Project Name	Estonia-Health Sector Development
Region	Europe and Central Asia Region
Sector	Hospitals; Secondary & Tertiary
Project ID	EEPE70993
Borrower(s)	GOVERNMENT OF REPUBLIC OF ESTONIA
Implementing Agency	Address MINISTRY OF SOCIAL AFFAIRS Gonsiori 29 15027 Tallinn, Estonia Contact Person: Mr. Ahti Kallikorm, M.D. Tel: 372-626-9800
Environment Category	F
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1. Country and Sector Background
Current Sector Issues:In the decade following independence, the first phase of health reform in Estonia introduced laws and institutional reform in line with provisions in many EU countries and began modernization of health services. The first phase of reform successfully put in place the main structural reforms required and created a basis for more efficient planning and management of health care and health care financial resources. However, the first phase of reform did not fully address the need for organizational reform of the hospital and specialist sector. As well, skills for efficient management, analysis and planning need to be strengthened. More development is needed to strengthen public health administration and long term care.ñ Inefficient network of hospital and specialist facilitiesAlthough one third of hospital beds were closed between 1991 and 1995 and bed numbers have continued to decline, hospital capacity is still excessive at six beds per 1000 population compared to the EU average of 4.4 acute beds per 1000 and UK average of 2 acute beds per 1000 (1997 data), and is poorly configured. Average lengths of stay remain above norms in more efficient EU countries at 8.8 days, and occupancy rates are low (75%) compared to ALOS of 4.7-6.5 days n the Nordic countries and UK and occupancy rates averaging 80% in the EU. There are 78 hospitals in Estonia for a population of 1.4 million, including a number of single-specialty hospitals and many small local hospitals. A number of small hospitals have closed or converted to nursing homes or primary care facilities. But larger hospitals have not yet consolidated, and many operate with multiple sites and poor use of physical space. A review of existing hospitals capacity - the Estonia Hospitals Masterplan - estimated the capacity and configuration of hospitals needed in Estonia based on Estonian population characteristics and EU benchmarks for hospital efficiency. The Masterplan found that major efficiency gains will only be achieved by consolidation into a smaller number of hospital sites and buildings. Modernization of facilities and equipment is needed to achieve greater efficiency and raise

quality. Under-developed long term care services Acute hospitals currently provide inappropriate and inefficient long term nursing care and social care for patients who could be cared for with home support or with lower cost, more appropriate nursing home care. EHIF financing arrangement currently do not encourage home care (except for cancer patients). The interface with locally financed and provided social care is an issue in Estonia, as in many countries. There are relatively low numbers of nursing home beds in many parts of Estonia compared to EU averages, and there are waiting lists for public nursing home places. If Estonia is to pursue an aggressive plan for downsizing acute hospitals and reducing ALOS without adverse social impact on chronically ill patients and social cases who currently rely on hospitals care, a vital concomitant of the plan must be development of nursing care services, with a strong emphasis on home-based care as well as development of nursing homes. Policy, governance and financial framework for investment for public sector health facilitiesThe 1994 law governing health care organizations does not specify clearly the responsibilities for ownership and governance of public hospitals or the planning of healthcare facilities, and the system of regulation and licensing is poorly specified. Capital investment in public healthcare facilities is problematic. Public investment funds are very limited at both state and municipal levels in Estonia, which has balanced budget legislation. There is no capital charge on public sector assets or on public investment funds. Revenue from the EHIF covers part but not all of the costs of capital. Providers have been borrowing from banks to finance investment, leading to loss of central control over investment and to mounting and poorly monitored financial risks at provider level. A new Healthcare Organization Law has been introduced into Parliament which seeks to create a stronger framework for hospital ownership, governance, accountability, and capital investment. The new law recentralizes planning functions to some extent, through mechanisms to promote implementation of the hospitals Masterplan and through assigning counties responsibility for primary care planning and monitoring; it also changes the legal status of hospitals to autonomous entities operating under private sector law, allowing for public-private partnerships (PPPs) and potential future privatization of healthcare facilities. It is expected that most future investment in the hospital network will be carried out with private resources. The law establishes a new licensing system for health professionals and provider institutions.ñ Human resource development needsIn the first phase of reform, Estonia has taken steps to address surplus doctor and specialist numbers and nursing shortages, to modernize the medical curriculum, and to develop health management training and public health specialist training. However, the planned optimization of the hospitals network and development of long term care services, creates a need for greater depth of management skills, and for retraining and redistribution of medical personnel. Development of analytical and administrative skills among health policy personnel and the public health administration is also a priority. ñ Efficient and equitable public health priorities and health policiesEstonia has already taken steps to shift the allocation of health resources to high priority areas (public health, primary care, essential drugs) and to allocate funds in an equitable way between regions (based on population). National health accounts have been produced and are regularly updated to monitor aggregate use of resources. However, with more sophisticated analysis of provider efficiency and the cost-effectiveness of interventions, much greater progress could be made

to obtain better value from health sector resources. There is a need to enhance Estonia's capacity to apply economic and social analysis to the setting of public health priorities, health expenditure priorities, and choice of sources of revenue. It is desirable for this analysis to focus on equity as well as efficiency, in view of the fact that ill health is more prevalent among the poor and disadvantaged and that disadvantaged groups tend not to participate equally in general trends towards improved healthy life expectancy.ñ Priority public health problems Life expectancy began to improve in Estonia in 1994, following some seven years of deterioration, but at 70.1 years remains below the EU average. Infant mortality has fallen steadily to 9.3 per 1000 in 1998. As in the EU countries, non-communicable diseases are the principle causes of premature morbidity and mortality. Diseases of the circulatory system and cancers are the first and second highest causes of death. Tobacco consumption is higher than EU average. Cancer survival in Estonia lags behind the EU. The incidence of alcohol-related illnesses (liver cirrhosis and alcoholic psychosis) appears to have risen in the past decade. As in the other Baltic states and Russia, Estonia has high prevalence of TB and significant rates of multi-drug-resistant TB. DOTS has been implemented. Current work by WHO on development of a "DOTS-plus" program for countries with multi-drug resistant TB is highly relevant to Estonia. In the past year, there has been a very sharp increase in reported cases of HIV/AIDS, concentrated in north east Estonia, and associated with IV drug use, though the national incidence remains lower than in neighboring countries. ñ EU Accession Preparation for EU accession is a high priority for the Government of Estonia (GOE). Direct implications of the Acquis Communitaire for health policy and the health sector are concentrated upon regulatory issues. Indirect effects on the health sector are also important, adding to the impetus for modernization and improvement of quality while also limiting the GOE's capacity to allocate additional resources to the social sectors.Government Strategy:Estonia began planning health reform at the end of the 1980's in anticipation of moves to greater autonomy, and in response to the major problems in its health system, typical of the former USSR. The major issues at that time were:ñ Excessive hospital capacity and numbers of specialists;ñ Weak and underdeveloped primary health care;ñ Declining health status (in particular, increases in injuries, violence and cardiovascular disease in men aged 20-50) and re-emergence of some infectious diseases, notably tuberculosis;ñ Lack of consideration of the costs of care. Reform encompassed the following major measures: ñ establishing a social insurance system for financing health care (in 1992) This system has proved to be stable and sustainable. It provides relatively comprehensive coverage for most of the population. An estimated 9 percent of people who are uninsured are covered by safety net provision of emergency care. Unlike most transition countries, Estonia achieves effective risk pooling for over 80 percent of health expenditure through social health insurance and budget-financed health programs, with out-of-pocket payments by patients accounting for 11-12% of expenditure. Patient fees are regulated to ensure affordable access for higher users of care. Total health expenditure has been stable at around 6% of GDP since 1994. ñ developing primary health care / family medicine Family medicine was recognized as a specialty in 1993 and retraining of primary care doctors as family practitioners has been going on for the past 10 years. Financing for primary care shifted to a modified capitation system in 1998, conducive to patient choice, private practice, and clearer family doctor responsibility

for patients. In most of the country, the new system has been fully implemented, but Tallinn has been more conservative about this change, due to the presence of large polyclinics and high specialist numbers.ñ strengthening public health servicesPublic health services have been modernized and enhanced through establishment of a National Center for Health Promotion and Education, an earmarked budget for health promotion initiatives within the Central Sickness Fund (EHIF), establishment of a public health department and public health specialization within the Tartu University medical school, pre-EU-accession development of health protection and occupational health, and a expanded range of budget-financed national programs for health promotion and disease prevention, including TB prevention and HIV/AIDS and STD prevention. ñ pharmaceuticals reformsRegulation for safety, efficacy and quality has been introduced in line with EU provisions, and an Agency for Medicines established to administer the regulations. Manufacturing, wholesale and retail distribution have been privatized. The Estonia Health Insurance Fund (EHIF) operates a reimbursement scheme for prescription drugs which is relatively liberal, and has led to unsustainably high trend real growth in this area of expenditure. Patient copayments are modest, and are reduced for disabled and retired people, and drugs for serious illnesses. In hospital drugs are free to patients. The rapid growth in pharmaceutical expenditure is being tackled by introduction of a reference pricing system by the EHIF. ñ decentralization, followed by some recentralizationDecentralization occurred in the health sector, as part of a wider trend of reaction to the centralization of decision-making in the former USSR. Ownership of hospitals and health facilities was largely decentralized to municipalities, and 17 sickness funds were established at county or city level. After some years of experience with this arrangement, awareness grew of the problems of higher transaction costs, lack of economies of scale, and limited pooling of health insurance risks with this degree of decentralization in the health system. Legislation was enacted in 2000 to recentralize financing responsibility under the Central Sickness Fund. A new Healthcare Organization Law currently proceeding through Parliament recentralizes health care planning.ñ reform of social careSocial care reform is shifting provision from a low-quality, stigmatized, institutional system to an open care system, with greater use of home care, support to families, and greater emphasis on social adaptation and community integration of disabled people, with encouragement of self-reliance. Social care is a local government responsibility. Long term nursing care remains a health sector responsibility. There has been some increase in private provision of nursing homes and home care, but this sub-sector has not undergone systematic reform.The first World Bank Estonia Health Project supported reform of health insurance, primary health care, public health and human resource development in the implementation phase from 1995 - 2000, with an IBRD loan of US$18 million.The Government of Estonia has approved a 15-year program - Estonia Health Project 2015 - for sustainable development of the health sector. This as a continuation of the program of reform implemented with the support of the first Estonia Health Project. In planning the program for the next 15 years, the economic memorandum composed by the Government of Estonia and the Bank of Estonia to the IMF for 2000-2001 was taken into consideration. The memorandum noted the need for reform in the health care sector and for the restructuring and investment program for hospital network with the aim of increasing effectiveness and decreasing costs. There are four parts of

the Estonia Health Project 2015, summarized below. The Government has prepared indicative cost estimates for the Project, and requested the support of the World Bank for implementation of the project through a second IBRD loan for the health sector.(a) Restructuring of the Health Care SystemThe first Estonia Health Project focused on development and reorganization of primary health care, which accounts for approximately 20% of health insurance expenditure. The 2015 Project has a major focus on the logical next phase of reform - the restructuring of hospital and specialized care, which accounts for around 70% of health insurance expenditure. The first Health Project supported preparation of the Estonia Hospitals Masterplan, now approved by the Estonian Government. The Masterplan envisages consolidation of specialised health care resulting in increased quality of services as well as increased efficiency. According to the Masterplan it would be optimal to have 13 acute care hospitals organized in four health care regions. In each region there will be one central or regional hospital (more in Tallinn). Alongside consolidation of the acute hospital network, the Masterplan envisages an expansion of long-term nursing care. Acute hospitals currently function as inappropriate and inefficient providers of long term care and social care. Consolidation will create a need to develop alternative more appropriate long term care and nursing care services. The Masterplan envisages that the profile of many existing hospitals will be altered from acute, curative services to nursing and long-term care beds. However, the Bank sees a need to ensure that home-based alternatives to institutional long-term care are also developed. The GOE does not expect the Masterplan to cause drastic reduction of jobs. Instead, there would be a need for specialized clinical training and retraining among doctors and middle level health care personnel, and redistribution of staff. The indicative estimate of the costs of the 15-year investment plan for consolidation of the hospital network is US$250 million. The Estonian Government aims make the project credible and attractive for private investors, and seeks the participation of the World Bank as a critical ingredient in achieving the necessary credibility. Alongside plans for investment, the Government wishes to develop the kind of regulatory and financial policies for the hospital sector which would foster public-private partnerships (PPPs). In the first years of the program the Government plans to address the following policy issues in co-operation with the World Bank: the inclusion of capital costs to the price-list of health care services; finding solutions to the problems that might arise from changes in the ownership of the hospitals; financial analysis of investments; the sustainability of private initiative and competition in the market after the implementation of the hospital masterplan. (b) Human Resource DevelopmentThe first phase of reform commenced the training of family medicine specialists, public health specialists (as part of the Biomedicum established under the first Estonia health project), and graduate training programs for nurses and social workers. The 2015 Project will continue this training to meet the need for larger numbers of trained personnel in these fields. In addition, a masters program in health management is planned to be established, to increase the depth of management skills to meet the increased demands of restructuring and raising quality standards. The 2015 Project also envisages establishment of a Health Care Quality Center to coordinate a quality strategy, develop standards, and coordinate training in quality management. (d) Project Management The management and control of the Estonian Health Project is carried out under the steering committee of the project. The head of it is the Minister of Social

Affairs. Representatives of Tartu University and the EHIF are also on the committee. Working groups have been established for the components and sub-components of the project, with participation of hospital managers as well as MSA, Ministry of Finance, EHIF and private sector experts. Public health programsAlthough specific public health programs do not fall under the ambit of the 2015 Project, the Government of Estonia has planned further reforms in public health administration and programs. In the 2001 Budget, it recognized the need for very prompt intensive intervention to prevent the spread of HIV/AIDS following the rapid increase in reported cases in north east Estonia, and increased funding of the prevention program by 25%. Estonia is also participating in the Baltic Sea Action Plan on HIV/AIDS. 2. Objectives(a) i. to achieve a step increase in hospital efficiency through implementing a comprehensive hospital capacity optimization plan;(a) ii. to develop policy and a regulatory framework which support sustainable and efficient financing of investment in health care facilities, fostering public- private partnerships where these can add value; (b) to increase and assure quality in the health care delivery system through alignment of training, standards, and quality and performance management arrangements with international best practice; (c) to improve the efficiency and equity of public health strategy and health resource allocation.

2. Objectives
(a) i. to achieve a step increase in hospital efficiency through implementing a comprehensive hospital capacity optimization plan;(a) ii. to develop policy and a regulatory framework which support sustainable and efficient financing of investment in health care facilities, fostering public- private partnerships where these can add value; (b) to increase and assure quality in the health care delivery system through alignment of training, standards, and quality and performance management arrangements with international best practice; (c) to improve the efficiency and equity of public health strategy and health resource allocation.

3. Rationale for Bank's Involvement
ñ The Bank's experience in similar projects in other Bank client countries (e.g., Georgia, Moldova) and the Bank Team's experience in hospital organizational reform and PPPs in OECD countries would benefit the project by bringing to it the lessons learned elsewhere and facilitating the transfer of knowledge, including the possibility of engaging experts from other countries and/or organizing study tours., ñ The Bank can assist in strengthening economic and financial analyses in hospital management, and in creating increased pressure to make "tough decisions" where necessary based on economic and social analysis. ñ The Bank can help to bring financial partnerships with other development banks and private sector to the hospital rationalization program. The advice given to the Bank team by IFC, EBRD and NDB is that these agencies are reluctant to invest in the hospital sector in this region because of difficulty encountered with initial attempts at PPPs. These agencies articulate a need for partnership with the Bank to ensure that appropriate development of health policy, regulatory and financing arrangements are in place before this type of investment is undertaken, since they do not have this type of capacity in-house. These agencies view the general institutional and financial environment in Estonia as favorable for this type of initiative and are therefore interested to re-engage with the hospital sector in partnership with the Bank in this proposed Project, in part because of the

potential for this Project to serve as a pilot or demonstration site for other countries in the region.ñ The Bank's expertise in project impact evaluation can strengthen Estonia's efforts to learn as much as possible from the innovative aspects of the hospital reform in order to fine-tune the project design during implementation and thereby achieve the most health benefit for the population over the long run.

4. Description

A. Optimization of hospital and specialist health care services
This component will support some of the investment needed in hospital consolidation and upgrading during the first four to five year phase of implementation of the hospitals Masterplan. The intention is to develop a model for preparation of the business case and plans for a major hospital investment project and to pilot a public-private partnership for finance and development of one major investment in hospital consolidation and upgrading. This component is expected to account for the largest share of project costs. In parallel, other investments in hospital consolidation under the Masterplan will begin, financed from other sources.
A1. Optimization of the North Estonia Regional Hospital Network
A group of state-owned hospitals in Tallinn is forming a single legal entity, which will provide tertiary level health services to the northern half of Estonia and some national services. Plans are being developed to consolidate the hospital from a number of existing hospital sites, predominantly onto one site, and to reorganize services in a more efficient way. The network includes a specialist hospital for tuberculosis and lung diseases, and specific attention will be paid to the appropriate future for TB hospitals in view of the relatively high prevalence of multi-drug resistant TB in Estonia. Planning and evaluation of the consolidation will take place during the project preparation period. The proposed loan would support the consolidation project. The Project will seek to engage private partners and other investment banks in this component of the project during the preparation period.
A2. Preparation for optimization of health services in Ida Virumaa
Development and agreement of plans for optimizing hospital and specialist services in this north-eastern part of Estonia are at an earlier stage. In this area, the County faces the challenge of coordinating planning and decision making among a number of municipalities which own the hospitals, within a context where there are significant socio-economic problems and associated health needs among the local population.
A3. Implementation and communication of the framework for hospital and specialist health care
During the project preparation period, the legal and regulatory framework for hospital and specialist care is being developed, with the support of a grant from the Japanese government. It is intended that this framework will apply to all of the public hospital network and all of the hospital investment projects under the Masterplan, whatever the financing source. This framework will be implemented during the project period and the project may support some technical assistance for implementation in areas such as development of quality standards, development of performance monitoring, development of capacity for investment planning, appraisal and financing in the health system. Another critical aspect of implementation of the plans for hospital optimization in public information and communication. Communication and consultation will be undertaken with health professionals and health sector employees, with communities

surrounding hospitals involved in the Project and with the general public.
B. Development of long term nursing care services
Alongside reduction in the capacity of acute hospitals, it will be important to increase capacity for long-term care and nursing care, to support patients who are discharged earlier from hospital and to provide a more appropriate form of care for long term patients currently treated in hospitals. The Project will seek to support a pilot in one area of development of a more appropriate form of long term care and nursing care. This is likely to involve re-profiling an existing hospital for long term care and development of home care services.
C. Public health strategy and capacity building
EU accession gives greater urgency to the need for Estonia to strengthen and modernize its public health administration and tackle some high priority public health problems which are of particular concern to the international community. During the project preparation period, a study will be carried out with the support of the Japanese government of equity in health status and in access to health care in Estonia, in coordination with an EU iniative to tackle health inequalities, in which Estonia is participating. The Project itself may support development of capacity to contribute to EU-oriented public health analysis and strategies. It may also support specific initiatives in areas of high priority public health need identified by the study and the MSA's strategy. This may include support for measures to address the epidemic of HIV/AIDS which has emerged in some parts of Estonia in the past year. The GOE is seeking the support of bilateral and multilateral donors to enhance its public health strategy and address urgent public health problems.
D. Project Management

5. Financing

	Total (US$m)
Total Project Cost	40

6. Implementation
6.1 Implementation responsibilities and institutional arrangementsOverall responsibility and authority for the project will reside within the Ministry of Social Affairs (MSA). A Steering Committee, headed by the Minister of Social Affairs, has been established to oversee management of the Project. Other members of the Committee will include professional staff in the Ministry, as well as representatives from the Central Sickness Fund and Tartu University. Working Groups have been established to oversee individual components and sub-components of the Project. The new management team of the Tallinn Regional Hospital Network will play a vital role in leading the decision making process, and guiding the technical assistance.A fully functioning and fully staffed Project Coordination Unit (PCU), funded by the Government, remains in place from the first Estonia Health Project. This unit is working closely with the Working Groups and the Steering Committee to help to manage preparation activities. They are managing the PHRD Grant, preparing bidding documents, terms of references and working closely with the Ministry of Social Affairs to coordinate preparation activitiesIn addition, the PCU will be responsible for: (a) the management and coordination of all the project activities and preparation of regular implementation reports; (b) maintaining all financial and procurement records, including a database of costs of civil works, goods and services; (c) prior review and project oversight responsibilities such as monitoring the content and

implementation of sub-project activities by the provinces; and (d) project evaluation with inputs from the provinces. Implementation will be guided by a Project Implementation Plan. 6.2 Project supervision, monitoring and evaluationThe PCU will work closely with the Working Groups to monitor overall project implementation including progress and effectiveness of technical assistance, components and sub-components, based on the agreed key performance indicators. Monthly meetings will be held with the Steering Committee for periodic monitoring and evaluation of progress. The Bank will carry out regular supervision visits (usually twice a year), a review of progress reports, and day-to-day monitoring of implementation of progress and performance. A mid-term review will be conducted jointly by the government and the Bank by March 2004. A detailed plan for evaluation will be finalized during appraisal.6.3 ProcurementProcurement activities will be carried out by the PCU in consultation with Ministry. The Project Implementation Plan for the project will include, in addition to the procurement procedures, the Standard Bidding Documents to be used in each case, as well as a request for quotations and contracts or purchase orders to be awarded on the basis of price quotations. Where no relevant standard contract exists, other standard forms acceptable to the Bank will be used. Annex 6 summarizes procurement procedures and arrangements.6.4 Financial management and disbursementTraditional disbursement procedures, operating on a reimbursement basis in accordance with the Bank's Disbursement Handbook, will be followed in support of Bank claims. IBRD funds will flow from Washington to the Ministry of Finance on a basis/frequency to be determined against incurred and pre-financed expenditures, with direct payments and special commitments being available as needed. Independent auditors will be appointed on terms of reference acceptable to the Bank.

7. Sustainability
The following factors are critical for sustainability of project benefits:(i) Stable or growing public health revenue;(ii) Stability in health sector strategy and sector management;(iii) Government's willingness and capacity to infuse health system with increased incentives for efficiency, quality and affordable access;(iv) Private sector's willingness and capacity to invest in and manage health servicesWhile it is not possible to avoid political change during the life of the Project, the participatory approach to preparation, widespread public communication and public debate about the Hospitals Masterplan, and the participation of management of affected agencies in project preparation and implementation, helps to increase the prospect of stable commitment to the policies supported by the Project. Involvement of the CSF and of the Ministry of Finance in project preparation is also helpful to ensure financial realism and sustainability of the strategies adopted.

8. Lessons learned from past operations in the country/sector
The first Estonia Health Project to support the Government health reforms became effective in 1995 and closed on June 30, 2000. The project financing included US$18 million IBRD loan, US$14 million Government contribution and it mobilized US $4.5 million of other bi- and multilateral donor financing. The project supported the launch of primary health care reform, capacity building of the Ministry of Social Affairs, public health programs, and training and organizational development of central sickness fund. The implementation of the project has been satisfactory and it achieved its developmental objectives. Work done

under the first health project has set the ground for the next stage of the health sector development agenda that is the basis of the proposed second Estonia Health Sector Development Project. Although the first health project was assessed to be complex and ambitious, project components proved to be a binding common goal for academia, policy makers, and the community at large, resulting in successful implementation. Stakeholder participation and consultation has been recognized by the Bank and has rightly become a mandatory part of the project preparation process.The Bank added significant value in providing impartial technical know-how to implementclient-driven activities in the first project. The Bank proved to be a valuable partner to the client by providing knowledge of international practice and standards as well as ensuring that sound technical checks and cost controls were put in place. While the client clearly is capable of implementing a project, Estonian counterparts perceived from their experience with the first Project that working in partnership with international experts, who bring knowledge and an impartial assessment of a project, provides a system for checks and balances that prevent political, local, or personal biases from occurring, and thus achieves the optimum technical and economical solution for the benefit of the community at large.Monitoring indicators were critical to maintaining focus on development objectives. Attention given early during supervision missions to systematically assess progress in achievement of defined project performance indicators enhanced project performance and helped to steadily steer the project towards its goals, or amend them as needed. The relevance and appropriateness of monitoring indicators is crucial for maintaining credibility of the supervision process.Project start-up needs intensive and immediate attention through Bank Supervision. Projectsoften do not receive start-up supports supervision support immediately after loan approval, though this is the most critical point for the client and stakeholders as they transition from planning design and theory to results on the ground. The first Health Project, however, did suffer some neglect during startup which resulted in initial delays and lack of coordination with stakeholders. Fortunately, significant project management technical assistance provided some support to impart the needed management and administration knowledge and skills for project implementation. During these times of budget constraints, it is critical that appropriate financial commitments be forthcoming.

9. Program of Targeted Intervention (PTI) N

10. Environment Aspects (including any public consultation)

Issues : The only potential issues involve the rehabilitation of some hospitals, which potentially could be undertaken as part of the rationalization program. Plans for the rehabilitation of such hospitals would include aspects that would ensure that the environment would not be negatively affected by the civil works supported under the Project. No adverse environmental effects are anticipated because rehabilitation is expected to occur on existing hospital sites, within existing structures. Additional concerns might arise from the possible decommissioning of certain hospitals, requiring environmental analysis and audits; the incorporation of environmental management issues in institutional planning and management; an upgrading of existing institutional capacity to handle collection, disposal and management of hospital waste. The Project will follow accepted Bank procedures in these matters. All hospital and health center activities will incorporate

appropriate and safe disposal of wastes. An environmental action plan will be developed and agreed upon with the Environment Unit.

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Note: This is information on an evolving project. Certain components may not be necessarily included in the final project.

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