escalation of pharmaceutical costs; better defining the benefit package to be covered by health insurance, and ensuring the more transparent and affordable contribution of private financing. In addition to the Government resources, support for these efforts is being pursued from the EU and other donors. The related PAL conditionality is keeping the attention of the broader government focused on these issues.

Figure 1: Public Financing as % Total Health Care Costs



Progress in the area of **capacity and efficiency improvements** has included preparing and approving a high-level rationalization strategy and regional health service plans; closing about 15 percent of acute hospital beds, converting acute hospitals to medico-social care units; developing contracting approaches for home care; and piloting public-private partnerships, with support from IFC. APL 1 and PAL 1 played a key role in supporting the overall thrust of these reforms, while APL 2 and PAL 2 and 3 will continue to support the remaining agenda, through improving distribution of human resources with incentives for medical staff to practice in remote or underprivileged areas; developing models of care adapted to rural and remote population needs, and continuing to close, convert or restructure unnecessary or underutilized hospital facilities. Figure 2 shows the current situation comparing Romania to other countries in the region, as well as the target based on the adopted rationalization strategy (marked as Plan). It should be noted that this target assumes and will need significant investments in complementary

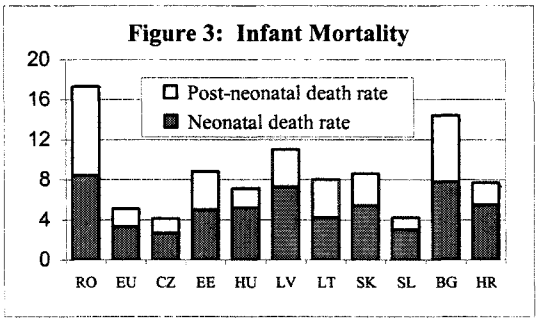
Figure 2: Hospital Beds/1,000

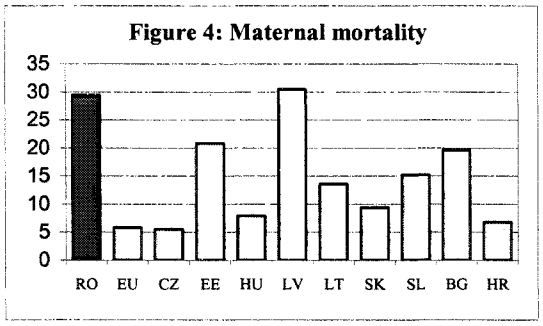


services, such as home care, social long-term care, and ambulatory/day care services.

The need for **improved infrastructure** has been addressed through the upgrade of equipment for essential hospital services and pre-hospital emergency care, a major upgrade of hospital equipment financed through commercial credits with Government guarantee, and a lease scheme for medical offices. APL 1 has played a key role in a number of these areas, and APL 2 will help address the continued need for investments, especially rehabilitation of buildings, modernizing the maternity and neonatal care system, and completing investments in the emergency care system. By introducing new financiers to the health system in Romania, and supporting the development of capacity to apply for and utilize EU structural funds in the future, APL 2 is also helping to ensure that financing is available for further infrastructure improvements.

Population health needs have been addressed through the development of a public health strategy, capacity building, and strengthening national programs (especially TB, reproductive health and HIV/AIDS). Important tobacco control legislation has also been passed and community nursing has been implemented on a pilot basis. There are many development partners in this area, including the Bank (APL 1), the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM), USAID, and UNFPA (United Nations Population Fund), and the MOH has greatly increased its capacity in this area. These partners and the MOH will assist in expanding the scope of prevention and health promotion activities, and also focus on improving key health indicators. In this regard, the Bank is taking a lead through APL 2 by focusing on maternity and neonatal MDG's. Figures 3 and 4 illustrate the critical need for attention to these areas.





The area of **consumer satisfaction** has seen relatively little activity, although there have been some information campaigns on rights of insured. In the future, however, this agenda will be moved along through increasing the focus on informal payments and explicitly addressing patient satisfaction. Both APL 2 and PAL 2 and 3 will play a key role in putting these issues in front of policy-makers and developing working models to address these issues.

2. Rationale for Bank involvement

To date, the Bank has had two investment operations in the health sector. The first project, with a total cost of US$224 million (including US$150 million IBRD loan) was implemented in 1992-1999 and supported the upgrade of selected primary health care, maternity and emergency medical services, procurement of essential drugs, tuberculosis control and capacity building. The

second project, Health Sector Reform Phase 1, was completed in June 2004. The US$69 million project (including US$40 million IBRD loan, disbursed over 98 percent) covered the upgrade of essential hospital care (operating room and intensive care services), further improvements in emergency medical services, support for primary care in six judets (counties), strengthening of planning capacity within the MOH and judets, including the development of judet-level rationalization plans, and selected public health interventions.

In addition, key sector reforms would be leveraged by PAL and related policy actions to:

- improve performance of health sector financing regarding predictability, risk protection of the insured, equity and efficient management of public resources;
- revise arrangements for health insurance revenue generation, improve provider contracting and accountability mechanisms of National Health Insurance House (NHIH);
- reduce corruption and increase transparency in the health sector;
- support implementation of a National Hospital Rationalization Strategy and create a legal/regulatory framework conducive for the organizational reform and rationalization of hospitals.

Technical assistance was supported by APL Phase 1 and continues through the PPIBL (Public Private Institution Building Loan, the technical assistance loan that supports the PAL program) in the area of health sector financing. Additional technical assistance needs are being addressed by APL 2 including monitoring and evaluation, development of National Health Accounts, as well as further support for future investment planning.

3. Higher level objectives to which the project contributes

The proposed project is included in the FY02-04 CAS that sets as one of its objectives the improvement of delivery of health services. This project is one of the targeted poverty interventions identified in the CAS to address inequity of access to basic social services across regions and for vulnerable groups.

B. PROJECT DESCRIPTION

1. Lending instrument

This investment project will be Phase 2 of an agreed Adaptable Lending Program. The estimated cost is US$206.5 million (€167.9 million), supported by a US$80.0 million (€65.1 million) IBRD loan, a US$81.8 million (€66.4 million) European Investment Bank (EIB) loan, and US$44.8 million (€36.4 million) in funding from the Government of Romania. It is closely linked to the overall program objectives and builds on activities initiated in the first phase. The project will be implemented over a four year, seven month period and will finance civil works, goods, technical assistance, training and incremental operating costs. Recurrent operating costs as well as taxes and duties will be financed by the Government contribution. An APL was chosen as a lending instrument because: (i) an investment operation is needed to finance activities that follow on from those in Phase 1 of the APL, and (ii) the investments to be financed by this loan will

complement other reforms which will be achieved through ongoing adjustment lending (PAL) conditionality and policy discussion. The loan terms are consistent with the standards set by the Ministry of Finance in its dealing with the Bank. During the implementation period, opportunities will be explored to rely more heavily on internal MOH and national fiduciary systems.

2. Program objective and phases

The proposed project will continue the support provided to the Government of Romania by the World Bank in the implementation of key elements of the program set out in 2000, adding also support for the rehabilitation of the maternity and neonatal care units. The strategic purpose of this program is a healthy Romania, with lower morbidity and fewer premature deaths, equitable access to health services, and improved efficiency of the health system. The goals of the program were reaffirmed in the 2001-2004 Program of the Romanian Government.

The objectives of the overall APL Program are as follows:

a) improve efficiency and equity in the planning and regulation of the health service delivery system;
b) reduce preventable deaths among emergency medical cases;
c) improve access and quality in primary health care in poor and remote areas; and
d) help the Romanian health sector to better focus on priority public health problems, thereby reducing preventable illness and deaths.

The specific objectives of Phase 1 were the following:

a) improving the capacity for policy, planning and regulation, finance and management in the health sector;
b) improving quality, cost-effectiveness and technical efficiency in selected poor and remote areas, essential hospital and ambulatory health care services and emergency medical services; and
c) modernization of public health services in the areas of tobacco control, tuberculosis prevention, AIDS/HIV prevention, STD prevention, and community-based mental health care.

Through Phase 1, substantial progress has been made in these areas (see Annex 1), as well as the trigger indicators which were previously established to guide the movement from APL Phase 1 to Phase 2. An overview of the status of these indicators is presented in the following table.

Trigger Indicators	**Achievement**
Policy Indicators	
If required, amendments to the legal and regulatory framework for health care providers and for financing of health sector investment will be initiated by the MOHF.	Fully met. Numerous amendments made to health related legislation to improve the operating environment and remove barriers to cost-effective health care service delivery.
Public Health Strategy with targets in priority areas issued.	Fully met. The National Public Health Strategy has been approved by the Government in July 2004, and was published on August 3, 2004.

A lending and/or leasing scheme for financing family physicians in primary health care practices has been established by the Health Insurance House and operating at least on a pilot basis for six months or more	Fully met. The Government approved in June 2004 a medium term lease scheme (low fees for the first 5 years), for primary health care physician offices. and implementation norms were approved in July 2004. APL2 will provide funds for sub-loan lines to support equipment investments.
Project Implementation Indicators	
3-4 judets in each socio-economic development region (at least 30 in total) have completed health services plans and associated investment and human resource plans for developing and rationalizing capacity in the sector	Judet-level health services plans have been developed for all 42 judets, with technical assistance supported by the project.
Substantial progress has been made on contractual commitments (at least 80 percent) and disbursements (at least 70 percent) from APL I.	As of September 1, 2004, 98.3 percent of the loan has been disbursed.

3. Project development objective and key indicators

The project development objective is as follows:

> *Provide more accessible services, of increased quality and with improved health outcomes for those requiring maternity and newborn care, emergency medical care and rural primary health care.*

This objective is consistent with the overall program strategic purpose and objectives. Principal beneficiary groups would be the users of services targeted for improvement by the project: pregnant women and newborns, rural populations, and those needing emergency services. In addition to the obvious benefits of reducing maternal and infant mortality, general mortality in rural areas, and overall improvement of quality of care, this project would demonstrate the impact of the rationalization approach across a vertical program throughout Romania. This would support more extensive implementation of the rationalization plans developed in Phase 1.

Proposed project performance (outcomes) indicators include: the percent of maternal deaths formally documented/investigated, neonatal and post-neonatal deaths and death rates, the percent of deliveries where birth-weight is less than 2500 grams, utilization rates for primary and emergency care stratified by residence and income status, the percent of deaths within 48 hours and ER discharge for patients with major trauma or cardiac emergencies arriving alive at the hospital emergency department.

4. Project components

The project has five components, as follows (figures in parentheses are total costs):

COMPONENT 1: Maternity and Neonatal Care Component (US$129.0 million, €104.9 million) This component will fund facility rehabilitation for maternity and neonatal care units plus medical and other equipment necessary for high quality neonatal and maternity services. Technical assistance and training will be provided to ensure implementation of best international

practices, building on already existing partnerships between the Government and WHO, UNICEF, UNFPA. and bilateral donors (USAID and Swiss Cooperation). Support will be provided to improve the capacity of health care authorities and provider units to monitor service quality and access.

The MOH has developed a three layer concept for the structure and functioning of the future network of maternity and neonatal care units. Under this approach, maternities will be structured according to the complexity of the services provided, with appropriate regional distribution for each level, in order to cover the entire country with all levels. The selection of sites for each level is done based on specific criteria, e.g., number of births, distance to the medical facility. The project will support the upgrading of a total of 183 facilities (out of which approximately 160 include civil works) as follows: 123 for Level 1, 40 for Level 2, and 20 for Level 3. Based on the results of a detailed analysis of training and other human resources needs in this sector, which was undertaken during project preparation, training and quality improvement programs will be financed to ensure that the maximum benefits are achieved from the physical investments that are made.

COMPONENT 2: Emergency Care Services (US$58.1 million, €47.2 million). This component will upgrade hospital emergency areas and develop and implement integrated ambulance dispatch capability. Both interventions are essential to maximizing the impact of the investments that have been made to date, and the effectiveness of the emergency medical services system generally.

Sub-component 1: Upgrade Hospital Emergency Areas. Phase 1 revealed that many hospital emergency departments – even in major regional centers – lacked the minimum equipment needed to cope with trauma and emergency medical care. The objective of this sub-component will therefore be to increase the quality of patient care, resulting in increased survival rates for the patients arriving in the ER, through adequate equipment, training and improved protocols. A total of about 60 emergency rooms are included in the project.

Sub-component II: Integrated Ambulance Dispatch System. This sub-component will up-grade the existing communication system of the National Public Medical Pre-hospital Emergency Service in order to integrate with the Central Emergency Call Center – unique 112 number – and to enable voice and data communication between the county (judet) ambulance central dispatcher and sub-stations or ambulances. This will provide a nation-wide communication system and interaction with the other emergency units (police, defense and fire-brigades). Modern communications equipment, in line with the EU standards, IT equipment, and necessary technical assistance and training will be supported by this sub-component. It is expected that the new system will optimize the time between the emergency request and ambulance departure, decrease the time between the call and the arrival at the case, increase the accuracy between the initial and actual diagnosis, and improve the use of the human resources and of the existing infrastructure.

COMPONENT 3: Primary Health Care and Rural Medical Services (US$14.0 million, €11.4 million). This component will focus on improving the accessibility and quality of basic

medical services in rural and small urban areas, and will support two of the most important activities included in the Primary Care Strategy recently approved by the Government:

Sub-component 1: Multipurpose Health Centers. Support will be provided to establish multi-purpose health centers, developed as a new concept which builds upon the existing rural health centers. These centers will allow the provision of diversified services by family doctors, ambulatory care specialists, community nurses, as well as home care and social services in remote rural areas and small towns. This will lead to more effective integration of primary care with ambulatory and hospital services, consistent with the National Health Programs. Specialty training as well as medical equipment will be financed under this program that will be implemented in a phased approach, starting with three pilot counties in the first year, 10 in the second year and then covering all the remaining counties, so that by the end of 2008, each county will have one such center. As part of this process, innovative financing mechanisms will also be pursued, together with the MOH and the National Health Insurance House, to address demand side issues.

Sub-component 2: Sub-loans for family doctors. Sub-loans fund/funds for family doctors will be established using project funds, in order to finance specific investments for medical equipment, consumables, transportation means and IT equipment that will enable them to improve the access to a wider range of health services and to improve the quality of the services provided in selected areas (including, but not limited to, rural areas).

COMPONENT 4: National Health Accounts and Planning (US$0.64 million, €0.52 million). This component will support the development of National Health Accounts and the preparation of proposals for rationalization and service development projects, under the following two sub-components:

Sub-component 1: National Health Accounts (NHA). For the development of NHA support would be provided to adapt the internationally validated methodology, propose changes of regulations regarding reporting of financial information in the health sector, perform analysis of existing financial information and surveys, conduct additional surveys, train staff, and prepare, publish and disseminate reports.

Sub-component 2: Planning and Program Development. The activity supported by this sub-component will provide to MOH, District Public Health Authorities, health care institutions or local authorities the resources for preparation of projects to be submitted to financing institutions and donors. The projects will aim to implement the rationalization strategy and service plans prepared in APL 1 and make use of the capacity for planning developed at local level. This preparatory work will increase the capacity to use EU structural funds in the future.

COMPONENT 5: Project Management (US$4.72 million, €3.85 million). This component will support the operation of the Project Management Unit (PMU), building on the implementation arrangements of Phase 1 and expanding its responsibilities in order to properly cover the new activities related to the physical rehabilitation of the buildings infrastructure and the on-site equipment delivery, and ensure appropriate monitoring and evaluation of project activities.

5. Lessons learned and reflected in the project design

Phase 1 provided valuable lessons for the design of the second phase. Despite a significant number of varied activities, a good implementation plan which was developed in advance proved to be critical in ensuring that project execution remained on schedule. The availability of committed counterparts, not only at the PMU level, but also in each of the subject matter areas, was also critical to success. Where there were breaks in this continuity, due to changes in working group composition, for example, the impact on project implementation was fairly clear and immediate. Additional efforts on the part of both the Bank and the PMU were needed to get the schedule back on track. Phase 1 also showed that more effort is needed up front on these two areas: (i) planning for the training associated with the project interventions, including lining up the necessary funding in advance, and (ii) clearly developing and planning for project monitoring and evaluation, including methods for ensuring data accuracy and consistency.

6. Alternatives considered and reasons for rejection

(a) **No project** – given the level of interest of the GOR, up to and including the Prime Minister's Office, in the interventions supported by this project, not proceeding with Phase 2 was rejected early on;

(b) **Keep original project amount (US$20M) and reduce project scope** – although the original plan of having a smaller amount in Phase 2 than Phase 1 was considered unusual, some thought was given to preparing a project within this total budget. This idea was rejected because the amount would not even cover the maternal and child component, which was the highest priority.

(c) **Keep original project amount (US$20M) and add financiers** – a second option was to add co-financiers beyond the EIB to make up the difference. However, it was felt that if the Bank was the financier with the smallest contribution, it might adversely affect its ability to effectively manage project implementation. The Ministry of Finance also felt that adding financiers would over-complicate the project, especially given the number of additional donors that might need to be involved.

(d) **Increase project size but with only one financier** – given the level of interest by the EIB and others in cooperating with the Bank, as well as impending EU membership, this option was rejected early, in favor of a more SWAP-like approach.

(e) **Changing project content to focus on other priority areas** – the components chosen reflect the top priorities identified by the Government of Romania, including action on the MDG's, hospital rationalization, and improvements in primary health care services. Completing reforms in the emergency medical services sector is also a key priority, given the investments already made in this sector. The Government considers that it can utilize its own or other resources to address other important public health and health financing issues, and that the components chosen would benefit most from the Bank's involvement.

C. IMPLEMENTATION

1. Partnership arrangements

To date, the MOH has worked with various partners in the health field – IBRD, DFID, USAID, the Swiss Agency for Development and Cooperation (SDC), UN agencies – but it is interested in broadening this base, both to access EU structural funds and loans from other EU financial institutions. For this project, the Government is working with the EIB to co-finance a substantial proportion of the project costs. Other donors have also been asked by the MOH to participate in financing some of the technical assistance and training activities. Although confirmation is not yet available, there appears to be a high probability that other donor funding can be mobilized prior to effectiveness. Should this happen, loan funds would be reallocated to other uses within the overall program, as the MOH prefers to utilize other donor funds for these purposes.

Technical assistance for the development process was obtained from WHO experts, UNFPA, UNICEF, USAID/JSI and others, especially in conducting a baseline survey, which serves the dual purpose of providing both a baseline for project interventions, and a follow-on to previous Reproductive Health Surveys. The Government is also working closely with these partners to align services and programs in Romania to evidence-based interventions recommended in Safe Motherhood/PEPC (Promoting Effective Perinatal Care) and IMCI (Integrated Management of Childhood Illnesses) programs. Efforts are ongoing to ensure close collaboration with USAID, especially in the reproductive health area.

2. Institutional and implementation arrangements

In the last year of the APL1 implementation, the PMU was reorganized and expanded in order to cope with the increased responsibilities generated by the implementation of the GFATM Grant (US$38 million). Although additional staff dealing with procurement, financial management, monitoring and evaluation and information technology have been recruited, several key (core) staff are still assigned to perform tasks related to both projects. To date, the costs associated to the PMU activities for both projects were supported by the GFATM. Additional staffing will be put in place, including a project coordinator and staff with clearly defined responsibilities and dedicated full time to the Bank financed project. In this way, the current PMU will continue to exist and implement the two programs under a two pillar structure, one pillar for GFATM and one pillar for the WB/EIB financed project.

The PMU will provide management and logistical support only to the implementation process, while all technical inputs will come from line departments within the Ministry of Health. During project implementation, the PMU will also engage in extensive capacity building and "technology transfer" in the areas of monitoring and evaluation and project planning and execution, so that by the end of the project, the capacity will exist within the MOH to independently perform these functions. Organizationally, the PMU will continue to be closely tied into the MOH structures, with a reporting relationship to the Secretary of State for International Cooperation, and a direct contractual relationship with the Minister of Health.

The Bank will also need to provide intensive supervision and implementation support. This will be accomplished through day-to-day interaction with technical experts based in the Bank office in Romania, as well as frequent visits by appropriate headquarters-based staff. About 20-30 weeks of staff time will be spent on these activities.

3. Monitoring and evaluation of outcomes/results

A comprehensive monitoring and evaluation (M&E) strategy has been developed for this project, which includes the following key elements:

(a) the capacity of the PMU with respect to M&E has been expanded with the addition of M & E staff funded through the Global Fund, as well as an IT/database specialist.

(b) as part of the project preparation, a database is being established containing information on all facilities included in the project to serve as a baseline for ongoing monitoring and evaluation, with adjustments to respond to PMU specific M&E needs. Existing M&E indicators from Phase 1 will also be added to this database.

(c) the social survey funded through the PHRD Grant provides critical qualitative and socio-economic information and will be repeated during project implementation to monitor progress on issues of access (especially for the poor and those in rural areas), and to provide important indicators of public attitudes and perceptions. Linkages will continue to be maintained with other development partners (see Section C.1 above), to leverage the available resources to maximize the coverage and information value of these surveys.

(d) staff will continue to receive training under the project and will work together with the Project Coordinators and other staff and be responsible for evaluating the impact of the proposed project during the course of implementation and after it has been completed. This would entail monitoring project performance indicators for the duration of the project (per agreed indicators – Annex 3), establishing a plan for M&E activities of the MOH, continuing to monitor the impact of Phase 1 interventions, and agreeing with the Bank on the evaluation studies to be conducted prior to the completion of the project.

(e) Mechanisms will be developed, both through the monitoring and evaluation and national health accounts activities, to encourage the use of the information collected in day-to-day decision-making within the Ministry of Health.

4. Sustainability

All interventions planned in this project, except for National Health Accounts, are already part of the Ministry of Health or NHIH funded activities, so that ongoing sustainability is assured. The PAL process and vehicles will be pursued to ensure the sustainability of the health system as a whole. Long-term system sustainability also depends upon ongoing efforts to implement regional health services master plans, and shift resources and health services from hospital to outpatient, primary care, and social care settings. The project will contribute to these efforts by providing concrete examples of the types of interventions that are needed in this area, as well as a specific case study of service rationalization in a vertical health program (maternal and neonatal care).

5. Critical risks and possible controversial aspects

Risk	Risk Rating	Risk Mitigation Measure
Hospital restructuring slows down or level of commitment is reduced for implementing rationalization activities and improvement of financing mechanisms according to stated reform strategy.	S	(i) Rationalization strategy has been approved by Government (ii) Provide leverage through sequence of PAL conditionalities/triggers and support through Technical Assistance funded from PPIBL. (iii) Monitor progress on implementation of rationalization program as part of ongoing policy dialogue during project implementation.
Government resists difficult decisions needed to rationalize services, focusing on equipment procurement and renovations, jeopardizing achievement of the development objective.	M	(i) Clearly stated Government strategy in all areas covered by the project. (ii) Closely monitor and explicitly link "hard" investments with policy decisions and actions. (iii) Ensure that timing of training and related technical assistance is closely aligned with the equipment and civil works investments.
Required level of co-financing or donor financing may be insufficient or untimely.	M	Ensure firm agreements with donors before project approval
Appeal for investing in development of high-end services, overlooking access/equity issues	M	Document differences in access during preparation, involve stakeholders with interest in poverty reduction in oversight, and support development of systematic mechanisms for monitoring equity
Overall Risk Rating	M	

Risk Rating - H (High Risk), S (Substantial Risk), M (Modest Risk), N (Negligible or Low Risk)

6. Loan/credit conditions and covenants

Conditions of Board Presentation: None.

Conditions of Effectiveness: None.

Other Loan Conditions:

Disbursement Condition: the Operational Manual, satisfactory to the Bank, has been approved by the Borrower, and an Administration Agreement has been executed between MOH and a respective Sub-loan Service Provider with respect to a Sub-loan Fund for which the Borrower has requested a withdrawal from the Loan Account.

Implementation Conditions:

- PMU to be maintained throughout the Project with qualified staff and adequate resources.
- No later than May 31, 2005, establish a unit in each of the eight District Public Health Directorates, to support the PMU in implementation of Project activities at the local level.
- No later than May 31, 2005, establish Project Steering Committees for each Part of the Project.

- No later than September 30, 2005, establish an Evaluation Committee within MOH for appraising and selecting eligible Sub-projects and Beneficiaries in accordance with the Operations Manual.
- Select Sub-loan Service Providers in accordance with the eligibility criteria and procedures set forth in the Operations Manual and in accordance with the provisions of Section III.A of Schedule 4.
- Authorize each selected Sub-loan Service Provider to establish a revolving fund for provision of Sub-loans under Part C.2 of the Project, which fund shall be replenished through withdrawals from the Loan Account from time to time, in accordance with the terms and procedures set forth in the Operations Manual.
- Enter into an Administration Agreement with each Sub-loan Service Provider, under terms and conditions set forth in the Operations Manual and which shall have been approved by the Bank.
- Cause each Sub-loan Service Provider to provide Sub-loans to selected Beneficiaries on the basis of a Sub-loan agreement between the Sub-loan Services Provider and a Beneficiary, on terms and conditions set forth in the Operations Manual.
- Not amend, abrogate or terminate any provisions of the Operations Manual without the Bank's prior agreement.
- Ensure that measures to carrying out of the Environmental Management Plan are taken in a timely manner.
- Maintain policies and procedures adequate to facilitate monitoring and evaluation.
- A mid-term evaluation report to be prepared by the borrower by March 31, 2007.
- Mid-term review to be completed no later than June 30, 2007.

D. APPRAISAL SUMMARY

1. Economic and financial analyses

A combined cost effectiveness and cost benefit analysis was undertaken as part of project preparation. The analysis uses available data from the first phase of the APL, such as local costs and service utilization data, morbidity and mortality data, and relevant information from international experience. These results indicate that the project will potentially save nearly 4,700 lives through improvements in the healthcare system. In addition to the project costs of US$206.5 (€167.9) million, the analysis includes costs of the capital and recurrent expenditure related to improving access to primary health care services, strengthening emergency services, and restructuring the hospital network of maternities and neonatology units. In summary, the project would yield a present value of net benefits, after investment and recurrent costs, of over US$109 (€88.5) million and produce an internal rate of return (IRR) of 30 percent.

2. Technical

Project interventions in the areas of mother and child care and emergency services are targeted at priority areas of preventable morbidity and mortality, and are expected to contribute to improving the health status for conditions where Romania lags behind other EU accession countries. Investments supporting higher quality and improved access to effective primary care and regionalized perinatal care have achieved substantial improvements of health outcomes and

more efficient use of resources in other countries in the region. Finally, the interventions being chosen all use proven technologies which have been shown to produce good outcomes. The implementation process itself will provide the greatest technical challenge, especially ensuring the proper timing and mix of technical assistance, training and physical investments.

3. Fiduciary

The financial management arrangements of the project are acceptable to the Bank. As of the date of this report, the Borrower is in compliance with the audit covenants of existing Bank-financed projects. The PMU's previous and current project financial statements and auditing arrangements are satisfactory and it has been agreed that these will be replicated for Phase 2. The annual audited project financial statements will be provided to the Bank within six months of the end of each fiscal year and also at the closing of the project.

Romania is a EU pre-accession country with relatively strong public financial management capability but moderate to high perceived levels of institutional corruption. Procurement and financial management for Phase 2 will be provided by staff from the existing PMU, which has extensive experience with Bank-financed activities, including Phase 1, various trust funds, as well as the GFATM Grant. The fiduciary capacity is considered capable of satisfactorily recording all transactions and balances, supporting the preparation of regular and reliable financial statements, safeguarding the project's assets, and effectively overseeing procurement processes. Additional staff have been added to deal with civil works, which the PMU has not previously managed, and training in this area is planned for existing staff.

4. Social

The social impact of the project and overall impact in terms of improvements in health outcomes is likely to be largest if the project focuses on rural *and* poor localities. Household survey data suggest that health care utilization conditional on reporting an acute illness varies significantly by poverty status and not by urban/rural residence. More detailed targeting mechanisms for project interventions will be used, such as the Romania Poverty Map, developed as part of the 2003 World Bank-supported Poverty Assessment. This poverty mapping exercise has been fully completed at this stage, and will be used in collaboration with CASPIS (Romania Anti-Poverty and Social Inclusion Commission) to target program interventions, especially in the primary health care component.

Empirical findings are that: (i) health-center/dispensary availability is not a strong predictor of self-reported health status; (ii) health-center/dispensary availability is correlated with the health of those who are wealthier rather than those who are poorer; and (iii) the poor are more likely to use hospitals for outpatient consultations, even though their overall health care utilization rates are much lower for this group than the non-poor. One possible explanation for these findings is that the poor do not have sufficient access to lower-level health facilities. Indeed, the poorest quarter of the population has a 28.6 percent likelihood of having a public health center or dispensary in their locality while the same statistic for the wealthiest quarter of the population is 67.8 percent. The differential persists if one focuses only on rural areas (12 percent versus 16 percent).

Four of the top five reasons for dissatisfaction with medical services are likely to influence the poor more than they influence the non-poor. Three of the five leading reasons have to do with costs (cost of drugs and medical services, informal payments). Another reason in the top five is distance to closest clinic, which is an issue for rural residents. These findings provide support for the proposed project interventions focusing on the improvement of medical services in rural areas, although the project needs to be explicit about the targeting scheme within rural areas.

These and other elements will be monitored as part of the project implementation activities. A full social assessment is available in the project files.

5. Environment

The project envisages limited minor construction, such as remodeling, renovation and refitting of existing buildings, and the provision of equipment to health facilities. Safeguard issues relating to the planned rehabilitation of health facilities will be addressed in the context of project preparation studies and surveys of the health facilities to be included under the project. An Environmental Management Plan has been prepared and published, and public consultation with stakeholders was held in September 2004.

Safeguard policies

Safeguard Policies Triggered by the Project	Yes	No
Environmental Assessment (OP/BP/GP 4.01)	[x]	[ ]
Natural Habitats (OP/BP 4.04)	[ ]	[x]
Pest Management (OP 4.09)	[ ]	[x]
Cultural Property (OPN 11.03, being revised as OP 4.11)	[ ]	[x]
Involuntary Resettlement (OP/BP 4.12)	[ ]	[x]
Indigenous Peoples (OD 4.20, being revised as OP 4.10)	[ ]	[x]
Forests (OP/BP 4.36)	[ ]	[x]
Safety of Dams (OP/BP 4.37)	[ ]	[x]
Projects in Disputed Areas (OP/BP/GP 7.60)*	[ ]	[x]
Projects on International Waterways (OP/BP/GP 7.50)	[ ]	[x]

6. Policy Exceptions and Readiness

No policy exceptions are anticipated for this project.

The procurement documents for the first year of the project are expected to be completed by project effectiveness. The Operations Manual for sub-financing has been developed and will be formally approved by the Government as a disbursement condition. The Project Implementation Plan is expected to be finished by project effectiveness.

* *By supporting the proposed project, the Bank does not intend to prejudice the final determination of the parties' claims on the disputed areas*

Annex 1: Country and Sector or Program Background

ROMANIA: HEALTH SECTOR REFORM II

Strategic context at the beginning of the Program

As in many transition countries, Romania inherited a highly centralized health system, with excess hospital capacity, limited focus on primary care and modern prevention, and little client responsiveness. Despite initial optimism and some preparatory activities in the early 1990s, Romania started only in 1997 to enact key reforms, aimed at shifting the health system from the model of centralized government financing and delivery of services to a more decentralized and pluralistic approach. The main change was the establishment of a compulsory health insurance fund, paid for through an earmarked wage tax and contracting services from public and private providers. The reforms envisioned decentralization of service delivery; an increase in hospital autonomy; and establishment of general practice doctors (GPs) as private practitioners, paid on a mixed capitation and fee-for-service basis.

In 1997-1998 the Government elaborated a more comprehensive health reform strategy, outlined in the 1999 Letter of Sector Development Strategy, that served as a basis for the World Bank supported program currently under implementation. The strategy identified as main issues:

- weaknesses in governance of the system and the legislative framework;
- shortcomings in the efficiency, equity and transparency of sector financing;
- inefficient use of physical capacity and human resources in health care delivery;
- critical inadequacies in infrastructure through years of lack of investment and maintenance;
- mismatch between the health needs of the population and the distribution and priorities of health services; and
- consumer dissatisfaction with the health services.

The strategic purpose of the program set out in 1999 is a healthy Romania, with lower morbidity and fewer premature deaths, equitable access to health services and improved efficiency of the health system. The goals of the program were reaffirmed in the 2001-2004 Program of the Romanian Government. To address the problems listed above, interventions were implemented in the following four areas: (i) organization and management of the health system; (ii) financing of the health system; (iii) rationalization and upgrading of physical and human resources; and (iv) the health of the population. The Health Sector Reform Project primarily focused on implementation of reform plans in the third and fourth of these areas.

Progress achieved through APL Phase 1

The main areas of progress in implementing reform actions to date are: improvement of the legislative framework for health care financing and organization (major revisions of the health insurance law, changes in ownership and accountability of health care units, involving local authorities, new organization of physicians' offices, regulation of public-private partnerships); increase in public funding for the health sector; piloting of new case-based payment mechanisms

for hospitals, preparation of a high-level health sector rationalization strategy and initial actions for its implementation (e.g., closing of about 15 percent of acute hospital beds, development of home and community care), developing public-private partnerships, preparation of first generation of health services development plans based on review of health care needs and service capacity, significant investments in upgrade of equipment for essential hospital services and pre-hospital emergency care, expansion of services and programs for tuberculosis (TB), reproductive health and HIV/AIDS, passing of tobacco control legislation. In spite of the important efforts and investments to date, improvements in health outcomes and health system quality have been slow, and reforms remain fragile. They have not yet led to the expected increase of efficiency and public satisfaction.

Review of Progress on APL 1 Development Objectives

Development objective: (a) improving the capacity for policy, planning, regulation, finance, and management of the health sector, (b) improving quality, cost-effectiveness and technical efficiency of PHC in selected poor and remote areas, essential hospital and ambulatory health care services and emergency medical services; and (c) modernization of public health services in the areas of tobacco control, tuberculosis prevention, AIDS/HIV prevention, STD prevention and community-based mental health care.

Substantial progress has been made in a number of areas with regard to achieving the development objectives. As noted above, improvements have been made to the regulation of the health sector and the legal framework. Through the Diagnostic Related Groups (DRG) project and other initiatives, the provider payment and financing system is being improved, while the various activities with regard to improving health planning capacity are also underway. A new strategy for health services has been approved in June 2004. Essential equipment for hospitals, primary health care, ambulatory care, and emergency medical services has been made available and a certain amount of the training has been provided. Evidence provided to date indicates that this equipment is being used effectively to improve outcomes and provide superior patient care. Up to 2002, the percent of hospital admissions by general practitioners increased slowly; however, in 2003, there was a slight decrease. With regard to the public health component, increases in the incidence of tuberculosis and sexually transmitted diseases were registered until 2002, with preliminary 2003 data suggesting for the first time since the late 80s a small decrease. The change in the trend of TB incidence is expected after several years of expansion of the TB control program, better detection, more wide-spread use of the DOTS protocols and an improving cure rate for tuberculosis. The level of funding from the state budget for preventive activities related to TB, HIV/AIDS, mental health and tobacco control appears to have decreased in 2002 and 2003, although additional resources were provided for TB and HIV/AIDS treatment. Resources for HIV/AIDS and TB prevention will increase through the use of the funds obtained from the GFATM, that will finance mainly prevention activities. A positive development was a package of major legislative changes to promote a smoke-free environment and reduce tobacco consumption. On balance, satisfactory progress has been made toward the achievement of the development objectives.

Review of APL 1 Implementation

The Project was composed of six components: (a) Planning and Regulation of Healthcare Delivery System, (b) Essential Upgrade of District Hospitals, (c) Primary Health Care Development, (d) Emergency Medical Services, (e) Public Health and Disease Control, and (f) Project Management. All components were rated as Satisfactory at the end of the project, with the exception of the last one, which was rated Highly Satisfactory.

Planning and Regulation of Healthcare Delivery System Component. The final report of the planning and regulation technical assistance includes a first set of plans for development and rationalization of health services at judet, regional and national levels, as well as a roadmap for implementation of the updated National Hospital Rationalization Strategy. Government has formally approved this strategy. Capacity for planning has been developed at the local level, supported by comprehensive data collected and validated by the consultants. The completion of the judet and regional plans included also a substantial process of consultation with key stakeholders. The proposals from the district plans regarding establishment of multipurpose health centers, and their organization, financing and location are being used in the preparation of the second phase of the project.

DFID-financed technical assistance (implemented by NICARE) has supported training in planning for MOH staff and development of capacity at the community level to identify and address health problems. The MOH is exploring options for disseminating the successful experiences of these community development pilots in other judets and communities.

In addition to the project-related activities, the PMU was also closely involved with the IFC team in their evaluation of potential public-private partnership opportunities for Bucharest hospitals and their implementation as demonstration transactions (e.g., outsourcing of diagnostic services, concession of dialysis services, private management of public hospitals). Overall, a great deal was accomplished in this component, consistent with the initial plans for the component.

Essential Upgrade of District Hospitals Component. All activities related to this component were carried out in a timely and efficient manner. A total of 27 hospitals received this equipment, with the operating room equipment completed by the end of June, 2003. Because of savings and identified needs, additional equipment for endoscopy and burn patient management were purchased later in the project. A great deal has been accomplished in this component, with the only concerns being delays in the timing of training for the effective use of the equipment, and the collection of timely and consistent monitoring and evaluation data to complement the anecdotal evidence regarding the effective use of this equipment.

Primary Health Care Component. Outpatient diagnostic and primary care equipment totaling just over US$3 million has been delivered and installed in 19 outpatient departments and 47 dispensaries in the six districts covered by this component. Integrated assistance models were developed to provide the appropriate linkages for referrals from primary care to specialist consultations and diagnostic investigations. Together with the Open Society Foundation, training centers for family physicians and specialty courses were provided. The MOH has organized in 2001 and 2002, through the Center for Postgraduate Training, courses for a large

number of physicians contracted as family doctors who had started to work in primary care before the residency in family medicine was introduced. Completion of these courses allowed these physicians to pass their specialty examinations in family medicine in 2002. NICARE carried out a training needs assessment for family doctors that was used to improve training programs in family medicine and supported development and dissemination of guidelines for management of four common conditions in primary health care. Although the component was rated satisfactory, an evaluation showing the effective use of the equipment and functioning of the integrated service model is needed. This will be done as part of the Implementation Completion Report (ICR).

Emergency Medical Services Component. This component completed all of the planned activities. Tenders were carried out to procure ambulances of several types, as well as extrication vehicles, equipment for disasters intervention and medical motorboats. The final destinations for equipment were organized and the beneficiaries were established. All deliveries were finalized, and specific training programs for physicians, nurses and firemen were organized and started. The process of obtaining a contractor through the Swiss funds for training and technical assistance was delayed, but the Ministry compensated for this by undertaking a certain amount of training using its own resources. Most of the training activities, for about 1200 staff, are being completed in 2004. There appears to be a variable degree of integration from judet to judet, and an evaluation is needed to determine the extent to which this has affected the achievement of the development objectives. There is anecdotal evidence that the equipment is being used effectively and having an impact on improved patient care and outcomes, but there have been difficulties with quality of data for the M&E indicators. As a result of this, improvements to monitoring and evaluation approaches are a high priority in the second phase.

The project also examined the area of communications, and there was consideration of an initiative to pilot an integrated computer-aided dispatch (CAD) system in a number of judets. This is one of the main unfinished areas in the continuum of emergency care. This initiative was driven in part by the Government's decision to implement a universal 112 system in Romania, which would not be compatible with existing ambulance dispatch approaches. These activities were shifted to Phase 2 once it was clear that there would be delays in the 112 implementation.

Public Health and Disease Control Component. This component of the project is composed of the following two sub-components: Strategy Development and Capacity Building, and Priority Prevention Programs. The Public Health Strategy has recently been completed and approved, and health promotion training was concluded for key staff at national and local level. Equipment for the reference public health laboratories has been delivered and installed. Smoking cessation centers were refurbished and equipped and their staff was trained. Support was provided to information and education activities for tobacco control. The Government has adopted legislation regarding smoking in public places and limiting tobacco advertising. A new mental health law has been passed, incorporating recommendations of the technical working group supported by WHO. The project supported training of staff in new methods of delivery of mental health services.

Important steps in passing laws and regulations coherent with project development objectives and allocation of resources from Government-funded National Health Programs towards activities in the priority areas outpaced initially the implementation of key project activities

financed from the loan. A few activities (e.g., IEC activities related to HIV/AIDS and TB) were shifted to support from other donors. By the end of the project most of the planned activities were completed.

Project Management. Project management was handled very smoothly, both in terms of the organization and the content. Specific requests for information or follow-up were handled quickly and efficiently. In addition to a significant workload from project implementation, the PMU also played a major role in successfully organizing the jointly sponsored WB-MOH PCU Conference, and also provided excellent support to IFC throughout their public-private partnership (PPP) planning and contracting process. The management of the MOH was also quite engaged in both policy and management issues related to the project, although frequent changes in Ministers and key ministry staff in the second half of the project caused some continuity problems.

From APL 1 to APL 2 - Review of Trigger Indicators

A total of 5 trigger indicators were established to guide the movement from Phase 1 to Phase 2. Three indicators are directed at policy issues, while two relate to project implementation. The box below shows each of the triggers, and the progress achieved to date in meeting them is discussed in the text.

Trigger Indicators

Policy Indicators:

1. If required, amendments to the legal and regulatory framework for health care providers and for financing of health sector investment will be initiated by the MOH.
2. Public Health Strategy with targets in priority areas issued.
3. A lending and/or leasing scheme for financing family physicians in primary health care practices has been established by the Health Insurance House and operating at least on a pilot basis for six months or more.

Project Implementation Indicators:

4. 3-4 judets in each socio-economic development region (at least 30 in total) have completed health services plans and associated investment and human resource plans for developing and rationalizing capacity in the sector, and improving integration between different types and levels of care delivery.
5. Substantial progress has been made on contractual commitments (at least 80 percent) and disbursements (at least 70 percent) from APL 1.

With regard to the first trigger indicator, a number of legislative amendments have been passed and new regulations issued in the areas of: health insurance (major revision of insurance legislation through Ordinance 150/2002), health professions (physicians – Law 306/2004, nurses – Law 307/2004, pharmacists – Law 305/2004), ownership and accountability of health care units (transfer of responsibilities for a large part of public providers of health services to local authorities through Ordinance 70/2002), organization and accreditation of hospitals, organization of physicians' offices (family doctors and specialists) and ambulatory care departments of

hospitals, public-private partnerships for improvement of health services quality and efficiency (Government Decision 717/2001), development of case-based, DRG-type payment mechanism for hospitals (specific provisions allowing piloting in 23 hospitals included in a framework contract for insurance funded health services for 2002), strategy for hospital reform (Government Decision 826/2002), leasing premises of publicly owned medical offices to physicians (Government Decision 884/2004), private health insurance (Law 212/2004) are currently in process. Based on this progress, this trigger indicator is considered **Fully Met.**

A formal public health strategy has been developed in consultation with key experts and has been published and endorsed by the Ministry of Health. This trigger indicator is also considered **Fully Met.**

In reviewing the third trigger carefully, the MOH, together with the NHIH, determined that the more immediate issue was access by current GP contract-holders to some degree of certainty with regard to their practice locations. Accordingly, options of allowing family physicians to purchase or obtain long-term commercial leases for their current premises were reviewed. The Bank team supported this approach and agreed that successfully implementing this program will satisfy this indicator. Government Decision No. 884/2004 on leasing premises of publicly owned medical offices to physicians was passed in June, 2004, and thus the trigger is considered **Fully Met**.

The planning process got off to a slow start; however, interest in this process picked up just before the project mid-term review (MTR), and a two-pronged approach was undertaken. First, an overall national health rationalization strategy was developed using an individual consultant. This process resulted in the development of broad parameters to guide the detailed rationalization planning process. The second part of this process was to contract an international firm through a competitive process to assist a number of judets in developing their detailed plans, consistent with the parameters outlined in the "top-down" approach. The firm was in place in May, 2003, and it worked with the judets to develop a "bottom-up" process involving extensive consultation with key stakeholders and the community as a whole, finalizing its work in all 42 judets by June, 2004. This indicator is considered **Fully Met.**

As of September 1, 2004, actual disbursements for this project were 98.3 percent, thus this indicator is considered **Fully Met**.

Strategy update

The Bank-financed project was of course not the only contributor to health reform in Romania over the last six years. Table 1 below shows the progress that has been made in addressing the reform agenda, including not only the impact of the Health Sector Reform Project, but also the activities of the Government and MOH themselves, other donors, and the impact of the PAL 1 conditionalities.

Although substantial progress has been made in the areas of legislative changes, accountability, improved health services, and public health, a substantial agenda remains to be completed. As a result of internal capacity built over a number of years through a variety of donors, an increasing proportion of this agenda will be carried forward directly by the MOH, the NHIH, and other

government institutions. For example, the Ministry is able to take the lead in expanding activities in the areas of public health. In other areas, further assistance needs have been identified, either through World Bank-financed activities or conditionality (APL 2, PPIBL, PAL, 2,3) or other donors (e.g., GFATM, PHARE). The PAL is considered essential in ensuring broader Government attention to, and involvement in, the overall health reform agenda, and covering the important gaps in this agenda.

TABLE 1 – PROGRESS ON HEALTH REFORM IN ROMANIA

Identified Health System Issue	Changes since 1998	Instrument used				Current Status and Remaining Agenda	Instrument to be used			
		GOR/MOH	APL 1	PAL 1	Other Donors		GOR/MOH	APL 2	PAL 2, 3	Other Donors
Weaknesses in governance of the system and the legislative framework	▪ Major revisions of the health insurance law strengthen accountability of insurance fund ▪ Increased role of local authorities in ownership and accountability of health care provider units ▪ New organization form for physicians' offices, regulation of public-private partnerships ▪ Law on hospital organization ▪ Development of planning capacity at MOH and local level	X	X		X DFID	▪ Further improve legal framework for organization of providers (specialist ambulatory care, multipurpose health centers, medico-social units) ▪ Develop and implement governance and management arrangements for hospitals conducive to increased efficiency ▪ Develop a modern health services accreditation body and adequate quality management monitoring systems	X	X	X	
Shortcomings in the efficiency, equity and transparency of sector financing	▪ Increase in public funding for the health sector, capacity building for health insurance, piloting of new case-based payment mechanisms for hospitals	X			X USAID PHARE	▪ Increase resources allocated for primary care services, ambulatory care, hospital day surgery ▪ Roll out new payment mechanisms for hospitals ▪ Contain escalation of pharmaceutical costs ▪ Better definition of benefit package covered by health insurance ▪ More transparent and affordable contribution of private financing	X		X	X

Identified Health System Issue	Changes since 1998	Instrument used				Current Status and Remaining Agenda	Instrument to be used			
		GOR/MOH	APL 1	PAL 1	Other Donors		GOR/MOH	APL 2	PAL 2, 3	Other Donors
Inefficient use of physical capacity and human resources in health care delivery	▪ Prepare/approve a high-level rationalization strategy and initial actions for its implementation (closing ~15 percent of acute hospital beds, convert acute hospitals to medico-social care units), ▪ Health service plans prepared ▪ Development of contracting for home care ▪ Piloting public-private partnerships (with IFC support)	X	X	X		▪ Improve distribution of human resources - incentives for medical staff to practice in remote or underprivileged areas, ▪ Develop models of care/ providers units adapted to rural and remote population ▪ Continue closing, conversion or restructuring of the unnecessary or underutilized hospital facilities	X	X	X	
Critical inadequacies in infrastructure through years of lack of maintenance and investment	▪ Upgrade of equipment for essential hospital services and pre-hospital emergency care ▪ Major upgrade of hospital equipment financed through commercial credits with Government guarantee ▪ Lease scheme for medical offices	X	X			▪ Continued need for investments, especially rehabilitation of buildings. ▪ Priority areas for Government: maternities, psychiatric care units. • Complete investments in emergency care system	X	X		X limited
Mismatch between the health needs of the population and the distribution and priorities of health services	▪ Public health: strategy development, capacity building, strengthening national programs (especially TB, reproductive health and HIV/AIDS), tobacco control legislation passed ▪ Pilot of community nursing	X	X		X Global Fund USAID UNFPA	▪ Key health indicators, including MDG, although improving are still worse than EU and most CEE countries ▪ Expanding prevention and health promotion activities	X	X		X PHARE Global Fund
Consumer dissatisfaction with the health services	▪ Information campaigns on rights of insured				X	▪ Addressing informal payments and explicitly addressing patient satisfaction	X	X	X	

To pull these various activities together, a health services strategy was prepared and endorsed by Government in June 2004. It has as a main objective to improve access of the population to high quality services, delivered efficiently. The strategy includes actions that aim to achieve a better balance between hospital inpatient services and other types of care: primary care services

(including family medicine and community care), ambulatory care, hospital day services. Specific objectives of the health services strategy are the following:

1. Establishing a better performing hospital sector that delivers more efficient and effective treatment services, such as integrated hospital ambulatory care, hospital day care (day surgery) and better diagnostic and therapeutic services.

2. Increasing the primary care services, especially home care, ambulatory prescribed drugs, multi-purpose health centers in both urban and rural areas, and integration of primary care with ambulatory and hospital services, consistent with the national Health Programs.

3. Providing adequate and sustainable financing, to promote hospital performance, according to national health policies and national bed supply plan and to provide incentives for efficient health care delivery.

4. Closing, conversion or restructuring the unnecessary or underutilized hospital facilities in order to reduce the financial losses and using the recovered resources for developing the new health priorities based on decreasing of hospital inpatient admissions and the average length of stay together with an increase in bed occupancy rate and hospital outputs.

5. Improving the governance and operational management systems and providing a better capability to manage and monitor the strategic health reforms.

6. Amending the regulatory framework at the central level to support rapid implementation of the health service reforms, including the further decentralisation of operational and financial management, to identify the most appropriate solutions for the local needs, including services for the poor and vulnerable.

7. Development of a modern health services accreditation body and adequate quality management monitoring systems.

8. Increasing the participation of the private sector in financing the health care services, allowing for competition between providers for additional funds, distinct from compulsory health insurance.

9. Transferring social cases and elderly care from the hospital system to the Ministry of Social Solidarity, Labor and Family and/or Local Authorities, so that hospital may focus on acute care activities.

Finally, an updated letter of development policy has also been prepared (see Annex 1.1), which builds on the strategic directions identified at the beginning of the program, states the Government's commitment to implement the health services rationalization strategy developed in APL 1, and identifies main areas for APL 2 support.

Unfinished agenda in the area of mother and child health

One area of increasing concern to the Government over the past few years is the state of the maternal and child health system in Romania. Improvements in basic health indicators have been slow and substantial differences still exist compared to neighboring countries and new EU accession countries in particular. The following table highlights the key indicators:

TABLE 2: KEY MATERNITY-NEONATAL INDICATORS

Country	Low birth weight (<2500 g)	Neonatal death rate	Post-neonatal death rate	Maternal mortality 3-yr. Avg.
Romania	8.8	8.4	8.9	29.4
EU average	6.6	3.3	1.8	5.8
Czech Republic	6.0	2.7	1.4	5.5
Estonia	4.3	5.0	3.8	20.8
Hungary	8.5	5.2	1.9	7.9
Latvia	5.1	7.3	3.7	30.5
Lithuania	4.5	4.2	3.8	13.6
Slovakia	7.0	5.4	3.2	9.4
Slovenia	5.7	3.0	1.2	15.2
Bulgaria	9.1	7.8	6.6	19.6
Croatia	6.2	5.5	2.2	6.8

Source: WHO Health-for-All Database, year 2001 or latest year

Within Romania, variation is high across districts. For example, in 2001, the infant mortality rate ranged from 11.1 in Cluj to 29.5 in Ialomita. Recent reports suggest that official infant mortality data might even underestimate actual rates, and conditions leading to excess perinatal deaths have become an issue of increasing concern for the public and the media.

During the last few years, the Ministry of Health has expanded activities and resources for the national program for mother and child care. A strategy for rehabilitation and reorganization of hospital-based obstetrics and gynecology and neonatology care was approved by the Government, a detailed assessment of existing maternity services was conducted, and a plan for rationalization was prepared. With funding from the state budget and support of several donors, new activities were started: improvement of access of low-income groups to reproductive health care, a training program for community nurses, and provision of additional funding for their employment by local health authorities, pilot improvement of maternity and neonatology services in 2 regions. Recent WHO guidelines in the area of safe motherhood, reproductive health and infant and child health have been adopted by the Government as the basis for future interventions, including those in the proposed Bank-financed project.

Annex 1.1 – Signed Letter of Sector Development Strategy
DATED OCTOBER 25. 2004

GUVERNUL ROMÂNIEI
MINISTERUL SĂNĂTĂȚII

Mr. Anand Seth
Country Director
World Bank

Dear Mr Seth,

In the last four years the Ministry of Heath developed with support from the World Bank and other international agencies the APL I - Health Reform Project focused on some major areas of intervention of the Health System Reform Strategy - document integrated in the Strategy for Governance of the Cabinet - organization and financing of the health sector, the health services and health of the population. The project closed by June 30. 2004 and the targets of the program have been fully achieved.

The first component of the APL I addressed the existing problems in delivery the health services, identified priorities and proposed plans for rationalization. Within the component, the Strategy of the Health Services (SHS) has been issued and a first health services planning exercise for all the districts have been completed with technical assistance. The Government approved the SHS before the in June An Interministerial Committee will support and supervise the necessary steps to fulfill the objectives of the RSHS. The Strategy will orientate the main changes in the governance, financing and rationalization of the services in the health sector.

The second component targeted the areas of preventable morbidity and mortality, through improving the quality of selected essential services from districts and emergency hospitals, assuring basic equipment for operating theaters and intensive care units All the units have been rehabilitated, received the equipment and the staff has been trained. The quality of the care substantially increased

The third component focused primary care, especially in remote areas to improve the access of the population to the health services. The medical offices and ambulatory clinics from the pilot districts are offering higher quality of the services for the population in rural areas at the level of community.

The fourth component addressed to a part of the emergency services – especially pre-hospital- in an integrated manner. The program provided B and C ambulances, emergency boats for the Danube Delta, extrication equipment and mass casualty units which are used in common teams - the ambulance system personnel and fire fighter brigades; an important training program is on going with Swiss support.

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The fifth component focused on improving the system capacity for health education and public health, supported interventions in four priority diseases: TB, STI, HIV/AIDS and mental health. The program financed the rehabilitation of the TB, STI and communicable diseases laboratory network, creation a mental health rehabilitation center, as well as training programs in public health and health promotion, elaboration of the public heath strategy, etc.

Other financiers (Swiss Government, GB Government) contributed with technical and financial support to achieve the best results within the implementation of the project.

Some other important changes have been introduced in the last years. The general practitioners are private practitioners which are contracting with the Health Insurance House. The concession of the medical offices to the doctors is regulated through a Government Decision approved by in May 2004. Private sector participation has been identified to increase the performance of the heath sector. An important private sector is already active on the market especially on specialized ambulatory care services. A strategy for PPP has been approved in 2002 through Government Decision focusing the hospital sector and some models of PPP have been implemented in Bucharest with IFC technical assistance. The experience has been extended with good results to other hospitals in the country, for out-sourcing clinical and non-clinical services. A Law of Private Medical Insurance has been approved by the Parliament.

As a requirement of the Public Propriety Law the transfer of the buildings of the hospitals from the Ministry of Heath to the district and local authorities has been made in 2002. This decision is permitting to the local authorities to co-finance and take decisions together with the Ministry of Heath and the Health Insurance House on the improvement of health services in their region.

Based on evaluation of the performance of the hospital sector, a first wave of the downsizing of the hospital beds has been done in 2003, when have been closed around 22 000 hospital beds. The Ministry of Health initiated also a process of transforming part of the low performance hospitals in the rural areas in other types of services - medical-social units - which are required by the population and could be financed in co-operation with the local authorities.

The new strategy for rationalization of the health services is creating a long term vision for the health system. The implementation of the strategy will improve the quality of hospital services and expand the non-hospital services. It will achieve a better balance between inpatient services, ambulatory care (hospital and community based), hospital day services and primary care services, including family practitioner, community care and other non-hospital services.

The main objective of the new rationalization strategy is to create a perform ant health sector, which can deliver quality services that the population needs and in a cost efficient way.

We are co-coordinating the future SHS with the requirements of the proposed PAL program concerning the improvement of the regulatory framework for rationalization of the health services, improving the performance of the financing of

the health sector, reducing corruption and increasing the transparence of the health sector. In the same time, there are legislative public health requirements to be updated and harmonized for the accession to European Union. An important support has been received from the Gobal Fund for a comprehensive and multisectorial project addressed to two major diseases HIV/AIDS and TB.

We are very committed to implement the important changes outlined by the strategy. As a major intervention, the Ministry of Heath selected some priority interventions, based on rationalization of the health services. A first major rationalization decision has been taken in 2002, when a Government Decision has been issued for establishing a hierarchy of the maternities and neonatology departments in the country. The new proposed project is focused on providing more accessible and increased quality services for newborns and mothers, improving the organization and quality of the emergency dispatch system and emergency services in the hospitals, increasing the access of the population to primary, social services and other types of services in poor and remote areas, and developing he capacity of the Ministry of Heath to develop a National Health Accounts.

In the last thirteen years the World Bank has been an important partner and advisor for the Ministry of Health in the most important actions for the reform. As we closed already the API. I program, financed by the World Bank, we trust that this process will continue. The API. II project has been prepared and we estimate that the loan to be borrowed is around 160 mil USD. As you know a common appraisal mission with EIB has been made in October 18-22. The mission has been completed successfully with the agreement of cooperation of both Banks for our health project.

I believe that you would appreciate our efforts to continuously improve the health system and provide your support for the health API. II. In the spirit of our traditional very good relationship, I am convinced that the World Bank will continue to support both professional and financial the future health program, in the benefit of the Romanian population.

In this respect I am kindly ask your official position regarding the availability of the World Bank to co- finance our project.

Sincerely yours,

Dr. Ovidiu Brinzan
Minister of Health

Cc: Mr. Owaise Saadat

Annex 2: Major Related Projects Financed by the Bank and/or other Agencies

ROMANIA: HEALTH SECTOR REFORM II

The Bank has financed two investment operations in the health sector. The first project, with a total cost of US$224 million (including US$150 million IBRD loan) was implemented in 1992-1999 and supported upgrade of selected primary health care, maternity and emergency medical services, procurement of essential drugs, tuberculosis control and capacity building. The second project, Health Sector Reform Phase 1, closed on June 30, 2004. The US$69 million project (including US$40 million IBRD loan, disbursed almost 100 percent) covered the upgrade of essential hospital care (operating room and intensive care services), further improvements in emergency medical services, support for primary care in six judets, strengthening of planning capacity within the MOH and the judets, including the development of judet-level rationalization plans, and selected public health interventions.

The current health sector support strategy envisions a combination of adjustment and investment lending to support key reforms and priority investments. Key sector reforms would be leveraged by the proposed PAL conditionalities/ policy actions aiming to:

- improve performance of health sector financing regarding predictability, risk protection of insured, equity and efficient management of public resources;
- revise arrangements for health insurance revenue generation, improve provider contracting and accountability mechanisms of National Health Insurance House;
- reduce corruption and increase transparency in the health sector;
- support implementation of a National Hospital Rationalization Strategy and create a legal/regulatory framework conducive for the organizational reform and rationalization of hospitals.

Technical assistance was supported by APL Phase 1 (for rationalization activities) and by the PPIBL (TA loan supporting the PAL program) in the area of health sector financing. Additional TA needs, to be addressed by APL 2, include monitoring and evaluation of health system performance, National Health Accounts, and further support for investment planning.

To date, the Government has worked with a number of partners in the health field —IBRD, DFID, USAID, SDC, UN agencies – but it is interested in broadening this base, to access EU structural funds and as well as loans from other EU financial institutions. Project design was coordinated with ongoing technical and training support for reproductive and mother and child health activities provided to Romania by WHO, UNFPA, UNICEF and USAID. SDC is already supporting improvement of neonatal care in two regions. Other donors, including the Humana Foundation and SDC, have expressed an initial interest in funding some of the training activity. Opportunities will be pursued to utilize the Bank's and other donors' comparative advantages to maximize the combined impact of the various programs. The Government has received a grant from the Global Fund to Fight AIDS, TB and Malaria for US$38 million to address tuberculosis and HIV/AIDS, and is getting EU funds for several public health activities (strengthening of communicable disease surveillance, tobacco control). Availability of these funds, together with the ongoing state budget commitment to public health activities generally, suggest that further support for investments from the Bank in these areas is not a priority at this time.

Annex 3: Results Framework and Monitoring

ROMANIA: HEALTH SECTOR REFORM II

Results Framework

PDO	Outcome Indicators	Use of Outcome Information
Provide more accessible services, of increased quality and with improved health outcomes for those requiring maternity and newborn care, emergency medical care and rural primary health care.	▪ percent of maternal deaths formally documented/ investigated ▪ Neonatal and post-neonatal deaths and death rate ▪ percent of deliveries where birth-weight is less than 2500 grams ▪ Utilization rates for primary and emergency care stratified by residence and income status percent of deaths within 48 hours and ER discharge for patients with major trauma or cardiac emergencies arriving alive at the hospital emergency department	Information used to: ▪ provide performance feedback for health care providers, and to set targets and agree on strategies for performance improvement ▪ evaluate the effectiveness of project interventions and identify priorities for future policy and investment interventions ▪ identify issues and actions for changes to project design and approach during project implementation
Intermediate Results One per Component	**Results Indicators for Each Component**	**Use of Results Monitoring**
Component One: Rationalized maternity and neonatal care system is up and running and operating effectively.	**Component One:** ▪ Percentage of maternity beds utilizing "rooming in" system ▪ percent of deliveries attended by skilled health personnel in appropriate level of care ▪ Occupancy rates by unit ▪ Average length of stay by unit ▪ Proportion of cases fulfilling pre-defined criteria of quality ▪ Patient satisfaction with revised maternity and neonatal services	**Component One:** ▪ Ensure that all affected hospitals are on track and operating according to original design concept ▪ Ensure that actual operations are meeting original expectations in terms of quality, efficiency and patient satisfaction
Component Two: Effective dispatch communications capability established in all regions, and improved emergency reception capability is established in all affected hospitals.	**Component Two :** ▪ Utilization rates for dispatch ambulance and ER services, ▪ Response times for emergency services by urgency and severity ▪ Case fatality rates for ER and	**Component Two:** ▪ Ensure that dispatch centers and ERs are on track and operating according to original design concept ▪ Ensure that actual operations are meeting original expectations

	ambulance cases by type of case ▪ Communications problems leading to delayed or missed calls ▪ Patient satisfaction with revised ambulance and ER services	in terms of quality, efficiency and patient satisfaction
Component Three: New approaches to primary health care are established in rural and remote areas, and general primary care interventions are completed.	**Component Three:** ▪ Performance of new MPHC pilots relative to original design proposal (utilization, quality, etc.) ▪ Patient/physician satisfaction with different models of revised primary health care services and sub-loan scheme ▪ Repayment rate for credit/ lease scheme	**Component Three:** ▪ Ensure that new approaches are operating according to original design concept ▪ Evaluate which approaches are most effective in which situations ▪ Ensure that those in rural areas and the poor are actually being reached by the services ▪ Ensure that operations are meeting original expectations in terms of quality, efficiency and patient satisfaction
Component Four National Health Accounts system is implemented.	**Component Four:** ▪ NHA information is used in decision-making relating to the financing or organization of the health system in Romania	**Component Four:** ▪ Evaluate usefulness, impact and sustainability of NHA approach in Romania ▪ Identify obstacles to effective production or use of NHA data
Component Five Phase 2 Health project is implemented and all key activities are completed.	**Component Five:** ▪ Matching of civil works and equipment acquisition activities to required training and related technical assistance ▪ Progress on M&E updating	**Component Five:** ▪ Evaluate needs for corrective action early, so that changes can be made before major issues arise ▪ Identify obstacles to effective implementation of Phase 2 activities.

Arrangements for results monitoring

		Target Values					Data Collection and Reporting		
Outcome Indicators	**Baseline**	**YR1**	**YR2**	**YR3**	**YR4**	**YR5**	**Frequency and Reports**	**Data Collection Instruments**	**Responsibility for Data Collection**
▪ percent of maternal deaths that are formally documented/investigated	Developed in Year 1	no chg.	no chg.	80 %	90 %	100 %	Semi-annual reporting by maternity departments	Part of M&E system	PMU & hospitals
▪ Neonatal deaths and rate	National 8.4/1,000	no chg.	no chg.	10 % decr.	12 % decr.	15 % decr.	Annual National Statistics plus Semi-annual reporting by maternity departments	Part of national reporting plus M&E system	PMU & hospitals
▪ Post-neonatal deaths and rate	National 8.9/1,000	no chg.	no chg.	10 % decr.	12 % decr.	15 % decr.	As above	As above	PMU & hospitals
▪ percent of deliveries where birth-weight is less than 2500 grams	National [1] 8.8 percent	no chg.	no chg.	10 % decr.	15 % decr.	20 % decr.	As above	As above	PMU & hospitals
▪ Utilization rates for primary and emergency care stratified by residence and income status	Developed in Year 1, + survey	no chg.	no chg.	10 % incr.	10 % incrr.	20 % incr.	Semi-annual reporting by PHC units plus surveys at MTR and project end	Part of M&E system	PMU, EMS, hospital ER departments and PHC centers
percent of deaths within 48 hours for patients with major trauma or cardiac emergencies arriving alive at the hospital emergency department	Developed in Year 1	no chg.	no chg.	10 % decr.	15 % decr.	20 % decr.	Semi-annual reporting by emergency departments and ambulance service	Part of M&E system	PMU & hospital ER departments
Results Indicators for Each Component									
Component One : ▪ Percentage of maternity beds utilizing "rooming in" system.	37.2 %	no chg.	no chg.	50 % beds	60 % beds	70 % beds	Semi-annual reporting by maternity departments	Part of M&E system	PMU & hospitals
▪ percent of deliveries attended in appropriate level of care	Developed in Year 1	no chg.	no chg.	50 % del.	60 % del.	70 % del.	Semi-annual reports by maternities	Part of M&E system	PMU & hospitals
▪ Occupancy rates and average length of stay by unit	Developed in Year 1	no chg.	no chg.	10 % imp.	15 % imp.	20 % imp.	Semi-annual reports by maternities	Part of M&E system	PMU & hospitals
▪ Proportion of cases fulfilling pre-defined criteria of quality	Developed in Year 1	no chg.	no chg.	30 percent	60 %	70 %	Semi-annual reports by maternities	Part of M&E system	PMU & hospitals

[1] value for 2001 from WHO HFA database, 2003 MOH figure 9.5, figure from facility survey was 9.9 percent.

▪ Patient satisfaction with revised maternity and neonatal services	Developed in Year 1	no chg.	no chg.	40 %	60 %	70 %	Baselines survey, & surveys at mid-term & end of project	Public opinion surveys & patient surveys	PMU
Component Two : ▪ Utilization rates for dispatch ambulance and ER services	Developed in Year 1	no chg.	no chg.	10 % imp.	20 % imp.	30 % imp.	Semi-annual reporting by EMS and ER	Part of M&E system	PMU, hospitals and ambulance service
▪ Response times for emergency services by urgency and severity	Developed in Year 1	no chg.	no chg.	20 % imp.	25 % imp.	30 % imp.	Semi-annual reporting by EMS and ER	Part of M&E and MOH reporting system	PMU, hospitals and ambulance service
▪ Case fatality rates for ER and ambulance cases by type of case	Developed in Year 1	no chg.	no chg.	10 % imp.	15 % imp.	20 % imp.	Semi-annual reporting by EMS and ER	Part of M&E and MOH reporting system	PMU, hospitals and ambulance service
▪ Communications problems leading to delayed or missed calls	Developed in Year 1	no chg.	no chg.	<20 % calls	<10 % calls	<5 % calls	Semi-annual reporting by EMS and ER	Part of M&E and MOH reporting system	PMU, hospitals and ambulance service
▪ Patient satisfaction with revised ambulance and ER services	Developed in Year 1	no chg.	no chg.	30 %	50 %	75 %	Baselines survey, & surveys at mid-term & end of project	Public opinion surveys & patient surveys	PMU, hospitals and ambulance service
Component Three: ▪ Utilization rates for MPHC by type of service and sub-populations if possible (percent of business plans targets)	Per proposal	NA	NA	60 %	70 percent	80 %	Semi-annual reporting by new PHC providers and controls	Part of M&E system	PMU, PHC providers
▪ Hospital utilization rate of population in MPHC area.	Developed in Year 1	N/C	N/C	10 % decr.	15 % decr.	20 % decr.	Annual reporting from Medical Statistics Dept.	National reporting	Hospitals in MPHC areas
▪ Patient/physician satisfaction with different models of revised primary health care services and sub-loan scheme	Developed in Year 1	N/C	N/C	60 %	70 %	80 %	Baselines survey, & surveys at mid-term & end of project	Public opinion surveys & patient surveys	PMU & PHC providers
Repayment rate for sub-loans (percent of expected amount)	NA	NA	NA	100 %	100 %	100 %	Reporting by sub-loan service providers	Part of sub-loan contract	Sub-loan service providers
Component Four: ▪ NHA information is used in decision-making relating to the financing or organization of the health system (percent of relevant documents)	None	0	0	Used in <10 % docs.	Used in >20 % docs.	Used in >40 % docs.	Annual	Review use of and access to NHA reports and statistics	PMU

Component Five: ▪ Matching of civil works and equipment acquisition activities to required training and related technical assistance	None	Lag < 3 mos.	Lag < 3 mos.	Lag < 3 mos.	Lag < 3 mos.	Lag < 3 mos.	Ongoing	Monitoring by PMU	PMU
▪ Progress on M&E updating	None	On time	On time	On time	On time	On time	Ongoing	Monitoring by PMU	PMU

Annex 4: Detailed Project Description

ROMANIA: HEALTH SECTOR REFORM II

Component 1. Maternity and Neonatal Care

This component will support the Government's program to improve maternity and neonatal services throughout Romania. The program aims to upgrade and improve health services for pregnant women, new-born children and their mothers by: (i) providing access to health services for mothers and newborns according to risk status by means of regional structures for neonatal health care; (ii) developing a hierarchy of hospital unit of obstetrics and gynecology and neonatology specialties with specific competences and activities for each level; (iii) assessing of the obstetrical risk factor and supervision during pregnancy to ensure an appropriate level of skilled assistance; and, (iv) ensuring transport "in utero", in cases of high risk pregnancy to Regional Centers (Level III) with adequate care available for premature and sick newborns, or transport of newborns after birth to an appropriate Regional Center where circumstances warrant, using specialized neonatal transport units.

Maternity and neonatal care would be provided by integrated regional networks. One network includes a level III Regional Center providing care of the critical cases as well as several level II and many level I units. Such a regional network covers a defined geographical area, where a number about of 15,000-20,000 births/year are registered, and where a newborn transport system with the transport duration of maximum 2 hours (from the units of taking over until regional Center) will be organized.

Pregnant women and/or newborns will be treated in the most appropriate level of care that is closest to the patients' residence. If necessary care is not available locally, patients will be transferred to the most appropriate and closest referral center.

Units of gynecology, obstetrics, and neonatology are separated based on their capability according to three levels on three levels: I, II and III. In particular cases "0 level" units will be allowed to operate although they do not meet the minimal criteria for I level. These units would be in secluded areas (for example, the Danube delta or mountain areas), where the nearest I level unit is over 60 kilometers away, and would provide only physiological delivery or obstetrical emergency services when the pregnant woman cannot be transported for medical reasons or weather conditions. Within the framework of Level III units, some may be designated Centers of Excellence.

Level I units are expected to have a minimum of 350 births /year. Delivery assistance would include manual extraction of the placenta and/or manual/surgical instrument control of the uterine cavity, the control of soft tissue injuries and the suture of possible ruptures. Cases with high obstetrical risk would not be admitted to these units, except where it is not possible to transport the woman for medical or weather reasons. Neonatal care would be provided to healthy infants with normal weight or low birth weight without risk factors and gestation greater than 37 weeks. In emergencies, these units would provide resuscitation procedures and stabilization of vital functions for cases that need to be transferred to level II or III units.

Level II units provide all the services of the 1st level units, plus providing assistance for the cases with obstetrical risk, and the capacity of performing surgery one emergency cases. For neonatology, these units will have the capacity to provide medical care for low birth-weight infants with risk-factors; those in need of nutritional rehabilitation and neonatal intensive therapy for premature infant over 1,500 grams or over 32 weeks of age; and respiratory maturated or with transitory distress where an O2 or ventilation in CPAP (Continuous Positive Airway Pressure) system is needed. Transportation of newborns from a Level II level to a Level III unit will be made by the Unit of neonatal transport from Regional Center of 3rd level at the request of 2nd level unit.

The main differences between the units of 2nd and 3rd level include (i) compulsory establishment in the units of 3rd level of some wards for gynecological oncology and/or sterility and/or perinatal medicine; and (ii) existence in the framework of neonatology section of 3rd level a compartment of neonatal intensive therapy and or unit of neonatal transport (for the transfer of newborns with problems from the 1st, 2nd level to 3rd level).

The Level III units would handle all obstetrical and gynecological pathology. In terms of neonatology, Level III units assist newborns from its own maternity as well as those with high risk that have been referred, and newborns from Level I and II units coming in by its neonatal transportation unit. These units will deal with diagnosis and treatment of newborns with severe health problems, intensive therapy, premature infants under 1,500 grams and under 32 weeks, and newborns with respiratory distress which require ventilation, aspiration syndrome, persistence of fetal circulation, pneumothorax, and so on. Newborns with infections or risk of infections would also be treated in Level III facilities.

The component would provide the physical rehabilitation of maternity and neonatal facilities, equipment, technical assistance and training in modern obstetrical, gynecology and neonatal service delivery. There would be 123 Level I, 40 Level II and 20 Level III facilities included in the project.

Equipment will be adapted to each level. All units will be provided with resuscitation modules for emergency cases, basic equipment for assisting deliveries and care of healthy infants or those with minor medical problems. Level II and II units will be provided also with equipment for neonatal intensive care, monitoring of delivery and laboratory. Level III units will also receive equipment for long term monitoring and assessment of visual and hearing function of premature children. Units for newborn care in general or paediatric hospitals will be provided with equipment for basic care, intensive care, surgery and equipment for cardio-vascular investigation and intervention. A detailed assessment of equipment needs was conducted during project preparation.

The project will support technical assistance to strengthen performance monitoring capacity of MOH and introduce quality improvement mechanisms for maternity and neonatal care units. Training will be provided abroad and in Romania, using a training of trainers approach. It will build on the training program developed with Swiss support in

two pilot regions and establish training capacity in at least three other regional training centers.

Training abroad will be provided to about 35 neonatologists, paediatricians, general and cardiovascular surgeons, anaesthesiologists and nurses from level III regional centres and from other specialised units who will become trainers for other professionals working in level III units, neonatal intensive care department from maternities or from surgical departments that provide services for new-borns. The duration of training will be of 3 months for neonatal intensive care professionals and up to 12 months for surgeons and anaesthesiologists from cardiovascular surgery services.

Training in Romania will be provided to about 1000 professionals (neonatologists, paediatricians, obstetricians, anaesthesiologists, surgeons, nurses, technicians). This would cover training needs assessed during project preparation, representing about 60 percent of staff in level 2 and 3 units and 80 percent of staff in level 1 units. The training activities will be performed in level III units for level II unit professionals and in level II units for level I unit professionals. A contractor will be selected on a competitive basis for the coordination and support of training activities.

Component 2. Emergency Care Services

This component will help to develop and implement integrated automated ambulance dispatch capability and upgrade hospital emergency areas. Both interventions are essential to maximizing the impact of the investments that have been made to date, and the effectiveness of the emergency medical services system generally.

Sub-component 2.1: Upgrade Hospital Emergency Areas. The experience in Phase 1 has shown that the other major weakness in the emergency services system is the emergency departments in hospitals. Many departments do not have the minimum requirements for basic trauma or emergency medical care, even in the major regional centers. The objectives of the Emergency Room (ER) sub-component will therefore be to increase the quality of patient care, resulting in increased survival of patient arriving in the ER, through improved equipment, training and proven protocols. A total of 60 hospitals will be equipped, representing the major trauma and emergency receiving centers in the country.

Sub-component 2.2: Integrated Ambulance Dispatch. The objectives of the dispatch sub-component are to: (i) modernize the existing communication system of the Romanian National Public Medical Pre-hospital Emergency Service and (ii) harmonize it with the Central Emergency Call Center - 112 to cover audio and data communication for the county ambulance central dispatcher and the sub-stations or ambulances.

This would create a nation-wide communication network for the MOH, which would include uniform equipment allocation for all the positions held in the counties – including a central location situated in the county capital, plus number of sub-stations according to the covered area in the county – as well as communication equipment for all ambulances and emergency departments.

The proposed system will: (i) improve the accuracy of the initial diagnosis compared to the final, the real one; (ii) optimize the time frame between the emergency request and ambulance departure from the station and decrease the time between the call and the arrival at the case; (iii) enable better allocation of ambulances and proper management of programmed requests – dialysis transports, home release of the hospitalized patients etc. – improving the use of the human physical and decreasing the gasoline consumption; and (iv) ensure proper integration with the other general emergency structures (police, fire brigade etc.) due to the new Central Emergency Call Center -112.

The new system will use communications technology in line with the EU standards for emergency services. This investment will cover the whole country with a uniform, standardized and complete communication system for ambulances, with radio and data transmission. The resulting system will follow and report on all the requests for medical emergency response: (i) between the county ambulance central dispatcher and the sub-stations or ambulances, (ii) between counties equivalent institutions and (iii) towards the headquarters and national statistics centers. A total of 40 regional dispatch centers will be created, with an average of 6 sub-stations per region, and an estimated 400 Type A and B ambulances will be equipped with necessary communications equipment. Appropriate training and technical assistance will also be included.

Component 3. Primary Health Care and Rural Medical Services

The objectives of this component will be: (i) to improve the quality of services of family doctors mainly through new initiative in primary care (multipurpose health centers, group practice, practice association, mobile laboratory, community nurses, home care, ambulatory prescribed drugs) in rural areas and small urban localities; (ii) to increase the access to health services provided from multipurpose health centers by family doctors, ambulatory care specialists, community nurses, home care, social services; and (iii) to better integrate primary care with ambulatory and hospital services, consistent with the National Health Programs.

As a result of the policy recommendations made by the planning TA under the APL1, the MOH has prepared a primary health care strategy based on a consultative process. The strategy, which has been endorsed by the Government, lays out a wide set of measures (e.g. increased resources allocated to the primary health care from 6 percent to 9 percent of the total health insurance funds, financial incentives for the family doctors provided either by the state budget or by the local authorities, attractive new financing mechanisms, support for specialized training, establishment of multipurpose health centers) aiming to improve the quality of primary health care services country wide and to improve the access to these services in remote and rural areas.

The Project will support the implementation of two important activities included in the above mentioned strategy, targeted to the areas where new primary care services are required and where present services are inappropriate to the needs of the population: (i) the establishment of multipurpose health centers (MPHC) and (ii) the provision of financial support to allow the development and implementation of new initiatives of family doctors. The component will establish sub-loan lines that will finance specific sub-projects

designed according to the particular service needs and characteristics of each specific catchment area. The sub-projects will have to include business plans demonstrating their sustainability.

Sub-component 3.1: **Multipurpose Health Centers.** The new concept was identified as one of the key health service development priorities in the planning component of APL 1. MPHCs will aim to respond to the problem of providing relevant, effective and appropriate health services that closely fit the identified health needs of the community being served. The main target would be communities that are geographically isolated or under-served with basic health care.

The service focus will be on primary health care, with a mix of additional services (e.g., emergency care, outpatient specialist services, medico-social care) determined as part of the district health service planning process, taking into account the health service needs and priorities of the communities covered by the center. The financing arrangements and management structure for MPHCs should allow funding from multiple sources (e.g., health insurance, local authorities, and social assistance) and the use of those funds for the priority health service functions required by the community.

Medical services that will be provided will be selected from a wider range of services according to the specific local needs, but the overall framework should be flexible enough to adapt to possible changes in the community needs. The following services will be provided but not limited to: diagnosis, primary care, ambulatory care, medical transportation, day hospitalization, home care and others.

In order to provide the agreed services, who will be entitled to receive selected medical and IT equipment (e.g. biochemical and hematology analyzer, EKG, mobile radiological units, echograph, car, computer, printer, scanner) within a package of an estimated amount of US$110.000 per center.

The project will provide phased support for the development of MPHCs as follows: (i) a first pilot phase with 3 centers in the first year of the project implementation (counties of Galati, Targu Mures and Arges) followed by an interim evaluation and a further extension to 10 other centers in selected counties by the end of 2006, based on assessments and recommendations of the planning TA in APL 1 and on the results of the interim evaluation; and (ii) a second phase covering the other 30 counties (about one center per county) to be finalized by the end of 2008, based on the lessons and adjustments during the pilot phase.

The General Department of Medical Assistance will be in charge of the implementation of the MPHCs sub-component, in close cooperation with District Public Health Directorates, local authorities and local social assistance offices. A Steering Committee (comprising relevant representatives of MOH, MOILA, MOLSSF and HIH) will coordinate the main decisions related to the legal, governance, financing and other major issues relevant for MOHCs.

Sub-component 3.2: Sub-loans for family doctors. The financial support for the improvement of the family doctors practices will allow, according to the Operational Manual, the acquisition of medical equipment, consumables, transport means, IT equipment, etc., as proposed by the applicant family doctors through the sub-projects submitted, under sub-loans administered by a sub-loan service provider selected on a competitive basis. The financial terms of the sub-loan will have to be attractive for the beneficiary, but without introducing distortion in the capital market. The sustainability of this subcomponent will be substantially influenced by including in the future contracts with the NHIH expanded services that can appropriately be provided by family doctors;

A competitive approach for the access to these financing mechanisms will be designed based on criteria related to explicit policy objectives and interventions (e.g. improvement of access in underserved areas, expansion of preventive services, specific initiatives for preventing unnecessary hospitalizations, local administration support, group practice). An Evaluation Committee established within the MOH will evaluate the eligibility of the sub-projects submitted by the family doctors, based on the criteria presented in the OM.

Component 4. National Health Accounts and Planning

This component will support the development of National Health Accounts (NHA) and preparation of proposals for rationalization and service development projects.

For the development of NHA, support would be provided to adapt the internationally validated methodology, propose changes of regulations regarding reporting of financial information in the health sector, perform analysis of existing financial information and surveys, conduct additional surveys, train staff, and prepare, publish and disseminate reports. A working group for NHA development should be established, including representatives of MOH, MoF, National Health Insurance House, National Statistics Institute. The project will finance participation in training, seminars and workshops, investments in IT equipment and software, surveys and studies, local and foreign TA.

The second activity supported by this component will provide to MOH, District Public Health Authorities, health care institutions or local authorities the resources for preparation of projects to be submitted to financing institutions and donors. The project will aim to implement the rationalization strategy and service plans prepared in APL 1 and make use of the capacity for planning developed at local level. This preparatory work will increase the capacity to access and use EU structural funds in the future.

Component 5. Project Management

In the last year of the APL1 implementation, the PMU was reorganized and expanded in order to cope with the increased responsibilities generated by the implementation of the GFATM Grant (US$38 million). Although additional staff dealing with procurement, financial management, monitoring and evaluation and information technology have been recruited, several key (core) staff are still assigned to perform tasks related to both projects. To date, the costs associated to the PMU activities for both projects were supported by the

GFATM. Additional staffing will be put in place, including a project coordinator and staff with clearly defined responsibilities and dedicated fulltime to the Bank-financed project. In this way, the current PMU will continue to exist and implement the two programs under a two pillar structure, one pillar for GFATM and one pillar for the WB/EIB-financed project.

The PMU will provide management and logistical support only to the implementation process, while all technical inputs will come from line departments within the Ministry of Health. During project implementation, the PMU will also engage in extensive capacity building and "technology transfer" in the areas of monitoring and evaluation and project planning and execution, so that by the end of the project, the capacity will exist within the MOH to independently perform these functions. Organizationally, the PMU will continue to be closely tied into the MOH structures, with a formal reporting relationship to the Secretary of State for International Cooperation, and a direct contractual relationship with the Minister of Health.

In order to properly supervise/monitor the implementation of the large number of civil works contracts and the on-site delivery of the medical equipment country-wide, eight Regional Supervisory Units comprising two staff each, will be established as regional extensions of the PMU, located in the premises of the selected Public Health District Authorities. They will report to the PMU Director. Each unit will have a car to allow proper coverage of the supervised region.

In aggregate the PMU structure will comprise 29 persons (staff and consultants): a Project Manager, a Project Technical Coordinator, two Component Coordinators, two Monitoring and Evaluation Coordinators, four Procurement Specialists (two for civil works, one for goods and one for services), a Chief Accountant, an accountant, a secretary, and sixteen Regional Supervisors.(eight for civil works and eight for medical equipment).

The Minister of Health will appoint specialized/technical steering committees for each of the project components, in order to take technical decisions regarding the project implementation. At the level of the Public Health Judet/District Directorates, small teams may be organized as needed, comprising specialized staff who will monitor the implementation of the programs in each judet.

Annex 5: Project Costs

ROMANIA: HEALTH SECTOR REFORM II

	Project Costs by Financiers (US$ million)			
	IBRD	EIB	Government	Total
1. Maternal and Neonatal Care	21.09	81.72	26.16	128.96
2. Emergency Medical Services	43.48	0.00	14.64	58.12
3. Primary Health Care	12.02	0.00	2.02	14.04
4. National Health Accounts and Planning	0.50	0.00	0.14	0.64
5. Project Management	2.91	0.00	1.81	4.72
Total PROJECT COSTS	80.00	81.72	44.77	206.49
Commitment Charges	0.00	0.00	0.16	0.16
Front-end fees	0.00	0.00	0.40	0.40
Total Disbursement	80.00	81.72	45.33	207.05

[1]Identifiable taxes and duties are US$ 42.8 million, and the total project cost, net of taxes, is US$163.7 million.

	Project Costs by Financiers (EUR million)			
	IBRD	EIB	Government	Total
1. Maternal and Neonatal Care	17.21	66.40	21.26	104.87
2. Emergency Medical Services	35.33	0.00	11.90	47.23
3. Primary Health Care	9.77	0.00	1.64	11.41
4. National Health Accounts and Planning	0.41	0.00	0.11	0.52
5. Project Management	2.38	0.00	1.47	3.85
Total PROJECT COSTS	65.10	66.40	36.38	167.88
Commitment Charges	0.00	0.00	0.13	0.13
Front-end fees	0.00	0.00	0.33	0.33
Total Disbursement	65.10	66.40	36.84	168.34

[1]Identifiable taxes and duties are EUR 34.9 million, and the total project cost, net of taxes, is EUR 133.5 million.

Annex 6: Implementation Arrangements

ROMANIA: HEALTH SECTOR REFORM II

The Ministry of Health will have overall responsibility for project implementation. A Project Steering Committee for each component will be established to supervise project implementation. The Ministry will be supported by a Project Management Unit, in charge of overall coordination, planning, management and fiduciary aspects of project implementation. Working groups will be established to advise on implementation of each of the components. In the last year of the APL1 implementation, the PMU was reorganized and expanded in order to cope with the increased responsibilities generated by the implementation of the GFATM Grant. (US$38 million). Although additional staff dealing with procurement, financial management, monitoring and evaluation and information technology have been recruited, several key (core) staff are still assigned to perform tasks related to both projects. To date, the costs associated to the PMU activities for both projects were supported by the GFATM. Additional staffing will be put in place, including a project coordinator and staff with clearly defined responsibilities and dedicated full-time to the Bank financed project. In this way, the current PMU will continue to exist and implement the two programs under a two pillar structure, one pillar for GFATM and one pillar for the WB/EIB financed project.

The PMU will provide management and logistical support only to the implementation process, while all technical inputs will come from line departments within the Ministry of Health. During project implementation, the PMU will also engage in extensive capacity building and "technology transfer" in the areas of monitoring and evaluation and project planning and execution, so that by the end of the project the capacity will exist within the MOH to independently perform these functions. Organizationally, the PMU will continue to be closely tied into the MOH structures, with a formal reporting relationship to the Secretary of State for International Cooperation, and a direct contractual relationship with the Minister.

The EIB will co-finance a substantial proportion of the project costs. World Bank procurement procedures are acceptable for the EIB. From the point of view of loan administration and disbursement, parallel financing of project activities between the World Bank and EIB is regarded as the most suitable financing and disbursement arrangement. However, some flexibility will be guaranteed not to restrict the participation rate of the banks for financing individual packages. From the EIB perspective, there is no constraint regarding the financing rate of each invoice; globally, EIB would commit itself to financing within its usual limits of up to 50 percent of total project investment costs (PIC) or 100 percent of costs eligible under the EIB's rules, whichever is the lesser. It is the EIB's policy to leave the entire responsibility of the procurement procedures to the Borrower (with appropriate technical assistance) and the EIB limits its intervention to ensuring that its funds are used in the most economic, transparent and efficient way possible. The EIB and World Bank have defined with the Romanian counterparts joint technical supervision of project implementation, and from a technical point of view, the no-objections will be given by the IBRD, as well as those financed out of the EIB.

Annex 7: Financial Management and Disbursement Arrangements

ROMANIA: HEALTH SECTOR REFORM II

1. Country Issues.

A Country Financial Accountability Assessment (CFAA) was completed in 2003. The executive summary of the CFAA states, in part:

> *The **overall fiduciary risk** associated with the PFM [Public Financial Management] and financial accountability arrangements of the Romanian government administration is considered to be **moderate,** with the systems for accounting, financial reporting and internal control representing the areas with significant risks and budgeting, cash management and external audit and Parliamentary oversight representing the moderate risks.*

This indicates that particular care is needed in ensuring that potential project risks are identified and mitigated. The Ministry of Health is currently the exception in fully utilizing a program budgeting approach, and also appears to be exceptional in having implemented a ministry-wide fully automated accounting system (SAP). The implications of this in terms of the Bank-financed project are discussed below.

2. Risk Analysis.

A summary risk analysis from the Financial Management Assessment is presented below.

	Risk Rating	***Risk Mitigation Measures***
Inherent Risk (from CFAA)		
Budgeting	M	
Treasury & Cash Management:	M	
Accounting & Financial Reporting	S	
Internal Control & Internal Audit	S	Use external auditor
External Audit & Parliamentary Oversight	M	Use external auditor
Fiduciary considerations - Bank investment lending operations	L	
Overall Inherent Risk	M	
Control Risk		
1. Implementing Entity	N	N/A
2. Funds Flow	N	N/A
3. Staffing	M	N/A
4. Accounting Policies and Procedures	N	N/A
5. Internal Audit	N	N/A
6. External Audit	N	N/A
7. Reporting and Monitoring	N	N/A
8. Information Systems	M	N/A
OVERALL CONTROL RISK	N	N/A

3. Strengths and Weaknesses.

The significant strengths that provide a basis of reliance on the project financial management system include: (i) the experience of PMU and its Chief Accountant of implementing Bank-financed projects and satisfying Bank financial management requirements; and (ii) the unqualified audit reports and positive management letters issued by the project auditors. There are no significant weaknesses.

4. Implementing Entity.

The PMU was established in 1994, and was created specifically to implement all Bank-financed Health projects. It has already established a successful track record in its implementation of the first project and Phase 1 of the Health Sector Reform Project. The PMU is a functional unit of the Ministry of Health (MOH), and is also charged with the implementation of the Global Fund project. Because of the size of APL 2, additional staff have been hired within the PMU, although it is expected that the key FM staff will be retained to work for the Bank-financed project.

5. Funds Flow.

All project funds will flow from the Bank, either via a single Special Account which will be replenished on the basis of SOEs, or by direct payment on the basis of direct payment withdrawal applications.

6. Staffing.

The PMU includes a Director, a project technical coordinator, a finance team comprising a Chief Accountant and a financial coordinator, several Procurement Specialists, and various teams established to implement the various projects' components and sub-components. Several of the procurement staff also have significant financial management experience. The PMU has significant experience implementing Bank-financed projects and has demonstrated that it is fully capable of fulfilling the accounting and reporting needs of the project.

7. Accounting Policies and Procedures.

The accounting books and records are maintained on a cash basis and project financial statements are presented in both Romanian Lei and Euros. The PMU has instituted a set of appropriate accounting procedures and internal controls, including authorization and segregation of duties.

8. Internal Audit.

Internal audit is currently performed by authorized persons within the MOH, according to the legislation currently in force. The internal audit department reports directly to the Minister of Health.

9. External Audit.

No significant issues have arisen in the audits of previous Bank-financed projects implemented by the PMU. Previous and current auditing arrangements and findings are satisfactory to the Bank and it has been agreed to use similar audit arrangements for APL 2. The audit of the project will be conducted by independent private auditors acceptable to the Bank, on terms of reference acceptable to the Bank (revised standard Terms of Reference), and procured by the PMU through the Least-Cost Selection procurement process. The annual audited project financial statements will be provided to the Bank within six months of the end of each fiscal year and also at the closing of the project. A multi-year contract will be pursued to reduce costs, with continuation subject to satisfactory performance. The cost of the audit will be financed from the proceeds of the Loan.

10. Reporting and Monitoring.

The PMU's produces all financial reports and SOEs for the Bank with the project accounting software, Scala, together with Excel. Despite repeated attempts during the Phase 1 Health Sector Reform Project, the Scala software has not been able to produce project management-oriented Financial Monitoring Reports (FMRs), even when the requirements for FMRs were loosened from those for the PMRs.

In addition to the Scala system, all financial transactions are also entered into the Ministry of Health SAP accounting system. While the current approach meets the internal control needs of the Bank, it is proposed that during project implementation an alternative approach be explored, in order to get the MOH system to produce the necessary FMRs, using agreed formats.

11. Information Systems.

As noted above, the Scala software is used. The PMU is awaiting the finalization of the project components before completing the Chart of Accounts and loading the relevant budget data. The Chart of Accounts will be based on the standard Romanian Government Chart, which must be used for entering data into the SAP system.

12. Impact of Procurement Arrangements. See Annex 8.

13. Disbursement Arrangements.

Bank funds will be disbursed under the Bank's traditional procedures including SOEs and direct payments. Supporting documentation for SOEs, including completion reports and certificates, will be retained by the Borrower and made available to the Bank during project supervision. Disbursements for expenditures above the SOE thresholds will be made against presentation of full documentation relating to those expenditures. There is no plan to move to periodic disbursements.

The PMU will open and manage a Special Account in Euro specifically for this project, in a bank acceptable to the Bank, including appropriate protection against set-off, seizure and attachment in the case of a commercial bank. Withdrawal applications for the replenishments of the SA will be sent to the Bank at least every three months, or when the balance of the SA is equal to about half of the initial deposit or the authorized allocation, whichever comes first.

14. ***Action Plan, If Required (Agreed with Borrower).*** None

15. ***Conditions.*** None

16. ***Financial Covenants.***

The PMU will maintain a financial management system acceptable to the Bank. The project financial statements, SOEs and Special Account will be audited by independent auditors acceptable to the Bank and on terms of reference acceptable to the Bank. The annual audited statements and audit report will be provided to the Bank within six months of the end of each fiscal year.

17. ***Supervision Plan.***

During project implementation, the Bank will supervise the project's financial management arrangements through: (i) review of semi-annual project financial management reports and annual audited financial statements and auditor's management letter; and (ii), review the project's financial management and disbursement arrangements (including a sample of SOEs and movements on the Special Account) during the Bank supervision missions. A Bank-accredited FMS will direct this process.

Disbursement of Loan Proceeds

	Category	Amount (Euro)	percent Financed
(1)	Dispatch equipment	13,500,000	100 % of foreign, 80 % local
(2)	Goods (other than dispatch equipment)	40,850,000	100 % of foreign, 80 % local
(3)	Consultant's services	3,520,000	75 % local consultants, 85 % foreign consultants
(4)	Training	1,500,000	100 % foreign, 75 % local
(5)	Sub-loans under Part C.2	4,000,000	100 %
(6)	Works	830,000	80 %
(7)	Operating costs	800,000	45 %
(8)	Unallocated	100,000	
	TOTAL	65,100,000	

The term "operating costs" means incremental operating costs incurred by the PMU on account of Project implementation, including staff salaries (other than Government employees), office supplies, vehicle insurance and fuel and communications costs. The Borrower will finance the recurrent cost of the investments provided through the project.

Annex 8: Procurement Arrangements

ROMANIA: HEALTH SECTOR REFORM II

General

Procurement for the proposed project will be carried out in accordance with the World Bank's "Guidelines: Procurement Under IBRD Loans and IBRD Loans" dated May 2004; and "Guidelines: Selection and Employment of Consultants by World Bank Borrowers" dated May 2004, and the provisions stipulated in the Legal Agreement. Project inputs financed on a co-financing basis by European Investment Bank (EIB) will be procured in accordance with the IBRD Procurement Guidelines and provisions stipulated in the co-financing agreement. For each contract to be financed by the Loan, the different procurement methods or consultant selection methods, the need for pre-qualification, and time frame are agreed between the Borrower and the Bank project team in the Procurement Plan in Table A. The Procurement Plan will be updated at least annually or as required to reflect the actual project implementation needs and improvements in institutional capacity. Other procurement information, including IBRD's review process etc. is presented in Tables B1 and B2.

The project will be financed from the proceeds of a proposed EUR 65.1 million Loan from IBRD, a EUR 66.4 million Loan from EIB and the local expenditure contributions from the Government of Romania (EUR 36.4 million). The total cost of the project is EUR estimated at 167.9 million.

The supervision will be conducted jointly by IBRD and EIB with prior review to be conducted by IBRD for all procurements which require such review. In case the contracts entirely financed by EIB, the final no-objection will be issued by EIB upon receipt of input from IBRD.

1. Procurement of Works: Works procured under this project and financed from the Loan will include works for emergency rooms and works for MHC. Contracts shall be grouped to the extent possible and considering project objectives, in package sizes that would encourage competitive bidding. The following methods of procurement will be followed:

(i) **International Competitive Bidding (ICB):** Procedures may be used for procuring works that meet the criteria set forth in Section II of the Bank guidelines with contracts estimated to cost above €3,000,000 equivalent. In the comparison of bids for works procured through ICB, a domestic preference would not apply. The IBRD Standard Bidding Documents (SBD) for Procurement of Works, revised May 2004, will be used.

~~(ii)~~ **National Competitive Bidding (NCB):** Procedures may be used for procuring works that meet the criteria set forth in paragraph 3.3 and 3.4 of the Bank guidelines with contracts estimated to cost below €3,000,000 equivalent. The ECA regional Standard Bidding Documents (SBD) for NCB Works will be used.

(iii) **Shopping:** This procedure may be used for simple works estimated to cost less than €80,000 per contract. This requires obtaining at least three quotations from contractors, in cases where other competitive methods are not justified on the basis of cost or efficiency. The ECA Regional sample format for shopping "Invitation to Quote" available on the ECA Procurement Web Site will be applied.

2. Procurement of Goods

Goods and related technical services consisting of medical and communication equipment, etc. shall be grouped to the extent possible and considering project objectives, in package sizes that will encourage competitive bidding. The following methods of procurement will be followed:

(iv) **International Competitive Bidding (ICB):** Procedures would be used for procuring goods that meet the criteria set forth in Section II of the Bank guidelines with contracts estimated to cost above €300,000 equivalent. In the comparison of bids for goods procured through ICB, a domestic preference may apply in accordance with the provisions of the Procurement Guidelines. The IBRD Standard Bidding Documents (SBD) for Procurement of Goods, revised May 2004, will be used.

(v) **National Competitive Bidding (NCB):** Procedures may be used for procuring goods that meet the criteria set forth in paragraph 3.3 of the Bank guidelines with contracts estimated to cost above €100,000 equivalent but below €300,000 equivalent. The ECA regional Standard Bidding Documents (SBD) for NCB Goods will be used and the conditions applicable for conducting NCB procurement attached to the Loan Agreement will be followed.

(vi) **Shopping:** This procedure may be used for procurement of off-the-shelf goods estimated to cost less than €80,000 per contract. Shopping, which requires obtaining three quotations, is used here because more competitive methods are not justified on the basis of cost or efficiency. The ECA Regional sample format for shopping "Invitation to Quote" available on the ECA Procurement Web Site will be applied.

(vii) **Direct Contracting (DC):** would be used, on an exceptional basis, and subject to the Bank's prior approval, to procure proprietary equipment and spare parts for the existing equipment.

(viii) **Community Participation in Procurement**: Items to be financed under sub-component C.2 of the Project, may be procured in accordance para 3.17 of Guidelines and OM acceptable to the Bank as described below (see Special Procurement Applications).

3. Selection of Consulting Services

Contracts shall be packaged for consulting services from firms or individuals required under the proposed project. Short lists of consultants for services estimated to cost less than $200,000 equivalent per contract may be composed entirely of national consultants in accordance with the provisions of paragraph 2.7 of the Consultant Guidelines. The following methods of procurement would be followed:

(i) **Quality and Cost-based Selection (QCBS)** procedures may be used for contracting consultant services that meet the criteria set forth in Section II of the Bank guidelines.

(ii) **Consultant Qualification** procedures in accordance with para 3.7 of the Guidelines may be used for contracting most qualified firms with contracts under €200,000.

(iii) **Least Cost Selection** procedures may be used for contracting the financial audit services, design and technical supervision. The shortlist shall consist of firms acceptable for the Bank financed projects.

(iv) **Individual Consultants** may be hired in accordance with Section V of the Guidelines. Individual consultants may be hired for small assignments of short-term duration for consulting services to meet the requirements of the proposed IBRD Loan.

(v) **Single Source (for firms)/sole source (for IC)** procedures may only be used in cases provided in para 3.9-3.10 of the Guidelines and upon prior concurrence of the Bank.

(vi) Expenses for the training (study tours, workshops etc.) under the project related to the project will be covered under training category and disbursed based on SOE.

4. Special Procurement Applications:

Sub-loans (under sub-component 3.2) A competitive approach for the access to these sub-loans will be designed based on criteria related to explicit policy objectives and interventions in rural areas, as well as underserved, isolated or poor areas. The OM will include, *inter alia*, the criteria for selecting sub-loan service providers, the maximum amount of sub-loans, selection criteria for beneficiaries, eligible activities and expenditures, financial mechanisms and procurement procedures to be followed by beneficiaries, and a standard contract to be entered into between the sub-loan service provider and a beneficiary. An Evaluation Committee established within MOH, will evaluate the eligibility of the subprojects submitted by the family doctors, based on the provisions in above-mentioned OM. Given the nature of micro-finance, the procurement of goods and services, including the purchase of medical equipment, consumables, transport means, IT equipment etc, as proposed by the applicant may be procured using community participation in procurement practices following para 3.17 of the Guidelines and procedures described in the

OM to be agreed between the Borrower and the Bank. The amount proposed for the sub-loans is EUR 4 million.

5. Incremental Operating Costs

The operating costs, which planned to be financed by the project, may be procured after approval by the IBRD of the PMU's annual budget for operational expenses.

6. Notification of Business Opportunities

A General Procurement Notice (GPN) shall be published in the UN "Development Business" on -line (UNDBonline) and in the Development Gateway's dgMarket around the period of Loan Negotiation. For ICB goods and works contracts and large-value consultants contracts (more than €200,000), Specific Procurement Notice would be advertised in the Development Business on -line (UNDB online) and in the Development Gateway's dgMarket, Official Gazette of EU for procurements co-financed by EIB and national press, and in the case of NCB, in a major local newspaper (in the national language).

7. Review by the IBRD of Procurement Plan

The Borrower, at appraisal, developed a Procurement Plan for project implementation which provides the basis for the procurement methods. This plan has been agreed between the Borrower and the Project Team as shown in Table A. Procurement of goods, works and services for the project would be carried out in accordance with the agreed procurement plan, which will be updated in agreement with the Project Team annually or as required to reflect the actual project implementation needs and improvements in institutional capacity.

Prior Review

(i) *Goods and works:* Prior review of bidding documents, including review of evaluation, recommendation of award and contract would be conducted for all *ICB and DC for works and goods, first two NCB and first two shopping contracts for goods and works respectively.*

(ii) *Consulting Services*: Requests for Proposal (RFP), short lists, terms of condition of contracts as well as evaluation reports and recommendation for award would be prior reviewed by IBRD for contracts for individual consultants above €50,000 and firms above €100,000. All documents and recommendations involving single source for firms and sole source for individual consultant contracting would be subject to IBRD prior review. Terms of reference for consulting assignments subject to prior review will be reviewed by the Task Team Leader.

After award of contracts, should any material modifications or waiver of terms and conditions of a contract resulting in an increase or decrease above 15 percent of the original amount, IBRD would undertake a prior review of such modifications (including modifications to contracts for consulting services).

8. Custom Duties and Taxes

All custom duties and taxes for goods specifically imported for the project would be financed by the Borrower.

9. Assessment of the agency's capacity to implement procurement

Overall responsibility for the supervision of the procurement function would rest with the Ministry of Health (MOH). The Project Management Unit (PMU) set up in 1992 by the Government of Romania (GoR) under MOH has implemented the Health Services Rehabilitation project, financed by an IBRD loan of US$150 million with a total project cost of US$224 million, and the Phase 1 of the Health Sector Reform Project, financed by an IBRD loan of US$40 million with a total project cost of US$69 million. The PMU's activities are overseen by the Ministry of Health. Its function is to undertake procurement of goods and consulting services/training for the Project. In preparing the Request for Proposals and bidding documents and evaluation of proposals/bids, PMU would be supported by inputs from MOH working groups for different components.

The PMU's procurement is managed by the Director with two procurement specialists under Phase 1, with one specialist trained in Bank's Indian Office and the other specialist trained on the job. An engineer was hired by the PMU in February 2004 under the GFATM Grant and attended procurement training in ILO, Turin in May 2004. The current Procurement Team with three specialists is responsible for ensuring that all procurement under Phase 2 undertaken in conformity with rules stated in the Bank's Procurement Guidelines and the Loan Agreement, with assistance whenever necessary from the technical departments of the MOH.

The bidding documents for design will be prepared by the PMU. The procurement for the consultant services for design will be organized by the PMU on a regional basis. The country will be divided into eight regions, with seven geographical regions containing four to seven counties and the eighth region of Bucharest, which contains ten Level III hospitals.

The procurement of civil works for rehabilitation of maternities will be carried out by the PMU at the county level, except for two cases (Vaslui and Iasi), where the PMU will organize 2 tenders for each county. The supervision of the PMU regarding development and completion of the civil works will be done at the regional level. The PMU will be in permanent contact with its regional level units, which will support the implementation of the program. Each unit will contain 2 people, one for monitoring civil works, and the other for monitoring the delivery and use of the goods.

Most of the issues/ risks concerning the procurement for implementation of the project have been identified. It was proposed by the Bank team that additional staffing and a revised organizational structure may be needed to deal with the implementation of both the GFATM Grant (US$38 million), and the expanded Phase 2 of the Health Sector Reform Project. It is appropriate to establish a separate PMU to coordinate project implementation including procurement, which was proposed to MOH to take place between negotiations and effectiveness, and key staff most familiar with Bank-financed project implementation could possibly be retained in the PMU.

RFPs and bidding documents for the first year of project implementation will be prepared before loan effectiveness. This report indicates "High" risk based on the country environment assessed by Country Procurement Assessment Report (CPAR) completed in 2000.

Based on assessment of the capacity for procurement administration of the project, the following Action Plan to strengthen the procurement administration capacity of the MOH and PMU is recommended:

i. The PMU Director and procurement specialists would be given the opportunity to receive updated procurement training on Bank's new procurement guidelines and courses on procurement of civil works at the regional workshops run by the World Bank or at ILO in Turin to be financed under the APL 2 loan.
ii. Initiating a Project Launch Workshop in early 2005 before the loan effectiveness, as part of the project implementation/capacity building initiatives for MOH, especially in procurement.
iii. The project would be subject to the intensified supervision by the Bank. During the first year of project implementation, there would be at least two supervisions.
iv. Periodic ex-post review by the Bank of 1 in 5 contracts during the supervision missions.

Overall Procurement Risk Assessment: High

Table A. Procurement arrangement involving International competitive bidding

1 Comp.	2 Contract Description	3 Estimated Cost (USD)	4 Estimated Cost (EUR)	5 Proc. Method	6 Expected Bid-Opening Date	7 Comments
Component 1: Mother and Child						
	Goods.					
1	Therapy and Diagnostics Equipment for Neonatology	6,721,600	5,461,829	ICB	July 2005	
2	Equipment for new-born care	7,730,600	6,281,721	ICB	July 2005	
3	Anesthesia, monitoring and ICU equipment	11,089,000	9,010,685	ICB	Sept 2005	
4	Specialized beds, stretchers and interventional tables	2,775,500	2,255,312	ICB	Jan 2006	
5	Equipment for resuscitation and respiratory support	3,275,900	2,661,927	ICB	Sept 2005	
6	Other equipment for intensive care and diagnostic	3,575,000	2,904,969	ICB	Nov 2005	
7	Laboratory equipment	3,740,000	3,039,044	ICB	Nov 2005	
8	X-RAY and imagistic equipment	4,720,000	3,835,372	ICB	Jan 2006	
10	Emergency neonatology / OG equipment	123,000	99,947	ICB	Feb 2006	
11	Instruments for delivery and caesarean section	750,000	609,434	ICB	Feb 2006	
12	Sterilizers	1,038,000	843,457	ICB	Nov 2005	
	Subtotal	**47,538,600**	**38,628,555**			
Component 2 – Emergency Medical Services						
	2.1 Emergency Room of ICU					
	Goods					
17	Transport and resuscitation equipment	5,407,500	4,394,019	ICB	Apr 2006	
18	Airway management	4,490,922	3,649,227	ICB	Apr 2006	
19	Emergency care monitoring and fluid administration	8,318,656	6,759,563	ICB	Apr 2006	
20	Examination equipment	4,392,148	3,568,966	ICB	May 2006	
21	Imaging equipment	3,635,371	2,954,025	ICB	May 2006	
	Subtotal	**26,244,596**	**21,325,800**			
	2.2 EMS communication system					
	Goods					
	Radio stations	1,496,845	1,216,304	ICB	Oct 2005	Procurement method and packages to be established after analysis of documents presented by specialists
	Printer and comm..-printer interface	600,000	487,547	ICB	Oct 2005	
	Radio stations for ambulances	2,600,000	2,112,705	ICB	Oct 2005	
	AVL-GPS controller for ambulances	938,000	762,199	ICB	Noiv2005	
	Portable communication units	13,608,130	4,912,038	ICB	Sept 2005	
	Equipment for dispatches	3,802,000	3,089,424	ICB	Feb 2006	
	Technical integration services	1,072,000	871,084	ICB	Feb 2006	
	Subtotal	**16,553,845**	**13,451,302**			

Component 3: Primary Health Care and Rural Medical Services

Goods.					
Medical equipment for MPHCs	4,707,999	3,825,620	ICB	May 2006	
Furniture	407,997	331,530	ICB	April 2006	
Services.					
Sub-loan administrator	750,000	609,434	QCBS	Aug 2005	
Sub-loans	5,000,000	4,062,894	AP		over Loan implementation period
Subtotal	**10,865,997**	**8,829,478**			
TOTAL	**100,453,038**	**81,626,001**			

This procurement plan includes only the net costs. It does not include 19 percent VAT, 10 percent customs duties for equipment and 15 percent for communication systems, or 0,5 percent customs commission.

Table B1: Thresholds for Procurement Methods and Prior Review

Expenditure Category	Procurement Method Threshold (EUR)	Prior-Review Threshold (EUR)
1. Works	ICB over 3,000,000 NCB below 3,000,000 Shopping below 80,000	All ICB, First two NCBs and all DC
2. Goods	ICB over 300,000 NCB over 100,000 Shopping below 80,000	All ICB and DC First two NCBs and shopping and all DC
3. Services		Firms above 100,000 IC above 50,000 All SS contracts.

Table B2: Procurement and Technical Assistance Requirements

Ex-post Review	Section 1: Ex-post review mechanism: Review carried out in accordance with Para. 4 of Appendix 1 of the Bank's Guidelines and reviews during supervision missions. Frequency of procurement supervision missions proposed: One every six months and once a year during subsequent years (includes special procurement supervision for post-review).
	Section 2: Training, Information and Development on Procurement
	Estimated date of Project Launch Workshop: March 2005 Estimated date of publication of General Procurement Notice: December 2004 Indicate if there is procurement subject to mandatory SPN in Development Business: Yes. Domestic Preference for Goods: Yes Domestic Preference for Works, if applicable: No. Retroactive financing: No Advance procurement: No.
	Explain briefly the Procurement Monitoring System: All procurement related documentation that requires IBRD's prior review would be cleared by Procurement Specialists or a PAS and relevant technical staff. Packages above mandatory review thresholds would be reviewed by the RPA. The Borrower would maintain complete procurement files, especially for the contracts subject to post-review, which would be reviewed by IBRD's supervision missions. The Procurement Plan would be updated annually. Procurement information would be recorded by the PMU using Client Connection. The PMU will submit PMRs on semiannual basis starting from July 2005. This information would include: revised cost estimates for the different contracts; revised timing of procurement actions, including advertising, bidding, contract award, and completion time for individual contracts. A Management Information System (MIS), with a procurement module would help the MES monitor all procurement information. Co-financing: Yes.
	Section 3: Procurement Staffing
	Indicate name of Procurement Staff or Bank's staff part of Task Team responsible for the procurement in the Project: Name: Yingwei Wu Ext: 35291 Explain briefly the expected role of the Field Office in Procurement: N.A.

Annex 9: Economic and Financial Analysis

ROMANIA: HEALTH SECTOR REFORM II

Macroeconomic and Sector Background

Although the performance of the Romanian economy during transition has been mixed, macro-economic stability and growth rates have improved in recent years, and the government has strived to support these positive developments with structural and institutional reforms in the public sector. The reforms are expected to help alleviate poverty through sustained economic growth, and to improve the delivery of public services, particularly with regard to public finance management, and key social and infrastructure services. Real GDP growth has been around 5 percent in 2002 and 2003, and CPI inflation has fallen from very high levels in the mid 1990s to 14.1 percent in 2003. The Romanian health care system is characterized by the shift from a centrally, government-financed system to a more decentralized, social insurance based system in the late 1990s. A compulsory health insurance fund was established, financed from earmarked salary-based contributions and contracting services from public and private providers with a view to increase the resource base in the health sector. However, public health expenditure as percentage of GDP is comparatively low and was 4.1 percent in 2003. Total government health expenditure amounted to 77,044,250 million lei, or US$2,320 million in 2003. Of this amount, around 14 percent was allocated to the state health budget, 1.1 percent to local health budgets, 78.8 percent to the Health Insurance Fund and 5.7 percent to external loans and credits.

Economic Analysis

This annex presents the summary results of the cost-benefit analysis of the Romania Health Sector Reform Project, based upon the project's costs and the measurable economic benefits that would eventually result from the successful implementation of the proposed program. The project will support the Romanian Health Sector Reform Program through structural improvements and investment in the healthcare system. In addition to the project costs of US$206.5 (€167.9) million, the analysis includes costs of the capital and recurrent expenditure related to improving access to primary health care services, strengthening emergency services, and restructuring the hospital network of maternities and neonatology units. In summary, the project would yield a present value of net benefits, after investment and recurrent costs, of over US$109 (€88.8) million and produce an internal rate of return (IRR) of 30 percent.

Assumptions

The following parameters are considered relevant in estimating the economic benefits of the proposed project: the length of the project horizon and the time to impact the health of the population, the size of the target population, the existing patterns of morbidity and mortality, the number of years of productive life added as a result of the percentage decrease in mortality, and the existing cost structure in the health sector. Given the medium-to-long-term effect of the changes, the estimates presented in terms of reduced morbidity, which assume a project horizon of only 10 years, are conservative. The analysis of the Romania Health Reform Project uses the following assumptions to measure the direct and indirect benefits:

Component A:

(i) maternal mortality would be reduced by 15 percent;
(ii) neonatal mortality would be reduced by 20 percent;
(iii) the number of low birth weight babies would be reduced by 20 percent
(iv) the number of Caesarean sections would decline by 15 percent
(v) target population coverage would be 80 percent

Component B

(vi) mortality from traffic accidents, injury and poisoning, ischaemic heart disease and other external causes would be reduced by 10 percent;
(vii) target population coverage would be 50 percent

Component C

(viii) a 10 percent reduction over time in hospital discharges for infectious diseases;
(ix) a 15 percent reduction in cardiovascular discharges;
(x) infant mortality would be reduced by 20 percent;
(xi) target population coverage would be 20 percent

The analysis uses a discount rate of 10 percent for all components. In the following sections, these assumptions will be used evaluate the benefits of the project and to assess, from an economic perspective, the impact of the project on public finances.

Summary of Costs and Benefits

The cost-benefit analysis distributes the benefits over a time horizon of 10 years by the three major project components: benefits accruing from the Maternal and Child Health Component, the Emergency Medical Services Restructuring Component and the Primary Health Care Component. The benefits from Component 1 are the expected benefits accruable to the project from a reduction in the number of maternal and infant deaths, the average length of stay following deliveries, the number of Caesarean sections, and low birth weight babies. For Component 2, the analysis assumes a reduction in the number of deaths resulting from accidents, injury and poisoning, ischaemic heart disease and other external factors. In the context of Component 3, strengthening rural primary health care would be expected to reduce hospital stays, eliminate unnecessary admissions, reduce consultations and eventually yield savings from restructuring and downsizing of hospital facilities. Direct benefits result from a reduction in the costs of provision of services, particularly the number of hospital beds, and indirect benefits are related to the potential life years saved by the project and the economic and financial value of increasing productivity. The cost-benefit analysis assumes that the project-related changes in the health care system will target up to 17.8 million people, equivalent to 80 percent of Romania's population under Component 1, around 50 percent for component 2, and around 50 percent, or 4.4 million, of the population for Component 3, and that a ten year period is required to reflect the flow of costs and benefits.

The project will shift healthcare provision from expensive hospitals to more efficient and higher quality primary care centers. This change will save over 2.5 million unnecessary bed days over 10 years, and produce savings in monetary terms of up to US$7.7 million per year once the

expected benefits become fully effective. The restructuring that will subsequently follow the strengthening of the primary health care system will allow the Ministry of Health and Judet Health Authorities to consolidate hospitals and polyclinics in support of the recently adopted hospital rationalization strategy, if the restructuring program is executed as planned. Furthermore, the project will establish structures for maternal and neonatal health care, that will enable the provision of preventive and curative services at the appropriate level of care, improve monitoring, screening and early action to help reduce morbidity and mortality of mothers and children.

In terms of indirect benefits, it is estimated that the project will potentially save more than 4,700 lives as a result of applying the aforementioned assumptions to the pattern of mortality in the country. The reduction in mortality is taken as the base line assumption to calculate the indirect benefits of the project. The estimates of reduced mortality are based on conservative estimates based on historical trends in Romania and international literature on cost-effectiveness. To calculate the indirect benefits, the discounted life years saved attributable to these reductions are then converted to monetary terms by using estimates of the discounted life time earnings lost from each death, as reflected by the use of average wage levels, adjusted for labor market participation, and the number of years of life lost for each death. The following tables summarize the results of the analysis for each of the components.

Table 1: Summary of Estimated Costs and Benefits
(US$)

Year	Total Project Costs	Benefits MCH	Benefits EMS	Benefits PHC	Total Benefits	Net Benefits
1	29,651,688	0	0	0	0	(29,651,688)
2	71,974,148	0	0	0	0	(71,974,148)
3	41,430,253	13,287,195	14,040,792	3,525,845	30,853,831	(10,576,422)
4	21,662,146	16,311,515	24,247,598	6,666,180	47,225,293	25,563,147
5	2,040,952	20,564,152	50,220,497	10,073,165	80,857,813	78,816,861
6	21,393,716	20,572,489	51,976,998	13,101,372	85,650,859	64,257,143
7	22,385,245	20,580,965	53,762,905	13,354,111	87,697,980	65,312,735
8	38,382,088	20,589,571	55,576,145	13,610,717	89,776,433	51,394,345
9	38,371,107	20,598,139	57,381,417	13,866,196	91,845,753	53,474,645
10	38,373,332	20,606,743	59,194,104	14,122,724	93,923,571	55,550,239
TOTALS	325,664,675	153,110,769	366,400,456	88,320,308	607,831,533	282,166,858
Net Present Value (10 percent)	$297,687,300	$82,352,094	$188,305,893	$45,379,948	$316,037,934	$109,872,549
Net Present Value (5 percent)	$254,875,886	$110,852,398	$259,365,666	$62,510,260	$432,728,324	$177,852,437
					IRR	**30 percent**

As shown in the table, and depending on the discount rate used, benefits outnumber investments up to nearly two to one. Over ten years, the net present value of the project using a discount rate of 10 percent would yield net benefits of US$109 (€88.8) million. Using a discount rate of 5 percent these benefits would rise to US$177 million. The project is expected to generate annual savings to the system that outstrip the investment cost after year 3 of implementation, thereby paying for them. The internal rate of return (IRR) for the project is estimated at 30 percent, reflecting the high benefits relative to project costs. This ratio can be used to demonstrate the value of this project relative to other projects in other sectors; any number lower than the discount rate would imply that the project should not be carried out.

In terms of the costs of implementation, the analysis considers three basic elements: (i) the investment costs of the World Bank-financed project; and (ii) the recurrent costs financed by the Government of Romania during project implementation, and (iii) recurrent and investment costs to replace equipment after the end of the project (recurrent costs are assumed to be equal to 5 percent of the investment in equipment adjusted for inflation to cover depreciation, operation and maintenance). Investment and recurrent costs after the end of the project will continue to be financed by the Government of Romania.

While the above results are conservative, it is important to test the robustness of the results with regard to potential delays or reductions in benefits. This is done through the use of sensitivity analysis assuming delays of 2 and 4 years, as well as a reduction in benefits of 20 percent and 40 percent. The following table summarizes the results of the sensitivity analysis.

Table 2: Summary of Sensitivity Analysis

Type of Sensitivity Analysis	NPV (US$)		IRR
Discount rate	10 percent	5 percent	percent
Base case	$109,872,549	$177,852,437	29.6
20 percent reduction in benefits	$46,664,962	$91,306,773	19.4
40 percent reduction in benefits	($16,542,625)	$4,761,108	5.9
2 year delay	$29,326,458	$51,025,055	8.9
4 year delay	($37,288,780)	$17,439,233	6.2

The previous table shows the effect of delays and lower than expected benefits on the NPV and IRR. Overall, the project would remain justifiable even assuming a 4 year delay in project benefits or a 40 percent reduction in the benefits received, assuming the traditional parameters which dictate that annual rate of return earned should be greater than or equal to the discount rate of the project, to maintain an efficient allocation of Bank resources. The same would apply for a reduction of up to 75 percent of the expected benefits of the Emergency components, or if no benefits would accrue from the Maternal and Child Health and Primary Health Care Components. The high IRR also underscores the cost-effective nature of the program.

Fiscal Impact and Sustainability

The economic analysis assumes that hospital consolidation would free up substantial resources from the Ministry of Health budget in the later years of project implementation, and after

implementation ends, that can be spent on other forms of care. The assumptions are that a substantial reduction in number of bed-days would take place through the more efficient delivery of care at the primary health care level, and more focused maternal and neonatal interventions at the appropriate level of care. According to the calculations based on the above assumptions, total direct savings over the 10 year period would be almost US$ 53 million.

The impact of increasing spending on primary care, maternal and neonatal health services and emergency services would also produce substantial additional indirect benefits for Romania. In addition, the sector's reorganization would allow for the improvement in the quality of care at the hospital level. However, the recurrent costs associated with sustaining the investments, providing adequate supplies and a salary structure providing incentives for physicians, nurses and other staff to guarantee the effective implementation can only be financed through restructuring. A failure or delay to restructure would potentially have negative effects on the budget of the MOH and the Judets as the investments would have been made and the savings would not be present.

Taking into account the necessity to provide adequate resources for recurrent costs and replacement of equipment over a horizon of 20 years, the project is likely to have a negative net impact on the health budget. This results from the high level of indirect benefits with no immediate fiscal impact on the health sector as such. However, it is expected that the positive impact and leverage resulting from a reduction of morbidity and mortality, and increased labour market participation, in addition to general economic growth, will have a highly positive impact on overall government revenue through increased tax and social insurance collections. Furthermore, overall project costs as a percentage of public health expenditure are estimated at between 0.7 percent and 1.8 percent of the total public health budget, well below the present level of external financing of 5.7 percent. It is also important to note, that the project is not expected to contribute to an overall decrease in the health budget, and that savings made through the project should remain in the health sector. In essence, savings made through restructuring hospitals should be reallocated to the primary level.

The project will improve overall allocative efficiency, among others through the introduction of National Health Accounts and the application of District Health Plans introduced during the first phase of the Health APL, so that future spending will improve value for money in the sector. At the same time, the project will be potentially fiscally positive as restructuring will reduce future government liability for infrastructure, salaries and pensions; and improve future government tax revenues as a result of better productivity, reduced premature morbidity and mortality.

In terms of the project's sustainability, all indications point to a relatively low burden of recurrent spending on the MOH and central government budget, assuming restructuring. The model assumes that: (i) recurrent expenditures for operation and maintenance of approximately 5 percent of the investment amount per year occur after project implementation, (ii) replacement of equipment starts from year 8 after project implementation, and it is assumed that the equipment will be replaced in a phased approach over 10 years, (ii) for financing the usual IBRD loan terms apply (front-end fee and commitment fee plus repayment); (iii) MOH spending grows in line with GDP per annum; and (iv) direct savings are estimated based on a reduction in the number of

hospital stays resulting from reorganization of services and restructuring. The results of the model are shown in the following table.

Table 3: Financial Impact of Project Costs on the Budget
(US$)

Year	Project Costs + Government Contribution	Financing Costs*	Total Costs	Total Public Health Expenditure	Costs as a percent of Public Health Expenditures	Direct Savings	Direct Savings as percent of Total Public Health Expenditures	Net Impact on the Health Budget
1	29,226,462	425,226	29,651,688	2,320,605,056	1.28 %	0	0.00 %	(29,651,688)
2	71,920,220	53,928	71,974,148	2,436,635,309	2.95 %	0	0.00 %	(71,974,148)
3	41,365,775	64,478	41,430,253	2,558,467,074	1.62 %	2,855,081	0.11 %	(38,575,172)
4	21,632,958	29,188	21,662,146	2,686,390,428	0.81 %	4,719,105	0.18 %	(16,943,041)
5	2,040,952	0	2,040,952	2,820,709,949	0.07 %	6,726,539	0.24 %	4,685,587
6	3,061,428	18,332,288	21,393,716	2,961,745,447	0.72 %	7,729,393	0.26 %	(13,664,323)
7	4,592,142	17,793,103	22,385,245	3,109,832,719	0.72 %	7,729,393	0.25 %	(14,655,852)
8	21,128,170	17,253,918	38,382,088	3,265,324,355	1.18 %	7,729,393	0.24 %	(30,652,695)
9	21,656,374	16,714,733	38,371,107	3,395,937,329	1.13 %	7,729,393	0.23 %	(30,641,715)
10	22,197,784	16,175,548	38,373,332	3,531,774,822	1.09 %	7,729,393	0.22 %	(30,643,939)
15	25,114,755	13,479,623	38,594,378	4,296,944,088	0.90 %	7,729,393	0.18 %	(30,864,985)
20	28,415,040	10,783,699	39,198,738	5,078,530,388	0.77 %	7,729,393	0.15 %	(31,469,346)
Total	**493,729,763**	**218,942,721**	**712,672,484**	**72,894,364,362**		**130,241,614**		**(582,430,870)**
NPV 10 %	**224,051,017**	**73,636,283**	**297,687,300**	**27,310,782,174**		**46,049,126**		**-251,638,175**
NPV 5 %	**315,279,781**	**122,888,209**	**438,167,990**	**42,502,527,792**		**74,480,257**		**-363,687,733**

*IBRD Credit terms apply
Note: It is assumed that the share of health expenditures in GDP will remain constant over the next ten years.

For the active years of the project, the impact of project costs on the health budget is between 0.8 and 2.95 percent of the total public health budget. After the end of the project, the burden of repayment, recurrent costs and replacement investment on the budget decreases to 0.7-1.18 percent per year.

In summary, the Romania Health Sector Reform Project will produce substantial savings for the sector. These savings would be available to be spent on the maintenance of the investments done in primary care, maternal and neonatal care and emergency care through the project and on pharmaceuticals, medical supply and staff incentives to improve the quality of the system. In addition, high indirect benefits will support restructuring in the health sector through improvements in revenue collection and hence the overall fiscal situation. The restructuring process, and the subsequent improvement in allocative and technical efficiency in the sector, will yield significant net benefits for the sector and improve value for money.

Annex 10: Safeguard Policy Issues

ROMANIA: HEALTH SECTOR REFORM II

Environmental Assessment

The project will support the rehabilitation of 152 maternities and 7 Emergency Services Units of Pediatric hospitals, as well as 40 emergency reception areas throughout Romania. The main physical investments for the proposed project are minor rehabilitation of existing maternity hospitals and hospital units, and refurbishment and equipping rehabilitated units with medical equipment, which will also be provided by the project. The project will also provide medical equipment to selected primary health care facilities and hospital emergency reception areas.

The immediate impact on the environment from the envisaged small scale rehabilitation works will be limited. Potential adverse environmental impacts are summarized below and are restricted in scope and severity:

- Dust and noise due to demolition and construction;
- Disposal of construction wastes;
- Risk for inadequate handling of hazardous wastewater, waste gases and
- Spillage of hazardous material during operation of the building;
- Disposal of expired pharmaceuticals; and
- Risk from inadequate handling of medical waste.

These risks can be effectively anticipated in advance of project implementation and addressed by direct mitigation activities in the design, planning and construction supervision process as well as during the operation of the facilities. The project is classified under the Environmental Category B in accordance with World Bank operational policies and requires the preparation of an Environmental Management Plan (EMP) which has now been completed. No major environmental impacts are anticipated under the proposed program given the relatively small size of most of the investments. These investments are expected to be environmentally beneficial, non of the units to be financed is expected to have any large scale, significant and/or irreversible impacts. No new structures of works of significant size are envisaged under the project. The potential negative environmental impacts are expected to be localized or able to be mitigated during the implantation stage.

Mitigation measures

Existing environmental regulations in Romania provide for mandatory control and supervision of construction works. Contracts and bill of quantities will include clauses for appropriate disposal of unacceptable construction material and disposal of construction waste. Procurement documents will specify that no environmentally unacceptable materials will be used. Bidding documents will include rehabilitation of adequate sanitary facilities, including appropriate disposal of wastewater and sewerage. Specific environmental management guidelines will be made an integral part of the civil works contracts.

Institutional and Implementation Arrangements

An Environmental Specialist will be identified within the General Directorate of Public Health and Sanitary State Inspection that will be responsible for coordination and supervision of the environmental plans and risk mitigation measures undertaken in the project. The Specialist will work in close coordination with regional project coordination staff and the PMU and will:

a) coordinate environmental training for staff, designers and local contractors;
b) disseminate existing environmental management guidelines and develop guidelines in relation to issues not covered by the existing regulations, in line with EU standards for implementation, monitoring and evaluation of mitigation measures;
c) ensure contracting for construction and supply of equipment includes reference to appropriate guidelines and standards; and
d) conduct periodic site visits to inspect and approve plans and monitor compliance.

The environmental issues including mitigation measures will be supervised periodically by the Bank, the MOH, the General Directorate of Public Health Services and Sanitary State Inspection, and the District Public Health Directorates.

Site Specific Environmental Screening and Review

As a part of the EMP, all project supported activities for rehabilitation of the maternities will be subjected to a site-specific environmental screening and review process, according to provisions of the Order of the Minister of Heath No. 219/2002. The Local authorities are obliged according to the law to submit an Environmental Approval for the civil works. This process would minimize site-specific environmental impacts and would use a standardized appraisal format that includes, but is not limited to, review of:

a) current environmental problems at the sites (soil erosion, water supply contamination, etc.);
b) potential environmental impacts, if any, due to the project (disposal waste from construction, medical waste handling and disposal, construction noise and dust, etc); and
c) potential requirements, if any, for temporary relocation of services for patients and location of patients and clinical staff during the construction activities.

ENVIRONMENTAL MANAGEMENT PLAN

The Environmental Management Plan (EMP) has been prepared in order to integrate environmental concerns into the design and implementation of the proposed project. The EMP will support:

(a) inclusion of EMP follow-up procedures in the operational processes of the General Directorate of Public Health and Sanitary State Inspection from the MOH and also of the County Authority of Public Health;
(b) highlighting the EMP follow-up responsibility in the job description of the MOH inspectorate staff;

(c) training of designated staff from the health centers participating in the project as well as from the General Directorate of Public Health and State Inspection from the MOH and also from the County Authority in project implementation;
(d) site-specific environmental screening concerning all project supported activities for the rehabilitation of the maternities;
(e) monitoring and evaluation of mitigation measures identified in the site-specific reviews; and
(f) development of Environmental Guidelines for ecological planning and design of healthcare facilities and for waste handling (including demolition and construction debris and medical waste).

The full EMP is available at the Info Shop.

EMP Cost Estimate and Time Schedule

The cost of the EMP implementation is covered in the project components as an integrated part of the capacity building and training, project preparation, design and construction supervision. The cost of respective staff is included in the Project Management Component. The training of staff and the preparation of procedures and standardized appraisal formats for the site-specific environmental screening and review process will be included in the PIU Operation Manual.

Annex 11: Project Preparation and Supervision

ROMANIA: HEALTH SECTOR REFORM II

	Planned	Actual
PCN review	02/18/2004	02/18/2004
Initial PID to PIC	03/03/2004	03/03/2004
Initial ISDS to PIC	03/03/2004	03/04/2004
Appraisal	10/18/2004	10/18/2004
Negotiations	10/25/2004	10/26/2004
Board/RVP approval	12/16/2004	
Planned date of effectiveness	05/31/2005	
Planned date of mid-term review	12/31/2007	
Planned closing date	12/31/2009	

Key institutions responsible for preparation of the project:

Ministry of Health, PMU
Dr. Carmen Angelutha, Director, Project Management Unit
Dr. Alin Stanescu, Advisor to Minister of Health

Bank staff and consultants who worked on the project included:

Name	Title	Unit
Dominic S. Haazen	Sr. Health Specialist, Task Team Leader (appraisal)	ECSHD
Silviu Calin Radulescu	Sr. Health Specialist, Task Team Leader (preparation)	ECSHD
Richard Florescu	Sr. Operations Officer	ECSHD
Dorothee B. Eckertz	Health Specialist	ECSHD
Cem Mete	Human Dev. Economist	ECSHD
Yingwei Wu	Procurement Specialist	ECSPS
Vladislav Krasikov	Procurement Specialist	ECSPS
Jennifer Manghinang	Program Assistant	ECSHD
Viviana Mangiaterra	Peer Reviewer	HDNCY
Michael Borowitz	Peer Reviewer	EASHD
Irina L. Kichigina	Sr. Counsel	LEGEC
Nicholay Chistyakov	Sr. Finance Officer	LOAG1
George Moldoveanu	Team Assistant	ECCRO
Crisitina Zirimis	Team Assistant	ECCRO

Bank funds expended to date on project preparation:

1. Bank resources: $156,355
2. Trust funds: PHRD Grant $521,000
3. Total: $677,355

Estimated Approval and Supervision costs:

1. Remaining costs to approval: $50,000
2. Estimated annual supervision cost: $90,000

Annex 12: Documents in the Project File

ROMANIA: HEALTH SECTOR REFORM II

Project Concept Note, February 2004

Comments on the Project Concept Note received from the Peer Reviewers, February 2004

Social Review of the PCN from ECSSD, February 2004

Quality Enhancement Review (QER) Final Report, August 4, 2004

Back-to-Office Report of Romania (RO) Health Sector Reform Project (HSRP) APL II, November 25, 2003

Back-to-Office Report of RO HSRP APL II, March 2, 2004

Back-to-Office Report of RO HSRP APL II, June 23, 2004

Aide-Memoire Preparation Mission of RO HSRP APL II, October 13-17, 2003

Aide-Memoire Preparation Mission of RO HSRP APL II, February 11-20, 2004

Aide-Memoire Preparation Mission of RO HSRP APL II, March 10-14, 2004

Aide-Memoire Preparation Mission of RO HSRP APL II, May 17-28, 2004

National Public Health Strategy, document prepared by the Ministry of Health by the Center for Health Policies and Services from a World Bank Loan, June 2004

Romanian Government Decision No. 534 for the Approval of the Strategy regarding the Rehabilitation and Reorganization of the Specialty Hospital Medical Assistance in Obstetrics and Gynecology and Neonatology in RO, for the 2002-2004 period, May 30, 2002

Cost-Benefit Analysis of Telecommunication Services Used by Pre-Hospital Emergency Medical Services in the Seven REMSSY III-Program Countries, Copyright CPSS 2004

Ministry of Health and Family - DECREE No. 910/2002, November 18 Concerning the Hierarchical Parting Criteria for Obstetrics and Gynecology and Neonatology Specialty Hospital Departments

Social Assessment, Cem Mete, ECSHD, July, 2004

Evaluation of the Obstetrics/New Born Sections Departments, Ministry of Health, October 2004

Summarized Evaluation Report on the Telecommunications Services Used by the Pre-Hospital Emergency Medical Services in the Seven Counties Operating the REMSSY III Program, Health-Care Policies and Services Center, May 17, 2004

Annex 13: Statement of Loans and Credits

ROMANIA: HEALTH SECTOR REFORM II

			Original Amount in US$ Millions						Difference between expected and actual disbursements	
Project ID	FY	Purpose	IBRD	IDA	SF	GEF	Cancel.	Undisb.	Orig.	Frm. Rev'd
P008791	2005	PAL	150.00	0.00	0.00	0.00	0.00	152.06	0.00	0.00
P075163	2004	HAZ MITIG	150.00	0.00	0.00	0.00	0.00	150.00	0.00	0.00
P043881	2004	IRRIG REHAB	80.00	0.00	0.00	0.00	0.00	79.85	1.65	0.00
P067367	2003	FOREST DEVT	25.00	0.00	0.00	0.00	0.00	24.96	2.86	0.00
P068062	2003	ENERGY EFF (GEF)	0.00	0.00	0.00	10.00	0.00	8.53	7.15	0.00
P069679	2003	PPIBL	18.60	0.00	0.00	0.00	0.00	17.80	-0.80	0.00
P073967	2003	RURAL EDUC	60.00	0.00	0.00	0.00	0.00	58.06	4.27	0.00
P081406	2003	ELEC MARKET	82.00	0.00	0.00	0.00	0.00	87.68	-1.96	0.00
P066065	2002	AG POLLUTION CONTROL (GEF)	0.00	0.00	0.00	5.15	0.00	2.65	0.70	0.00
P068808	2002	SDF 2 (APL #2)	20.00	0.00	0.00	0.00	0.00	11.33	-8.67	0.58
P057960	2002	RURAL DEV (APL #1)	40.00	0.00	0.00	0.00	0.00	35.72	8.22	0.00
P008783	2001	SOC SECT DEV (SSD)	50.00	0.00	0.00	0.00	0.00	44.42	34.66	0.00
P056891	2001	RURAL FIN (APL #1)	80.00	0.00	0.00	0.00	0.00	69.43	39.53	-3.57
P043882	2000	AGR SUPPORT SERVS	11.00	0.00	0.00	0.00	0.00	4.36	4.36	-0.10
P056337	2000	MINE CLOSURE	44.50	0.00	0.00	0.00	0.00	22.92	22.92	6.42
P044176	1999	BIODIV CONSV MGMT (GEF)	0.00	0.00	0.00	5.50	0.00	1.75	1.75	0.64
P058284	1999	CULTURAL HERITAGE	5.00	0.00	0.00	0.00	0.00	1.57	1.57	1.57
P039251	1999	PIBL	25.00	0.00	0.00	0.00	1.10	3.99	5.09	0.00
P034213	1998	GEN'L CADASTRE	25.50	0.00	0.00	0.00	0.00	14.50	14.50	3.23
P039250	1997	ROADS 2	150.00	0.00	0.00	0.00	0.00	14.99	14.99	0.00
		Total:	1,016.60	0.00	0.00	20.65	1.10	806.57	152.79	8.77

ROMANIA
STATEMENT OF IFC's
Held and Disbursed Portfolio
In Millions of US Dollars

		Committed				Disbursed			
		IFC				IFC			
FY Approval	Company	Loan	Equity	Quasi	Partic.	Loan	Equity	Quasi	Partic.
1999	Ambro	2.90	0.00	0.00	0.00	2.90	0.00	0.00	0.00
2003	Arctic	12.10	0.00	0.00	0.00	12.10	0.00	0.00	0.00
2002	Banc Post	0.00	0.00	10.00	0.00	0.00	0.00	10.00	0.00
2003/04	Banca Comerciala	0.00	111.00	0.00	0.00	0.00	111.00	0.00	0.00
2001	Banca Romaneasca	3.95	0.00	0.00	0.00	3.95	0.00	0.00	0.00
1998	Bilstein Compa	0.31	0.00	0.00	0.31	0.31	0.00	0.00	0.31
2001	ICME	11.09	0.00	0.00	0.00	11.09	0.00	0.00	0.00
1998	Krupp Compa	1.43	0.00	0.00	0.61	1.43	0.00	0.00	0.61
2002/03/04	MFI MFB Romania	10.00	0.00	0.00	0.00	5.00	0.00	0.00	0.00

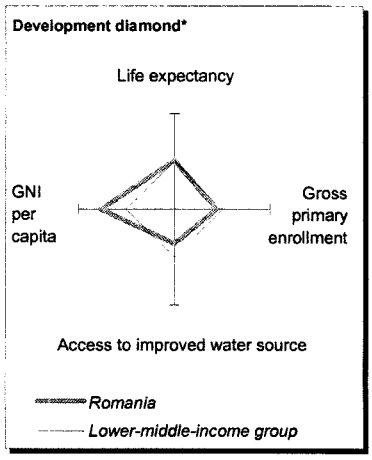
2004	RZB Romania	40.00	0.00	0.00	0.00	40.00	0.00	0.00	0.00
1997	Rambox	0.43	0.00	0.00	0.00	0.43	0.00	0.00	0.00
2003	Ro-Fin	5.00	0.00	0.00	0.00	0.37	0.00	0.00	0.00
2004	Romanian-Amer...	3.00	0.00	0.00	0.00	2.00	0.00	0.00	0.00
1994/01	Romlease	2.22	0.00	0.00	0.00	2.22	0.00	0.00	0.00
2004	Transilvaniabank	24.20	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	Total portfolio:	116.63	111.00	10.00	0.92	81.80	111.00	10.00	0.92

		Approvals Pending Commitment			
FY Approval	Company	Loan	Equity	Quasi	Partic.
2005	Banvit Romania	0.02	0.00	0.00	0.00
2004	Mindbank	0.01	0.00	0.00	0.00
2003	Ro-Fin Mortgage	0.00	0.00	0.00	0.00
2004	Schwarz Group	0.05	0.00	0.00	0.00
	Total pending commitment:	0.08	0.00	0.00	0.00

Annex 14: Country at a Glance

ROMANIA: HEALTH SECTOR REFORM II

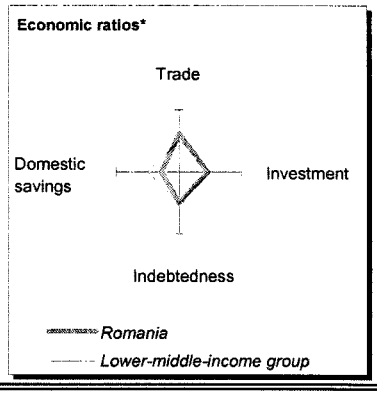
POVERTY and SOCIAL	Romania	Europe & Central Asia	Lower-middle-income
2003			
Population, mid-year *(millions)*	21.7	473	2,655
GNI per capita *(Atlas method, US$)*	2,260	2,570	1,480
GNI *(Atlas method, US$ billions)*	49.2	1,217	3,934
Average annual growth, 1997-03			
Population *(%)*	-0.6	0.0	0.9
Labor force *(%)*	0.1	0.2	1.2
Most recent estimate (latest year available, 1997-03)			
Poverty *(% of population below national poverty line)*	25	..	..
Urban population *(% of total population)*	56	63	50
Life expectancy at birth *(years)*	70	69	69
Infant mortality *(per 1,000 live births)*	20	31	32
Child malnutrition *(% of children under 5)*	..	..	11
Access to an improved water source *(% of population)*	58	91	81
Illiteracy *(% of population age 15+)*	2	3	10
Gross primary enrollment *(% of school-age population)*	99	103	112
Male	100	104	113
Female	98	102	111



KEY ECONOMIC RATIOS and LONG-TERM TRENDS

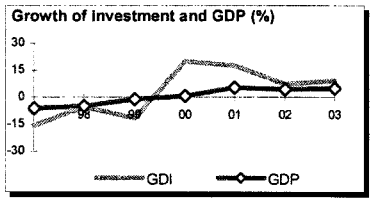
	1983	1993	2002	2003
GDP *(US$ billions)*	..	26.4	45.7	57.0
Gross domestic investment/GDP	..	28.9	23.1	24.6
Exports of goods and services/GDP	..	23.0	35.4	36.3
Gross domestic savings/GDP	..	24.0	17.3	16.8
Gross national savings/GDP	..	24.2	19.7	18.2
Current account balance/GDP	..	-4.5	-3.3	-5.8
Interest payments/GDP	..	0.5	1.2	1.4
Total debt/GDP	..	16.2	34.3	39.8
Total debt service/exports	15.2	6.3	19.0	17.5
Present value of debt/GDP	..	..	33.2	..
Present value of debt/exports	..	..	91.3	..

	1983-93	1993-03	2002	2003	2003-07
(average annual growth)					
GDP	-3.1	0.7	4.3	4.9	5.0
GDP per capita	-3.3	1.2	7.2	5.2	5.0

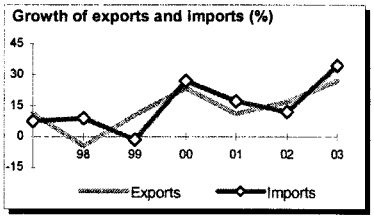


STRUCTURE of the ECONOMY

	1983	1993	2002	2003
(% of GDP)				
Agriculture	..	22.6	13.1	13.0
Industry	..	42.1	38.1	37.9
Manufacturing	..	28.7	..	31.5
Services	..	35.3	48.8	49.1
Private consumption	..	63.7	76.0	70.8
General government consumption	..	12.3	6.6	12.4
Imports of goods and services	..	28.0	41.2	44.1



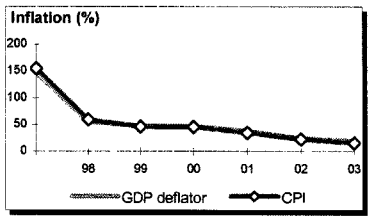
	1983-93	1993-03	2002	2003
(average annual growth)				
Agriculture	1.4	-1.5	-3.9	3.0
Industry	-4.3	0.9	7.2	4.6
Manufacturing	..	..	..	..
Services	..	1.5	5.6	5.2
Private consumption	..	3.2	3.0	7.3
General government consumption	..	-0.3	2.1	4.6
Gross domestic investment	..	0.3	7.3	9.2
Imports of goods and services	..	11.9	12.1	34.4



* The diamonds show four key indicators in the country (in bold) compared with its income-group average. If data are missing, the diamond will be incomplete.

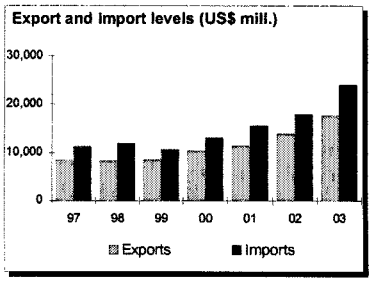
PRICES and GOVERNMENT FINANCE

	1983	1993	2002	2003
Domestic prices				
(% change)				
Consumer prices	..	256.1	22.5	15.3
Implicit GDP deflator	-0.4	227.4	24.2	19.2
Government finance				
(% of GDP, includes current grants)				
Current revenue	..	33.2	29.6	29.9
Current budget balance	..	4.3	0.6	1.3
Overall surplus/deficit	..	-0.4	-2.6	-2.2



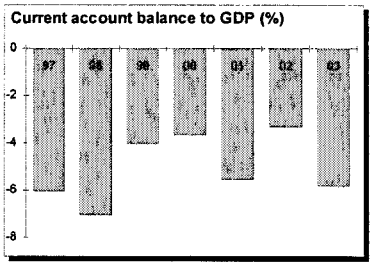
TRADE

	1983	1993	2002	2003
(US$ millions)				
Total exports (fob)	..	4,892	13,876	17,618
Textiles	..	959	1,782	2,282
Metals	..	574	1,181	1,482
Manufactures	..	2,856	9,851	12,534
Total imports (cif)	..	6,522	17,862	23,983
Food	..	964	1,174	1,737
Fuel and energy	..	1,872	2,272	2,615
Capital goods	..	1,432	5,111	7,017
Export price index *(1995=100)*	..	..	79	79
Import price index *(1995=100)*	..	..	70	71
Terms of trade *(1995=100)*	..	..	114	111



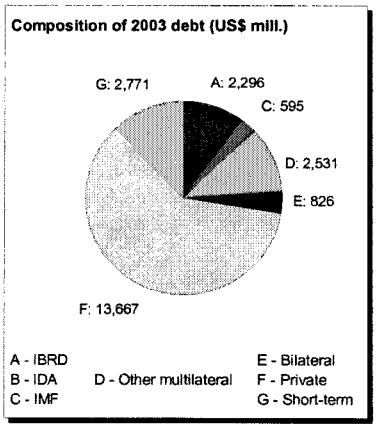
BALANCE of PAYMENTS

	1983	1993	2002	2003
(US$ millions)				
Exports of goods and services	12,239	5,691	16,223	20,646
Imports of goods and services	10,369	6,934	18,825	25,113
Resource balance	1,870	-1,243	-2,602	-4,467
Net income	-710	-145	-459	-705
Net current transfers	0	214	1,536	1,861
Current account balance	1,160	-1,174	-1,525	-3,311
Financing items (net)	-1,538	1,120	3,327	4,445
Changes in net reserves	378	54	-1,802	-1,134
Memo:				
Reserves including gold *(US$ millions)*	..	956	7,306	9,364
Conversion rate *(DEC, local/US$)*	..	760.0	33,055.5	33,200.1



EXTERNAL DEBT and RESOURCE FLOWS

	1983	1993	2002	2003
(US$ millions)				
Total debt outstanding and disbursed	9,129	4,282	15,680	22,686
IBRD	1,742	403	2,173	2,296
IDA	0	0	0	0
Total debt service	1,875	363	3,163	3,673
IBRD	220	19	196	214
IDA	0	0	0	0
Composition of net resource flows				
Official grants	0	99	259	0
Official creditors	317	743	143	16
Private creditors	-123	167	2,060	1,967
Foreign direct investment	0	94	1,144	0
Portfolio equity	0	0	21	0
World Bank program				
Commitments	0	120	340	222
Disbursements	362	189	335	131
Principal repayments	102	0	120	145
Net flows	259	189	214	-14
Interest payments	118	19	76	69
Net transfers	141	169	139	-82



MAP SECTION