Document of
The World Bank

Report No: 19373-GE

PROJECT APPRAISAL DOCUMENT

ON A

PROPOSED CREDIT

IN THE AMOUNT OF SDR 12.2 MILLION

(US$ 16.5 MILLION EQUIVALENT)

TO

GEORGIA

FOR A

STRUCTURAL REFORM SUPPORT PROJECT

June 4, 1999

Poverty Reduction and Economic Management Unit
Human Development Unit
Europe and Central Asia Region

CURRENCY EQUIVALENTS
(Exchange Rate Effective May 1999)

Currency Unit = Lari
LC = US$0.5
US$1.00 = Lari 2.00

FISCAL YEAR
January 1 – December 31

ABBREVIATIONS AND ACRONYMS

CAS	Country Assistance Strategy
CD	Customs Department
CSB	Civil Service Bureau
ESAC	Energy Sector Adjustment Credit
EU	European Union
GNERC	Georgian National Electricity Regulatory Commission
HRF	Hospital Restructuring Fund
IDA	International Development Association
IMF	International Monetary Fund
MoC	Ministry of Communications
MoE	Ministry of Economy
MoEF	Ministry of Energy and Fuel
MoF	Ministry of Finance
MoH	Ministry of Health
MoJ	Ministry of Justice
MoSSLE	Ministry of Social Security, Labor and Employment
MoSPM	Ministry of State Property Management
NBG	National Bank of Georgia
PCU	Project Coordination Unit
PIU	Project Implementation Unit
PSR	Public Sector Reform
SAC II	Second Structural Adjustment Credit
SAC III	Third Structural Adjustment Credit
SATAC II	Second Structural Adjustment Technical Assistance Credit
SDS	State Department of Statistics
SHF	State Health Fund
SMIC	State Medical Insurance Company
SPC	State Pension Fund
SRS	Structural Reform Support Credit
THMP	Tbilisi Hospital Master Plan
UNDP	United Nations Development Program
USAID	United States Agency for International Development
WHO	World Health Organization

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Georgia
Structural Reform Support Project

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Annexes

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Structural Reform Support Project

Project Appraisal Document

Europe and Central Asia Region

Date: June 4, 1999
Country Director: Judy O'Connor, ECC03
Team Leaders: Cyril Muller, ECC03; Laura Rose, ECSHD
Sector Leaders: Ataman Aksoy, ECSPE, Annette Dixon, ECSHD
Project ID: GEPE-52154 Sector: Health, Institutional
Program Objective Category: EA
Lending Instrument: SIL/TAL
Program of Targeted Intervention: [ ] Yes [X] No

Project Financing Data [ ] **Loan** [X] **Credit** [ ] **Guarantee** [ ] **Other [Specify]**

For Loans/Credits/Others:

Amount (US$m/SDRm): SDR 12.2 million / USD$16.5 million equivalent
Proposed terms: [X] Multicurrency [ ] Single currency, specify
Grace period (years): 10 [ ] Standard Variable [ ] Fixed [ ] LIBOR-based
Years to maturity: 35
Commitment fee: 0.50%
Service charge: 0.75%

Financing plan (US$m):

Source	Local	Foreign	Total
Government	$3.3 m		$3.3 m
Cofinanciers			
IDA	$3.0 m	$13.5 m	$16.5 m
Total	$6.3 m	$13.5 m	$19.8 m

Borrower: Government of Georgia
Guarantor: N/A
Responsible agencies: Ministry of Finance, Ministry of Health, Office of the President, Ministry of Economy, Ministry of Justice, Ministry of State Property Management, Ministry of Energy and Fuel, Georgia National Electricity Regulatory Commission, National Bank of Georgia, Ministry of Social Security, Labor and Employment, State Pension Fund.

Estimated disbursements (Bank FY/US$M):

	2000	2001	2002
Annual	4.8	6.7	5.0
Cumulative	4.8	11.5	16.5

Project implementation period: 2.5 years Expected effectiveness date: 09/99 Expected closing date: March 2002

A: Project Development Objective

1. Project development objective and key performance indicators (see Annex 1):

The objective of the proposed credit would be *to accelerate the change in the respective functions of the public and private sectors in delivering key services in Georgia.* Changing functions is a necessity due to the severe public revenue constraints and failure of the public sector to cover such basic needs as electricity supply and health care. The project components would aim to improve economic efficiency and social equity through technical assistance in private sector development, public sector reform/public information, and social sustainability, along with implementation of a hospital restructuring program. The program provides support to the key reform measures included in the proposed Third Structural Adjustment Credit (SAC 3) and Energy Sector Adjustment Credit (ESAC). The project's main components include:

Hospital Restructuring: This first component has two primary objectives: (i) to improve the efficiency of the health care system by reducing the number of hospitals and personnel in the city of Tbilisi; and (ii)to ensure the quality and financial sustainability of the hospitals that remain in the public sector. To this effect, the component will support the establishment of a revolving hospital restructuring fund, whereby the proceeds from the sale of excess hospitals will be reinvested in the public sector health system. In addition, new governance, organization, and management structures will be introduced in the public sector, and steps will be taken to improve the risk pooling of the large portion of out-of-pocket spending prevalent in the country today.

Private Sector Development and Financial Sector: The component will address three of the critical challenges facing the privatization program and the banking sector. It will: (i) support the open, competitive and strategic privatization of a few large infrastructure enterprises through the financing of financial, legal and technical advisory services; (ii) strengthen the capacity of the energy and infrastructure regulatory institutions to enable strong private sector participation; and (iii) strengthen the supervision department and monetary policy capacity of the National Bank of Georgia (NBG).

Public Sector Reform/Public Information: The objectives of this component are to: (i) assist the Government in strengthening budget management and begin developing a medium-term expenditure framework process, and to strengthen the institutional capacity of the Ministry of Finance; (ii)support the implementation of public procurement reforms; (iii) improve the licensing regime to make it less discretionary and more transparent; and (iv) support the program of public information and public relations on economic reforms, with an aim to broaden its coverage, improve coordination of Government information services, and begin reaching out to the regions of Georgia.

Social Sustainability: The proposed component, which supports the establishment of a credible and affordable safety net, has three main objectives: (i) to establish a continuous information and monitoring system that can track and report on the social impact of economic developments and support existing efforts to confirm eligibility and access to social assistance programs; (ii) to study the feasibility and desirability of workfare as a means to target assistance to the poor, including the design and pilot testing of such a scheme; and (iii) to assist the Government in developing a pension reform strategy and to build institutional, technical, and human resources capacity for its successful implementation.

The success of the project will be assessed on the extent to which the following *key performance indicators* are achieved:

(a) Decrease in number of public medical facilities and in their staffing (facilities sold as real estate, restructured hospitals), changed composition of remaining hospital staff, shorter average length of stay in hospitals, fewer hospital infections and decrease in the prevalence of informal payments for hospital services in Tbilisi.

(b) Increased strategic investment in Georgia, including privatization of telecommunication companies and private operation of Poti port, with necessary laws and regulations in place in time to attract foreign strategic investors, and the establishment of regulatory capacity. Fewer banks in Georgia, with those banks that remain having stronger balance sheets and institutional capacities, and with NBG capacity to manage bank failure strengthened.

(c) Improvements in budget management leading to a reduction in arrears and actual execution of the planned budget. Improved capacity of the Ministry of Finance to formulate a realistic and consultatively prepared budget, and to more effectively monitor budgetary expenditures. Implementation of the reformed procurement regime in central and local governments, with the independent Department for Public Procurement in the Ministry of Economy fully operational and fulfilling its functions. Satisfactory implementation of the new Law on Licensing, with decreasing number of licensing abuse complaints. Improved coordination and quality of information across government agencies, with the Information Center transferred to the President's Office and effective in coordinating with other Press Offices.

(d) Improved lists of social assistance recipients, with those ineligible removed from the lists, thus improving targeting. Feasibility of using workfare as a means to reach the poor satisfactorily assessed; and a pilot workfare scheme designed and evaluated for suitability in the Georgia context. Pension reform strategy formulated, and capacity to manage and model the public pension fund built.

B: Strategic Context

1. Sector-related Country Assistance Strategy (CAS) goal supported by the project (see Annex 1):

CAS document number: 17000-GE Date of latest CAS discussion: October 21, 1997

The Bank Group's strategy in Georgia for the period 1998-2000 supports the Government's development agenda with the following four themes: (i) strengthening public finance; (ii) deepening and diversifying sources of growth; (iii) protecting the environment, and (iv) reducing poverty. Three of the four CAS objectives are being addressed under the proposed project: The *Hospital Restructuring* and *Social Sustainability* components aim to reduce poverty and widen access to social services. The *Private Sector Development and Financial Sector* component will seek to deepen and diversify the sources of economic growth through supporting privatization of a few large, strategic, enterprises, as well as through assistance with strengthening the regulatory capacity of utilities/infrastructure in areas with key private sector participation, and through assistance in banking sector supervision and, where necessary, liquidation. The *Public Sector Reform/Public Information* component supports the CAS objective of strengthening public finance. Assistance will be provided in strengthening the government's public expenditure management performance, and in supporting key elements of the Government's anti-corruption strategy, including by supporting the Ministry of Economy's implementation of the new public procurement reform and strengthening of the Public Procurement Department, and assisting the Ministry of Justice in monitoring and supervision of a simplified and more transparent licensing regime.

2. Main sector issues and Government strategy:

The main sector issues and Government strategy are discussed extensively in the President's reports for the proposed Third Structural Adjustment Credit and Energy Sector Adjustment Credit. The following are the key strategic issues common to these operations and the proposed SRS credit:

Hospital Restructuring:

- Limited public financing for health care dictates that the Government use its resources as efficiently as possible, which they have tried to do by targeting public spending on a basic benefit package (including essential public health programs) and health services for the poor. Over time, however, the scope of services has increased while the proportion of the planned budget which is actually executed has decreased, leaving the sector in a perpetual financial crisis.
- Government could improve the efficiency of public spending through consolidation of health facilities and reduction of staff, but efforts to do so have failed, probably due to the fact that with only 13% of the spending, the Government is not a very big player in the system.
- The Poverty Assessment showed that the poor are particularly vulnerable to a deterioration of their health status. Risk pooling is non-existent, but a necessary step to improve access to health services for the poor.

Private Sector Development and Financial Sector:

- The privatization program has been limited to-date to small- and medium-sized enterprises. Only a few large enterprises such as Telasi and Chiaturia Manganese have actually been privatized.
- Infrastructure privatization requires the establishment of enabling regulatory framework.
- Partly as a result of the Russia crisis, consolidation of the banking sector has accelerated and the NBG's supervisory capacities have been stretched.

Public Sector Reform/Public Information:

- Public expenditure management remains weak with large discrepancies between planned and executed budgets which leads to arrears and expenditure shortfalls in core social expenditures.
- Institutional strengthening of the Ministry of Finance has been proceeding for the last several months and has strong ownership.
- Among the key elements of the anti-corruption action agenda, public procurement reform and the de-licensing measures are most advanced.
- Information on economic reforms is more widely available, but coordination of Government information flows and the outreach to the provinces remain weak.

Social Sustainability

- Poverty is wide-spread and severe. Scarce fiscal resources limit the extent and efficiency of public financing of the social safety net.
- The bulk of the poor are able to work and difficult to target, and there is need to rely on self selection mechanisms to identify the vulnerable.
- The public pension system is near collapse despite extremely low benefits and a high retirement age.

C: Project Description Summary

1. Project components (see Annex 2 for a detailed description and Annex 3 for a detailed cost breakdown):

Component	Category	Cost Incl. Contingencies (US$M)	% of Total	Bank-financing (US$M)	% of Bank-financing
A. Hospital Restructuring A1. Hospital Consolidation A2. Hospital Operations Improvement A3. Component Management	Civil Works, Goods, TA, Training, and Incremental Operating Costs	**10.0**	**51%**	**7.4**	**45%**
B. Private Sector Development and Financial Sector B1. Strategic Privatization of Large-Scale Enterprises B2. Development of Regulatory Capacity B3. Financial Sector Strengthening	TA,Training, Goods	**4.5**	**23%**	**4.3**	**26%**
C. Public Sector Reform/Public Sector Management C1. Public Expenditure Management C2. Public Procurement C3. Licensing C4. Public Information	TA, Training, Goods	**2.7**	**13%**	**2.4**	**15%**
D. Social Sustainability D1. Poverty Monitoring and Targeting D2. Workfare Schemes D3. Support for Pension Reform	TA, Training Goods	**2.5**	**12%**	**2.2**	**13%**
E. Project Management Costs (components B-D)		**0.2**	**1%**	**0.2**	**1%**
	Total	**19.8**	**100%**	**16.5**	**100%**

2. Key policy and institutional reforms supported by the project:

The project will provide assistance in the implementation of Georgia's economic reform program, which is supported under the proposed SAC 3 and ESAC. Specific measures include:

- Satisfactory Implementation of Hospital Restructuring Plan (SAC 3)
- Strengthened Public Expenditure Management including institutional strengthening of the Ministry of Finance (SAC 3)
- Adequate and timely expenditures for the social sectors: health, education, and social protection (SAC3 and ESAC)
- Satisfactory Implementation of the Privatization Strategy for Telecom and Poti Port (SAC 3)
- Strong regulatory capacity in electricity sector, including market rules and tariff setting (ESAC)
- New and transparent public procurement and licensing regimes under satisfactory implementation (SAC 3)
- Strengthened social safety net and improved targeting (ESAC and SAC 3)

From an institutional perspective, the project faces the challenge of strengthening a large number of institutions involved in the reform program. Components under SRS will address capacity building needs of the Ministry of State Property Management, the Georgia National Electricity Regulatory Committee, the National Bank of Georgia, the Ministry of Finance, the Ministry of Economy, the Ministry of Justice, the Public Information Center; the Ministry of Social Security, Labor and Employment, and the Pension Fund. The same program set-up as under SATAC 2, which has been successful in providing assistance to a large number of agencies, will be maintained, i.e., all assistance has been discussed and agreed at the sectoral and Government-wide levels.

3. Benefits and target population:

The three main benefits of the proposed project are: (a) alleviation of fiscal pressures through generation of privatization proceeds and more efficient use of public resources; (b) a stronger infrastructure and large enterprise sector through strategic investment in sectors that are critical to sustain long-term growth (telecommunications, transport, energy); and (c) poverty reduction through improved financial access to health facilities in Tbilisi and better targeted social programs.

Most of the activities financed by the credit provide benefits to the entire population. Everyone will benefit from improved health care services, establishment of a well-functioning pension system, improved infrastructure resulting from large-scale investment in telecommunications, energy and transport, and more efficient resource allocation from a stronger banking sector. Health care workers would benefit from better working environment, better tools to perform their functions, higher salaries, and increased funding available to the sector. The socially vulnerable will benefit through better targeting of benefits, and implementation of workfare schemes, if found feasible, to lessen the effects of wages lost due to unemployment. The Government and the private sector would benefit through better, more competitive public procurement processes and reduced opportunities for corruption from the delicensing program.

4. Institutional and implementation arrangements:

The institutions directly involved in implementing the project will be: (a) the Health ProjectCoordination Unit (PCU) which will take responsibility for the largest component, Hospital Restructuring; and (b) the SATAC Project Implementation Unit (PIU) under the Ministry of Trade and Foreign Economic Relations (currently managing SATAC II, and two IDF Grants) which will manage the three remaining components: Private Sector Development and Financial Sector; Public Sector Reform/Public Information; and Social Sustainability. The implementation arrangements are designed to make best possible use of existing institutional resources, build ownership and provide for focused project implementation.

Implementation Responsibilities:

The Health Project Coordination Unit (PCU) will be solely responsible for the implementation of the Hospital Restructuring component. Established in 1995 to implement the IDA Health Credit, it has a comparative advantage in procuring medical equipment, hospital civil works, and technical assistance for health specialists, such as hospital architects and health planners. The main functions of the PCU will be to: (a) support and oversee all program implementation related to the Hospital Restructuring component, including quality assurance; (b) produce consolidated management reports to the Bank for the component; and (c) ensure that Bank guidelines and procedures are followed.

The SATAC PIU was established by a Presidential decree in 1994 and has successfully implemented the IBC (closed June 1998), SATAC I (closed December 1998), and the ongoing SATAC II, and IDF Grants for Public Procurement and the Georgia Investment Center. Although the PIU staff have excellent skills in the areas of consultant contracting and procurement of goods, they will need to receive some training in financial management in order to manage this project. The main functions of the PIU would be to: (a) support and oversee all program implementation related to the three other components includingquality assurance; (b) produce consolidated management reports to the Bank for the three components; and (c) ensure that Bank guidelines and procedures are followed.

Project Operational Manual (POM). A POM is being prepared to facilitate the management and implementation of the project. The POM includes: (i) detailed project objectives and description; (ii) key implementation issues and strategies; (iii) summary of procedures for monitoring project implementation; (iv) guidelines for processing withdrawal applications under the Credit; (v) methods of procurement to be followed as per the Procurement Schedule in the Credit Agreement; (vi) guidelines for the use of Statements of Expenditures (SOEs) and overall project funds; (vii) procedures for using the Special Account, including those for replenishment; (viii) sample bidding documents and contracts for national shopping of civil works; and (ix) financial management. ***Assurances were received at Negotiations that the POM would be completed by December 31, 1999 and maintained in a form satisfactory to IDA.***

Disbursement Mechanisms. The proposed project is expected to be disbursed over a period of two and one-half years. The disbursement profile of the project has been based on experience gained during the three previous IDA projects. The project has been designed within the capacity of the Health PCU and SATAC PIU to execute over a two and one-half year period. The Closing Date will be March 31, 2002.

By project effectiveness, an acceptable financial management system (FMS) will have been put in place. Disbursements will start using traditional disbursement mechanisms – Statements of Expenditures (SOEs) reimbursements, direct payment, etc. After the PCU and PIU have gained experience with the FMS and reporting under project management reports (PMRs), and provided that an improved FMS is reviewed and found satisfactory by the Bank, the project could move to PMR-based disbursements. All disbursements against contracts for goods exceeding US$200,000 equivalent, and services and training for consulting firms valued at $100,000 or more, and for individual consultants valued at $50,000 or more, will be fully documented. This documentation will be made available for the required audit as well as to the Bank supervision missions, and will be retained by the PCU and PIU for at least one year after

receipt by the Bank of the audit report for the year in which the last disbursement was made. The processing, disbursement and monitoring of the allocations of the proceeds of the IDA Credit and Borrower counterpart financing will be managed by the PCU and PIU in coordination and consultation with the Ministry of Finance.

Special Accounts. To facilitate timely project implementation, the Borrower will establish, maintain and operate, under conditions acceptable to the Bank, two Special Accounts – one for Part A of the Project being implemented by the Health PCU and one for all other Parts of the Project being implemented by the SATAC PIU -- in US dollars in a commercial bank(s), acceptable to the Bank. During the early stage of the project, the initial aggregate authorized allocation of both Special Accounts will be limited to US$400,000. However, when the aggregate disbursements under the credit (all Parts) have reached $1.5 million equivalent, the initial allocations of both Special Accounts may be increased up to an authorized allocation of $800,000 by submitting the relevant Application for Withdrawal. The minimum amount of each application should be 20% of the authorized allocation. Replenishment applications should be submitted by the respective PCUs at least every three months, and must include reconciled bank statements as well as other appropriate supporting documents.

Finance, Accounting, and Auditing Arrangements. The Health PCU and the SATAC PIU will each be responsible for the financial management of the project. The Financial and Accounting Officers in the PCU and PIU will design a Project and Financial Management Information System (MIS) which will include, *inter alia*, an accounting and control module with the capability to record and retrieve, in a timely manner, all financial transactions under the project. The MIS will comply with internationally accepted standards, and will: (i) reliably record and report all assets, liabilities, and financial transactions of the project; (ii) provide reliable financial information for managing and monitoring project activities. The accounting module will have a Chart of Accounts, which will reflect the sources of funds; it will be broken down into different types of expenditures by type and component. Furthermore, it will provide information on the receipt and use of funds and will be able to produce financial reports comparing budget with actual expenditures at any given time. The system will be capable of providing financial data to measure performance when linked tot he outputs of the project. The PCU and PIU will each maintain consolidated accounts and will ensure appropriate recording of the funds provided. The PCU and PIU will prepare PMRs on a quarterly basis. These reports will include financial statements, project progress reports and procurement management reports. The PMR will be in a format discussed during Negotiations and will follow examples given in the Bank's LACI Implementation Handbook. The Special Accounts will be audited in accordance with the *Guidelines for Financial Reporting and Auditing of Projects Financed by the World Bank* (March 1982) and the *Financial Accounting Reporting and Auditing Handbook,* 1995. The audit reports will be of such scope and detail as the Bank may reasonably request, including a separate opinion by an independent auditor, acceptable to IDA, for SOEs against which disbursements have been made or are due to be made from the credit, and SOEs which will be included in the audit reports accompanying the financial statements. The audited financial statements of the Special Accounts, and SOEs of the preceding year, including a separate opinion by the auditor on disbursements made against certified SOEs, will be sent to the Bank within six months of the end of the fiscal year.

D: Project Rationale

1. Project alternatives considered and reasons for rejection:

Split this operation into two credits – a Hospital Restructuring credit, and a stand-alone TA credit. During project preparation it became clear that programs such as hospital restructuring and strategic privatization required strong political will and ownership throughout the Government structure. For the Hospital Restructuring component to succeed, support and cooperation from other ministries (Ministry of Finance, Ministry of State Property Management, Ministry of Social Security, Labor and Employment) are essential. Likewise, strategic privatization and strengthening of regulatory authority in sectors suchas energy, transport, and telecommunications require coordination and agreement between the sector

ministries, the Ministry of Economy, the regulatory bodies, the Ministry of Finance, and the Ministry of State Property Management. By packaging assistance in this manner, it was possible to build ownership and commitment to the operation both vertically, and horizontally, within Government.

Implementing hospital restructuring in other regions of Georgia: This is a very political and difficult step and thus it is necessary to proceed in a phased manner. Similar hospital master plans have already been prepared for the main cities in Georgia and an alternative strategy has been developed for rural areas. These could proceed once success has been demonstrated in Tbilisi. The project would cover additional technical assistance to help the regions in this process.

Restructure other types of facilities such as ambulatories, polyclinics, and san-epid stations: The necessary investment to improve the quality of health care in Georgian hospitals is unaffordable at this time and according to the IFC, this investment is unlikely to come from outside Georgia. The rationalization plan not only solves the problem of an excessive delivery system, but also provides needed funds for these capital investments. Hospitals also consume a larger share of resources and therefore are better candidates for efficiencies gains. Restructuring polyclinics and ambulatories is a logical next step and could be supported by the proposed Health II project.

Leave the support for large scale privatization to other donors: Other donors such as the European Union and USAID have been very active in preparing the privatization of the telecommunication sector and of Poti Port. However, the Government would prefer that the Bank takes the lead in assisting with the actual transactions to avoid possible national preferences in attracting strategic investors. The Bank would closely coordinate with all donors involved.

2. Major related projects financed by the Bank and/or other development agencies (completed, ongoing and planned):

Sector issue	Project	Latest Supervision (Form 590) Ratings (Bank-financed projects only)	
		Implementation Progress (IP)	Development Objective (DO)
Bank-financed			
Technical Assistance (privatization, health sector reforms, development of capacity to carry out household surveys).	SATAC I	S	S
Technical Assistance (preparation of hospital restructuring plan, strategic privatization of electricity sector, assistance in drafting private pension law and regulation, assistance to MOF, Customs and Tax Administration, and poverty monitoring).	SATAC II	S	S
Technical Assistance (accreditation and licensing of medical schools, health care providers and health care facilities, consolidation of hospitals in Zone 1 in Tbilisi as part of the project).	Health	S	U
Public Sector	Public Sector Reform (planned)	N/A	N/A
Public Sector	Civil Service IDF	N/A	N/A
Public Sector	Procurement IDF	N/A	N/A
Other development agencies			
USAID	Hospital partnership to improve management capacity and quality of care in a Tbilisi hospital twinned with a hospital in Atlanta (completed).	N/A	N/A
	Executive management program at the Center for Continuing Education and graduate program in Health Care Administration (planned).	N/A	N/A
Japanese International Cooperation Agency (JICA)	Provision of equipment to hospitals in Tbilisi (planned).	N/A	N/A
UNICEF	Community financing initiatives (planned).	N/A	N/A
UK Know How Fund, WHO	Revolving pharmaceutical scheme in Kutaisi (ongoing).	N/A	N/A
UK Department for International Development (DFID)	Assistance for Civil Service Reform.	N/A	N/A
Health-Net International	Management training at district level (planned).	N/A	N/A
EU-TACIS	Employment Services Project (ongoing).	N/A	N/A
	Privatization program for Poti Port.	N/A	N/A
USAID	Fiscal Reform Project (ongoing).	N/A	N/A
	Assistance to Ministry of Finance.	N/A	N/A
	Assistance to GNERC.	N/A	N/A

IP/DO Ratings: HS (Highly Satisfactory), S (Satisfactory), U (Unsatisfactory), HU (Highly Unsatisfactory)

3. Lessons learned and reflected in the project design:

Technical assistance projects have a mixed performance record both within the Bank and the ECA Region. However, without adequate technical assistance in place, essential policy and institutional reforms cannot be implemented successfully and are unlikely to be sustainable. Georgia has used well the four approved technical assistance credits (IBC, SATAC, SATAC 2, Oil IBC). All of them have disbursed according to expectations, and project components have met their development objectives. This successful track record may be explained in part by the very close relationship between technical assistance activities financed under World Bank projects and the Government's economic reform program. In this context, the proposed SRS credit is similar to previous operations, as it supports the SAC 3 and ESAC policy measures.

A review of lessons from implementation of health projects in ECA countries shows that: (1) health sector reform is a lengthy, politicized process requiring (a) carefully sequenced changes; (b) strong support to strengthen countries' over-stretched institutional capacity for implementing reforms; and (c) marketing of reforms to lawmakers, the medical community and the public. (2) simple projects with uncomplicated implementation arrangements are more likely to succeed; and (3)shorter projects linked to smaller, more realistic sets of reforms are more likely to be effective. The hospital restructuring component takes these factors into account by:

- Taking advantage of the momentum and political commitment that has developed in Georgia following the preparation of the hospital restructuring plan.

- Focusing on a single key issue, restructuring the sector, in order to save money to invest in improving the quality of health services.

- Including a large amount of technical assistance to ensure true capacity building and sustainability of the investment.

- Including an extensive public relations program, which has already begun with a conference in April 1999 where the plan was discussed with physicians, lawmakers, government officials, and other key decision-makers.

In developing anti-corruption strategies for countries in the Region, use of surveys and publication of the results with an Action Plan has served as a strong signal of Government and political commitment to reform. They have also been extremely effective in creating external pressures for reform, and for introducing greater transparency about the implementation and impact of reform. These instruments were used in Georgia, and the components in this project seeking to address corruption (delicensing and public procurement reforms) were developed and agreed as a part of the Government's anti-corruption strategy. While implementation of the anti-corruption action plan has been mixed, the proposed SRS credit focuses on the two most successful areas, i.e., procurement reform and delicensing.

The lack of public understanding, and resulting opposition, to certain World Bank sponsored reform programs in the past has resulted in substantial allocation of funds for Public Education and Information, with the aim of bringing stakeholders on board and enlisting their support for the program.

4. Indications of borrower commitment and ownership:

During the preparation mission, the Bank team met with all Government ministries and agencies involved in this project. Counterparts were supportive of the operation and encouraged a rapid approval. Even the hospital restructuring component, which is particularly controversial, has the support of not only the Ministry of Health, but of the Ministry of Finance, Ministry of State Property Management, and the

President's Office. This commitment extends to the highest levels of Government – during his visit to Washington in April, President Shevardnadze requested early approval of this project from Mr. Wolfensohn.

Much of the technical assistance required to prepare the project was financed by the Government under SATAC II. For example, for the hospital restructuring component, SATAC II financed the preparation of the Hospital Masterplan, options for human resources strategies, legal advice, and design of a communications program.

5. Value added of Bank support in this project:

The Bank's support is critical. Several of the reforms supported under this operation require political will, and/or effective communications to the public regarding the rationale and need for these changes. Examples include hospital consolidation, privatization of difficult sectors such as telecom and ports, and anti-corruption measures supported under the project. The Bank is well-placed to respond to the Government's requests in these areas by combining policy advice, balance of payment and budgetary support, and financing of technical assistance.

Significant work is ongoing in all areas supported by this proposed credit – through projects under preparation or implementation, or through economic and sector work. The Health project has provided a good foundation for the work on the Hospital Restructuring, and much of the preparatory activities were funded by prior technical assistance credits. The Bank was asked to assist the Government in examining options for privatization of the telecommunications companies and Poti port, and has worked closely with EU-TACIS and USAID in this area. Significant work in the energy sector has been done, including assistance in privatization of Telasi (Tbilisi's electricity distribution company), and assistance to GNERC on regulatory issues. Technical assistance and policy advice in developing an anti-corruption action plan, including surveys and workshops conducted, has framed the discussion on key measures, such as procurement and licensing reforms, the Government can take to lessen the opportunities for corruption. The Bank has worked closely on banking sector issues, including through ongoing sector work, and technical assistance in this area was provided in response to the Russia crisis. A recently completed Poverty Assessment has shaped the discussions with Government on urgent actions necessary to protect the socially vulnerable, and the Government has asked for the Bank's support in this area.

E: Summary Project Analysis (Investment Component Only —*Hospital Restructuring Component*) Detailed assessments are in the project file, see Annex 5)

1. Economic:

[x] Cost-Benefit Analysis : NPV=US$ million; ERR= % [ ] Cost Effectiveness Analysis:
[ ] Other (Specify)

With nearly 12,000 hospital beds in over 50 hospitals, Tbilisi has more hospitals than are needed or than are economically sustainable. Clear indicators of excess capacity include occupancy rates of around 40 percent and average lengths of stay or more than 11 days – both much higher than seen in OECD countries, for example. Assuming 70 percent occupancy, a more efficient average hospital size of 300 beds, and a 20 percent reduction in average length of stay , an economically optimal number of hospital beds would have been around 3,300. However, the feasibility of reducing capacity by more than 70 percent was deemed excessive taking into account uncertainties related to the demand for services. This analysis was confirmed by a set of national health account projections prepared in 1998 to assess the economic viability of several different policy options.

*2. **Financial** (see Annex 5):* NPV=US$ million; FRR= %

With the objective of reducing the number of hospitals and beds in Tbilisi, the project alternative of establishing a hospital restructuring fund which would raise at least $56 million from privatization proceeds that would be reinvested in the remaining hospitals was found to be more financially viable than other alternatives considered, including doing nothing, building totally new facilities, or upgrading all existing facilities. A financial analysis at the facility level found that the average annual cost per bed could be expected to double compared to actual reimbursement rates paid today. However, since these rates do not cover full costs, this increase is less than would be seen if all hospitals were to raise prices to reflect actual costs. The analysis found that this higher level of costs would be financially viable under the project if prices increased by 10 percent per year starting in 2002 and if payment arrears from state and municipal sources were reduced to 10 and 20 percent respectively.

*3. **Technical:***

Experience in other countries has shown that while getting incentives right in the financing of health care is essential, it is usually not sufficient to reach optimal supply levels. Instead, more proactive government intervention is required. The proposed hospital restructuring program in Georgia, if successful, could become a model for the region, where nearly every country faces similar problems but none have succeeded in significantly reducing supply. The program has the added benefit of providing additional capital that would otherwise not be available for the sector

Similarly, closing hospitals will not necessarily improve efficiency or quality of the operations of the hospitals unless organizational reforms are present. In the project, this would be accomplished through modifying the incentive structure and governance of the hospital sector as well as ensuring the availability of skilled managers.

*4. **Institutional:***

a. Executing agencies: The Health PCU and SATAC PIU would be responsible for technical coordination and daily operation and monitoring of all program activities (working closely with the relevant line ministries).

b. Project management: Project management arrangements are discussed in Section C.3. Existing PIUs (Health PCU, and SATAC PIU) will be used to implement this project, and both are quite experienced in implementing the type of operation proposed. They will each be strengthened with additional staff, to ensure their capacity to implement this operation.

c. New institution: The Hospital Restructuring Fund (HRF) will be established as part of the project in order to take responsibility for implementing the restructuring program when the project is complete. Key functions and the institutional set-up of the HRF have been agreed upon and are indicated in the Government's Statement of Intent (see Attachment 1).

*5. **Social:***

In analyzing the social impact of the proposed project, several sources of information were used. A stakeholder analysis, "Perceptions of Health Reform" was undertaken in November, 1998 as part of the mid-term review for the Georgia Health project. The study provides an understanding of the various perspectives that stakeholders have about the major accomplishments, problems, impact, and future priorities of the reforms. The stakeholders interviewed included representatives from central government, hospitals, polyclinics, providers, refugees and patients. The perspective and potential impact of hospital

restructuring on health care providers was further explored in a series of focus groups conducted in April 1999. Providers are the group most likely to face negative consequences of hospital consolidation and closure. Additional insights into the more general situation of coping strategies for unemployment are also provided in "A qualitative study of impoverishment and coping strategies", a background paper for the Poverty Assessment.

In the stakeholder analysis, the overwhelming issue identified by all groups was the lack of funding in the sector and the corresponding lack of access to good quality health care services. The overall opinion of the reforms had worsened between the baseline study in 1996 and the 1998 report. There was a sense of disillusionment and distrust in Government to do anything right. The proposed project clearly addresses the identified needs of many stakeholders in the system.

An issue identified by health care providers in both the stakeholder analysis and the focus groups was the low levels of pay. This has been substantiated by the Poverty Assessment, which found the official salaries of health care workers to be amongst the lowest in the country. However, the study also found that the income of those workers was amongst the highest. The incidence of informal payments was cited by many patients as being problematic and raises serious equity concerns (as well as being a substantial loss in tax revenue for the Government). The project will attempt to address this issue by reducing the number of staff in the sector and increasing the wages of those who will remain. Improved management in the remaining hospitals should also help to reduce the level of informal payments. The proposed study of informal payments should identify other mechanisms for decreasing the practice as well as monitoring their prevalence and level during the project.

The human resource aspects of the project pose the most social problems as it is inevitable that some staff will be laid off. The most generous compensation package that is possible given financial and labor market constraints will be offered. Other options such as retraining programs and supplementary pension funds will also be explored. The entire program will be accompanied by a communications program that will be as interested in what people have to say as in communicating what is happening and why it is happening.

6. Environmental assessment: **Environmental Category** **[ ] A** **[X] B** **[ ] C**

Justification/Rationale for category rating: The only component expected to have environmental concerns is the Hospital Restructuring component, and specifically that sub-component designed to consolidate health facilities. The component will face four issues: (i) waste management; (ii) pollution control of the incinerator; (iii) asbestos in the material of facilities to be privatized, and iv) medical waste in the facilities to be privatized. The project proposes to mitigate the above factors by: (i) providing technical assistance that will improve the operations and management of the two main host facilities (Republican Children's and Gudushauri General Hospitals) and will specifically address the issue of waste management; (ii) including incinerators in the designs of the rehabilitation to make waste disposal more safe and cost effective; (iii) ensuring that the incinerators are designed according to Western standards and are suitably located; (iv) ensuring that all buyers of privatized facilities are aware of the asbestos content of the buildings, its hazards, and locally available alternatives to use during any future rehabilitation; and (v) conducting an inventory of existing medical waste in the facilities to be privatized and preparing a removal action plan approved by IDA.

7. Participatory approach:

Several project components employed some form of participation in their design.

- The development of the hospital restructuring program was done through continuous consultation with health care providers (especially head doctors) and the Ministry of Health and later presented at a workshop to inform the public and the provider communities and get feedback.
- the social sustainability component drew from the Poverty Assessment, which used participation to better understand the nature of poverty in Georgia and coping strategies of the poor. This work contributed to the component design, and was instrumental in gaining Government ownership of the proposed reforms.

F: Sustainability and Risks

1. Sustainability:

The Government is committed to this project, up to the level of the President, assuring strong political will. Project sustainability will also be enhanced through dialogue and conditionality under SAC III.

2. Critical Risks (reflecting assumptions in the fourth column of Annex 1):

Risk	Risk Rating	Risk Minimization Measure
From Outputs to Objective		
Government implements Hospital Restructuring Program, including open, competitive sale as real estate of facilities to be closed under Phase 1. Government provides adequate budgetary support to social sectors, including health. Adequate governance of publicly owned hospitals is adopted.	S	Government has signed a Statement of Intent which outlines the principles of the program agreed upon by all agencies (MoH, MoF, MoSPM). SAC 3 conditionality on budget formulation/ execution. A public education/ relations program has been included to overcome resistance of public/providers.
Political will to support selling of largest state assets is maintained, and regulatory power granted to independent entities.	S	SAC 3 Conditionality. Actions taken to date (sale of Telasi, GNERC) support assessment of Government commitment.
Medium- to long-term sequenced and strategic support needed to make lasting institutional changes to the budget process.	M	Technical assistance will be provided to develop and implement a longer-term strategy. Ongoing work on public sector reform leading to a PSR follow-up credit will provide continued support and policy leverage.
Strict enforcement of Licensing Law and operational guidelines followed to support new Law on Public Procurement.	M	Technical assistance will be provided to assist the MoJ and MoE in this process. Ongoing work on public sector reform, leading up to a PSR adjustment credit provides policy leverage.
Political willingness to review social assistance recipient lists and improve targeting.	M	Government commitment is strong, with recognition that providing small amounts to many prevents the Government from providing meanful assistance to those most in need.

Financially sustainable public pension system and pension strategy is dependent on Government ability to manage its budget execution in a way that does not underfund pensions.	S	SAC 3 and IMF conditionality.
From Components to Outputs		
Adequate revenue from sale of hospitals not realized.	M	Project design assumptions have been used that mitigate this risk – only 80% projected value of the building (not land) has been used as an assumption.
Adequate and timely provision of required counterpart funding.	S	Project design has ensured Government ownership at all levels, vertically and horizontally. Close project supervision and dialogue will ensure that counterpart funding is provided on schedule.
Implementation capacity of Government to manage the project.	N	PIUs managing the project are very experienced, and performing well. Close project supervision will be provided.
Overall Risk Rating	S	

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

G: Main Loan Conditions

1. Effectiveness Conditions:

(i) Opening of two Borrower contribution accounts and deposit of an amount of US$ 50,000 into each account.
(ii) FMS acceptable to the Association in place.
(iii) Independent auditors have been appointed by the Borrower with experience and qualifications under terms of reference acceptable to the Association.

2. Other:

(i) Borrower to maintain two Project Accounts with a minimum balance of $50,000 each to be replenished quarterly.
(ii) Borrower's PIU and PCU to submit audit reports and audited financial statements not later than six months after the close of the fiscal year.
(iii) Mid-term review by November, 2000 to assess overall progress in project implementation, identify problem areas in project implementation and recommend remedial actions and follow-up.
(iv) Borrower to maintain adequately staffed PIU and PCU with appropriate skills.
(v) Borrower to submit to IDA by March 31, 2002, its contribution to the Implementation Completion Report.
(vi) By March 31, 2000 the Hospital Restructuring Fund has been legally established, with an Operations Manual acceptable to IDA.
(vii) PCU and PIU to strengthen its Financial Management System by December 31, 1999 to enable preparation of Project Management Reports.
(viii) The Borrower shall issue, through its Ministry of Education, standards for accreditation of medical schools based on conditions and criteria satisfactory to the Association not later than October 1, 1999, and immediately thereafter initiate the process of accreditation.

Disbursement conditions:

(ix) As a condition of disbursement for the Civil Works under the Hospital Restructuring component, the Borrower will carry out an inventory of medical waste in the facilities to be privatized, and furnish to the Association a satisfactory action plan for the removal of such waste.

(x) As a condition of disbursement for the Public Sector Reform/Information component, the Public Information Center will be legally reestablished under the Office of the President.

H. Readiness for Implementation

[X] The engineering design documents for the first year's activities are complete and ready for the start of project implementation. [ ] Not applicable.

[ ] The procurement documents for the first year's activities are complete and ready for the start of project implementation.

[X] The Project Implementation Plan has been appraised and found to be realistic and of satisfactory quality.

[ ] The following items are lacking and are discussed under loan conditions (Section G):

I. Compliance with Bank Policies

[X] This project complies with all applicable Bank policies.

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Sector Leaders: Ataman Aksoy, ECSPE and Annette Dixon, ECSHD

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Annex 1

Project Design Summary

Georgia: Structural Reform Support Project

Narrative Summary	Key Performance Indicators	Monitoring and Evaluation	Critical Assumptions
Sector-related CAS Goal: Three of the four CAS objectives are being addressed under the proposed SRS: (i) "strengthening public finance" through improved tax and customs administration, civil service reform, increased cost recovery, and shifts in expenditure composition; (ii) "deepening and diversifying sources of growth" through mobilization of private capital and reduced government role in productive functions; and (iii) "reducing poverty" through better targeted social safety net programs.			**(Goal to Bank Mission)** Factors outside of control of government (such as civil conflicts, Russia crisis) would negatively influence economic performance and increase poverty.
Project Development Objective: The objective of the project is to accelerate the change in the respective functions of the private and the public sectors in delivering key services.			**(Objective to Goal)** Political environment continues to be supportive of building a market-based economy with an increased "public goods" focus for government intervention. Weak resource mobilization performance threatens sustainability of reforms and poverty alleviation goal.
Outputs: (a) Fewer public sector hospitals with improved quality and efficiency of services.	Decrease in number of public medical facilities (facilities sold as real estate, restructured hospitals). Decrease in overall staffing and changed composition of staff; shorter average length of stay in hospital. Decrease in post-operative infection rates. Decrease in informal payments in Tbilisi Hospitals	Hospital Restructuring Fund to establish monitoring and reporting system. Project reports and supervision.	**(Outputs to Objective)** Hospital Restructuring Program fully implemented. Competitive public procurement procedures are accepted and followed; contractors are competent.

(b) Improved allocation and higher effectiveness of budget management process and the use of public resources.	Decrease in difference between budgeted and executed expenditure for core expenditure categories in FY2000.	Ministry of Finance Project reports and supervision.	No arrears accumulation in FY2000.
(c) Competitive procurement introduced and effective licensing.	Department for State Procurement (MOE) fully operational and fulfilling its functions. Licensing of economic activities in accordance with new Law on Licensing; decreasing number of licensing abuse complaints.	Ministry of Economy Ministry of Justice	New institutional and legal framework is rapidly implemented and operational guidelines followed. Strict enforcement of Law on Licensing.
(d) Improved government communications on reforms.	Improved coordination and quality of information across agencies. Information Center transferred to President's Office and effective in coordinating other Press Offices.	Information Center in the President's Office. Project reports and supervision.	Continued political support for improved communication on reforms. Overcome existing weaknesses in information sharing.
(e) Privately-owned infrastructure "operators" for telecommunications, energy, and ports. Improved quality of services.	Telecommunication companies privatized and Poti port privately operated. Strategic investment in sectors.	Ministry of State Property Management	Political resistance to selling largest state assets is overcome. Investor interest in Georgia is sufficient to mitigate external risks.
(f) Regulatory frameworks adopted and operational for telecom, energy, ports.	Laws and regulations in place in time to attract foreign investors. Establishment of regulatory capacities.	GNERC, Ministry of Economy, Parliament	Granting regulatory power to independent entities is accepted.
(g) Consolidated banking sector.	Fewer banks with stronger balance sheets and institutional capacities. Improved capacity of NBG to manage failing banks.	NBG	NBG's independence is maintained.
(h) Social safety net programs reaching their recipients and improved information base for revising programs.	Lists of recipients are reviewed and targeting improved.	Ministry of Social Security, Labor and Employment	Willingness to identify ghost recipients and continue strengthening targeting capacity.

(i) Financially sustainable public pension system and pension strategy designed.	Improved capacity to manage and model public pension fund. Pension reform strategy formulated.	Ministry of Social Security, Labor and Employment; State Pension Fund	Long term view of pension provision (fighting "short term blindness")
Project Components/Sub-components: (see Annex 2 for project description) A. Hospital Restructuring and Financing of Health Care B. Private Sector Development and Financial Sector C. Public Sector Reform/Public Information D. Social Sustainability E. Project Management (components B-D)	**Inputs: (budget for each component)** $9.97 $4.49 $2.70 $2.48 $0.16		

Annex 2
Georgia Structural Reform Support Project
Project Description

Project Component A – Hospital Restructuring–

US$ 9.97 million of Total Project Costs (project files contain more detailed information on this component)

Background:

The Georgian fiscal crisis has hit the health sector particularly hard. Public financing for health fell to less than US$7 per person in 1998, representing 6% of public spending. A comprehensive health sector reform began in 1995 and is supported by a World Bank financed project. Public enthusiasm for creating what some considered to be revolutionary change in the health system has been replaced by disillusionment and frustration. For the reforms to succeed, two main sectoral issues must be addressed: (1) additional resources must be raised by improving the tax collection system; and (2) efficiency must be improved by reducing capacity. The proposed structural adjustment program proposes to do both.

The majority of public financing for health comes from a 4% payroll tax and transfers from the central budget. But 87% of *total* health spending comes from patients themselves. This is an unprecedented level of out-of-pocket spending which not surprisingly, has been found to be one of the major causes of families slipping into poverty. Additional public revenue is needed to allow risk pooling and targeting of services for those unable to pay.

The excess capacity in the Georgian health system is a remnant of the old Soviet system. Today, Georgia has 287 hospitals with nearly 25,000 hospital beds, with a ratio of 4.5 beds per 1000 population compared to 2.5 per 1000 population on average in OECD countries, and occupancy rates of 28% (more than one hundred hospitals had occupancy rates less than 10% in 1998) and average lengths of stay (ALOS) of 10.5 days. Improvements in primary health care and introduction of new forms of technology are also likely to further diminish the demand for hospitals. There is a corresponding surplus of health care providers, especially physicians, with one physician per 245 population compared with one per 400 population in the OECD. This situation could potentially worsen with the opening of more than fifty private medical schools since 1995.

Spreading scarce resources over so many facilities has diluted the amount of money spent on capital investments, maintenance, supplies, and salaries in hospitals. Reducing the number of hospital beds without concurrent reductions in space (thus saving on utility and maintenance expenses) or staff will result in little cost savings for the hospital. An assessment of all of the hospitals in Tbilisi determined that financing only the civil works needed for these buildings to bring them up to minimal standards would cost US$100 million. More than 80% of the existing medical equipment is either outdated or out of service and should be replaced as well. To upgrade all 287 hospitals in the country would cost more than US$200 million.

Hospitals have been reluctant to lay off staff, despite the Government having removed more than 130,000 health workers from the budget in 1995. The practice of low official salaries paid to health care providers, supplemented with illegal payments made directly from patients, provides them with little incentive. Today, the average annual salary of a typical physician practicing in a hospital is 573 GEL, while the minimal subsistence level of income in Georgia for one person is 1,080 GEL (as cited in the

Poverty Assessment). This results in absurd staffing ratios. A recent cost study of 41 hospitals in Georgia found that on average, one and a half physicians served each occupied hospital bed. The importance of performing sufficient clinical procedures to maintain skill levels is well documented and the problems with excess supply in Georgia directly affect quality as well. The social assessment documents cases where health providers had to *pay* to get access to hospitals and wards with more patients so that they would be able to earn more from informal payments.

Clearly, these deteriorations in the system also affect the quality of care in more direct ways. Many hospitals lack water or electricity and there are reported incidents of patients dying on the operating table when the power has gone off. During preparation of the hospital masterplan, 90% of hospitals in the country were found to be unsafe. Certainly the decline in rates of hospitalization and lengths of stay can in part be explained by a decreasing ability of patients to pay for these services out of pocket and but also a recognition that hospitals today in Georgia can be very dangerous places.

Government's strategy to reduce the capacity of the health care system

In 1995, in response to the economic crisis that brought public expenditures on health to a level of less than US$1 per capita, the Government launched an ambitious health sector reform program. The vision of the future health system was a social insurance model, maintaining the principles of solidarity and equity. Good health would be maintained through a primary care based system, which emphasized health promotion and disease prevention. While financing was to remain semi-public through social insurance, provision of services was to be mostly private, with a few key facilities remaining in public hands in order to ensure access to remote areas and specialized services. Competition between providers was to be introduced, and reimbursement for services provided paid through a new intermediary agency, the State Health Agency.

The Government's 1996 Health Strategy identified excess capacity as an issue and proposes three alternative means to address the problem:

- changing the incentives to providers with a new payment system that reimbursed only those services actually provided;
- accrediting and licensing medical institutions and personnel and denying the right to practice to those not licensed; and
- privatizing a large portion of the sector

Provider Payment Reforms: As part of the reforms, the legal status of hospitals was changed from budget institution to state enterprise. The main implication of this action was creation of a financial separation for health facilities from the national budget and introduction of a new case-based payment method. Simultaneously, staff salaries were also removed from the budget and employees were no longer considered civil servants. This was an attempt to put in place the right incentives for improving the efficiency of the system and also to divest the central government from many responsibilities it was no longer able to fulfill. Unfortunately, the government is such a small player in financial terms any more, that its ability to influence the sector through financial incentives is limited.

Licensing and Accreditation: The Ministry of Health has assumed the role of licensing health facilities and by end 1998, more than 250 hospitals had been licensed. The process of licensing health care providers is now underway with significant numbers of both graduating students and practicing physicians failing the exam. The law stipulates that all physicians must be licensed by December 31,

2000. The most problematic issue has been the growing number of medical schools. More than fifty private medical schools have opened since 1991, with an enrollment of 14,000 and an expected annual graduating class of 3,000. A Commission of Accreditation was formed in 1996 in accordance with the Health Law. Newer legislation in 1998, however, passed this responsibility over to the Ministry of Education, resulting in some delays in the process and closure of few schools. While the number of entrants has begun to decline in response to the market, it is important that the process of accreditation resume.

These two strategies – changing incentives through new provider payment mechanisms and denying the right to practice to those who do not pass minimum qualifying standards - have been somewhat successful and explain a part of the decrease in beds and physicians that is seen since 1995, when the reform program began. However, as has been seen in other countries, market approaches to capacity reduction are not sufficient to reach optimal supply levels. The health care market has many peculiarities including an asymmetry of information between providers and consumers and the ability of providers to generate their own demand. The market approaches must be complimented with a more proactive policy to liquidate government-owned assets and limit entry into the medical profession.

In 1996, the Law of Privatization of Public Enterprises established the general rules for the privatization of state enterprises as well as special rules for the privatization of health care facilities. A two-year privatization program drafted by the MoH has been in operation since 1995. The law divides health facilities into three *groups*: 1) pharmacies and dentists' offices; 2) ambulatories and policlinics; and 3) hospitals. In addition to the three groups, facilities were divided into three *categories*. Categories A and B create restrictions in the property right of purchasers, while category C gives unrestricted property rights. Category A facilities must continue to operate as health service organizations providing the same type and scope of services as they did prior to privatization. This was done primarily to ensure access to isolated groups or highly specialized services. Category B facilities have a ten-year period before their use becomes unrestricted. Category C facilities have no restrictions or property rights.

A first batch of 400 facilities was privatized during 1996-1997 including pharmacies and dental offices. Progress in the other two groups has been slow. In December, 1997 a Presidential Decree was issued giving the Ministry of Health one month to produce a list of "essential" facilities to be kept under public ownership. Another order from President Shevardnadze was issued in 1998 listing the 250 Category A hospitals, policlinics, and research centers that were to remain in the public domain. The order also listed the facilities to be privatized (120) with most (70) in Tbilisi. Originally, the revenues from privatization were earmarked to go to the State Health Fund (since merged with the State Medical Insurance Company – SMIC) and approximately 2.1 GEL were earned and transferred. Later however, as part of the budget reforms, the money was reassigned to the central budget (as was revenues from excise taxes) and the SHA was to receive its funding from two sources – the 3+1 payroll tax and the central budget).

The Bank has encouraged development and implementation of a rational approach to privatization of health care facilities, particularly hospitals, in its policy dialogue and adjustment lending. This is further supported by the Health Project, which will consolidate maternal and child health services into two referral centers in Tbilisi and Kutaisi.

Development of a Hospital Masterplan and Restructuring Strategy

Most recently, Bank financing from SATACII supported preparation of a hospital masterplan and development of a restructuring and privatization strategy. In Tbilisi there are currently more than fifty hospitals with 11,915 beds serving a population of approximately 1.4 million. The needs assessment projected approximately 3,600 beds would be sufficient, using conservative assumptions on demand, occupancy rates, average lengths of stay, and population growth. A computerized inventory of each of

the 287 hospitals in the country was completed in 1998. The intent is that these data be used not only as input into the hospital master plan, but also be used as a management tool for both the individual hospitals and the Ministry of Health. Using the data from the inventory, each hospital passed through a 4-stage screening process. The criteria for passing through stage 1 were based on location, bed capacity, age of the building, and seismic safety. Hospitals were stopped at stage 2 if they had low capacity or utilization, did not meet certain departmental standards (e.g. for laboratory and radiology) or it was determined that physical upgrades would be overly expensive. Stage three evaluated the level of investment needed to bring each facility to an appropriate standard. The final stage selected facilities to remain in the public domain based on location, scope and level of services, and necessary capital investments. The plan for Tbilisi was completed first and discussed with the Government and other stakeholders in September, 1998 and the plan for the rest of the country in April, 1999.

The Tbilisi Hospital Masterplan

The implementation plan for hospital restructuring has progressed furthest in Tbilisi, where more than half of all the country's beds are located and efficiency gains are likely to be greatest. This component of the proposed project would support implementation of the Tbilisi Hospital Masterplan (THMP), which could later be extended to other areas of the country. The plan recommends:

- 12 facilities remain in the public sector (category A)
- 7 facilities be leased to the private sector (category B)
- 27 facilities be sold (category C)
- 5 facilities remain property of the Ministry of Health but be converted into housing for nurses or geriatric nursing homes.

Attachment 2 lists the twelve hospitals that would remain under public ownership. The guiding principles are that the hospitals will be managerially independent, self-financing, restructure their staff so that salaries can be increased, and introduce strong quality assurance programs. Three hospitals, Republican Children's, Republican Central, and Policlinic #5, have been designated as the primary centers for each zone. The plan was developed so that access would be ensured. Everyone in the city is within 30 minutes of one of these hospitals and within 20 minutes of emergency services. Many of the hospitals slated for closure are research institutes, which see very few patients and have indicated their preference for moving into the larger and better-endowed hospitals. As part of the exercise, the team interviewed head doctors at many of the facilities, attempting to assess their opinions towards various restructuring options such as merging with other hospitals with a renovated building and sharing support services; privatizing and remaining in their facility, or remaining as today. There was a surprising level of support, especially in research facilities that see very few patients.

The implementation section of the Tbilisi Hospital Masterplan proposed an innovative way to finance the program: set up a fund to use privatization proceeds to upgrade facilities remaining in the public sector and cover the costs of the transition, such as employee compensation and a public relations program. Consolidation and relocation of the needed beds and functions in larger, newer facilities releases the oldest, smallest, most inflexible and therefore least suitable buildings for hospitals, for sale or lease. These are located in the best parts of town and are well suited for renovation into hotels, housing, clubs, etc. Most are of great historic value and also have the highest real estate values. They would be sold as buildings, not as hospitals. Sale of these buildings at 80% of market prices (as determined by local real estate agents) is estimated to recover US$56 million. Recent passage of a law allowing privatization of urban land should increase the value of the properties. In order not to flood the real estate market and to minimize disturbing the delivery of services, the plan would be implemented in three phases. Phase 1, which this project proposes to partly finance, would lead to the sale of at least ten buildings estimated to

be worth US$18 million. The construction and remodeling costs to integrate services from these institutions into the twelve remaining public institutions would cost US$2.1 million. The remaining funds would be used to provide more extensive upgrades throughout the hospitals, purchase medical equipment, provide redundant workers with severance packages and/or retraining, and run an intensive public relations program about the project. Detailed breakdowns of the cost of remodeling, construction, and equipment as well as market value of the facilities to be sold is included in Attachment 3.

Human Resources Strategy:

The masterplan recognizes the need to decrease the number of staff, but focuses mostly on the identification, phasing, and cost of consolidating and selling the hospitals. Additional funds from SATAC II have been used for technical assistance to explore options for dealing with the human resources (HR) issues associated with the restructuring program. The first objective of the strategy is that it be based on the principle that the transitional package will be attractive to employees, will assist in fostering "buy in" to the change, and will be within the cost constraints imposed by the availability of funds. To be effective this package must: (1) assist in the retention of essential staff; (2) encourage employees without requisite skills to leave; and (3) provide incentives for retraining or redeployment to those who already have the necessary skills or are capable of acquiring those skills. The second objective of the strategy is to develop an ongoing human resources regime that ensures remuneration is linked to performance and actual delivery of health services.

The scale of change envisaged under the restructuring program will mean that significant numbers of staff will lose their jobs – the MoH estimates approximately one-third. To facilitate the acceptance of the change and to reduce opposition the MoH will: (1) ensure compliance with all legal requirements; (2) inform staff very clearly of the rationale, process, timeframe, and range of options open to them; and (3) put in place a communications strategy to inform the public of the reasons for the changes and expected benefits.

Several possible options will be considered: redeployment, retraining, job search and career counselling, early retirement, supplementary pension fund, and a one-time severance payment. Most countries that have undergone similar reductions in their public sector have opted for a one-time payment, partly because it tends to be the option preferred by employees as well. Several severance options have been identified and preliminary cost estimates are available. Assuming the number of redundancies is approximately 1000, the cost of providing the absolute minimum compensation required by Georgian law would be approximately 400,000 GEL. Modeling four different options depending on length of service and trying to account for informal income of providers, the most expensive severance option totaled with a range of 2,822 GEL to 144 GEL per employee, depending on position. The government will need to decide early on which option to implement.

Objectives of the Component:

The Hospital Restructuring Component has two objectives, to improve the efficiency of the health care system by reducing the number of hospitals and personnel in the city of Tbilisi and to ensure the quality and financial sustainability of the hospitals that remain.

Sub-Component A1. Hospital Consolidation – US$ 8.63 million (total project cost)

Specific activities to be financed

The project will help the GoG set up and initiate activities of a Hospital Restructuring Fund (HRF). The Fund would be revolving -- replenished with proceeds from facilities that were sold and using them to

upgrade the remaining facilities and compensate redundant staff. The HRF will likely continue to function for at least ten years as the rationalization process is carried out in three-phases in Tbilisi. The following expenditures would be eligible for financing under the HRF:

- Remodeling and upgrading building infrastructure of facilities which are to remain under public ownership (twelve according to the THMP).
- Medical equipment for the public sector facilities.
- Human resources programs including a transitional package for redundant staff which might include severance payments and retraining programs.
- Public relations program.
- Feasibility studies for other related activities such as setting up a supplementary pension fund, establishing a hospital based HMO, etc.
- Operating expenses of the HRF.

Development of a Hospital Restructuring Fund:

Implementation of a hospital restructuring program in Tbilisi will extend beyond the life of this project. In order to ensure continuation of the implantation of the program, part of the project will be devoted to establishing an HRF. The Fund would have a Board comprising representatives of various stakeholders such as the MoH, the Ministry of Finance, the Ministry of State Property Management, the municipality of Tbilisi, and employee and employer representatives. The Board's responsibilities would be primarily to oversee the implementation as well as monitor the impact of the agreed upon restructuring program. The Bank would finance technical assistance to advise the Board to carry out its functions and evolve into an independent fund, such as additional market research, legal counsel, and financial management. By March 31, 2000 the Fund will have been established as a legal entity and an operational manual prepared. By the end of the project, the Fund will be fully capable of assuming fulltime responsibility for implementing the rest of the restructuring program in Tbilisi and perhaps nationwide. At some point the mandate of the HRF might be extended to include policlinics. The Bank would also finance minor civil works and office equipment and furniture to set up the location of the HRF.

The Government has signed a Statement of Intent confirming the key elements of the Hospital Restructuring Program. The Statement of Intent also includes the following agreements:

- *the privatization will be open and competitive, with no preference given to the staff.*
- *the building is being purchased as real estate and can be used for any purpose.*
- *The Ministry of State Property Management will take 7 percent of the sale price as payment for managing the transaction and the remaining money will be put into an earmarked account for implementation of this program.*
- *that eligible expenditures are the hospital investment program, severance packages and other transitional costs related to the privatization, a public information campaign, and administrative expenses of the HRF.*

Remodeling and Equipping Facilities:

During the life of the project, the facilities will be privatized and sold as real estate in a competitive market. The actual process of privatization will be carried out by the Ministry of State Property Management (MoSPM). The Board of the HRF would work with the MoSPM to oversee the phasing of the sales. Bank financing would be used to initiate the civil works and purchase of medical equipment and medical furniture in four hospitals that will receive the services of the ten hospitals slated for closure under the project . A detailed description of the rehabilitation needs and medical equipment requirements

is provided in the project implementation plan. The cost estimates for phases two and three of the program assume substantial investments in medical equipment which may need to be financed elsewhere, possibly by other donors. The viability of future phases will depend on how successful the first phase progresses, particularly on the value received for the privatized facilities and land. Technical assistance for the engineering design and construction supervision will be financed under the project. Computer and IT equipment and office furniture would be purchased for those staff moving from research institutes.

Development and Implementation of Human Resources Programs:

The consolidation of Tbilisi hospitals poses some human resources issues that are relatively new to the health sector in Georgia. Those issues are:

- The management of a transition involving redundancy for a significant number of staff and the transfer of staff between facilities and functions;

- The management of a transitional package with a range of options being made available to affected workers; and

- A requirement to re-appoint staff to positions on the basis of merit rather than service.

This process is important to the success of the overall project as changes to management and performance culture in the renewed facilities are essential to ensure that those facilities focus on improved health outcomes. The component will provide technical assistance to the Georgian agencies involved in the following areas: i) refinement and selection of the final options in regard to the transition process; ii) new processes such as appointments, staff transfers, development of contracts and performance agreements; iii) assistance with the transition process, e.g. notice requirements and timing; and iv) development of an human resource strategy for the sector.

Public Information Campaign:

The Government recognizes that disseminating information, monitoring public opinion and promoting successes are keys to implementing reforms successfully. The hospital restructuring program could face significant opposition that would slow and possible derail its implementation. Therefore, the Public Information Campaign would provide essential support to the restructuring program by: (i) informing the general public and health care providers about the goals and progress of the reforms; and (ii) using this information and targeted messages to highlight the benefits and build support among key beneficiary groups. Specifically, this component would implement a campaign strategy over the life of the project by strengthening the Information and Media Department of the Ministry of Health; running programs and advertisements on TV, the radio, and in newspapers; and hosting public events and seminars. The impact of the campaign would be monitored through the use of benchmark and tracking polls as well as focus groups. Specific phasing has been established to update the campaign as necessary.

This component would finance foreign and local technical assistance, workshops and seminars; development, production and distribution of campaign materials (posters, banners, etc.), information handouts and booklets; production and broadcasting of TV and radio programs and advertisements; surveys, focus groups, and polls.

Sub-Component A2. Hospital Operational Reform – US$ 1.16 million (total project cost)

Specific activities to be financed

Hospital Governance, Organization and Management:

This project will address both the relationships the hospital has with Government as well as internal, organizational reforms. At the end of implementation of the hospital consolidation program, approximately twelve hospitals will remain under public ownership in Tbilisi. The Government is committed to ensuring the success of these institutions, both financially and clinically. As part of this project, the relationship between the Government, particularly the Ministry of Health, and the hospitals will be altered. It is the Ministry's intent to not be directly involved in the management of the hospitals that remain in the public sector. Decisions about the extent to which the government has control over the management and financing of, and is ultimately accountable for, the facilities are critical to the success of this project. The main principles are outlined in the Statement of Intent and will be further developed with technical assistance financed from SATAC II and from this sub-component.

The sub-component will also look at organization *within* the hospital and how it can be changed to improve efficiency and quality. The component will finance technical assistance to develop operational plans for the hospitals remaining in the public sector. These will include descriptions of the management structure, clinical operations, and quality assurance programs. The project will also finance the preparation of financial plans for the facilities that can be used as the basis for contract negotiations and risk management as well as ensuring the financial viability of the institution. Indicators of quality and efficiency that will be monitored include post-operative infection rates, complications from selected surgical procedures, average length of stay, occupancy rate, hospitals' balance sheets, and patient satisfaction.

The activities in operational reform will be complemented by a management training program for the four public sector hospitals to be included in the project. The program will include initial training in Tbilisi followed by a short-term practical internship abroad. Once managers return to their hospitals, a long-term consultant will be available in Tbilisi to rotate through the four hospitals to provide additional training.

Improving Equity of Health Care Financing:

It is not sufficient to invest in the hospital sector without ensuring the availability of funds to maintain and operate that investment. Yet the reality in Georgia today is that very little money in the health sector passes through the hands of either the central or municipal governments. A study of health expenditures in Georgia found that only 15 percent of spending on secondary and tertiary care was public. The rest was paid directly out-of-pocket by patients. In order to improve the risk pooling of this spending, ensure equal access for rich and for poor, and facilitate payment to hospitals, the project would prepare several risk pooling pilots that could be implemented with the assistance of NGOs or other international organizations. These pilots might be based on geographical area, occupation, or other group large enough to ensure sufficient pooling of risks.

The component will also study the prevalence and effects of illegal, informal payments which patients are required to pay in addition to what the Government already pays as part of the basic package or what hospitals officially charge. These payments pose serious equity concerns and also change the incentive structure put into place by the official provider payment system. Reduction in the size of these payments is an objective of the project and the study will not only identify solutions for addressing the problem, but also provide important information to monitor and evaluate the project's impact.

The component would finance foreign and local technical assistance as well as a study tour.

Sub-Component A3. Project Management (US$0.182 million of total project cost)

The Bank will finance additional cost to the Health Project PCU for procurement and financial management under this component. This will include office equipment, furniture, and training.

Project Component B –Private Sector Development and Financial Sector - US$ 4.49 million

Background

Private Sector Development: Georgia has privatized about 10,000 small-scale and 1,000 medium- and large-scale enterprises to date. While these are impressive figures, over three-quarters of the enterprise sector equity as measured by book value remains in Government's hands. In 1998, the Government expanded the scope of the privatization program to cover key infrastructure. The first transaction was completed in December, 1998, i.e., the sale of Telasi to AES. The challenge for 1999 and the years ahead is to attract strategic investors in the large remaining state-owned enterprises and to expand the program of infrastructure privatization. The Government's strategy is to rely on strategic privatization/investment and to retain financial/legal advisors to assist in the preparation and promotion of those transactions. As a signal to international investors, the Government will offer for sale in 1999 the two telecommunications companies and Poti Port. An adequate regulatory framework is critical to attract strategic investors in infrastructure enterprises. A first example can be taken from the Energy Regulatory Commission which has been granted an independent status and is strongly supported by donor programs to fulfill its function.

Financial Sector: In the second half of 1998 Georgia's financial sector faced unexpected pressures due to the impact of the Russia crisis and weaknesses in emerging non-banking financial institutions. The response of the National Bank and of the Government was rapid, letting the exchange rate float and assessing the vulnerability of banks. The consolidation of the banking sector has been accelerated with a few banks failing, and increased pressures on the NBG to loosen their licensing requirements.

Objectives of the Component

This component would address three of the critical challenges facing the privatization program and the banking sector: (i) The privatization program is currently facing the difficult challenge of infrastructure and large enterprise privatization. In this context, SRS would aim at supporting the open, competitive, strategic privatization of a few larger enterprises through the financing of financial, legal and technical advisory services. (ii) In addition this component would aim at strengthening regulatory capacity of infrastructure/utilities to enable strong private sector participation. (iii) The NBG needs to strengthen further its supervision functions and monetary policy capacity. The proposed SRS aims at continuing Bank support in this area.

Sub-component B1 Strategic Privatization of Large-Scale Enterprises (US$2.60 million)

This subcomponent would fund financial, technical and legal advisors to the Government of Georgia on strategic privatization. The first activity under this subcomponent will support the privatization of the two telecommunications companies. Draft terms of reference for the advisors have been prepared and agreed with the Ministry of State Property Management (under USAID financing). Additional funding will be reserved to cover at least one to two other state enterprises under this program, including, depending on readiness: gas companies, ports, railways, and water utilities. In addition, support in the form of two

local advisors and support to the power privatization implementation unit would be provided to the Ministry of State Property Management to assist in implementing power and gas sector privatization.

Sub-Component B2. Regulatory Capacity (US$1.20 million)

The SRS would continue to support the development of regulatory capacity in line with work begun under SATAC II. This subcomponent would finance technical assistance and training in energy utility regulation to the Georgian National Electricity Regulatory Commission, Anti-Monopoly Service, members/staff of relevant Parliamentary committees, and staff of major energy enterprises. Financing would also be provided for local working groups and a limited amount of equipment. Assistance would also be provided to develop the legal and regulatory frameworks for port operations. Additional funding will be set aside for work in other key sectors, e.g., telecommunications, private insurance/pensions, depending on the sequencing of reforms, and urgency of need.

Sub-Component B3. Financial Sector Strengthening – US$ 0.64 million

In response to a longstanding request from the President of the National Bank the proposed credit would finance a long-term advisor to the President to strengthen the NBG's overall policy-making ability, including monetary policy and strategic organization (terms of reference discussed and agreed with the IMF). In support of NBG's commitment to strengthen its bank supervisory role and liquidate problem banks, the proposed credit would finance local assistance for one year. The credit would also finance the purchase of equipment for the NBG Supervision Department to allow the upgrading of off-site supervision capacity.

Project Component C – Public Sector Reform and Public Information – US$ 2.70 million

Background

Public finance has been on the top of the Government's reform agenda since the first stage of economic reforms – the revenue base in 1994 was among the weakest in the world. The Government strategy has been three-pronged: (i) tax reform; (ii) strengthening tax and customs administration; and (iii) improving the efficiency of public spending through better expenditure planning, execution and downsizing of government. Progress has been good in tax policy and in starting the process of civil service reform. While improvements in tax and customs administration were successful in doubling the share of tax revenues to GDP during the 1995-1997 period, these efforts were not sufficient to maintain the growth momentum in 1998 and 1999. This stagnation in revenues has led to renewed tax and customs administration efforts. The Bank has been assisting in cooperation with other donors in strengtheningtax and customs administration, including through support of the ongoing contracting-out of key customs functions.

While the priority remains to increase revenues, improving the efficiency of public expenditures and of the civil service, have become essential. Civil service reform is off to a strong start, with initial legislation adopted, a government-wide Bureau in charge of coordinating the reforms appointed, and pilot programs ongoing in the Ministries of Transport and Finance. President Shevardnadze's anti-corruption program has yielded some results and important measures aimed at strengthening public procurement and delicensing of economic activity are underway. However, the challenge of designing and implementing a comprehensive anti-corruption action plan remains. Public procurement reforms are critical to introduce discipline in public expenditure, abate misuse of public funds, and to support the ongoing economic reforms and emerging private sector. Licensing reforms (actually de-licensing) are crucial so as not to

stifle private sector development and encourage rent-seeking. While initially opposed by many line ministries with licensing authority, and following an extensive consultation process with all key stakeholders in Government and Parliament, agreement has now been reached on almost all aspects of the proposed licensing regime and Parliament is expected to support the proposals.

The Government's objective in improving expenditure management is to ensure that it is efficient, transparent, and in line with the approved budget. In the past, priority expenditures, such as those on health, education and poverty benefits have suffered from revenue shortfalls, liquidity constraints and cash management weaknesses which caused large arrears especially for core social expenditures. The Government expenditure reform strategy will include measures to improve the budget management process at the planning and execution stage. A reorganization of the Ministry of Finance along functional lines is underway and management planning systems will be introduced to improve the efficiency and effectiveness of all departments within the Ministry of Finance.

Objectives of the Component

The objectives of this component are to: (i) assist the Government in developing a medium-term expenditure framework, in order to improve public expenditure allocation, budgeting, and management; (ii) support the implementation of new public procurement reforms and reform the licensing regime to make it less discretionary and more transparent; and (iii) support the continuation of the capacity building program in public information and public relations, with an aim to broaden its coverage, improve coordination of government information services, and begin reaching out to the regions of Georgia. A pre-condition for the public information component to move ahead would be a decision to move the Public Information Center to the President's Office with a clear mandate of coordinating and strengthening Government public information efforts.

Sub-Component C1. Public Expenditure Management -- US$ 0.33 million

Under this component assistance would be provided to: (a) strengthen the process and techniques of budget formulation and execution; and (b) undertake the institutional strengthening of the Ministry of Finance so that it can more effectively fulfill its mandate to formulate and execute the budget.

A public expenditure management strategy will be prepared which will include: (i) a brief review of recent progress in systems of public expenditure, taking note of external assistance provided and planned in these areas; and (ii) a detailed development program for both budget formulation and budget execution, including a timetable with major benchmarks and a program of training and technical support. In the first instance, assistance will be provided to develop the strategic approaches. Following agreement with IDA on the main conclusions of the strategies developed, assistance with a second stage of implementation in priority areas will be funded.

The technical assistance provided to enhance the budget preparation process will focus on the development of a strategy and consequently implementation of measures which will: (i) improve the coordination between macroeconomic parameters for the budget and the development of sectoral policies, priorities and expenditure programs (both for current and investment expenditures); and (ii) allow within the budget cycle a stronger phase of strategic allocation and a transparent decision-making process based on clearly articulated budgetary choices. These reforms should center around introduction of a budget framework exercise in the early stage of the budget cycle, including preparation of a budget framework paper prepared by an inter-ministerial working group headed by the Ministry of Finance. Further development of the framework will include: (i) use of the framework as a basis for consultation with the legislature on broad budget strategy; and (ii) publication of the framework as a public statement of Government expenditure plans.

The technical assistance provided for improving budget monitoring and execution will focus on a review of the progress so far in establishment of the treasury system and other aspects of budget execution and the preparation of a medium term program for further development of the treasury. The program will include a timetable for achievement of: (i) comprehensive coverage of the treasury system on a cash basis, including budget revenue and expenditure, extrabudgetary funds, and all off budget resources; and (ii) development of a comprehensive system for recording of expenditure commitments and introduction of effective commitment controls at the central and local levels.

The institutional strengthening agenda of the Ministry of Finance includes defining the functional division of responsibilities of structural units and staff of the Ministry in light of its changing role, providing for appropriate delegation of authority to different levels of staff, analyzing Ministry staffing levels and skills in relation to its tasks, preparation and implementation of a medium-term program for upgrading staff skills, preparation of realistic job descriptions and defining and implementing, as part of the civil service reform process, merit-based and transparent procedures for recruitment and promotion of staff.

This capacity building exercise has to proceed in parallel with the reassessment of the role of the state in its transition to a market-oriented economy, and of the functions that it should undertake. However, reviewing the state's functions can only be done appropriately in the context of a realistic estimate of available resources.

The technical assistance provided for the institutional strengthening element will, among other things, focus on the functional division of responsibilities of structural units and staff of the Ministry, analysis of staffing levels, preparation of job descriptions and development of merit-based and transparent procedures for recruitment, performance appraisal and career development.

Sub-Component C2. Public Procurement Reform – US$ 0.59 million

Technical assistance would be provided to strengthen the Public Procurement Department under the Ministry of Economy, and extensive training and sensitization workshops are planned to facilitate support and rapid implementation of procurement reforms.

Sub-Component C3. Licensing Reform – US$ 0.46 million

Technical assistance will be given to the Ministry of Justice to implement a new and simplified, less discretionary licensing regime based on a new Law on Licensing.

Sub-Component C4. Public Information/Education – US$ 1.32 million

Under the proposed credit, continued assistance would be provided to the Public Information Center within the State Chancellery. The Information Center has been successful in developing programs aimed at improving information available to the population on economic reforms. As a precondition for support, the Government has agreed to move the Public Information Center from the State Chancellery to the Office of the President, with a view to make it a government-wide department. The component includes financing for foreign technical assistance to the Unit; newspaper, television and radio coverage, along with advertising (on a scaled back basis); and limited training for Georgian journalists.

Project Component D – Social Sustainability – US$ 2.48 million

Background

The recently completed Georgia Poverty Assessment found that a significant portion of the population in Georgia is poor. Approximately 11% of the population can be considered poor when measured by a frugal poverty standard; and nearly 43% of the population is poor if measured by the (much more generous) official poverty line. Many of these poor Georgians will be able to escape poverty on their own, in response to economic growth and the opportunities it may generate. Others, however, may not be so fortunate: they will get stuck in chronic poverty, and without help, will fall further and further behind. For the latter, the Government has a responsibility to provide at least a minimum guaranteed level of protection, through a credible and effective safety net.

Georgia's scarce fiscal resources limit what it can achieve through traditional social protection measures. It is therefore essential to explore alternatives. It is also critical to monitor the impact of what meager social assistance does exist, and to ensure that it goes only to the most needy. Georgia's track record in this regard is not strong: despite having undertaken serious reforms of its social protection, there is a widespread perception that what assistance is provided does not reach those who are poor; or reaches them late and provides too little.

Two years ago the Government implemented an immediate five-year increase in the retirement age (to 65 for men and 60 for women). Even so, there are close to 900,000 pensioners in Georgia, over 16% of the population. At the same time, the Government abolished virtually all retirement privileges that existed in the Soviet system. Currently pensioners are receiving an extremely low (14 Lari) flat-rate monthly pension. The public pension system is in near collapse, due primarily to the very weak contribution base, given the steep decline in formal sector employment and plummeting real wages, and the widespread tax evasion and large informal economy. Given the Government's fiscal crisis, even the very minimal pension funding has not been provided on a regular basis, with arrears to the Pension Fund continuing to grow. Institutional capacity in the area of pensions is weak: there is a legal vacuum in public pensions regulation; the legal and regulatory framework and institutions necessary for pension system development are mostly lacking; and adequately trained and skilled staff are scarce. Soviet accounting methods are still being used, and auditing is not in place. The technical capacity to administer retirement benefits is extremely low, with depleted facilities, and no modern office equipment. The challenge facing the Georgian Government in the long-run is to develop a fiscally sustainable and sound multi-pillar pension system that can provide income security and prevent poverty in old age.

Objectives of the Component

This component has three objectives to support the establishment of a credible and affordable safety net.

- First, to *establish a continuous information and monitoring system* that can track the social impact of economic reforms. Such a poverty monitoring system is an essential component of informed policy making. It would provide the Georgian Government, legislative bodies, and civil society with an objective and unbiased view on the effects of currently pursued policies on different groups of the population, and help to evaluate potential outcomes for alternative courses of action. It would also support existing efforts to confirm eligibility and access to social assistance programs.

- Second, to study the *feasibility and desirability of workfare* as a means to target assistance to the poor. There are many reasons to believe that workfare is particularly well-suited to the Georgian context (for more information see analysis on workfare in project files). The SRS project would support the appraisal, design and pilot testing of such a scheme.

- Third, to assist the Government in developing a *pension reform strategy;* and to build institutional, technical, and human resources capacity for its successful implementation.

Sub-Component D1. Poverty Monitoring/Targeting – US$ 0.25 million

The basic foundation of a poverty monitoring system is already in place through the State Department of Statistics' (SDS) Survey of Georgian Households, which provides a high-quality tool for constant monitoring of living standards, poverty, and inequality. However, to keep up with policy demands and changing economic conditions, the survey has to undergo periodic changes in its sampling, questionnaires and data management. This sub-component would support the continued improvement and implementation of the survey, as well as greater outreach and dissemination efforts.

Activities covered under this sub-component would include: *(a) Support to the on-going Survey of Georgian Households*: update the address list; refresh the sampling frame of the Survey; design the data entry program to minimize errors in data; improve quality control of interviewers; redesign the questionnaire (consumption block) to minimize the number of imputations currently taken by SDS and ensure more accurate measurement of current consumption; revise the instruments to reflect changes in policy (mainly the introduction of vulnerability benefits and cost recovery measures in the energy sector); *(b) Support to the dissemination of poverty monitoring results*: select the format and dissemination media for periodic poverty monitoring updates; provide hands-on assistance in preparing two to three such updates and establishing channels for their dissemination; create a group in SDS responsible for preparing and disseminating the quarterly updates, train SDS staff; *(c) Collecting operative information on the impact of policies:* carry out a beneficiary assessment of vulnerability benefit recipients. This activity would be subcontracted to an experienced NGO. If successful, this program would be expanded to cover some of the assistance to refugees.

Sub-Component D2. Workfare Options/Pilot – US$ 0.71 million

Workfare programs aim to reduce poverty by providing low-wage work to those who need it. There are many reasons to believe that workfare could be effective in Georgia. However, these interventions are relatively complex to design, appraise and evaluate. Their success depends critically on the design and on the details. Hence, it is essential that a possible intervention be designed with care. The proposed SRS credit would finance a number of activities, focused on assessing the feasibility of using such programs in Georgia and aimed at providing the Government with several alternative design and financing schemes.

Planned activities include: appraisal of the feasibility of a workfare scheme; design of key program features including eligibility criteria for sub-projects and for recipients, wage rates, geographical location, financing mechanisms, institutional and governance structure, and evaluation mechanisms; evaluation of cost-effectiveness of proposed scheme(s) and comparison with other safety net interventions, and assessment of impact on wage earnings of participants and non-participants; and design of detailed action plan for implementation of pilot scheme. Depending on the outcome, a pilot program could be launched in the second year of implementation, with results to be evaluated at the conclusion of the pilot.

Sub-Component D3. Pension Reform – US$ 1.52 million

The proposed credit would provide financing for: (i) development of a pension strategy, and associated regulatory and supervisory framework, and technical assistance in establishment of appropriate

institutions, and associated training needs; (ii) development of an information management system, including a database on the current stock of pensioners and introduction of a personal identification number/individual account; (iii) technical assistance in developing actuarial modeling and in establishment of a pension analysis unit; (iv) supporting introduction of international accounting standards for pensions, including provision of training and equipment; and (v) evaluating disability certification practices and identifying measures to improve them, including if needed, providing assistance in drafting amendments to legislation and implementing regulations.

Component E. Project Management (US$0.16 million of total project cost):

The Bank will finance additional cost to the SATAC Project PIU for procurement and financial management under components B, C, and D. This will include salaries, communications, limited office equipment, supplies, utilities, and audit costs.

Annex 3
Structural Reform Support Project
Estimated Project Costs

Project Component	Local	Foreign	Total
	----------US $ million----------		
1. Hospital Restructuring and Financing of Health Care			
1a. Hospital Consolidation	2.98	4.86	7.85
1b. Hospital Operations Improvement	0.13	0.92	1.06
1c. Component Management	0.15	0.02	0.17
2. Support to Private Sector Development			
2a. Strategic Privatization of Large-Scale Enterprises	0.06	2.30	2.36
2b. Development of Regulatory Capacity	0.39	0.75	1.14
2c. Financial Sector Strengthening	0.23	0.35	0.58
3. Public Sector Reform and Public Information			
3a. Public Expenditure Management	0.09	0.20	0.30
3b. Public Procurement	0.20	0.34	0.54
3c. Licensing	0.05	0.37	0.42
3d. Public Information	0.62	0.58	1.20
4. Social Sustainability			
4a. Poverty Monitoring and Targeting	0.15	0.08	0.23
4b. Design and Piloting of Workfare Scheme	0.22	0.42	0.64
4c. Support for Pension Reform	0.35	1.03	1.39
5. Project Management	0.07	0.08	0.15
Total Baseline Cost:	**5.69**	**12.31**	**18.00**
Physical Contingencies	0.15	0.25	0.40
Price Contingencies	0.42	0.98	1.40
Total Project Cost	**6.26**	**13.54**	**19.80**

Annex 5

Economic and Financial Analysis

Hospital Restructuring Component

Today, there are nearly 12,000 hospital beds in Tbilisi in more than 50 hospitals. This level of capacity is clearly not sustainable in today's economy as evidenced by the deterioration of physical infrastructure. The most telling indicator of over capacity is the low occupancy rates which average 40 percent in Tbilisi. Nationwide, more than half of the hospitals had occupancy rates of less than 10 percent in 1997. These data can be compared to internationally accepted norms of around 80 percent. The situation is even more dire than these numbers would suggest given that the average length of stay in Georgian hospitals is around 11 days, or 25 percent higher than OECD averages.

Additional inefficiencies come from the size of the hospitals, which currently range from 40 to 1,100 beds. Reconfiguring the hospital system so that the average number of beds per hospital is in the range of 200-400 beds has been shown to be most efficient in order to take advantage of economies of scale while maintaining quality of services.

Assuming only 70 percent occupancy and a five percent increase in patient population growth, the number of hospital beds could still easily be cut in half, to around 5,500. An additional 20% decrease in bed need would be expected due to reductions in length of stay coming from changing technology and clinical practice. The economically optimal number of hospital beds would have been around 3,300 (even fewer if one uses the standards of an American HMO), but the feasibility of reducing capacity by more than 70 percent was deemed excessive taking into account uncertainties related to the demand for services.

The objective of the component is to reduce the number of hospitals in Tbilisi to a more economically viable 4,400 in twelve hospitals with an average bed size of 300. The project would assist the Government to begin a hospital restructuring fund (HRF) that is expected to raise at least $56 million from the sale of 27 hospitals in Tbilisi, of which $43 million will be used on civil works and equipment. The alternatives which this program were assessed against included:

- Building totally new facilities at the current level of need (3,300 beds) – this would cost $225 million and is not affordable without extensive external financing;

- Upgrading all existing facilities (12,000 beds) – the capital cost of this option would also be $225 million, but not would have the additional savings in operational costs coming from reducing hospital capacity nor raise the revenues expected from the sale of some of the hospitals;

- Do nothing – while this option would cost nothing in direct financial terms, it would risk the complete collapse of the health system as the cumulative effect of no maintenance or re-equipment slowly destroys the infrastructure; and

- Fund the consolidation program entirely from external financing – this option would call upon external resources, which are limited, when a domestic source of financing is available.

Based on this assessment, the most viable alternative was that chosen by the project (i.e., the hospital restructuring program).

At the facility level, a detailed financial analysis of one of the hospitals included under the project (Gudushauri General Hospital) estimated the average *annual* cost per bed (excluding depreciation) would be $9,655, assuming that occupancy rates increased to 80 percent and average lengths of stay were reduced by

twenty five percent by the end of 2002. According to a recently completed Hospital Financing Study, this is approximately twice as much as is currently reimbursed per bed today. However, if today's capacity is adjusted for the real costs, it would be more than twice as high as projected annual cost per bed under the project (see table below).

	Current Hospital Sector	Restructured Hospital Sector (assume decrease of 50% in beds and 45 percent in staff)
Current Official Prices	Price assumed to be 1	Price decreases by 1.6
Real Total Costs	Price increases by 4-5 times	Price increases by 2-2.5

The Gudushauri study found that this higher level of reimbursement was financially viable not only if the assumptions for occupancy rates and ALOS were met, but also if reimbursement prices increased by 10 percent per year starting in 2002 (when full capacity levels were expected to be reached) and if reimbursement rates reached 90 percent from SMIC, 80 percent from municipalities, and 97 percent from official user charges. In summary, the program would not incur any additional recurrent costs unless prices are allowed to increase to reflect the real costs of providing better quality services and even these higher costs are affordable assuming more reliable financing from state and municipal sources.

Annex 6

Structural Reform Support Project
Procurement and Disbursement Arrangements

Procurement

This section describes the procurement arrangements under the SRSP.

The procurement of civil works, goods and services of the Bank financed components will be procured in accordance with Bank's procurement guidelines. The project activities not financed by the Bank will be procured in accordance with the national regulations. The project elements, their estimated cost and procurement methods are summarized in Tables A and A1. The thresholds for each procurement method and Bank prior review (including aggregate values) are shown in Table B. A procurement plan detailing the packaging and estimated schedule of the major procurement actions is presented in Table C. All other procurement information, including capability of the implementing agency, estimated dates for publication of GPN and the Bank's review process is presented in Table D.

Annex 6, Table A: Project Costs by Procurement Arrangements
(in US$million equivalent)

Expenditure Category	Procurement Method					Total Cost (including contingencies)
	ICB	NCB	Other	Cons. Svcs.	N.B.F.	
1. Works						
Republic Children's & Sepsis	4.00					4.00
Center Rehabilitation	(3.34)					(3.34)
Gudushauri	0.40					0.40
	(0.33)					(0.33)
Republican Childrens – Institute #1		0.21				0.21
		(0.17)				(0.17)
TB Hospital		0.33				0.33
		(0.27)				(0.27)
Office space rehabilitation			0.05[a/]			0.05
			(0.04)			(0.04)
2. Goods						
Medical equipment and medical	.30		0.18[b/]			0.48
furniture	(.25)		(0.15)			(0.40)
Office Equipment including	.52		0.46[c/]			0.98
computers, printers, peripherals	(.43)		(0.38)			(0.81)
Office Furniture			0.05[d/]			0.05
			(0.04)			(0.04)
Brochures and other Public			0.08 [e/]			0.08
Information Material			(0.06)			(0.06)
3. Services						
Technical Assistance, training &				11.46[f/]		11.46
study tours				(10.79)		(10.79)
4. Incremental Project Mgmt. Costs						
Operating Costs for Health PCU			0.14[g/]			0.14
			(0.14)			(0.14)
Operating Costs for Institution			0.11[g/]			0.11
Building PIU			(0.11)			(0.11)
5. Recurrent Expenditures					1.51	1.51
					(0.0)	(0.0)
TOTAL:	5.22	0.54	1.07	11.46	1.51	19.80
	(4.35)	(0.44)	(0.92)	(10.79)	(0.0)	(16.50)

Note: N.B.F. = Not Bank-financed.
Figures in parenthesis are the amounts to be financed by the IDA credit
Figures may not add due to rounding.

Footnotes:

[a/] Minor Civil Works, consisting of rehabilitation/renovation of one office space. The threshold for Minor Works is $100,000. One contract is planned and the value of the contract is $50,000.

[b/] Includes readily available medical equipment and medical furniture of standard specifications will be procured through International Shopping for contracts under $200,000. Two contracts are planned (average value is $87,500).

[c/] Computer equipment will be procured through International Shopping for contracts under $200,000 and National Shopping for contracts under $50,000. Three IS contracts are expected (average value $137,000). Three NS contracts are planned (average value $17,000).

[d/] Office furniture procured through NS procedures for contracts below $50,000. Four contracts are planned (average value $11,750).

[e/] Literature and other materials for public information campaign and public procurement guidelines will be procured through NS procedures for contracts below $50,000. Several small contracts (thirteen) are expected to be awarded. The average value would be less than $6,000.

[f/] Consulting Services and Training will be procured in accordance with Bank's Guidelines. See Table A1 for details.

[g/] Small expenditures throughout the life of the project based on contracts, invoices, and/or receipts consisting of utilities, communication fees, banking charges, service/repair contracts, office supplies, and Project audit. The audits for each of the project units is proposed to be selected on a sole source basis since both units are already working with auditors acceptable to IDA that have been competitively selected. The aggregate value of these sole source contracts is expected to be $50,000.

Annex 6, Table A1: Consultant Selection Arrangements
(in US$million equivalent)

Consultant Services Expenditure Category	Selection Method							Total Cost (including contingencies)
	QCBS	QBS	SFB	LCS	CQ	Other	N.B.F.	
A. Firms	5.64 [a]/ (5.64)	0.28 [b]/ (0.28)			1.24 [c]/ (1.08)			7.16 (7.00)
B. Individuals						3.08 [d]/ (2.81)		3.08 (2.81)
C. Training Workshops, Seminars, and Study Tours						1.22 [e]/ (0.98)		1.22 (0.98)
Total	5.64 (5.64)	0.28 (0.28)			1.24 (1.08)	4.29 (3.79)		11.46 (10.79)

Note: QCBS = Quality- and Cost-Based Selection; QBS = Quality-based Selection; SFB = Selection under a Fixed Budget; LCS = Least-Cost Selection; CQ = Selection Based on Consultants' Qualifications; Other = Selection of individual consultants (per Section V of Consultants Guidelines) or Single Source

N.B.F. = Not Bank-financed.
Figures in parenthesis are the amounts to be financed by the Bank loan.
Figures may not add due to rounding.

Footnotes:

[a]/ QCBS will be used for all contracts unless otherwise specified. It is planned that there will be 16 QCBS contracts (ave. value $0.35 m.).

[b]/ QBS will only be used for only one highly important assignment, specifically designing and helping to implement a package of several different human resource related schemes including a severance package for excess personnel, pension plans, and re-training programs. The assignment is (i) highly complex; (ii) expected to have a large downstream impact; and (iii) could potentially be carried out in several different ways. The value of the contract is estimated to be $.28 million.

[c]/ Selection based on consultant qualifications will be used for very small assignments (less than $100,000). It is planned that nineteen contracts will be awarded based CQ procedures (average value $.06 million).

[d]/ Individuals will be selected for assignments (i) that do not require a team; (ii) no home office support is required; and (iii) and the experience of the consultant is paramount. Generally, these assignments are less than $50,000. A few key assignments meeting all of the above criteria, but valued at more than $50,000 will be awarded based on the selection procedure for individuals. In addition to meeting the criteria for individual selection, these assignments are usually (i) short-term in duration; and (ii) involve consultants that are expensive based on international market rates. Many local consultants, selected from the private, non-governmental sector will be contracted to form working groups to support the government agencies in almost each of the respective areas of the project. It is planned that 140 contracts will be awarded. As many are low value assignments awarded to local consultants, the average value of individual contracts is only $22,000.

[e]/ Unless a review of training options based on qualifications is available, training (including workshops costs, seminar fees, travel and per diem costs) will be financed on a sole source basis. The contract will either be with a firm (as when workshops are organized) or with an individual (as when travel and per diem are required for participation in a seminar or study tour). All TORs would be reviewed by IDA. Contracts valued at more than $20,000 will also be prior-reviewed by IDA. Because of the number of individuals estimated to participate in overseas seminars and workshops and the number of participatory workshops that are planned, it is estimated that there will be 76 contracts with an average value of less than $16,000.

Annex 6, Table B: Thresholds for Procurement Methods and Prior Review

Expenditure Category	Contract Value (Threshold)	Procurement Method	Contracts Subject to Prior Review / Estimated Total Value Subject to Prior Review
			US $ millions
1. Works			
	>$500,000	I.C.B.	All / 4.40 million
	<$500,000	N.C.B.	First contract / .21 mil
	<$100,000	Minor Works	
2. Goods			
	>$200,000	I.C.B.	All / .82 million
	<$200,000	I.S.	First contract per implementing agency / .26 million
	<$50,000	N.S.	
3. Consultant Services			
	>$100,000	QCBS, QBS, CQ (firms)	All TORs and contracts exceeding $100,000 / 6.00 million
	<$50,000	Individual consultants	All TORs; all contracts exceeding $50,000 / .400 million
		Sole Source	All TORs including proposed use of SS and contracts above $20,000 / .200 million
4. Miscellaneous Operating Expenses		Based on annual budgets.	Annual budgets to be approved by IDA.
	Total value of contracts subject to prior review:		$12.29 million

1. Procurement of Civil Works

Civil Works (US$4.99 million) will be procured as follows:

(a) International Competitive Bidding (ICB). Civil works contracts estimated to cost more than $500,000 will be contracted according to ICB procedures. There are two contracts for which ICB will apply. The first is a fairly large rehabilitation of the Republican Children's Hospital (estimated value $4.0 million). The second contract is for a minor rehabilitation of the Gudushauri General Hospital (estimated value $.40 million). This last rehabilitation will be packaged together with the major rehabilitation of the same hospital currently being tendered under the Georgia Health Project (CR2852-0). At the time of SRS project appraisal, firms were preparing their pre-qualification proposals. The additional scope of work is not expected to change substantively the nature or estimated value of on-going process. Also, the packaging of these two works together will ensure the cost-effective and efficient use resources in terms of time and funding. Therefore, the aggregate value for ICB under the SRS is expected to be $4.40 million. The Bank's standard bidding documents for small works will be used.

(b) National Competitive Bidding (NCB). All civil works contracts estimated to be above US$100,000 and under $500,000 equivalent will be procured through NCB procedures up to an aggregate of US$540,000. The standard bidding documents of the Bank's ECA region for procurement of NCB will be used accordingly. Two minor rehabilitation of health facilities (merger of first Institute into the Republican Children's hospital and the merger of the TB Institute into the TB Hospital) will be procured using NCB procedures.

(c) Minor Civil Works (MCW). One civil works contract for a minor office space rehabilitation, with an estimated value of US$50,000, will be procured under lump-sum, fixed price contracts awarded on the basis of three quotations obtained from three qualified domestic contractors in response to a written invitation. The invitation shall include a description of the scope of work, including basic specifications, the expected completion date, a form of contract acceptable to the Bank, and the relevant drawings if applicable.

2. Procurement of Goods

Goods (approximately US$1.58 million) consisting of basic medical equipment for hospitals; computers and related software, office and training equipment, promotion materials and public procurement guidelines will 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:

(a) International Competitive Bidding (ICB) procedures will be used for contracts above US$200,000 equivalent for a total amount of US$.82 million (52% of total goods). These goods will consist of medical equipment/medical furniture and information technology equipment and software. The Bank's standard bidding documents for the procurement of goods and for the procurement of information systems will apply.

(b) International Shopping (IS) procedures will be used for readily available off-the-shelf goods (medical equipment and information technology equipment and software) of standard specifications estimated to cost less than US$200,000 equivalent per contract up to an aggregate amount of US$.59 million (37% of total goods). These procedures will require quotations from at least (3) three suppliers from two different countries.

(c) National Shopping (NS) procedures will be used for contracts valued under US$50,000 up to an aggregate amount of US$.17 million (11% of total goods) consisting of goods ordinarily available in the country (furniture, computers, printing of brochures and guidebooks). Comparison of

price quotations obtained from at least (3) three suppliers to assure competitive prices will be required.

3. Selection Procedures for Consulting Services

Contracts for Consulting Services (US$10.24 million in technical assistance and US$1.22 million in training assignments is required for the Project) will be awarded following the World Bank Guidelines "Selection and Employment of Consultants by World Bank Borrowers" dated January 1997, revised September 1997 and January 1999. To the extent possible, contracts have been packaged to include a combination of related skills and services and increase competition. The following methods of procurement will be followed:

(a) Quality-and Cost-Based Selection (QCBS) procedures will be used for consultant services and training contracts up to and aggregate amount of US$5.64 million equivalent. It is planned that 16 contracts following QCBS procedures will be awarded. The average value of each contract is $352,500.

(b) Quality Based Selection (QBS) is planned to be used for only assignment, of a highly critical nature. Specifically the assignment would be responsible for designing and helping to implement a package of sensitive human resource-related initiatives, including the development of severance packages for excess medical personnel, pension options, and re-retraining programs. The total value of the assignment is estimated to be $280,000.

(c) Selection based on Consultant Firm's Qualifications (CQ). Selection based on consultant qualifications will be used for very small assignments (less than $100,000). Estimated amount of total contracts is $1.24 million.

(d) Individual Consultant based on Qualification procedures will be used for small assignments of short term duration throughout the life of the project. Estimate amount of total contracts is US$3.08 million.

(e) Single Source procedures will only be used for the direct costs associated with the holding of workshops, attending in-country and external seminars, and participation in study tours. Due to its capacity building nature, the project intends to focus a significant amount of resources to these types of activity. In aggregate, $1,215,200 of single source selection for training-related activities is planned. Additionally, the contracts for auditing services for both project units will be awarded on a sole source basis since both units currently have contracts with auditors acceptable to the Bank previously selected on a competitive basis. The aggregate value of the audited contracts is estimated to be $50,000.

4. Notification of Business Opportunities

A General Procurement Notice (GPN) will be published in the June 16, 1999 issue of Development Business and will be updated annually for all outstanding ICB procurement thereafter. For consultants' contracts above US$200,000 a Specific Procurement Notices/Request for Expression of Interest will be advertised in Development Business (in the English Language) and in a major local newspaper (in the national language). Civil Works contracts procured by ICB will be advertised in Development Business and in a national newspaper; NCB Civil Works will be advertised in a national newspaper.

5. Review by the Bank of Procurement Decisions

Scheduling of Procurement. Prior to the issuance of any invitation for bidding, the proposed procurement plan (Table C) for the project will be reviewed by the respective PCUs, and

the Bank will be advised of any revisions for its review in accordance with the provisions of paragraph 1 of Annex 1 of the Procurement Guidelines. Procurement of civil works, goods and services for the project will be carried out in accordance with the agreed procurement plan which will be modified as appropriate and included in the progress reports subject to Bank review.

Prior review: (a) Civil Works: Prior review all ICB tenders and the first NCB tender, including a review of bidding documents, evaluation report and recommendation for contract award, and the contract will be conducted. **(b) Goods:** Prior review of bidding documents, including review of evaluation, recommendation of award and contract will be conducted for all ICB procedures and the first contract for International Shopping (for each implementing agency) regardless of their value. **(c) Consulting Services:** Terms of reference for all consulting and training assignments will be subject to prior Bank review. Request for Proposals (RFP), short lists, terms and condition of contracts as well as evaluation reports and recommendation for award will be prior reviewed by the Bank for contracts for individual consultants above $50,000 and firms above $100,000. Contracts for training assignments above $20,000 will be subject to prior review.

After award of contract, should any material modifications or waiver of terms and conditions of a contract resulting in an increase above 15% of the original amount, the Bank will reserve the right to prior review of such modifications (including modifications to contracts for consulting services).

Ex-post review: All tenders, regardless of value, are subject to Bank ex-post review. All documentation, including, but not limited to: TOR, bidding documents or request-for-proposals, bids or proposals received, correspondence on all bids either prior to or following award of contract including Bank no objections, contracts and any subsequent amendments should be maintained until at least two years following the close of the Project. During Bank supervision missions, not less than 1 in 10 tenders not subject to Bank prior review will be examined ex-post until a period of satisfactory compliance can be shown in which case the number of tenders examined may be increased to not less than 1 in 20.

6. Preference for Domestic Manufacturers

For contracts to be awarded on the basis of ICB (both Civil Works and Goods), the Borrower may, with the agreement of the Bank, grant a margin of preference in accordance with Section II of the Guidelines for Procurement under IBRD Loans and IDA Credits, January 1995, Revised January and August 1996 and January 1999.

Disbursement

Allocation of loan proceeds (Table C)

The proposed credit would be disbursed against the project components as shown in Table D. It is expected that the proceeds of the Credit will be disbursed over a period of 2.5 years, which includes six months for completion of accounts and submission of withdrawal applications. As there is no standard disbursement profile for Georgia, the disbursement forecast is based on the Bank's experience in financing similar projects in other ECA countries, and other projects in Georgia. **The Project Completion Date is estimated to be September 30, 2001 and the Closing Date is estimated to be March 31, 2002.**

Use of statements of expenses (SOEs):

Some of the proceeds of the loan are expected to be disbursed on the basis of Statement of Expenditures (SOEs) as follows: (a) civil works for all contracts costing less than $500,000 equivalent each; (b) goods costing less than US$200,000 equivalent each contract; (c) services contracts for (i) individuals costing less than US$50,000 equivalent each; (ii) firms costing less than US$100,000 equivalent each; and (d) training and study for less than $20,000 equivalent each; and (e) implementation agencies incremental operating costs. Disbursements against goods and services exceeding the above limits will be made against full documentation and respective procurement guidelines. SOEs will be certified locally by the respective PCU. Related documentation in support of SOEs will not be submitted to the Bank, but will be retained by the respective PCU for at least one year, after receipt by the Bank of the audit report for the year in which the last disbursement is made. This documentation will be made available for review by the auditors and Bank supervision missions. If ineligible expenditures, included those not justified by the evidence furnished, or amounts in excess of agreed disbursement percentages are financed from the Special Accounts (SA), the Bank will have the right to withhold further deposits in the SA. The Bank may exercise this right until the Borrower has: (a) refunded the amounts involved, or (b) (if the Bank agrees) submitted evidence of other eligible expenditures that the Bank can use to offset the ineligible amounts.

Special account:

To facilitate timely project implementation, the Borrower will establish, maintain and operate, under conditions acceptable to the Bank, two Special Accounts – one for Part A of the Project being implemented by the Health PCU and one for all other Parts of the Project being implemented by the Structural Adjustment Technical Assistance PIU -- in US dollars in a commercial bank(s), acceptable to the Bank. During the early stage of the project, the initial aggregate authorized allocation of both Special Accounts will be limited to US$400,000. However, when the aggregate disbursements under the credit (all Parts) have reached US$1.5 million, the initial allocations of both Special Accounts may be increased up to an authorized allocation of $800,000 by submitting the relevant Application for Withdrawal. The minimum amount of each application should be 20% of the authorized allocation. Replenishment applications should be submitted by the respective PCUs at least every three months, and must include reconciled bank statements as well as other appropriate supporting documents.

The Borrower will be responsible for the appropriate accounting of the funds provided by the Bank under the Loan, for reporting on the use of these funds, and for ensuring that audits of the financial statements or reports are submitted to the Bank. A computerized accounting system has been established at each PCU. The Project Financial and Accounting Officer of each PCU will maintain consolidated accounts for the project and will prepare quarterly financial reports as part of PMRs. The PCUs have acquired experience in maintaining and consolidating accounts through previously Bank-financed credits and grants. The accounts will be maintained for all project funds, i.e. credit funds (see Annex 7 for details of financial management arrangements).

Annex 6, Table C: Allocation of Loan Proceeds

Expenditure Category	Amount	Financing Percentage
1. Civil Works	$3,800,000	84 % of expenditures
2a. Goods – Part A	$560,000	100% of foreign expenditures, 100% of local expenditures (ex-factory cost) and 80% of local expenditures for other items procured locally
2b. Goods – Parts B, C, D, E	$620,000	100% of foreign expenditures, 100% of local expenditures (ex-factory cost) and 80% of local expenditures for other items procured locally
3a. Consultant Services, Training and Study Tours – Part A	$2,280,000	100% of foreign expenditures and 80% of local expenditures
3b. Consultant Services, Training – Part C.4	$900,000	100% of foreign expenditures and 80% of local expenditures
3b. Consultant Services, Training and Study Tours – Parts B, C1-3, D, E	$6,620,000	100% of foreign expenditures and 80% of local expenditures
4a. Incremental Operating Expenses of the Health Project Coordination Unit	$110,000	100%
4b. Incremental Operating Expenses of the SATAC Project Implementation Unit	$90,000	100%
5a. Unallocated – Part A	$760,000	
5a. Unallocated – Parts B, C, D, E	$760,000	
TOTAL	**$16,500,000**	

Table D: Capacity of the Implementing Agency in Procurement and Technical Assistance requirements

Brief statement

Preliminary capacity assessments for both project implementing units have been completed. The capacity of both units is basically sound, although both of them require additional technical assistance and training
in the area of civil works procurement and management. This technical assistance and training is planned to be provided at the earliest stage of project approval. The Health PCU already has an experienced construction design and supervision firm assisting them with a civil works tender estimated to value more than $7.2 million. Their assistance will include participation in the pre-qualification of firms, development of the bidding documents, contract finalization and management. Additional assistance of similar nature is envisaged for the SRSP. Also, funds have been allocated participation in the Goods and Works training programs at the ILO center in Turin, Italy.

Country Procurement Assessment Report or Country Procurement Strategy Paper status	Are the bidding documents for the procurement actions for the first year ready by negotiations
A CPAR for the Georgia has not been completed. For this Project, the Government will follow the agreed Bank procurement procedures as described in this document and in the Credit Agreement.	Yes No X

Section 3: Training, Information and Development on Procurement

Estimated date of Project Launch Workshop	Estimated date of publication of General Procurement Notice	Indicate if there is procurement subject to mandatory SPN in Development Business	Domestic Preference for Goods	Domestic Preference for Works, if applicable
8/99	June 16, 1999	Yes x No	Yes x No	Yes X No

Retroactive financing	Advance procurement
Yes ☐ No X Explain:	Yes No X Explain:

Explain briefly the Procurement Monitoring System:
All procurement related documentation that requires Bank's prior review will be cleared by Procurement Accredited Staff (PAS) and relevant technical staff. No packages above mandatory review thresholds by RPA are anticipated. The PCUs of the Borrower will maintain complete procurement files which will be reviewed by Bank's supervision missions. The Procurement Plan will be Updated semi-annually. Procurement information will be recorded by the PCU and submitted to the Bank as part of the quarterly and annual progress reports. This information will include: revised cost estimates for the different contracts; revised timing of procurement actions, including advertising, bidding, contract award, and completion time for individual contracts; as well as compliance with aggregate limits (within 15%) on specific methods of procurement. A Management Information System (MIS) consisting of an accounting system capable of producing project management reports and Microsoft Project for maintaining procurement schedules will help the PCUs monitor all procurement information.

Co-financing: Explain briefly the Procurement arrangements under co-financing: None.

Section 4: Procurement Staffing

Indicate name of Procurement Staff or Bank's staff part of Task Team responsible for the procurement in the
Project: Structural Reform Support Project Name: C. P. Ranganathan
Following Project approval, G. Novotny will be the PAS for the Health Component of the Project.

Explain briefly the expected role of the Field Office in Procurement: The Field Office will provide non-fiduciary procurement support to the project including answering inquiries about general Bank procurement procedures, status of planned packages, how to access standard bank documents and guidelines, etc.

Annex 7

Georgia: Structural Reform Support Project

Financial Management

General:

A review of Financial Management System was undertaken as a result of a recent mission to Georgia from May 3rd through May 8th 1999 to (a) assess the Project's capacity and readiness for the implementation of LACI; (b) review the presence of the necessary elements for sound Project financial management system such as internal controls, Project accounting, Project staffing and audit arrangements; and (c) prepare a time-bound action plan for strengthening the financial management system to achieve Project Management Report (PMR)-based disbursement that would assist the Project to move towards LACI.

Implementation Responsibilities:

The Project would be implemented by two separate units: (a) the Health Project Coordination Unit (PCU) under Ministry of Health which will take responsibility for the largest component, i.e. Hospital Restructuring; and (b) the Structural Adjustment Technical Assistance Credit (SATAC) Project Implementing Unit (PIU) under the Ministry of Trade and Foreign Economic Relations, which will manage the three remaining components (Private Sector Development and Financial Sector; Public Sector Reform/Information; and Social Sustainability).

Assessment of SATAC PIU:

PIU Office Space:

The Project intends to use the existing Project Implementation Unit (PIU) facility. The present PIU was set up under the Institutional Building Credit in 1994 as well as SATAC I. It is presently being used for the ongoing IDF grants for Public Procurement and the Georgia Investment Center. The main observations are as follows:

PIU Staffing:

The PIU has six full time positions as follows:

(i) Head PIU;
(ii) Accounting Officer;
(iii) Disbursement Specialist;
(iv) Procurement Specialist;
(v) Interpreter/Secretary; and
(vi) Driver.

Accountant:

To further strengthen the existing financial capacity of the PIU, arrangements have been made to recruit a new accountant. Advertisements have already been placed in the local newspapers for this position. Funds have also been allocated for the training of the present as well as the new accountant (if necessary) in International Accounting Standards.

PIU Budget for equipment, salaries and auditors:

Although the SATAC PIU is fully equipped with adequate furniture and equipment, additional $150,000 has been allocated for staff salaries, office equipment, office supplies, utilities, accounting software, accounting training, and the audit services. The budget adequately covers the entire period of Project implementation.

Accounting Software System:

The PIU staff has been involved in managing Project finances for several years, but no formal accounting software was ever used. The need to select and purchase an appropriate software was, therefore, discussed with the PIU Director and the accountant. Names of various software packages were also provided to the PIU Director who will share them with the new accountant when hired. It is expected that the PIU will purchase 'Fundware' accounting software.

Financial Reporting and Auditing Arrangements:

The SATAC PIU will be responsible (for three components) to ensure that the financial statements, Special Account, and statements of expenditures (SOEs) are audited by an independent auditor, acceptable to the Bank, in accordance with standards on auditing that are acceptable to the Bank.

A French auditing firm has already been given 'no objection' (April 23, 1999) to carry out PIU's audit for the year ending 1998. Since there is no representation of any of the big-five accounting firms in Georgia, documentation were obtained which shows that this audit firm is a member of IFAC and has been doing similar work for other World Bank Projects in other countries also. It is expected that the PIU will similarly make necessary arrangements to identify the auditors for SRS Project before effectiveness.

The annual audit will be carried out in accordance with the *Guidelines for Financial Reporting and Auditing of Projects Financed by the World Bank (March 1982).* The audit report shall be in a format in accordance with the International Standards on Auditing promulgated by the International Federation of Accountants (IFAC). The audit report will include a separate opinion for SOEs against which disbursements have been made or are due to be made from the Credit and SOEs which will be included in the audit report accompanying the financial statements. The audited financial statements of the special accounts, and SOEs of the preceding fiscal year, including a separate opinion by the auditor on disbursements made against certified statement of expenditures, will be sent to the Bank within six months of the end of the fiscal year.

The audit of the financial statement will include: (a) an assessment of the adequacy of accounting and internal control systems to monitor expenditures and other financial transactions and ensure safe custody of Project-financed assets; (b) a determination as to whether the Project implementing entities have maintained adequate documentation on all relevant transactions; and (c) verification that expenditures submitted to the Bank are eligible for financing, and identification of any ineligible expenditures.

Assessment of Health Component PCU:

The Health PCU will be responsible for the implementation of the Hospital Restructuring component. This PCU was established in 1995 and has, over the years, gained considerable experience in carrying out procurement of medical equipment, hospital civil works, and technical assistance for health specialists such as hospital architects and health planners. The main functions of the Health PCU will be to: (a) support and oversee all program implementation related to the Hospital Restructuring component, including quality assurance; (b) produce management reports to the Bank for the component; and (c) ensure that Bank guidelines for financial and procedures are followed.

PCU Office Space:

The Project intends to use the existing health PCU facility of an ongoing Project. This PCU is fully equipped with necessary furniture and equipment including four computers, two printers, and fax machines etc.

PCU Staffing:

The PCU has eight full time staff as follows:

(i) Head PCU;
(ii) Financial Officer;
(iii) Financial Assistant;
(iv) Procurement Officer;
(v) Technical Assistance & Training Officer;
(vi) Planning & Monitoring Officer;
(vii) Administrative Assistant; and
(viii) Logistic/Driver.

Auditing Arrangements:

An audit firm acceptable to the Bank has already been selected on a competitive basis to carryout the audit (for the Health Project) for the year ending 1998. It was agreed that similar arrangements will be made, before effectiveness, in identifying and retaining an auditor for the Health Component of SRS Project also.

TA for Financial Management support:

For each, PCU and PIU, a Project financial and accounting program will be developed with support from the Bank FMS as well as an external consultant. Given the Project size, this will be kept as simple as possible, given the needs for Project oversight and preparation of Project documentation such as PMRs. The systems to be designed should have, an accounting and internal control systems with the capacity to record and retrieve in a timely manner, all financial transactions under the Project. The systems will: (a) reliably record and report all assets, liabilities, and financial transactions of the Project; and (b) provide reliable financial information for managing and monitoring Project activities. The accounting systems will be classified by component; they will reflect the sources of funds, and will be broken down into different types of expenditures for the Project. Furthermore, they will provide information on the receipt and use of funds and will be able to produce financial reports comparing budget with actual expenditures at any given time. The system will be capable of providing financial data to measure performance when linked to the outputs of the Project. Funds have been allocated for this activity.

Special Accounts:

To facilitate timely Project implementation, both the PCU and the PIU will independently establish, maintain and operate, under conditions acceptable to the Bank, two Special Accounts – one for Part A of the Project being implemented by the Health PCU and one for all other Parts of the Project being implemented by the Structural Adjustment Technical Assistance PIU -- in US dollars in a commercial bank(s), acceptable to the Bank. During the early stage of the Project, the initial aggregate authorized allocation of both Special Accounts will be limited to US$400,000. However, when the aggregate disbursements under the credit (all Parts) have reached $1.5 million equivalent, the initial allocations of both Special Accounts may be increased up to an authorized allocation of $800,000 by submitting the relevant Application for Withdrawal. The minimum amount of each application should be 20% of the authorized allocation. Replenishment applications should be submitted by the respective PCU/PIU at least every three months, and must include reconciled bank statements as well as other appropriate supporting documents.

Financial Reporting:

For both, PCU and PIU, it was agreed that the disbursements will start using traditional disbursement methods – Statements of Expenditures (SOEs), reimbursements, direct payment, etc. After PCU and PIU have gained experience with the financial management system and the reporting under PMRs, and provided that a financial management expert has reviewed and found satisfactory by the Bank, the Project would move to PMR-based disbursements. Both PCU and PIU will be responsible for preparing Project Management Reports (PMR) on a quarterly basis, and furnish to the Bank not later than 45 days after the end of each calendar quarter. The PMRs will be produced which:

(a) (i) sets forth actual sources and application of funds for the Project, both cumulatively and for the period covered by said report, and Projected sources and applications of funds for the Project for the six-month period following the period covered by said report and (ii) shows separately expenditures financed out of the proceeds of the loan during the period covered by said report and expenditures proposed to be financed out of the proceeds of the loan during the six-month period following the period covered by said report;

(b) (i) describes physical progress in Project implementation, both cumulatively and for the period covered by said report, and (ii) explains variances between the actual and previously forecast implementation targets; and

(c) sets forth the status of procurement under the Project and expenditures under contracts financed out of the proceeds of the loan, as at the end of the period covered by said report.

Project Operational Manuals:

Neither of the two implementing units had any implementing/operational manual. It was therefore, agreed that Project Operational Manuals (POM) would be prepared by the accountant of each implementing unit that would include: (a) the financial management system proposed under the Project, with special emphasis on accounting and auditing policies, standards and internal controls; (b) the role of the financial management systems in Project management and implementation; (c) the accounting arrangements required for Project management, the format for and content of Project financial reporting; and (d) the auditing arrangements that will be used during Project implementation. It is expected that by end December 1999the final POM will be ready, satisfactory the Bank.

Bank FMS staffing and supervision:

It was also agreed that during Project life, a financial specialist would take part in supervision missions to monitor the Financial Management (FM) arrangements of both the PCU and PIU and ensure compliance with ongoing FM covenants. It was further agreed that a financial specialist would have to return prior to effectiveness to monitor performance on the FM action plan. The FM procedures and assessment of the financial staff would be included in the POM.

Accounting software and assessment of Y2K risks:

Bank database of the financial accounting software packages was provided to both the PCU and PIU directors. It was explained that these are typically available off-the-shelf in many countries and range in cost from around US$800-$15,000, The Project size suggests that a figure of around US$2,000 would be adequate in this instance. It is expected that the Health component PCU may proceed with purchasing 'PeachTree' software.

The issue of Y2K risks was also discussed with the Heads of the PCU and PIU. Assurance was provided that new hardware and software to be purchased under the Project will be Y2K compatible. In this regard, appropriate contractual provisions will be made to ensure compatibility.

Conclusion:

The Project does not currently satisfy the Bank's minimum financial management requirements. However, an Action Plan is presented below which requires both the PCU and PIU to design and implement satisfactory financial management systems to address the above issues. Once this time-bound Action Plan is carried out successfully, it is believed that the Project will, by then, have developed an accounting system that will be able to produce the required level of financial management reports in a timely fashion.

Action Plan for both PCU and PIU:

1	Consultant acceptable to the Bank to be appointed to assist in the establishment of the Project's financial management arrangements	May 31, 1999
2	Accountant acceptable to the Bank to be recruited to the SATAC PIU	May 31, 1999
3	Define accounting software requirements including the format for the Project Management Reports acceptable to the Bank	June 15, 1999
4	Ms. Lali Bakhutashvili (present accountant), Mr. Demna and Ms. Natia to attend accounting course on IAS, together with the new accountant, if required	June 14, 1999
5	Complete evaluation of alternative accounting software solutions and purchase accounting software acceptable to the Bank	June 28, 1999
6	Open Special Accounts and Project Accounts	July 19, 1999
7	Present shortlist of Project auditors acceptable to the Bank (or justification for sole sourcing existing auditor)	July 19, 1999
8	Accounting software system to be installed, tested and capable of producing Project Management Reports 1A and 1F	July 19, 1999
9	Visit by Bank staff to confirm adequacy of financial management arrangements prior to effectiveness	July 19, 1999
10	Effectiveness	September, 1999
11	Produce full Project Management Reports (and quarterly thereafter)	December 31, 1999
12	Complete Financial Management Manuals (for inclusion into the Project Operational Manual)	December 31, 1999
13	Consider a move to PMR-based disbursements	June 30, 2000

For both the PCU and the PIU, disbursements will start using traditional methods - Statements of Expenditures (SOEs) reimbursements, direct payment, etc. After PCU and the PIU have gained experience with the financial management systems and reporting under of the PMRs, and provided that the are found to be satisfactory to the Bank, the Borrower and the Bank will consider moving to PMR-based disbursements.

Annex 8
Structural Reform Support Project
Project Processing Budget and Schedule

A. Project Budget (US$000)	Planned (At final PCD stage)	Actual
	$80,000	$63,000

B. Project Schedule	Planned (At final PCD stage)	Actual
Time taken to prepare the project (months)	3	3
First Bank mission (identification)	03/16/1999	06/22/1999
Appraisal mission departure	04/18/1999	06/22/1999
Negotiations	05/25/1999	06/28/1999
Planned Date of Effectiveness	09/30/1999	09/30/1999

Prepared by: Ministry of Health, Ministry of State Property Management, Ministry of Energy and Fuel, Ministry of Communications, Georgian National Electricity Regulatory Commission, National Bank of Georgia, Ministry of Economy, Ministry of Justice, Public Information Center, Ministry of Social Security, Labor and Employment, State Pension Fund

Preparation assistance: SATAC I and SATAC II

Bank staff who worked on the project included:

Name	Specialty
Cyril Muller	Team Leader
Laura Rose	Health
Jonathan Walters	Energy
Leila Zlaoui	Economics
Anna Akhalkatsi	Economics
Martin Slough	Financial Sector
Amitabha Mukherjee	Public Sector Management
Elene Imnadze	Public Sector Management
Ana Revenga	Social Assistance
Aleksandra Posarac	Pensions
Alexander Preker	Peer Reviewer
Melinda Roth Alexandrowicz	Peer Reviewer
Richard James	Financial Management
C.P. Ranganathan	Procurement Assessment
Kari Hurt	Operations/Implementation
Cheryl Martin	Operations/Implementation
Frances Rosenthal	Operations/Implementation

Annex 9
Structural Reform Support Project
Documents in the Project File*

A. Project Implementation Plan

B. Bank Staff Assessments

C. Other

Tbilisi Hospital Masterplan by Kaiser Permanente International
Perceptions of Health Reform: A Qualitative Stakeholder Analysis of the Progress of Health Reform in Georgia, 1997-1998 by Catherine Silansky
A Communications Plan for Hospital Restructuring by Ken Jaques
Social-economical Results of Privatization Process of Health Care Facilities, 1996-1997 by L. Svanidze
Hospital Financing Study by Curatio International Foundation
Tbilisi Hospital Consolidation and Phasing Plan, Human Resources Component by Alf Kirk
Preliminary Legal Analysis of Hospital Restructuring by Georgia Consulting Group
Report of Focus Groups on Hospital Reform, by Georgian Opinion Research Business International
Detailed Description of Workfare Scheme and Likely Suitability in the Georgia Context

*Including electronic files.

Status of Bank Group Operations in Georgia
Operations Portfolio

Project ID	Fiscal Year	Borrower	Purpose	Original Amount in US$ Millions				Difference Between expected and actual disbursements a/		Last PSR Supervision Rating b/	
				IBRD	IDA	Cancel.	Undisb.	Orig	Frm Rev'd	Dev Obj	Imp Prog
Number of Closed Projects: 5											
Active Projects											
GE-PE-8417	1995	MINISTRY OF FINANCE	MUNICIPAL INFRA. REH	0.00	18.00	0.00	1.02	2.65	0.00	S	S
GE-PE-39892	1996	GOVERNMENT OF GEORGIA	TRANSPORT	0.00	12.00	0.00	.09	.88	0.00	HS	S
GE-PE-8414	1996	GOVERNMENT OF GEORGIA	HEALTH	0.00	14.00	0.00	9.46	8.19	0.00	U	U
GE-PE-44830	1997	GOVERNMENT OF GEORGIA	OIL INSTITUTION BLDG	0.00	1.40	0.00	.56	.23	0.00	S	S
GE-PE-8415	1997	GOVT. OF GEORGIA	AGRICULTURE DEVELOP.	0.00	15.00	0.00	6.73	-3.52	0.00	S	S
GE-PE-35784	1997	GOVERNMENT OF GEORGIA	POWER REHAB.	0.00	52.30	0.00	2.70	-3.17	0.00	U	S
GE-PE-55573	1998	GOVERNMENT OF GEORGIA	CULTURAL HERITAGE	0.00	4.49	0.00	4.23	1.22	0.00	S	S
GE-PE-51034	1998	GOVERNMENT OF GEORGIA	SATAC II	0.00	5.00	0.00	1.50	1.38	0.00	S	S
GE-PE-39929	1998	GOVERNMENT OF GEORGIA	SOCIAL INVEST. FUND	0.00	20.00	0.00	17.30	5.39	0.00	S	S
GE-PE-50910	1998	GEORGIA	MUNICIPAL DEV.	0.00	20.90	0.00	18.61	7.74	0.00	S	S
GE-PE-8416	1999	GOVERNMENT OF GEORGIA	ENTERPRISE REHABIL.	0.00	15.00	0.00	14.90	0.00	0.00		
GE-PE-56514	1999	GEORGIA	TRNSPT MIN RESTRUCT.	0.00	2.30	0.00	2.44	1.54	0.00	S	S
GE-PE-50911	1999	REPUBLIC OF GEORGIA	INTEG. COASTAL MGT	0.00	4.40	0.00	4.34	.12	0.00	S	S
Total				0.00	184.79	0.00	83.88	22.65	0.00		

	Active Projects	Closed Projects	Total
Total Disbursed (IBRD and IDA):	97.44	213.56	311.00
of which has been repaid:	0.00	0.00	0.00
Total now held by IBRD and IDA:	184.79	209.90	394.69
Amount sold :	0.00	0.00	0.00
Of which repaid :	0.00	0.00	0.00
Total Undisbursed :	83.88	.01	83.89

a. Intended disbursements to date minus actual disbursements to date as projected at appraisal.
b. Following the FY94 Annual Review of Portfolio performance (ARPP), a letter based system was introduced (HS = highly Satisfactory, S = satisfactory, U = unsatisfactory, HU = highly unsatisfactory): see proposed Improvements in Project and Portfolio Performance Rating Methodology (SecM94-901), August 23, 1994.

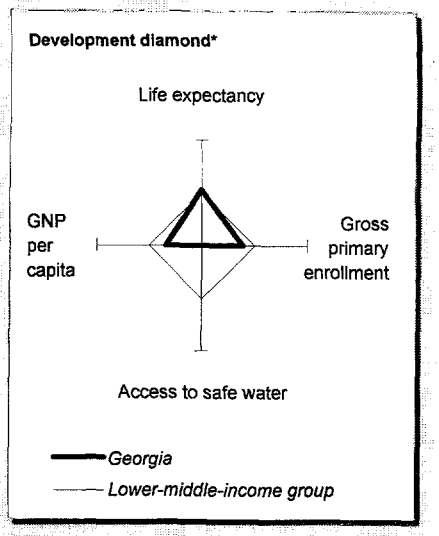
Note:
Disbursement data is updated at the end of the first week of the month.

ANNEX 11

Georgia at a glance

10/1/98

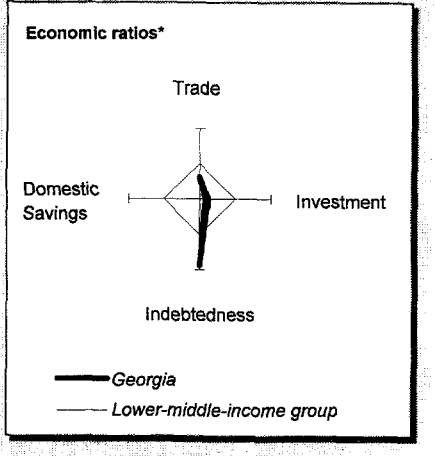
POVERTY and SOCIAL	Georgia	Europe & Central Asia	Lower-middle-income
1997			
Population, mid-year *(millions)*	5.4	476	2,285
GNP per capita *(Atlas method, US$)*	840	2,320	1,230
GNP *(Atlas method, US$ billions)*	4.5	1,106	2,818
Average annual growth, 1991-97			
Population *(%)*	-0.2	0.2	1.2
Labor force *(%)*	-0.1	0.5	1.3
Most recent estimate (latest year available, 1991-97)			
Poverty *(% of population below national poverty line)*	30	..	..
Urban population *(% of total population)*	58	67	42
Life expectancy at birth *(years)*	73	69	69
Infant mortality *(per 1,000 live births)*	18	25	36
Child malnutrition *(% of children under 5)*	..	..	..
Access to safe water *(% of population)*	..	..	84
Illiteracy *(% of population age 15+)*	1	..	19
Gross primary enrollment *(% of school-age population)*	86	92	111
Male	..	..	116
Female	..	..	113



KEY ECONOMIC RATIOS and LONG-TERM TRENDS

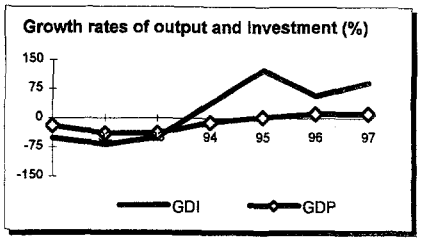
	1976	1986	1996	1997
GDP *(US$ billions)*	..	..	4.6	5.2
Gross domestic investment/GDP	..	29.9	6.0	6.7
Exports of goods and services/GDP	..	..	11.2	11.9
Gross domestic savings/GDP	..	29.8	-1.8	-4.2
Gross national savings/GDP	..	..	2.3	1.9
Current account balance/GDP	..	..	-9.1	-10.2
Interest payments/GDP	..	..	1.4	0.8
Total debt/GDP	..	..	30.1	29.6
Total debt service/exports	..	..	15.3	13.9
Present value of debt/GDP	..	..	23.9	19.1
Present value of debt/exports	..	..	213.4	208.9

	1976-86	1987-97	1996	1997	1998-02
(average annual growth)					
GDP	..	..	10.5	10.9	7.6
GNP per capita	..	..	12.7	12.8	8.1
Exports of goods and services	..	..	17.8	18.4	12.2

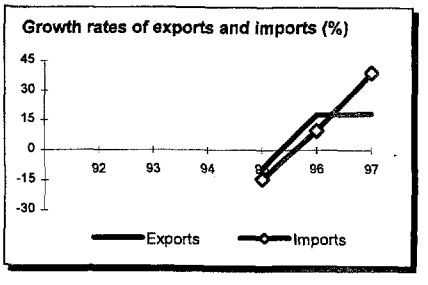


STRUCTURE of the ECONOMY

	1976	1986	1996	1997
(% of GDP)				
Agriculture	..	26.8	33.4	31.6
Industry	..	37.0	25.1	23.4
Manufacturing	..	27.8	18.8	17.5
Services	..	36.2	41.5	45.0
Private consumption	..	57.4	92.7	95.2
General government consumption	..	12.8	9.1	9.0
Imports of goods and services	..	..	18.9	22.7



	1976-86	1987-97	1996	1997
(average annual growth)				
Agriculture	..	..	3.0	3.5
Industry	..	..	2.0	2.0
Manufacturing	..	..	2.0	2.0
Services	..	..	16.8	17.2
Private consumption	..	..	2.2	15.4
General government consumption	..	..	40.0	10.9
Gross domestic investment	..	..	57.0	90.9
Imports of goods and services	..	..	9.7	39.2
Gross national product	4.4	-16.5	12.7	11.2

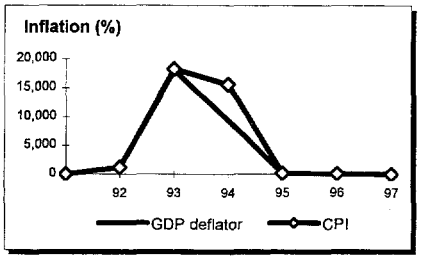


Note: 1997 data are preliminary estimates.

* 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.

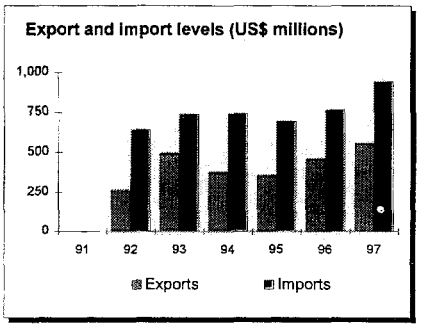
PRICES and GOVERNMENT FINANCE

	1976	1986	1996	1997
Domestic prices				
(% change)				
Consumer prices	..	..	39.4	7.1
Implicit GDP deflator	0.5	6.1	40.2	7.1
Government finance				
(% of GDP, includes current grants)				
Current revenue	..	..	8.1	9.9
Current budget balance	..	..	-4.6	-3.5
Overall surplus/deficit	..	..	-5.8	-4.6



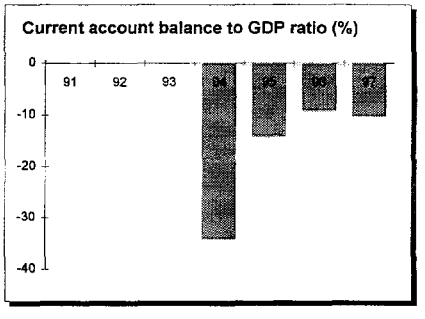
TRADE

	1976	1986	1996	1997
(US$ millions)				
Total exports (fob)	..	..	463	559
Black metal	..	..	80	101
Tea	..	..	19	24
Manufactures	..	..	231	236
Total imports (cif)	..	..	768	947
Food	..	..	213	154
Fuel and energy	..	..	184	196
Capital goods	..	..	129	330
Export price index *(1995=100)*	..	..	..	..
Import price index *(1995=100)*	..	..	..	..
Terms of trade *(1995=100)*	..	..	..	..



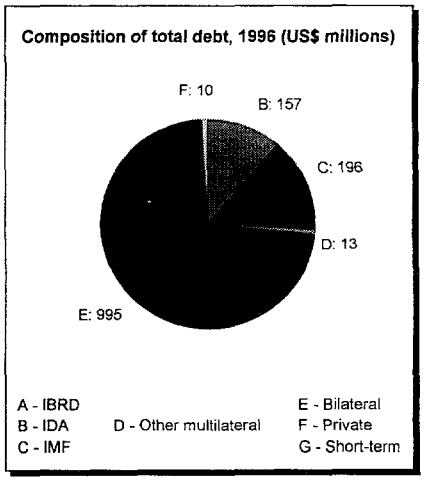
BALANCE of PAYMENTS

	1976	1986	1996	1997
(US$ millions)				
Exports of goods and services	..	..	511	623
Imports of goods and services	..	..	867	1,192
Resource balance	..	..	-356	-569
Net income	..	..	-62	34
Net current transfers	..	..	141	188
Current account balance	..	..	-418	-535
Financing items (net)	..	..	339	474
Changes in net reserves	..	..	79	61
Memo:				
Reserves including gold *(US$ millions)*	..	..	159	175
Conversion rate *(DEC, local/US$)*	..	..	1,263.0	..



EXTERNAL DEBT and RESOURCE FLOWS

	1976	1986	1996	1997
(US$ millions)				
Total debt outstanding and disbursed	..	..	1,378	1,550
IBRD	..	..	0	0
IDA	..	..	157	212
Total debt service	..	..	49	53
IBRD	..	..	0	0
IDA	..	..	1	1
Composition of net resource flows				
Official grants	..	..	141	84
Official creditors	..	..	186	192
Private creditors	..	..	0	0
Foreign direct investment	..	..	54	189
Portfolio equity	..	..	0	0
World Bank program				
Commitments	..	..	91	155
Disbursements	..	..	76	64
Principal repayments	..	..	0	0
Net flows	..	..	76	64
Interest payments	..	..	1	1
Net transfers	..	..	76	63



ATTACHMENT 1

Statement of Intent

Implementation of a Hospital Restructuring Program in Georgia

Background:

The excess supply of hospitals that Georgia inherited from the Soviet Union is no longer sustainable or desirable in Georgia today. Based on norms much higher than those in OECD countries, Georgia is now facing a stock of hospitals approximately three times larger than what needed, even when we consider the unique geography and epidemiology of the country. Because of lack of funds, the maintenance of the hospitals has deteriorated, the salaries of staff are extremely low, and quality of care has suffered.

The 1996 health reform strategy identified excess capacity as one of the main issues and proposed a three-pronged approach: changing the incentives to providers with a new payment system; instituting a licensing and accreditation system; and privatizing a large portion of the sector. Only recently have we completed the preparation of a comprehensive privatization strategy for hospitals.

The Hospital Master Plan

To prioritize the facilities that should remain under public ownership, we undertook at transparent process whereby each hospital passed through a series of screens. Hospitals which were unsafe, inaccessible, and of inadequate capacity were removed from consideration. Eventually, we identified around twelve hospitals in Tbilisi and about fifty-seven in the rest of the country that will remain in the public sector. While we are committed to the participation of the private sector in the provision of health services, we believe it is in the public interest to maintain some hospitals under public ownership, particularly to ensure adequate access for the poor and coverage of services that might otherwise not be supplied. The result of the work is summarized in the Hospital Master Plan that we broadly endorse.

In particular, we endorse the recommendations concerning:

- identification of hospitals to remain in the public sector, their size and functions;
- identification of hospitals that should be closed and sold as real estate;
- the total number of beds that should result from program implementation;
- the phased program of implementation of sales and refurbishment;
- need for improved governance and autonomous financial management;

- re-training, improved pay and work conditions to ensure that quality staff can be retained; and

- staff cuts will be necessary, but the redundancy programs will be designed to keep quality staff while providing fair compensation have been identified to those that will be laid off.

While the hospitals will be owned by the state, we intend to reform the governance and organization of these hospitals. The primary principles of this reorganization include: (i) selecting hospital directors through competitive and open process; ii) granting decision rights to managers; iii) exposing the facilities to market forces through a competitive environment; iv) improving accountability to stakeholders; and v) defining and subsidizing social functions.

Financing of the Program

Having decided which hospitals would remain in the public sector and which will be sold, we have prepared a plan whereby the cost of hospital closures and upgrading of the remaining twelve facilities would be financed from the proceeds from the privatization of hospitals which would go into a hospital restructuring fund (HRF). The program has been divided into three stages, with the first stage estimated to take two and half years and result in no fewer than ten hospitals being privatized and their services being merged into four of the twelve that will remain in operation.

For the process of privatization of facilities that will no longer serve as hospitals to generate adequate financing to support the restructuring of those facilities that will remain as well as the related human resources programs, the Government agrees to:

- clearly define all assets to be privatized;
- sell all assets as real estate and not as hospitals;
- follow a transparent, competitive and non-preferential sales' method (including allowing foreign investors to participate);
- MSPM transaction fees not to exceed existing legal thresholds;
- present a final list of facilities to be offered for sale under phase 1 of the program that has an assessed value of at least $18 million (as defined in the Hospital Master Plan); and
- create an account with the Treasury into which 100% of privatization and long-term lease proceeds (after fees) of health institutions will be deposited[1].

[1] The revenues for the HRF will come from the sale or lease of hospitals, other health institutions and corresponding land currently owned by the Government of Georgia. The process of selling or leasing these facilities will be the primary responsibility of the MoSPM, with significant input from the HRF. For its part, the MoSPM will receive its normal fee of 7% of the sale price. In addition, any agents contracted by the HRF to assist with the sale may receive up to 5 percent of the sale price. No less than 88 percent of the proceeds from the sale will be deposited into a special account in the Treasury which is earmarked for implementing the hospital rationalization program. The sale or lease of buildings will be free and open, with no preference given to current occupants. There will be no restrictions on the use of the buildings

Establishment of the Hospital Restructuring Fund (HRF)

The HRF will be the primary vehicle for carrying out the program of hospital restructuring. The HRF will be governed by a Board comprising members of the following institutions: the Ministry of Health, the Ministry of State Property Management, the Ministry of Finance, representatives of labor unions and associations of health care providers, and the Municipality of Tbilisi. The Fund will be formally established with an approved operational manual no later than February 1, 2000.

The following are the eligible expenditures of the HRF:

- *Capital investment.* The HRF will finance needed civil works and medical equipment for the remaining public facilities in order to improve the quality of care and prevent further deterioration of the capital stock.

- *Fair staff compensation.* The contribution of all employees in the health sector is highly valued. The HRF will finance the payment of fair compensation packages for the staff that will be laid off during the consolidation and sales of hospitals according to the optimization plan.

- *Human resources programs.* The human resource policies must look towards the future needs of the system and make sure that remaining staff are adequately trained. Initially, the project will focus on training the management team in the four hospitals to be refurbished in the first phase.

- *Public information.* The public and health care providers are entitled to know what is happening in the health care system and why. In addition, their contributions and support will be essential to the success of the program. The HRF will work with a firm selected competitively to carry out a public relations/communications program during the life of the program.

- *Monitoring and evaluation and other special studies*: Monitoring and evaluating the desired impact of the program will be an important function of the HRF. The HRF can also be used to finance special studies that are deemed appropriate by the Board, such as the feasibility of starting a supplementary pension scheme for health care providers or alternative risk pooling mechanisms.

- *Operating cost of the HRF.* The costs of establishing the HRF will be funded under the Structural Reform Support project. These include hiring staff and consultants, preparation of a operational manual, purchase of office equipment and furniture. At the end of the project, the operating costs of the HRF will be

---

once sold. While the HRF will be responsible for paying all wage arrears of staff in privatized hospitals prior to closure, they will not incur other liabilities of the hospitals.

financed from the proceeds of the facility sales. The HRF will undergo annual audits.

Timetable

By July 1, 1999, a working group empowered with the preparation of the charter of HRF and its operational manual will be appointed by the President of Georgia.

By August 1, 1999, the working group will have adopted its work program, including schedules for preparation and implementation of : (i) a new governance structure for publicly-owned hospitals; (ii) human resource programs; and (iii) public information campaigns.

By October 1, 1999, public information programs will have been approved by the working group.

By December 1, 1999, the working group will have submitted to the President a draft charter and operational manual for HRF.

By December 1, 1999, the working group will have finalized: (i) options for redundancy programs; (ii) information memorandum for the first facility to be offered for sale; (iii) a proposal for governance structure of hospitals.

By January 1, 2000, HRF will be established as a legal entity and its charter adopted.

By February 1, 2000, HRF will have adopted its operational manual.

ATTACHMENT 2

Table 1: Hospitals to remain in the public sector and planned number of beds

	Hospital	# of Beds
Zone 1		
	Republican Children's Hospital	552
	Gudushauri General Hospital	196
	Psychiatric Hospital	500
	City Clinic #4	300
	Research Institute of Therapy	150
Zone 2		
	Republican Central Hospital	472
	Sepsis Center	150
	TB Hospital	250
	Oncology Scientific Center	300
Zone 3		
	Hospital Policlinic #5	245
	City Clinic #1	400
	Republican Ophthalmology Center	120
Total		3635

Attachment 3

Tbilisi Hospital Master Plan by Zone
(Preliminary Plan - Names and Phasing of Hospitals subject to change)

Facilities Remaining in Public Domain (Zone 1)	Physical information			Designed beds	Utilized beds	Recommended revised # of new beds	Beds consolidated from:(facility name)	# of beds incorporated	Cost of remodel	Cost of remaining building infrastructure	Total construction cost	Total equipment cost	Total building and equipment	Value of real estate vacated
	Yr. built	Lot/size area m2	Total building area m2											
Secondary Care Centers														
Republic Childen's Central Clinical Hospital	1974	28,750	27,794	620	137.28	552	Research Institute of Pediatrics	Out pat	50,000					1,584,000
(Facility will include outpatient services)							Pediatric Infectious disease clinic	40	250,000					1,317,600
							Rep. Pediatric Rehabilitation Center	25	140,000					1,004,800
							Traumatology & Orthp. Med. Cent.B	25	250,000					400,128
Total Phase one								**90**	**390,000**	**1,980,601**	**2,370,601**	**1,040,000**	**3,410,601**	**3,906,400**
							City Clinic # 3	25	150,000					2,320,400
							Republic Clinic # 2	5	50,000					3,151,200
							Research Institute of Surgery	60	300,000					790,800
							Research Institute of Cardiology	50	300,000					688,000
Total phase two								**140**	**800,000**	**1,980,601**	**2,780,601**	**2,080,000**	**4,860,601**	**5,471,600**
							Maternity Home # 1	60	1,000,000					589,800
							Res. Inst of Perinatology & Gyn	25	250,000					4,044,000
							Research Institute of Therapy	100						
Total phase three								**185**	**1,250,000**	**990,300**	**2,240,300**	**2,080,000**	**4,320,300**	**4,633,800**
Total all phases				620	137	**560**		**415**	**2,440,000**	**4,951,502**	**7,391,502**	**5,200,000**	**12,591,502**	**14,011,800**
Gudushauri General Hospital	1989	75,000	18,080	240	27.22	196	OBGYN/Maternity NICU/pediatrics	70	High risk Maternity, Pediatric age 1-2 years acute care					
							Medical/surgical and ICU beds	99						
						200		169						
Maternity Home # 5	1988	25,920	11,512	250	89.47	**200**								
City clinic # 4	1960	63,000	19,460	360	64.80	**300**								
Total secondary Beds in Zone 1				**1,470**		**1,260**								
Total existing beds needed without Psych/Urology/ Narc/Ophthal/ in Zone 1						***816***	***444***	***Additional projected beds for Secondary care***						
Specialty Care														
Psychiatric Hospital	1972	72,800	20,814	500	159.22	**500**	Res. Inst. of Psych	20	152,000					1,509,440
Total Specialty Care				**500**		**500**								
Total Zone 1				**1,970**		**1,760**								

Attachment 3

Tbilisi Hospital Master Plan by Zone
(Preliminary Plan - Names and Phasing of Hospitals subject to change)

Facilities Remaining in Public Domain (Zone 2)	Physical information			Designed beds	Utilized beds	Recommended revised # of new beds	Beds consolidated from:(facility name)	# of beds incorp o-rated	Cost of remodel	Cost of remaining building infrastructure	Total construction cost	Total equipment cost	Total building and equipment	Value of real estate vacated
	Yr. built	Lot/size area m2	Total building area m2											
Secondary Care Centers														
Republic Central Clinical Hospital	1968	97,500	59,778	1,100	132.46	472	Res. Inst of Haemat. & Transfusion	25	150,000					2,192,700
(Facility will includes outpatient services)							Burn Center	25	525,000					207,000
							Res. Inst of Occupational Med	Out pat	150,000					1,413,600
							Res. Inst of Tropical Medicine	Out pat	50,000					1,194,400
							Pediatric Clinic # 1	10	150,000					2,146,196
Total Phase one									**1,025,000**	**3,655,808**	**4,680,808**	**1,475,000**	**6,155,808**	**7,153,896**
							Maternity Home Experimental	25	150,000					Demolish
							City clinic # 2	50	250,000					2,018,000
Total phase two									**400,000**	**3,655,808**	**4,055,808**	**2,950,000**	**7,005,808**	**2,018,000**
							Res. Inst of Reproductive medicine	30	100,000					2,774,400
							Maternity Home # 3	75	250,000					3,806,000
							War Veteran's Hospital	100						563,200
Total phase three									**350,000**	**1,827,904**	**2,177,904**	**2,950,000**	**5,127,904**	**7,143,600**
Total All phases				1,100	132	**700**		**340**	**1,775,000**	**9,139,520**	**10,914,520**	**7,375,000**	**18,289,520**	**16,315,496**
Medical Academy	1980	16,000	7,720	140	21.92	**120**	Medical Academy A	400	15,000					11,912,000
Oncology Scientific Center	1976	58,500	19,241	615	246.38	**300**	276 Adult Oncology beds needed	300						
Sepsis Center	1985	2,800	6,290	190	34.17	**150**	Rep.Infectious desease Clinic	40	500,000					5,589,120
Total secondary Beds in Zone 2				**2,045**		**1,270**								
Total existing beds needed without Psych/Urology/ Narc/Ophthal/ in Zone 1						***1,021***	***249***	***Additional projected beds for Secondary care***						
Specialty Care														
Research Institute of Narcology	1980	3,150	2,300	90	32.00	60	***Privatized***							
TB Hospital	1988	48,000	24,744	250	156.79	250	Research inst. of TB	180	250,000					423,080
Total Specialty Care				**340**		**310**		**180**	**250,000**					
Total Zone 2				**2,385**		**1,580**								

Attachment 3

Tbilisi Hospital Master Plan by Zone
(Preliminary Plan - Names and Phasing of Hospitals subject to change)

Facilities Remaining in Public Domain (Zone 3)	Physical information			Designed beds	Utilized beds	Recommended revised # of new beds	Beds consolidated from:(facility name)	# of beds incorp o-rated	Cost of remodel	Cost of remaining building infrastructure	Total construction cost	Total equipment cost	Total building and equipment	Value of real estate vacated
	Yr. built	Lot/size area m2	Total building area m2											
Hospital -Polyclinic # 5	1982	50,100	19,380	310	54.90	245	Rehabilitation Center	20	250,000					572,970
(Facility will includes outpatient services)							Res Inst of Dermat. & venerol. dcses	10	150,000					329,582
Total Phase one								40	400,000	1,191,152	1,591,152	950,000	2,541,152	902,552
							Rep. Cardiology and Rheumat. Hospi	5	100,000					781,200
							Medical University Clinic	20	200,000					1,899,216
Total phase two								25	300,000	1,191,152	1,491,152	1,900,000	3,391,152	2,680,416
							Maternity Home #2	100	1,000,000					987,560
							Pediatric Hospital # 5	25	250,000					254,480
Total phase three								125	1,250,000	595,576	1,845,576	1,900,000	3,745,576	1,242,040
Total all phases				310	54.90	280		190	1,950,000	2,977,880	4,927,880	4,750,000	9,677,880	4,825,008
City clinic # 1	1916	39,660	33,819	470	334.58	400	Reduction is bed number by demolition of the Experimental Maternity							
Maternity Home # 4	1969	12,500	4,352	120	87.25	110	*Privatized*							
Republic Ophthalmology Center	1980	13,760	11,775	180	37.77	120	Diffenrence in original sized is both due to change in size of rooms and the beds for zone 1 & 2 (only 62 beds are needed fro Tbilisi)							
Total secondary Beds in Zone 3				**1,080**		**910**								
Total existing beds needed without Psych/Urology/ Narc/Ophthal/ in Zone 1						***1,021***	***(111)***	***Bed Deficiency in the area***						
Specialty Care														
Research Institute of Urology	1978	1,000	6,970	140	80.91	120	119 Beds needed for Tbilisi @ 70% utilization							
Total Specialty Care				**140**		**120**	***Privatized***							
Total Zone 3				**1,220**		**1,030**								

Summary

All Zones														
Total all Zones for Secondary Care				**4,595**		**3,440**								
Total all Zones specialty Care and private centers				**980**		**930**								
Total all Zones for all beds				**5,575**		**4,370**								