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Report No: 27717-TU

PROJECT APPRAISAL DOCUMENT

ON A

PROPOSED LOAN

IN THE AMOUNT OF EURO 49.40 MILLION
TO THE

REPUBLIC OF TURKEY

FOR A

HEALTH TRANSITION PROJECT

IN SUPPORT OF THE FIRST PHASE OF THE

PROGRAM FOR TRANSFORMATION IN HEALTH

April 21, 2004

Human Development Unit
Europe and Central Asia Region

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CURRENCY EQUIVALENTS
(Exchange Rate Effective, March 22, 2004)

Currency Unit	=	Turkish Lira
1,333,333	=	US$1
US$ 1.47589	=	SDR 1
US$ 1.22685	=	Euro 1

FISCAL YEAR
January 1 – December 31

ABBREVIATIONS AND ACRONYMS

APL	Adaptable Program Lending
CAS	Country Assistance Strategy
COA	Chart of Accounts
DPT	Diphtheria, Pertussis and Tetanus
EU	European Union
FMM	Financial Management Manual
FMR	Financial Monitoring Report
FMS	Financial Management Specialist
GDP	Gross Domestic Product
GoT	Government of Turkey
HNP	Health Nutrition Population
HTP	Health Transition Project
IASC	Inter Agency Steering Committee
IAWG	Inter Agency Working Group
IT	Information Technology
MCF	Management Consultant Firm
MDG	Millennium Development Goals
M&E	Monitoring and Evaluation
MIS	Management Information System
MOH	Ministry of Health
MOLSS	Ministry of Labor and Social Security
NAB	National Advisory Board
NCD	Non-communicable Diseases
NHIF	National Health Insurance Fund
NPMDA	National Pharmaceuticals and Medical Devices Agency
OECD	Organization for Economic Co-operation and Development
OPV	Oral Polio Vaccine
PHC	Primary Health Care
PHCSP	Primary Health Care Services Project
PIU	Project Implementation Unit
PMR	Project Management Report
PMSU	Project Management and Support Unit
PPP	Purchasing Power Parity
PPSAL	Programmatic Public Sector Adjustment Loan
PTH	Program for Transformation in Health
RfP	Request for Proposals
SA	Special Account
SECAL	Sectoral Adjustment Loan
SIL	Specific Investment Loan
SPH	School of Public Health
SOE	Statement of Expenditures
SPO	State Planning Organization
SSK	Social Security Institute (Sosyal Sigortalar Kurumu)
TMA	Turkish Medical Association
TOR	Terms of Reference
TWG	Technical Working Group
UAP	Urgent Action Plan
UHI	Universal Health Insurance
WHO	World Health Organization

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TURKEY
Health Transition Project

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TURKEY

HEALTH TRANSITION PROJECT

PROJECT APPRAISAL DOCUMENT

EUROPE AND CENTRAL ASIA

ECSHD

Date: April 21, 2004 Country Director: Andrew N. Vorkink Sector Director: Charles C. Griffin Sector Manager: Armin H. Fidler	Team Leader: Enis Baris Sectors: Health (100%) Themes: Health system performance (P); Injuries and non-communicable diseases (S); Other social protection and risk management (S); Decentralization (S); Administrative and civil service reform (S)
Project ID: P074053 Lending Instrument: Adaptable Program Loan	Environmental screening category: C Safeguard screening category: S3

Project Financing Data

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

For Loans/Credits/Others:
Total Bank financing: (€ 49.40 million)
Proposed terms: VSL with 4 years grace period and 17 years maturity

Financing Plan (€ million)

Source	Local	Foreign	Total
BORROWER	7.84	4.02	11.86
INTERNATIONAL BANK FOR RECONSTRUCTION AND DEVELOPMENT	29.83	19.57	49.40
Total:	37.67	23.59	61.26

Borrower:
Republic of Turkey
Undersecretariat of Treasury
Ankara, Turkey
Tel: 90-312-213 0297; Fax: 90-312-212-8550
e-mail: hazine@hazine.gov.tr
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Responsible Agencies:
Ministry of Health
Ankara, Turkey
Tel: 90-312-4357100
e-mail: sabahattin@saglik.gov.tr
www.saglik.gov.tr

Ministry of Labor and Social Security
Ankara, Turkey
Tel: 90-312-212 0257 Fax: 90-312-212 5239

tteksoz@csgb.gov.tr
www.csgb.gov.tr

Estimated disbursements (Bank FY/€ million)									
FY	2005	2006	2007	2008					
Annual	6.84	20.00	17.61	4.95					
Cumulative	6.84	26.84	44.45	49.40					

Project implementation period: Start May 20, 2004 End: June 30, 2007
Expected effectiveness date: July 5, 2004
Expected closing date: December 31, 2007

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

Project development objective ***Ref. PAD B.2, Technical Annex 3***

Program's overall objective is to improve the governance, efficiency, user and provider satisfaction, and long-term fiscal sustainability of the healthcare system in Turkey.

The objective of Phase I is to assist the Government to strengthen the institutional environment for the implementation of the Program for Transformation in Health that will improve system stewardship, streamline financing and service delivery, and build the institutional capacity to extend health insurance coverage to the whole population in a fiscally sustainable manner.

The objective of Phase II is to enable the Government to complete its fiscal and institutional readiness for nationwide transition to family medicine and the implementation of universal health insurance.

Project description ***Ref. PAD B.3.a, Technical Annex 4***
The specific objectives, set in line with Government's PTH, are to : (i) re-structure MOH for more effective stewardship and policy making; (ii) establish a universal health insurance fund; (iii) introduce family medicine as the model for the provision of primary health care services (iv) ensure financial and managerial autonomy for all hospitals irrespective of ownership; and (v) set up a fully computerized health and social information system.
Component A: Restructuring the MOH for Effective Stewardship. This component supports MOH's institutional transition from a mainly provider of services to a policy maker and regulator of service provision, while retaining key public health functions.
Component B: Building Capacity of the Health Insurance and Social Security Institutions. This component supports the establishment of a single health insurance fund.
Component C: Reorganizing the Delivery of Healthcare Services. This component has four sub-components: (i) adoption of family medicine as an organizational model for the provision of outpatient or primary health care services; (ii) integration and harmonization of MOH and SSK hospitals towards great autonomy; and (iii) building a new patient referral mechanism to re-enforce system hierarchy.
Component D: Strengthening Human Resources Capacity aims at developing skills and competence of

health work force. *Component E*: Building Infostructure for Health and Social Security. This component supports the development of national standards in line with the realignment of institutional roles and responsibilities. *Component F*: Project Management. This component provides support for project coordination between the two ministries, overall project governance.
Which safeguard policies are triggered, if any? ***Ref. PAD D.6, Technical Annex 10*** None
Significant, non-standard conditions, **if any**, for: ***Ref. PAD C.7*** Board presentation: None. Full Board Presentation.
Loan/credit effectiveness: *Disbursement conditions*: 1. Criteria for application and eligibility for funding under the Population Health Grant be established before funds could be disbursed under Sub-component C.4; 2. Law of the School of Public Health enacted before the disbursement for the procurement of goods under Sub-component D.2.; and 3. The Bank has to review and provide its no objection to disburse loan proceeds for the Pilot sub-project category under Part C.1,2,3 and E of the project. *Other conditions*: 1. the PMSU and the PIUs to be maintained throughout the Project with qualified staff and adequate resources; 2. the IASC to be maintained throughout the Project with satisfactory terms of reference; 3. the POM to be maintained throughout the Project; 4. a mid-term review to be conducted not later than March 31, 2006; and 5. Population Health Grants to be provided under terms and conditions as agreed with the Bank.

A. STRATEGIC CONTEXT AND RATIONALE

1. Country and sector issues

While Turkey has made considerable progress in expanding healthcare coverage and improving on key health indicators, it continues to rank far behind most middle-income and EU accession countries in terms of health status and access to healthcare. Life expectancy is nearly ten years below the OECD average, and infant and maternal mortality rates are among the highest of middle-income countries. The health sector in Turkey is under-performing in achieving health outcomes commensurate with its level of socio-economic development and the amount of expenditures in healthcare which stand at about 6.9% of the GDP. Substantial and sustained efforts will have to be made if the country is to meet the European health and service standards and the Millennium Development Goals by the year 2015.

A recent World Bank sector study "Reforming the Health Sector for Improved Access and Efficiency" (Report No.: 24358-TU released in March 2003) identified the following issues as the main reasons behind the under-performance:

Inequalities in health and access to health care. A careful analysis of the allocation of human and financial resources reveals that there are wide discrepancies in the distribution of health personnel, with most physicians, particularly specialists, located in western and large urban areas. Similarly, the distribution of public health expenditures is not equitable; the richer regions spending more public money per person on health care. As for health insurance coverage, large segments of the population, mostly the rural and the unemployed, do not have adequate health insurance. Many are relying on the Government's Green Card scheme which only allows free access to hospitals, but not to primary health care or drugs. There remain gaps between the urban and rural contexts, and the different parts of Turkey across most health indicators.

Inefficiencies in resource allocation. Increasingly less is spent on preventive care and on maternal and child health. The primary health care system is under-funded and ineffective, relying more and more on user fees. A large number of health centers are understaffed in rural areas in general, and in the Eastern and South Eastern Anatolia regions of the country in particular. The majority of general hospitals are operated inefficiently, with considerable wastage of resources.

Inadequate system stewardship and governance. The Ministry of Health (MOH) had in the past limited interest and capacity in effectively performing key stewardship and regulatory functions with regard to setting health policies, criteria and standards. Until recently, there was traditionally little coordination between the MOH and the Ministry of Labor and Social Security (MOLSS) with both being responsible for both health financing and provision of health care.

2. Rationale for Bank involvement

While Bank's past involvement in the health sector in Turkey has not been very effective in bringing about systemic reform, the timing and scope of this new partnership is very opportune, as the current government is strongly committed to extensive reforms in the health sector, particularly in extending health coverage to the entire population, and reducing the inequalities in access to and utilization of services across the country. Indeed, both the Urgent Action Plan (UAP) and the Program for

Transformation in Health (PTH) have set tight deadlines for the necessary legislative and institutional reforms, and several new bills have already been drafted on restructuring the social security system, establishing the Universal Health Insurance (UHI), and reorganizing the MOH and its affiliated institutions. Many of these draft laws have now been opened to public scrutiny, and extensively discussed by government agencies, the civil society and other stakeholders. They would be read in the National Assembly subsequent to the passage of the Framework Law on Public Administration.

As for the day-to-day operations of the health care system, several positive changes have already been effected that have enhanced patient choice. Most important of all is that patients can now visit any MOH or MOLSS hospital, regardless of their eligibility, a major change of both symbolic and operational implications. Another important milestones is the recruitment, for the first time, of physicians by the MOH on a contractual basis to encourage posting in under-served areas. The momentum already set up by the demonstration of the strong political will and intent of the Government to bring about sweeping changes is unprecedented, and provides a unique window of opportunity for continued Bank support to the sector.

3. Higher level objectives to which the project contributes

The most recent CAS[1], and the Policy Note: "Turkey: Greater Prosperity with Social Justice" that was prepared in November 2002 to assist the incoming new government, Government's own UAP, released in January 2003, and its sectoral spin-off, PTH, all concur almost entirely that a fundamental overhaul – as opposed to piecemeal changes – is needed and that the system needs to be "transformed". There is a general consensus that the transformation should at least entail: (i) the separation of provision and financing of health care so as to achieve a more efficient resource allocation and use; (ii) introduction of universal public health insurance so as to ensure equity and access to health services; (iii) financial and administrative autonomy for public hospitals in order to improve technical efficiency and strengthen management; (iv) introduction of family medicine in order to integrate and streamline delivery of primary health care with inpatient care and ensure comprehensiveness and continuity in health care; and (v) increased emphasis on improving maternal and child health. This program is designed specifically to correspond and contribute directly to PTH's eight main objectives.

B. PROJECT DESCRIPTION

1. Lending instrument

Adaptable Programmatic Lending (APL) is considered to be the appropriate loan instrument for the following reasons: (i) the project is designed to support a large-scale program, GoT's own PTH, with a broad set of objectives aiming at reforming the entire health sector; (ii) there are two implementing agencies, working in tandem, albeit on different healthcare functions and in a sequenced manner; (iii) full implementation of the program requires the passage of a packaged set of new laws and amendments which need to come into effect in a sequenced manner and should precede major investments under the related component; and (iv) while PTH's full implementation will take time, and adjustments will undoubtedly be made along the process, there is a need for flexibility for the proper timing of Phase II to stay the course with the implementation of the UHI.

[1] Board Document No. R-2003-0181. Board date: November 6, 2003 – Report No. 267560-TU

Both the SIL and the SECAL were considered as possible alternatives, but given the mixture of investment and technical assistance needs, and the scope of the proposed First Programmatic Public Sector Adjustment Loan (PPSAL-I) covering Social Security in general, including the UHI, these instruments were not deemed appropriate.

Proposed financial terms reflect the preference of the Borrower and are in line with the terms applicable to the Bank's portfolio in Turkey.

2. Program objective and Phases

The overall Program objective is to improve the governance, efficiency, user and provider satisfaction, and long-term fiscal sustainability of the healthcare system in Turkey. Such a transformation would be the first step towards achieving the longer term sectoral goal of narrowing the gap in access to, quality and utilization of health services between Turkey and the EU countries. This Program, with a comprehensive and interrelated array of reform elements, is technically sound, yet very ambitious. As such, even a partial implementation would be a major improvement over the current highly fragmented and inefficient healthcare system. Experience from other OECD and middle income countries show that the track record of such reform initiatives is checkered, and implementation uneven, with both success stories and "lessons learned", depending upon the political economy. Yet, the same experience also shows that when a window of opportunity for a comprehensive health reform presents itself in the narrow policy space of a government - a rare occurrence, especially in Turkey - the design should encompass a full and mutually reinforcing reform agenda, inclusive of all the key functions of health financing, service provision and system governance.

Phase I: (FY05-FY08) will assist GoT to: (i) restructure MOH for more effective stewardship and policy making; (ii) design and pilot family medicine as a model for the provision of primary health care services; (iii) introduce financial and managerial autonomy for all public hospitals; (iv) lay the foundation for the establishment of the universal health insurance fund; and (v) design and pilot the "infostructure" for the health and the social security system. The estimated cost of investment in Phase I is about €49.40 million.

There will be four triggers for Phase II: (i) Universal Health Insurance Law has been adopted by the National Assembly; (ii) satisfactory progress has been made towards the establishment of the institutional arrangements for the social security system, particularly for the UHI and a unified[2] pensions system, using a common database and technological platform; (iii) "infostructure" for new social security agencies has been pilot tested and evaluated; and (iv) a new Primary Health Care (PHC) organizational model based on Family Medicine pilot has been tested and evaluated (please see Annex 4 for definitions and details).

Phase II will assist GoT to: (i) roll out family medicine as the model for the provision of primary health care services; (ii) complete financial and managerial autonomy for public hospitals; (iii) make the universal health insurance fund fully functional; and (iv) set up a fully computerized information

[2] "Unified" means harmonization of norms and standards with regard to obligations, entitlements and benefits across various pension plans.

system for health and social security. The estimated cost of investment in Phase II is about €114 million.
Phase I is designed to be self-contained in its investment and impact should the Government fail to deliver on its reform agenda. In fact, the size of the operation was influenced by what is needed to lay the ground for systemic changes through institutional capacity building and pilots, yet still sufficient to leverage policy changes. Should the reform process be interrupted, the project will still leave behind a better trained cadres of professionals, and experience from field-tested pilots on financing and service provision.

The project's overall objective and design are fully in line with the CAS diagnosis that "radical reforms are necessary in the health sector", and its own objective to support Government's UAP and its health sector objectives.

3. Project development objective and key indicators

The objective of Phase I is to enable the Government to strengthen the institutional environment for the implementation of its PTH that will improve system stewardship, streamline financing and service delivery, and build the institutional capacity to extend health insurance coverage to the whole population in a fiscally sustainable manner. Once the Program is fully implemented, all segments of the population would have full access to essential healthcare services, free choice of a family physician and a more transparent and equitable referral system.

The specific objectives, set in line with the Government's PTH, are to assist GoT to: (i) re-structure MOH for more effective stewardship and policy making; (ii) establish a universal health insurance fund; (iii) introduce family medicine as the model for the provision of primary health care services; (iv) ensure financial and managerial autonomy for all public hospitals irrespective of ownership; and (v) set up a fully computerized health and social security information system. Upon completion of the Program, it is expected that MOH will be a smaller and leaner agency, with a resource base and skills mix in line with its renewed mandate of system stewardship, namely doing "more steering and less rowing", or in health parlance, mostly policy setting and regulating with no responsibilities for service provision, except for that of public health programs (Tuberculosis, HIV/AIDS, etc.). Similarly, MOLSS is also expected to relieve itself from the function of service provision, increasingly specializing and building its institutional capacity in essential insurance functions of balancing revenues and expenditures, thus in risk assessment, actuarial analysis, the definition of an essential service package, premium setting, and strategic purchasing from and contracting with providers.

4. Project components

The proposed project has six components:

Component A: Restructuring the MOH for Effective Stewardship (Base Cost of € 9.60 million). This component supports MOH's institutional transition from a provider of services to a policy maker and regulator of service provision, while retaining key public health functions. This component has four sub-components: (i) restructuring of the MOH; (ii) establishment of a National Pharmaceutical and Medical Devices Agency (NPMDA); (iii) quality assurance and accreditation of health facilities; and (iv) establishing Monitoring and Evaluation (M&E) Capacity for the PTH.

Component B: Building Capacity of the Health Insurance and Social Security Institutions (Base Cost of € 3.00 million). This component supports the establishment of a single health insurance fund by means of consolidating the four existing health insurance schemes, and expanding its reach to an additional estimated 22 million citizens who are not fully covered.

Component C: Reorganizing the Delivery of Healthcare Services (Base Cost of € 15.67 million). This component has four sub-components: (i) introduction of family medicine as an organizational model for the provision of outpatient or primary health care services; (ii) harmonization of MOH and SSK hospitals towards greater autonomy; (iii) developing an effective patient referral system to re-inforce system hierarchy; and (iv) strengthening population health programs, including disease surveillance, maternal and child health, prevention and control of communicable and non-communicable diseases (NCDs). The reorganization will be implemented in a phased manner, with pilots in large cities during Phase I, to be rolled out nationwide during the second phase.

Component D: Strengthening Human Resources Capacity (Base Cost of € 8.72 million) aims at developing the skills and competence of the health workforce, in line with the changing role of the MOH and its affiliated institutions. It has two sub-components: (i) health and social security human resources policy and planning; and (ii) strengthening the School of Public Health (SPH), to become a center of excellence in advocacy, training and research for the MOH.

Component E: Building Infostructure for Health and Social Security (Base Cost of € 15.13 million). This component supports the development of national standards in line with the realignment of institutional roles and responsibilities in both MOH and MOLSS. This will be done in a phased manner, first with the development of standards and the establishment of a records and information network in the social security system, and thereafter between the social security system and the hospitals. It has two sub-components: (i) building the health information system; and (ii) building the social security information system.

Component F: Project Management (Base Cost of €2.60 million). This component involves activities related to project management. It will support project coordination between the two ministries as well as project implementation in each ministry, and an oversight mechanism for overall project guidance and policy support for both the PTH and the project itself. It will fund project management, including financial management and procurement, as well as technical assistance needed to support the Project Management Support Unit (PMSU).

The HTP was designed and will be implemented in parallel with the proposed PPSAL, which will provide budgetary support for the overall reform of the social security system. The synergies and inter-linkages between the two projects will provide both investment and budgetary support for the health reform agenda of the Government.

5. Lessons learned and reflected in the project design

The Health Transition Project will be Bank's fourth engagement in the HNP sector in Turkey. The previous First Health (1991) and Second Health (1994) projects were investment projects aimed to strengthen the delivery of health services in the country. The Primary Health Care Services Project (1997) was a reform-oriented project aimed at introducing family medicine in Turkey. Due to the difficulties in passing the necessary law, the project could not be implemented. The loan was eventually cancelled without disbursement.

Bank's past experience in the health sector in Turkey is rather checkered, with past macroeconomic instability, uncertain political environment and limited MOH absorptive capacity being the main reasons behind less-than-optimal project implementation. Delays in counterpart funding, numerous policy and personnel changes, equally applicable to both the Bank and the Government, hindered timely project implementation, leading to numerous project extensions.

The presence of a single party government with its large parliamentary majority may ease some of the problems that have been experienced in the past. However, other issues may still hinder effective project implementation. These include: (i) high staff turnover, with the consequent loss of project memory and skills; (ii) lack of additional financial incentives and limited career opportunities for civil servants who often have to work longer hours at Bank projects; (iii) reliance on external procurement agencies and the subsequent problems of compatibility with Government's own rules and regulations; and (iv) limited integration of MOH's technical and operational staff and capabilities with project design and operations, and the potential loss of ownership by and disengagement of the MOH staff from project activities.

Many of these issues are not particular to Turkey, affecting the effectiveness of most Bank operations, especially in the social sector. Several measures have been taken to mitigate the problems mentioned above, both in terms of the proposed project management structure (please see C.2 and Annex 6 for more details,) and the way the project has been prepared. For example, all relevant MOH technical units have been fully informed of Project's scope and purpose, and defined project activities. In addition, the new public procurement law should mitigate some of the past problems. The proposed project is quite different in nature from a typical investment operation in that it relies heavily on technical assistance, and focuses on system reform rather than investing in infrastructure and equipment. Finally, a Project Management Consultant Firm (MCF) will provide continuous technical and logistic support to the PMSU.

6. Alternatives considered and reasons for rejection

Two alternatives were considered and rejected for the following reasons:

1. *No new health project.* Given the past history of cancellations and delays in Bank-financed health operations, this option was seriously considered from a pure and narrow operations

perspective. However, as mentioned above, there is a unique window of opportunity to reform the health sector in Turkey which is an explicit and integral part of the UAP, the 8th Five Year Development Plan and the PTH. Indeed, given the commitment and political will to reform the health sector, the Government is poised to implement its own program regardless of the Bank's financial support. Moreover, the most recent CAS, and previous sector work, clearly point to a need for comprehensive reform, and concur almost fully with Government's own program. Therefore, this option was rejected as the Bank's financial and consequent technical involvement would provide the new Government with the necessary impetus, funding and support for a timely and thorough implementation of its reform strategy.

2. *Another Sector Investment Loan, or a pure Technical Assistance Loan.* These options were not considered as viable for the following reasons:

(i) Transition in the health sector is a long process which needs consistent and continuous support. The scope and components of any reform initiative, and the course and direction of implementation, are likely to change over time due to a myriad of political, social, economic and other reasons.
(ii) The transition of the health sector in Turkey is going to be a complex process, with many stakeholders becoming "winners" and "losers" as new institutions are being created, roles and responsibilities redefined, and lines of authority and accountability for key functions of financing, service provision and management realigned. It will be a lengthy process and therefore needs to be phased and sequenced appropriately.
(iii) The project departs significantly from previous projects in scope, design, components and activities. There will be no investment in health facilities and equipment; instead support will be for capacity building, institutional strengthening, and discrete technical assistance to the process of change, while adaptable to changing needs and policies along the way.

The proposed operation is ambitious in scope and in the nature of changes attempted. Therefore, a technical assistance loan would not be a suitable instrument for support to a long-term, sequenced and relatively complex reform initiative. The APL instrument also provides for triggers at the end of the first phase to provide impetus for continuous and sustained government engagement to bring about the necessary changes in the sector.

In this regard, an APL is considered the most suitable instrument to support both the process of policy dialogue, institutional support and actual reform implementation in the field while also encouraging the enactment of key legislation that would eventually establish the UHI and change the roles and responsibilities of both ministries, particularly the MOH. The design of the APL will mitigate the risk of losing commitment of the key stakeholders and credibility of Government's health reform agenda, while gradually investing, first rather modestly during Phase I and, subsequently, heavily once the UHI Law is enacted and its fiscal sustainability is assessed.

C. IMPLEMENTATION

1. Partnership arrangements

While there will not be any parallel or co-financing from other international agencies, agreements in principle have been reached both with the EU and WHO with regard to: (i) the EU's substantial

technical and financial support to MOLSS through a grant of approximately € 50 million to build its social security information platform and network; and (ii) WHO's Biennial Collaborative Agreement with MOH for CY 04-05. Accordingly, both the EU and the Bank will share information regarding the scope of their work, and tendering and procurement of goods and consultant services for the MOLSS to prevent any duplications and to ensure that their respective investments complement each other. Similarly, WHO has agreed to provide technical assistance to MOH for the M&E of the PTH which will also receive financial support under Component A.

2. Institutional and implementation arrangements

The Project will be implemented jointly by the MOH and the MOLSS. The existing Inter Agency Steering Committee (IASC) will remain in force, and will be responsible for project oversight, project performance and inter-agency coordination. A Technical Working Group (TWG) for each component and/or subcomponent will address technical issues such as preparation of TORs, review of proposals, and technical advice and assistance to the Project Manager and IASC.

Component B and sub-components D.1 and E.2 will be implemented by the MOLSS, and Components A, C and D and Subcomponent E.1 will be implemented by the MOH, with assistance from the PMSU. A Project Implementation Unit (PIU) in each of the two ministries will be established and be responsible for procurement, disbursement, and financial management for ministerial-level activities.

A PMSU headed by a Project Manager will have overall responsibility for project implementation, including liaising with the World Bank and coordinating project implementation with both ministries through the project officers in each ministry's PIU. The PMSU will also have overall fiduciary responsibility for the project, be based in the MOH, and report to the IASC on a regular basis.

An Inter Agency Working Group (IAWG), composed of six technical staff from the two ministries will be appointed for full time technical support to Project Manager. The IAWG will be responsible for the preparation of workplans, timing of activities and preparation of TORs in coordination with TWGs. Each TWG will have a focal point, a civil servant from the relevant technical unit of the responsible ministry for the component or sub-component, who will liaise with the IAWG for technical input and coordination.

The budget for the project (both the counterpart funding and the World Bank financing) will be included in the annual budgets of the respective ministries. There will be one Special Account (SA) for the project at the Central Bank of Turkey, and the PMSU will be responsible for managing this account. Respective ministries will be responsible for managing the counterpart funds.

3. Monitoring and evaluation of outcomes/results

The MOH and the MOLSS will be the main sources of data for monitoring of outcomes and results. In addition, the project will finance evaluation surveys that will produce additional data independent from the regular administrative data systems of the Borrower that are directly

evaluating the impact of the project. These evaluation surveys include: (i) physician, health, and users surveys; and (ii) evaluation surveys of the various pilot programs to be financed under the project. Finally, the PMSU will provide regular implementation progress reports, especially the Financial Monitoring Reports (FMR) that will provide quantitative data and information on the status of project implementation on a quarterly basis and projections for the next reporting period's implementation and financial resource requirements.

4. Sustainability

Past reform efforts in the health sector in Turkey have been marginally successful in terms of improving the health status of the population because of reasons related to overall political economy. The current government came to power, based on a platform of reform in the public sector and with a parliamentary majority to implement it. One important piece of legislation, the Public Administration Reform Law, is the organic law that will set the stage for reforming all ministries and government institutions. A series of laws on individual agencies, including the MOH and MOLSS, and their affiliated agencies are also under preparation.

In the health sector proper, the commitment to reform has been made public through the launching of the PTH. A series of bills are now being reviewed by the National Assembly. The passage of the law on the UHI, and the subsequent adoption of its regulatory base, will be critical in ensuring a fiscally and institutionally sustainable health and social security reform in Turkey. However, before the adoption of the law by the National Assembly, the MOLSS and the MOH will need to carry out studies and actuarial analyses to estimate future revenues and costs under various scenarios. The MOLSS will also design, develop and pilot the information platform for an effective implementation of the universal health insurance and social security schemes.

5. Critical risks and possible controversial aspects

Undertaking a large project in the health sector in Turkey presents risks to the proposed HTP that need to be carefully assessed. The key potential risks and proactive and remedial measures include the following:

Risk	Risk Rating	Risk Minimization Measures
Generic Risks (e.g., Macroeconomic and structural reform risks, political instability, etc.)	S	Macroeconomic: While the macroeconomic indicators are constantly improving, the GoT has significantly curtailed its investment budget, and needs to maintain a primary surplus of 6.5% of GNP during the current FY. The overall debt/GDP ratio is still high, with a large portion of government budget servicing the debt. The Bank strongly recommends that a full evaluation of the fiscal and institutional sustainability of the proposed UHI be carried out. and a financing plan be discussed before it becomes effective. A preliminary study has already been carried out by the Bank. Political: Several internal and external political issues will likely test the government's resolve and political will to effect large

		scale reform in the health sector. The HTP tries to mitigate this risk through triggers for Phase II, and is designed as a self-contained investment operation.
Coordination between MOH and MOLSS	M	***Coordination between the MOH and the MOLSS*** is much improved, compared with the situation under the previous government. However, it is possible that some of the initial goodwill and desire for collaboration may be lost, as laws are drafted and/or amended, roles and responsibilities are changed. This needs to be closely monitored during implementation. The project design tries to mitigate the risk through separation of components to each Ministry.
Resistance from Stakeholders	S	***Resistance from some stakeholders***, especially from the Turkish Medical Association (TMA) is likely to remain, especially from those who favor maintaining the *status quo*, namely keeping physicians on the public payroll. The project will engage such stakeholders through discussions and dialogue, public awareness campaigns and physician surveys to assess the degree of, and reasons for, resistance, and will conduct pilots to demonstrate that family medicine is a viable option in Turkey. Another potential source of resistance will be various health insurance institutions which may be reluctant to a merger and to the consequent consolidation and streamlining of staff and operations.
Institutional Capacity	M	***Institutional capacity*** is limited, especially in the MOH. Moreover, the MOLSS does not have any previous experience with the Bank. The project design includes the recruitment of a MCF that will assist the PMSU in the implementation (fiduciary and technical functions) and will build capacity.

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

6. Loan/credit conditions and covenants

Conditions of negotiations: The following conditions were met prior to negotiations: (i) Main PMSU (Project Manager, Procurement Officer, Financial Management Officer) and Ministerial PIU Project Officers appointed and office spaces readied; (ii) the Project Operational Manual (POM) prepared; and (iii) the Request for Proposals for the Management Consultant Firm prepared.

The following conditions were also met prior to *Board presentation*: (i) the Project Operational Manual adopted by the PMSU and the PIUs; and (ii) a functional financial management system established by the PMSU and the PIUs.

Disbursement conditions: (i) Criteria for application and eligibility for funding under the Population Health Grant agreed with the Bank and adopted before loan proceeds could be disbursed under Sub-component C.4; (ii) Law of the School of Public Health enacted before the procurement of goods under Sub-component D.2; and (iii) the Bank has to review and provide its no objection for the Pilot sub-projects before loan proceeds can be disbursed under Part C.1, 2, 3 and E of the project.

Other conditions: (i) the PMSU and the PIUs will be maintained throughout the Project with qualified staff and adequate resources; (ii) the IASC will be maintained throughout the Project with satisfactory terms of reference; (iii) the POM will be maintained throughout the Project; (iv) a mid-term review will be conducted not later than March 31, 2006; and (v) Population Health Grants will be implemented under terms and conditions as agreed with the Bank.

D. APPRAISAL SUMMARY

1. Economic and financial analyses

As has been noted previously, the HTP supports GoT's health reform initiatives as enunciated in the UAP and PTH, which outline the key policy issues in the health sector and targets all aspects of health care and health systems, including financing, delivery, management and organization. The HTP is expected to have a positive impact on access to and utilization of health services, and thus a positive impact on the health status of the population. The implementation of UHI is expected to provide financial coverage for health to the entire population, particularly the estimated 22 million or so presently without any form of insurance. The implementation of family medicine model will not only improve continuity of care but also increase emphasis on prevention and education. An additional benefit is the potential for cost reduction, since it is expected that some of the present expenditure on expensive specialist care and inpatient care will be reduced following more comprehensive coverage under family medicine. Improved stewardship and better policy-making will facilitate priority setting in the allocation of scarce resources in the health sector. In addition, better coordination and collaboration between MOH and MOLSS has the potential for cost reduction and avoidance of duplication, as patients enjoy greater access and choice among all public facilities. Modernization of information collection and analysis through an expanded and comprehensive network covering not only health but also social security institutions will facilitate more informed policy-making and better patient management. In the long run, significant savings are expected due to lower overall administration costs.

At the same time, it is useful to bear in mind that there are some areas that pose a particular challenge. In particular, as the analysis of expenditures under UHI demonstrates, the increased costs associated with extending UHI pose a serious resource challenge. If the number of the presently uninsured is indeed 22 million, then the fiscal impact of *Component B: Building Capacity of the Universal Health Insurance and Social Security Institutions* is likely to be adverse in the short-to-medium term, considering that the increased burden of insuring so many presently uninsured will be high, irrespective of the level and scale of the measures adopted. A preliminary exercise carried out by the Bank in collaboration with MOH and MOLSS finds that the introduction of UHI will require additional state outlays of between 3,826 trillion TL and 6,462 trillion TL for 2002, depending on which other reform measures are adopted and implemented along with UHI. The study concludes that, final details pending, the introduction of UHI can be a fiscally viable proposition only if there are marked improvements on the revenue side of the social security system in addition to efficiency-enhancing reforms in the health sector.

Overall, the potential benefits of the project (Phase I only; components and activities under Phase II can be evaluated only after the Phase I is satisfactorily completed) are significant, and to the

extent that the project components facilitate access and utilization and help in mitigating some of the known market failures in health, this is an economically viable project. On balance, the results of the economic analysis show that the project makes sound economic sense, subject to the general caveats of passage of the necessary supporting legislation and sound implementation of all the project components.

Fiscal impact

The project itself will have a net positive fiscal benefit over the long run, since it supports implementation of systemic health reforms aimed at increasing efficiency in production and delivery of health services. The introduction of the UHI will have a fiscal impact in the short run, largely because it involves extending financial protection to the presently uninsured. In the long run, however, efficiency gains from measures accompanying UHI - like the introduction of family medicine and autonomization of hospitals, both of which are supported by the project - are expected to yield substantial returns and the health system with UHI is expected to become fiscally sustainable.

The Government of Turkey will be contributing € 11.86 million toward project costs, spread over 3.5 years. The maximum contribution is expected to be in year 3 of the project (i.e., in 2006), and is expected to be about € 4.0 million. This is almost a negligible amount in terms of the expected total MOH budget (<1%), and is therefore not expected to be a fiscal burden for the government.

2. Technical

The conceptual and technical foundations of the project have been around for many years, discussed *ad infinitum* and reported in white papers, policy notes and national conferences. In this sense the project does not experiment with any new ideas in Turkey, but rather goes to scale in including all the building blocks of a comprehensive reform initiative overdue for about two decades, using a rare window of opportunity opened by current Government's UAP, and the subsequent launching of the PTH. It has to be noted that the proposed design concurs fully with the recommendations of the Sector Note "Reforming the Health Sector for Improved Access and Efficiency" in its drive for an overhaul of the entire system.

Internationally, most health sector reform initiatives involve changes in four levels: (i) *systemic*, to reduce inequalities in access to care and increase system efficiency; (ii) *institutional*, to ensure an adequate distribution of roles and responsibilities on the basis of key functions of health care such as financing and service delivery; (iii) *programmatic*, to improve technical efficiency in the way services are produced and provided; and (iv) *instrumental*, to build or strengthen the information and intelligence base of the system. HTP's design follows similar approaches in other countries that have undergone similar large-scale sectoral reforms.

The PTH, made public in early 2003, makes explicit reference to growing inequalities in health and health care in Turkey and the lack of long-term fiscal sustainability of the highly fragmented financing and service delivery structure, and advocates for a real change in the way the system is designed by proposing interventions and activities at all four levels. First, it supports

Government's political will to introduce UHI for full coverage of the population. However, such a sudden extension of (almost) free healthcare from the an estimated 66% population coverage requires considerable preparation including legislative changes, institutional realignment, fiscal sustainability assessment and redefinition of entitlements and obligations. The project will support all these activities, but also finance the "infostructure" necessary to operate such a large-scale health and social security system

Second, the Program advocates for a change in the realm of the responsibilities of the MOH, expressed in the motto "more steering, less rowing". The Ministry would shed most of its hitherto considered primary functions of financing and service provision, and concentrate on system stewardship, limiting its functions to policy making in health and health care; regulation of heath workforce, pharmaceuticals, medical devices and other health related matters; quality assurance and control; provision of population health programs; and informal training of health professionals. Equally important, is the proposed profound reform in public administration, including MOH, which would also devolve key functions of planning, resource allocation and management to provincial and/or local administrations, possibly to some municipalities where capacity is greater. Hence, MOH would no longer own, manage and operate health facilities, nor would it have a budget for doing so. The project will support this process.

As for the MOLSS, significant changes in its current structure are also proposed in the package of draft Bills for each of the pillars of social security. For health insurance, the existing four institutions would be merged to create a new NHIF with its own management structure. Similar changes would be made to Pension, Social Assistance and Unemployment schemes. Each would be run independently without any cross-subsidization, and be overseen by a new and autonomous Social Security Institute. As in the case of MOH, MOLSS would ideally no longer operate and finance hospitals, but rather would specialize, through its agencies, in various insurance functions, namely risk assessment, actuarial analysis, strategic purchasing and contracting with providers. The project, together with the proposed PPSAL, supports this process.

Third, there would be a fundamental change in the way preventive, primary and in-patient health care services are delivered. The introduction of family medicine would: (i) make general practitioners and family physicians gate keepers and independent providers of preventive and out-patient curative services; (ii) streamline the service use and patient referral; and (iii) allow families to choose their own provider. It is expected that eventually family physicians, through their representatives, would engage in a contractual agreement with the NHIF for the provision of their services. A similar change would occur in the hospital sector whereby all public hospitals would eventually become autonomous entities under the management of provincial and local authorities. The project will support this process.

Finally, the project will invest heavily in building healthcare system's information and intelligence base by: (i) setting up a Monitoring and Evaluation Unit; (ii) supporting the establishment of central laboratories for quality assurance and control; (iii) reactivating the School of Public Health; and (iv) building the health and social security management information "infostructure".

3. Fiduciary

Financial Management. A financial management assessment was carried out at appraisal. The proposed PMSU staffing structure includes a Financial Management Coordinator. He/she will work together with the PIUs finance officers. The Coordinator has been appointed with TORs satisfactory to the Bank.

The Special Account will be opened at the Central Bank of Turkey, and the PMSU will be responsible from managing this account. Respective ministries will be responsible for managing payments of the counterpart funds and obtaining approval of the MOF's Payment Office for payments from the Special Account. A copy of the payment documents related to the counterpart funds will be submitted to the PMSU for project accounting purposes.

The PMSU will maintain separate project accounts for each implementing ministry on a cash basis. An accounting system with technical specifications satisfactory to the Bank will be installed no later than project Board date with the necessary Chart of Accounts to allow for the timely submission of the quarterly FMRs by the PMSU. The format and the contents of the FMR have been discussed between the Bank and the PMSU, and an agreement has been reached as to its format, content and periodicity of reporting. A financial management manual is also being prepared, and made ready for use by Board presentation.

Procurement Management. Each ministry's PIU will coordinate its procurement fiduciary functions with the PMSU's procurement coordinator. Both the PMSU and PIUs will be assisted by local and international consultants in contract management and supervision.

Although the MOH has implemented two health projects, the procurement performance is less than satisfactory. Both ministries have limited capacity to carry out Bank's procurement procedures. To build their institutional capacity, the civil servants assigned for procurement in the implementing agencies would be sent to a training program to become familiar with procurement procedures and requirements under Bank-financed projects. In addition, a Consultant Management Firm and a procurement specialist will be employed by the Borrower to assist and support the civil servants appointed to the PMSU and PIUs.

4. Social

Social Impact. During project preparation a social assessment was carried out in four provinces (Ankara, Istanbul, Erzurum, and Osmaniye). The main findings of the assessment were: (i) lack of coherent and sustained health policy; (ii) lack of planning, coordination and management of the health sector; (iii) the centralistic structure of the health sector is hindering service delivery; (iv) inadequate education and training of the health workforce; (v) lack of investment in preventive care; (vi) non-functional referral system; (vii) services providers are underpaid; (viii) current system is prone to abuse and informal payments; (ix) lack of financial access to health services for the poor; and (x) lack of access to quality health care services, especially for the poor. Since these four provinces are not entirely representative of Turkey, the GoT agreed that the assessment will be expanded to include four additional provinces (Rize, Malatya, Muğla and Diyarbakır).

The HTP will directly or indirectly address all of the above-mentioned issues. However, it is important to understand that it will mainly lay the foundation for the transition in the health system, which will be implemented in full during Phase II with the introduction of the UHI and

the roll-out of Family Medicine. Thus Phase I will have minimal direct social impact. However, the overhaul of the whole healthcare system in Phase II is expected to affect the entire population as a result of universal financial access to an essential package of preventive and curative health care services.

Stakeholders and Participatory Elements. In July 2003, the GoT carried out a consultative stakeholder workshop with the participation of some 150 stakeholders prior to the last revision of the project concept note. In addition, the GoT is carrying out a stakeholder assessment using the "policy maker" tool, and a physician survey that are financed under the PHRD grant. These will help design the public awareness campaigns under Phase I.

Monitoring. The social impact will be monitored by the M&E Unit that is going to be set up under Component A. Furthermore, the pilots will also have built-in monitoring and evaluation.

5. Environment Category: C

The project involves no civil works, or use of natural resources, and is not expected to have any negative impact on the environment.

6. Safeguard policies

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

The Phase I of this Program will not trigger any safeguard policies.

7. Policy Exceptions and Readiness

There will not be any policy exceptions for this project. Most of the applicable readiness criteria have already been met, namely: (i) counterpart funds, already budgeted; (ii) establishment of the PMSU, and assignment of the main project staff, completed by negotiations; (iii) first year procurement plan, already drafted; and (iv) financial management and procurement arrangements, again completed by negotiations.

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

Annex 1: Country and Program Background

TURKEY: Health Transition Project

While Turkey has made considerable progress in expanding healthcare coverage and improving on key health indicators, the country continues to rank far behind most middle-income and the EU accession countries in terms of health status and access to healthcare. Whereas Turkey is the world's 17th most industrialized nation, it ranks only 96th out of 175 countries in the 2003 UNDP human development index. Its current ranking is at 16 ranks below of what it should have been according to its GDP per capita, estimated at PPP US$ 5,890 in 2001. Life expectancy is nearly ten years below the OECD average, and infant and maternal mortality rates are among the highest of middle-income countries.

By most accounts, the health sector in Turkey is under-performing in achieving health outcomes commensurate with its level of socio-economic development. Substantial and sustained efforts will have to be made in the coming years if the country is to meet the objective of improving the health status of its people, including meeting the health targets of the Millennium Development Goals (MDGs) by the year 2015.

MDGs for Reproductive and Child Health; Turkey's Challenge **Goal: Reduce Child Mortality** **Target: Reduce by two-thirds, between 1990 and 2015, the under-five mortality rate** **Indicators:** (i) Under-five Mortality Rate (from 67/1000 in 1990 down to 22/1000 in 2015) (ii) Infant Mortality Rate (from 58/1000 in 1990 down to 19/1000 in 2015) (iii) Proportion of 1 year olds immunized against measles (82% in 2002) (iv) Proportion of children immunized against DPT3 and OPV3 (78% in 2002) **Goal: Improve Maternal Health** **Target: Reduce maternal mortality ratio by three quarters between 1990-2015** **Indicators:** (i) Maternal Mortality Ratio; (from 55/100,000 in 1995 down to 14/100,000 in 2015) (ii) Proportion of births attended by skilled health personnel (81% in 1998)

A recent World Bank sector study "Reforming the Health Sector for Improved Access and Efficiency" (Report No.: 24358-TU released in March 2003) looked into the determinants of underperformance and found out that:

***Inequalities in health and access to health care*:**

- There are wide gaps between urban and rural populations and regional **disparities in outcomes** across almost all health indicators.
- **The poor** are much more likely **to not get treatment when ill** than the non-poor.
- The **distribution of public expenditures on health is not equitable**; the richer regions spend more public money per person on health care compared to the poorer regions.
- There are **wide gaps in the distribution of health personnel across the provinces and regions**; in particular, there is a concentration of physicians in the big cities and towns while rural areas are significantly understaffed.

- **Large segments of the population do not have adequate health insurance** or any other form of financial protection; in particular, over 50 provinces have 10 percent or more of their population not covered under any insurance or Green Card scheme.

Inefficiencies in resource allocation:

- **Very little is spent on preventive care and on maternal and child health**; in fact, allocations to preventive activities on a per capita basis have fallen in real terms over the last five years.
- **The primary health care system is under-funded and ineffective**; most people avoid public primary health care facilities and either directly seek care at outpatient facilities of hospitals or, if they can afford it, from the private sector.
- **A large number of health centers are understaffed** and many do not have even one physician; the situation is particularly grim in rural areas in general and in the Eastern and South Eastern Anatolia regions of the country in particular where a great number of health posts are not operating for lack of personnel (mid-wives).
- The majority of general **hospitals are operated inefficiently**, wasting resources.

Limited system stewardship and governance:

- Ministry of Health **has largely been preoccupied with administering its own hospitals, personnel issues and constantly seeking ways to get more funds to cover its deficits**. Key stewardship and regulatory functions, namely setting health policies, criteria and standards for population health, curative care, public health intelligence; regulating and enforcing all matters related to private healthcare financing and delivery; pharmaceuticals policy; accreditation of health facilities; and assessment of health technologies constantly get either short shrift, or are handled ineffectively due to limited institutional capacity.

- There has traditionally been **little coordination between the MOH and the MOLSS** which, between them, are responsible for most financing and provision of health care in Turkey; in particular, even though their activities overlap across most services and they have facilities in the same towns and cities. Until recently there was little sharing of resources and complementarities between them and almost no planning or collaboration at any level.

To meet the ultimate objective of improving the health status of the population, fundamental and systemic changes will be required in the ways that health care is financed, delivered, organized and managed. Piecemeal changes at the margin are unlikely to reform the health system. Indeed, the very same Sector Note, the most recent Country Assistance Strategy, and the Policy Notes, "Turkey: Greater Prosperity with Social Justice" prepared by the Country Team in November 2002 to assist the incoming new government all advocate for a comprehensive reform strategy to cover at least the following five areas: (i) separation of financing and provision functions; (ii) improvements in resource mobilization and allocation; (iii) universal access to health services, especially for the rural and the poor; (iv) improvements in efficiency in production and delivery of health services; and (v) improvements in system stewardship and governance.

It is noteworthy that World Bank's diagnosis and recommendations concur entirely with the "Urgent Action Plan" (UAP) of the government released in January 2003. The Plan outlines the

key policy issues in the health sector under the heading of "Healthy Society", addressing all aspects of health care– such as financing, delivery, management and organization, and thus representing a significant step in the country's ongoing efforts to improve the health outcomes. The cornerstones of UAP's Healthy Society and its more expanded sectoral spinoff PTH are the separation of provision and financing of health care so as to achieve a more efficient resource allocation and use; introduction of universal public health insurance so as to ensure equity and access to health services; financial and administrative autonomy for public hospitals in order to improve technical efficiency and strengthen management; introduction of family medicine so as to integrate and streamline delivery of primary health care with inpatient care and ensure comprehensiveness and continuity in health care; and an increased emphasis on improving maternal and child health.

In addition to the ambitious agenda, the UAP and PTH also set a tight deadline for the legislative and institutional reforms that are necessary to bring about the desired Transition in health. Accordingly, both MOH and MOLSS have begun in earnest to draft new or amend existing laws. Indeed, early drafts have already been either released for public review and comments, or are under internal review. These include:

1. Draft law on the establishment of the Universal Health Insurance (UHI) which would merge and integrate premium collection (SSK, budgetary support to MOH, Bag-Kur Scheme for the self-employed, Pension Fund, and financial outlays under civil servants health plan and Green Card program for the poor and the indigent) and all functions related to health financing, contracting and service purchasing, except for population health activities. Based on the principles of solidarity and risk pooling, all citizens of the country will be covered under one health insurance scheme, with the state making premium contributions on behalf of the indigent and others unable to do so on their own behalf;

2. Draft law on Social Security Reform which will restructure the four pillars of health, pension, social assistance and unemployment under one Social Security agency while making each autonomous in its management, without allowing for cross subsidization between the four schemes; and

3. A package of seven draft laws on: (i) the re-structuring of the MOH and its affiliates, School of Public Health, the Hygiene Institute, the Health Institute for Coastal and Border Areas and the Higher Health Council; (ii) establishment of the NPMDA; (iii) the amendment of the Medical Professions Law; and (iv) the revision of the Public Health Law. These legal and structural changes will strengthen MOH's ability to increase its policy oversight, regulate the private sector, health care technologies and pharmaceuticals, and fulfill its public health and quality assurance functions more effectively.

The separation of provision and financing provides an opportunity to introduce innovative methods in management of health facilities, and this will be achieved by granting financial and administrative autonomy to public hospitals. For instance, the distinction between SSK and MOH hospitals and health centers has already been removed and patients are now free to go to hospitals of their choice. The introduction of hospital autonomy will require appropriate legislation that will allow for public assets to be managed outside the direct purview of the government, and

related laws and regulation will be amended in order to facilitate the transition of MOH and SSK facilities to autonomous bodies.

In order to improve health several changes are proposed on the delivery side as well. Preventive and health services will receive high priority. They will be integrated with individual curative health care services and be provided under a newly established family medicine scheme, which will shift the emphasis from treatment of the sick to the promotion of health and prevention of illness. This new outpatient organization model will bring the physician and family members into closer and more personal contact, enabling the physician to play an important role in the family's health and the prevention of illness. On the curative care side, most outpatient diagnostic services and consultations will be provided by family practitioners with post-graduate training and new competencies across a broad spectrum of medical disciplines, including internal medicine, surgery, obstetrics and gynecology and pediatrics. Special emphasis will be placed on continuity and comprehensiveness of care, as well as on both psycho-social and technical quality of health services. Restructuring of primary health care on the basis of the main tenets of family medicine, together with the necessary changes in physician compensation schemes and incentives, are expected to: (i) prevent uploading hospitals and tertiary care services with morbidity that can easily be dealt with at the primary care level; (ii) streamline case mix; and (iii) strengthen the patient referral system.

To bring about significant reductions in maternal and infant mortality in the shortest time period, UAP's Healthy Society proposes to focus especially on infant and maternal health care. Complications of pregnancy and childbirth are the leading cause of deaths among women of reproductive age, and this problem is particularly acute in rural areas and poorer regions where full access to appropriate obstetrical care is not always available, and where utilization of available maternal and child health services is low. Special measures will be introduced to make motherhood safer, and special importance will be placed on prenatal care, safe delivery, post-natal care, obstetric emergencies, family planning and good nutrition in the context of family-based primary health care model.

The transition of the health sector will result in broad-spectrum structural changes, not only in health sector financing, management and organization, but also in the delivery of services and in patient-provider interaction. In order to manage these changes effectively as well as to oversee the functioning of the transformed system, the Minister of Health has indicated numerous times that he is keen to strengthen Ministry's stewardship and regulatory functions while letting go of the burdensome functions of service delivery, financing and management of health facilities. He and his counterpart in the MOLSS have both indicated that they would need World Bank's technical and financial support in order to implement the ambitious and time-bound agenda set by the UAP (please see attached Letters of Sector Policy).

REPUBLIC OF TÜRKİYE
MINISTRY OF HEALTH
Health Project General Coordination Unit

10 MAR 2004

NUMBER : B100SPK PPLS/ 452
SUBJECT :

Mr. James Wolfensohn
President
World Bank
1818 H Street, N.W.
Washington, D.C.
20433
USA

Dear Mr. Wolfensohn,

Subject: Letter of Sector Policy Regarding Health Transformation Program Support Project

Over the last fifteen years, various governments in Turkey have made considerable efforts to restructure health service delivery and financing so as to respond to the evolving health and healthcare needs and expectations of the Turkish society. During the same time span, the World Bank provided financial support to three health projects to improve the healthcare system, and these have been implemented satisfactorily, albeit with some problems.

However, I believe that the Turkish health care system needs a major overhaul as some changes and improvements on the edges will not resolve the intractable problems of weaker system governance and stewardship, chronic financial deficits, inefficiencies in the allocation of limited resources, inequalities in access to care and population's dissatisfaction with its overall performance. The "Urgent Action Plan" (UAP) prepared by the 58th and 59th Governments intends to significantly enhance the standards of living and quality of life of the

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Note: Please quote the above reference number and date in your reply

REPUBLIC OF TÜRKİYE
MINISTRY OF HEALTH
Health Project General Coordination Unit

NUMBER : B100SPK
SUBJECT :

Turkish population, of which good health is an integral part. To achieve this goal, the UAP envisages major changes in the way healthcare will be financed, managed and delivered. Hence, my Ministry, in cooperation with the Ministry of Labor and Social Security (MOLSS), launched a new program called "Transformation in Health" which aims at:

- Redefining the roles and responsibilities of the Ministry of Health (MOH) and restructuring its institutional setup in line with its new mandate and political and administrative functions;
- Providing universal health insurance for the entire population;
- Unifying health financing under a single and universal health insurance scheme;
- Allowing financial and administrative autonomy for all hospitals;
- Introducing family medicine as an organization model for first line service delivery;
- Improving mother and child health;
- Reinforcing preventive care services;
- Promoting private sector investments in the health sector;
- Transferring most technical and administrative authority to sub-national levels;
- Strengthening health workforce, and reducing distributional inequalities in regions with development priority; and
- Executing e-transformation in the fields of healthcare and health insurance.

Within this framework, I take pleasure in sharing with you my views on the scope and purpose of a new project in support of Government's Program "Transformation in Health", and on how I see World Bank's technical and financial assistance to help us achieve our program objectives.

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Health Project General Coordination Unit

NUMBER : B100SPK
SUBJECT :

The drive behind the Project is to narrow the gap in access to, quality and utilization of health services between Turkey and other middle-income countries and the European Union by extending health insurance coverage to all Turkish population and by reducing inequalities in access to health care, especially for the poor and those living in rural and peri-urban areas. In order to reach its goal, the Project will have four building blocks, which altogether constitute the core of Government's Program for Transformation in Health:

- Strengthening and re-shaping MOH's capacity for more effective sectoral governance and stewardship;
- Building the institutional, human and information basis for the introduction of Universal Health Insurance;
- Introducing the principles of family-based primary health care and autonomous in-patient service delivery; and
- Competent and highly motivated health workforce to provide care of standards at par with those of the European Union member states.

Full implementation of both the Program and the Project will obviously require new legislation as well as amendments of some existing laws, decrees and ordinances in force. In addition to the Draft Public Administration Framework Law, which is being read in the Parliament, and which redefines the functions and administrative setup of all government agencies, my ministry has also prepared a package of bills that are necessary for the inception of the "Transformation", subsequent to the passage of, and in compliance with, the Framework Law. We hope that the legislative process will bring about a profound change in that the MOH will no longer expend its energy in rowing, but rather will set the course and steer the healthcare system in the right direction.

We believe that a two-phased Adjustable Program Lending is the right instrument to support the program and the process of change, and we anticipate that it will last for about

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five to seven years. Accordingly, the first phase, which will probably last two years, will mainly focus on restructuring the Ministry of Health and setting up the legislative and organization infrastructure for the introduction of family practice in Turkey. The Second phase will primarily involve investment in establishing the infrastructure for e-health, together with Universal Health Insurance and the Social Security.

This project is also rather unique, in that for the first time, it sets up a partnership between the MOH and MOLSS as two implementing agencies aspiring to work in partnership to reach the same goal. Accordingly, my Ministry will be in charge of project components on sectoral stewardship, service provision and human resources development and e-health, whereas the MOLSS will assume the responsibility for those related to the introduction of the Universal Health Insurance and the institutional setup for Social Security. In this context, we have jointly established an Inter-Agency Steering Committee (IASC), composed of senior officials from our ministries and other state agencies (Undersecretaries of SPO and Treasury) for leadership to the Inter-Agency Working Group (IAWG), in charge of project preparation. We intend to keep IASC and IAWG functional once the project becomes effective, in addition to the Project Management and Support Unit that will be established, again with participation from each Ministry.

I would like to emphasize how important it is to benefit from World Bank's financial and technical support and how much we value our collaboration as we move towards full implementation of our program of Transformation in Health.

REPUBLIC OF TÜRKİYE
MINISTRY OF HEALTH
Health Project General Coordination Unit

NUMBER : B100SPK
SUBJECT :

Investments and services provided through technical and financial support from the World Bank within the scope of the First and Second Health Projects have made important contributions to public health services of our country as well as to the effectiveness and efficiency of these services. I believe that World Bank's continuous financial and technical support under this new project will consolidate and add value to what has hitherto been acquired, and thus further our efforts to reach the goal we set for ourselves to complete Turkey's integration to the European Union.

Yours Sincerely

Prof. Dr. Recep AKDAĞ
Minister of Health

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Note: Please quote the above reference number and date in your reply 5

05/03/2004

Mr. James Wolfensohn
President
World Bank
1818 H Street, N.W.
Washington, D.C.
20433
USA

SOCIAL SECURITY LETTER

Dear Mr. Wolfensohn,

Re: Letter of Sector Policy in Support of Government of Turkey's Program for Transformation in Health

This letter of sector policy describes the principal features of Government's Social Security Reform and the proposed structure, and provides information on the national priorities of the Social Security Project for which we are seeking World Bank's financial and technical support.

In Turkey, it is difficult to talk about a single social security system as various schemes have evolved over the years into different regimes with various structures, and rules and criteria for entitlements, rights and obligations. This process had the unintended consequence of bringing about considerable inequities and inequalities in access to social services and duplication and wastage of limited resources and administrative capacity. As a result, it is very difficult to sustain social security services, as they are no longer amenable to fiscal discipline and administrative simplicity. Indeed, all current schemes face insurmountable problems of premium collection, fund management and realistic actuarial forecasting of future expenditures. Consequently, despite the system's ability to collect contributions amounting to about US$ nine billion, sustenance of health and social services require significant outlays from Government budget to finance the deficit. Indeed, during the last decade these outlays were the main reasons behind intractable budget deficits, reaching in 2003 4.54 % of the GNP, or corresponding to about 10% of the general budget. Health expenditures will typically account for about one third of total social security expenditures, totally US$ 17 Billion according to the 2002 prices.

On the service provision side, there has been an escalation of costs and complaints from beneficiaries about the accessibility to and quality of health services. At present, health services are predominantly provided in government health facilities, and all activities ranging from resource utilization to pricing are governed by the central authority. The Ministry of Health (MOH) plays a major role in the provision of health services besides its regulatory, supervising, licensing and pricing roles, followed by the Social Insurance Institution (SSK), although the latter either provides services in its own facilities, or purchase them from other private or public health establishments. As for other social insurance schemes such as the Emekli Sandigi (Retirement Fund) and Bag-Kur, service purchasing is the norm. Either way significant improvements have to be made in system management and governance, based on the principles of managed competition and quality control in order to improve performance and efficiency in service provision and fiscal sustainability of all insurance agencies. This is all the more important given the current active/passive ratio of 1,86 and a dependency ratio of 3,86, and our objective to increase coverage from the current 60 million insured to the enitre Turkish population.

While serious efforts have been made to gradually leave populist policies and introduce actuarial accounting to ensure fiscal discipline, these remained palliative due to the instutional disorder and fragmented structure of the government and the lack of unity in standards.

Cognizant of the inherent weakness of the Social Security system, the 58th and 59th governments have, in their Emergency Action Plan, adopted the following principles:

- separation of service provision from financing in healthcare;
- establishment of a Universal Health Insurance scheme and its agency;
- uniformity of norms across all social security institutions;
- establishment of a unified social security network and its institutional setup;
- separation of long and short term insurance services;

- consolidation of all public pension schemes under a new Pension Fund;
- establishment of a unified social services and assistance network and its institutional structure;
- abolition of non-contributory payments for eligibility for and access to insured services.

Consequently, a legislative process has been initiated by my Ministry to either draft new or amend existing laws on Social Security. Draft laws have been submitted to other Ministries and nearly 150 non-governmental organizations for review and feedback, and are being reviewed for submission to the Parliament in the very near future.

It is expected that the new legislative and institutional framework will:

- increase competitiveness among service providers;
- improve efficiency in resource allocation and use;
- improve equality in contributions and entitlements;
- extend health care coverage to the entire population;
- bring about administrative simplicity through uniformity in contracting, regulating and setting service standards and a common "infostructure";
- reduce duplications and wastage thanks to consolidation of various schemes;
- establishment of objective criteria for entitlement to social services and increase users' and providers' satisfaction with streamlined and transparent contracting and provider payment methods;
- limit government contributions to transfers for those who cannot afford to pay their premiums;
- increase fiscal sustainability thanks to actuarial premium setting, realistic service costing and reduced overhead costs; and
- increase capacity in and compliance with premium collection under the responsibility of a single collection agency for all social security services.

Obviously, our legislative efforts are carried out in close collaboration with the Ministry of Health given the linkages between health insurance and health service provision.

Successful implementation of the social security reform hinges on technological and informational improvement in two crucial areas. First, there is an urgent need to establish a common database and a management information system to coordinate all related activities and provide fast, reliable, effective and efficient health and social services. We believe that this is the most important step in our reform endeavor. Second, it is equally important to set up an efficient, safe, objective, replicable and sustainable "means testing" mechanism that can be used to identify those citizens whose health insurance premiums shall be paid by the State.

Investment in the social security "infostructure" described above will require envisaged financial and technical assistance.It is of utmost importance to establish a social security information system that can be integrated with health information system so as to successfully implement a projected modern universal health insurance scheme up to standards of similar institutions in the countries of the European Union. I think that it will positively assist such a large investment to be closely coordinated between my Ministry and the Ministry of Health and I believe that World Bank's financial and technical support under the Health Transformation Project will be invaluable in this respect.

Yours Sincerely,

Murat Başesgioğlu
The Minister of Labor and Social Security

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

TURKEY: Health Transition Project

The First Health Project (FHP) Loan No 3057 – TU, was Bank's first experience in the HNP sector in Turkey. The FHP was approved on May 11, 1989 and became effective on October 1990. The loan amount was US$ 75 million. The objectives of the FHP were to: (i) improve the health status of people in eight underserved provinces by extending geographic access and improving the quality of services; (ii) enhance the efficiency of service delivery and improve financial sustainability; and (iii) strengthen the management capacity of the Ministry of Health.

The project was closed on December 31, 1998, with US$ 3.84 million undisbursed. According to the ICR of the FHP "the project was partially successful in achieving its objectives".

The Second Health Project (SHP) Loan No. 3802 – TU, was approved on September 22, 1994 and became effective on January 31, 1995. The specific objectives of the SHP were to: (i) improve equity of access to essential health services in 23 Eastern low income priority provinces and five provinces affected by the August 17 and November 12 1999 earthquakes; and (ii) improve the quality of health care management in the MOH and in selected institutions. In particular, the project aims at decreasing fertility rates, and improving life expectancy in the participating provinces.

The original total amount of the loan was US$ 150 million, later revised downward to US$ 130 million after restructuring. The original closing date of the loan was December 31, 2001. The Loan has been extended three times. The present loan closing date is December 31, 2004. According to the latest PSR, project development objective and implementation progress are rated as satisfactory.

The Primary Health Care Services Project (PCHSP) Loan No. 4201 – TU was approved in June 1997 and became effective in December 1997. The specific objectives of the PHCSP were to: (i) develop a primary health care system based on family physician and an effective referral system supported by financial incentives and improved infrastructure; (ii) evaluate the developed primary care system with a view to nationwide replication; and (iii) develop capacity for economic analysis in the MOH.

The loan amount was US$ 14.5 million. After 21 months of inactivity and no disbursement, the project was restructured and the loan's entire amount was reallocated towards financing emergency health interventions in the earthquake provinces. The loan was closed in June 2001, with an undisbursed balance of US$ 14 million.

In addition to the above Bank-financed activities in the HNP sector, the European Commission has granted € 55 million for reproductive health in Turkey. The project is managed by the MOH's Directorate General of Mother and Child Health and Family Planning, and it is in early stages of implementation.

Annex 3: Results Framework and Monitoring

TURKEY: Health Transition Project

Results Framework

Program Purpose	End-of-Program Indicators	Use of End-of-Program Information
Program Purpose (FY05-FY11) **Phase I: (FY05-FY07)** The objective of Phase I is to enable the Government to strengthen the institutional environment for the implementation of its Program for Transformation in Health that will improve system stewardship, streamline financing and service delivery, and build the institutional capacity to extend health insurance coverage to the whole population in a fiscally sustainable manner. **Phase II: (FY08-FY11)** The objective of Phase II is to enable the Government to complete its fiscal and institutional readiness for nationwide transition to family medicine and the implementation of universal health insurance.	Maternal Mortality Ratio is on course to reach the target of ¾ reduction by 2015. Child mortality rate is on course to reach the target of 2/3 reduction by 2015. Significant reduction in discrepancy in MMR, IMR and by region, urban/rural and income quintiles. Economic barriers to access to and use of essential health services covered by UHI are eliminated. Outpatient and inpatient service use indicators converge towards EU average by end of project. Physicians' choice of family medicine as a mode of practice increased. Increase in total and public health expenditures in line with country's economic development. Reliance on subsidy from the consolidated budget for balancing the UHIF budget reduced. Institutional and legal framework of the health and social security sector is in full compliance with the *acquis communautaire* as a pre-condition for EU accession.	1. Evaluate the magnitude of change in meeting the MDGs. 2. Determine the impact of MOH programs in reducing the geographic and socio-economic inequalities in the provisions of quality health care. 3. Monitor and evaluation the fiscal sustainability of the new Universal Health Insurance. 4. Determine the progress of meeting the EU accession criteria

PDO	Outcome Indicators	Use of Outcome Information
(APL I) – Governance of the health care system is realigned, and the roles of responsibilities of key government agencies are redefined along the functional lines of stewardship, financing, service provision, and health and social security information management.	1. MOH no longer involved in service provision except for public health programs. 2. MOLSS no longer involved in service provision. 3. Evidence of public hospitals operating under a new autonomous model. 4. Evidence of increased user and provider satisfaction as a result of family medicine pilot. 5. Evidence of capture and use of health, service use and financing data generated in the family medicine pilot by the newly integrated information system.	
Intermediate Results One per Component	**Results Indicators for Each Component**	**Use of Results Monitoring**
Component A: Restructuring the MOH for Effective Stewardship MOH restructured in line with the reform agenda and the amended Law on MOH institutional setup.	**Component A:** 1. MOH restructured 2. NPMDA established 3. Quality Assurance and Accreditation systems established 4. Monitoring and Evaluation System operational	**Component A:** 1. Determine the degree of success in restructuring the MOH to meet its new mandates. 2. Determine the impact of the success of the PTH.
Component B: Building Capacity of the Health Insurance and Social Security Institutions A new institutional basis for universal health insurance set up	**Component B :** 1. Universal Health Insurance established.	**Component B:** 1. Determine the institutional capacity of the universal coverage of health insurance for the whole population.
Component C: Reorganizing the Delivery of Healthcare Services A new (i) family medicine organizational model for primary health care piloted; (ii) autonomization of hospitals designed; (iii) referral system put in place; and (iv) Population Health Grant program established.	**Component C:** 1. Family Medicine Model defined and pilot tested. 2. Autonomous hospital model is developed and first phase hospitals selected. 3. Effective referral system established 4. Innovative new initiatives to promote population health carried out 5. Plan for new surveillance system developed	**Component C:** 1. Lessons learned from the pilot family medicine model will assist in the design of the national roll out. 2. Lessons learned in the pilot autonomization of hospitals will determine "best practice" for national coverage in Phase II. 3. "Best practice" from the new referral system will be applied nation-wide. 4. Innovative new health promotion and preventive

		health programs will be expanded if they are found to be cost-effective. 5. Improved surveillance system will provide early warning system for disease preventions.
Component D: Strengthening Human Resources Capacity A new human resources policy and plan developed and adopted.	**Component D:** 1. Human resources plan developed and ready for implementation. 2. School of Public Health is ready to conduct courses in health management and administration, health economics and financing, flagship programs, rational drug use, epidemiological intelligence service, and population health.	**Component D:** 1. The human resource planning will allow balancing the country's requirements and supply in the health sector thereby adjusting incentives for long term equilibrium. 2. The country's institutional capacity to carry out health sector policy and planning can be enhanced that will also be financially sustainable.
Component E: Building Infostructure for Health and Social Security A new health and social security information platform designed and piloted.	**Component E:** The newly developed health and social security information systems are successfully tested.	**Component E:** Successful testing of the infostructure systems at the MOH and MOLSS will lead to a single processing institution (MOLSS) for data and information to support information needs of the PTH.

Arrangements for results monitoring

		Target Values					Data Collection and Reporting		
Outcome Indicators	**Baseline**	**YR1**	**YR2**	**YR3**	**YR4**	**YR5**	**Frequency and Reports**	**Data Collection Instruments**	**Responsibility for Data Collection**
End of Program (FY05-FY11)									
1. MMR	55/100,000								
2. IMR	36/1000 (2001)								
3. % of public health expenditures	63.2%								
4. % health insurance coverage	89%								
Phase 1 (FY05-FY07)									
1. A new MOH organizational model including national drugs and medical devices agency, a policy and M&E unit, an accreditation and quality insurance agency and a reactivated School of Public Health.	limited MOH capacity								
2. Legal, regulatory and institutional arrangements for the introduction of family medicine is in place and a pilot model is implemented.	inexistent								
3. Legal, regulatory and institutional arrangements for the financial and managerial autonomy of public hospitals is in place.	Inexistent								
4. Legal, regulatory and institutional arrangements of the new universal health insurance fund is in place.	Draft Bills under preparation								

5. Infostructure agreed upon by all MOH and MOLSS and pilot tested. **Phase II (FY08-FY11)** 6. 80% of families in cities are registered with a family physician. 7. 80% of hospitals have financial and managerial autonomy. 8. The entire population is enrolled in the insurance fund and has access to the essential package of services. 9. The new health and social security infostructure is in place and working.	Inexistent TBD in FY08 TBD in FY08 TBD in FY08 TBD in FY08								
Results Indicators for Each Component									
Component 1 : 1. MOH restructured. 2. NPMDA established. 3. Quality Assurance and Accreditation systems established. 4. Monitoring and Evaluation System operational.	 Draft Law Draft Law Inexistent Limited under different form								
Component 2 : 1. Universal Health Insurance established.	 Four different independent schemes covering 89% of the population								

Component 3: 1. Family Medicine Model defined and pilot tested. 2. Autonomous hospital model is developed and first phase hospitals selected. 3. Effective referral system established. 4. Innovative new initiatives to promote population health carried out. 5. Plan for new surveillance system developed.	Inexistent Inexistent Limited Limited Inexistent								
Component 4: 1. Human resources plan developed and ready for implementation. 2. School of Public Health is ready to conduct courses in health management and administration, health economics and financing, rational drug use, flagship programs, population health, epidemiological intelligence service.	Inexistent Very limited								
Component 5: 1. The newly developed health and social security information systems are successfully tested.	Inexistent								

Annex 4: Detailed Project Description

TURKEY: Health Transition Project

This project is designed to support the Government to implement its Program for Transformation in Health, and as such its components are designed and sequenced to correspond and contribute directly to PTH's eight main objectives. The overall objective of the program is to improve the governance, efficiency, user and provider satisfaction and long-term sustainability of the healthcare system in Turkey. The program will be implemented in two phases, each with its own objectives. Phase I will be of a duration of about three years, and geared towards the institutional restructuring of the MOH for more effective stewardship, whereas Phase II, which is expected to last about four years, will mostly involve the large-scale implementation of the family medicine model and the establishment of the infostructure for both health and social security. Below is a detailed description of project components.

By Component:

Project Component A – Restructuring the MOH for Effective Stewardship (Base Cost of € 9.60 million)

This component will assist the MOH to redefine its roles and responsibilities and complete its institutional transformation from a mainly provider of services to a policy maker and regulator of service provision, while retaining key public health functions, including disease prevention and health promotion. The component has four sub-components, namely: (i) restructuring MOH and building its capacity to lead the sector, especially with regards to health and healthcare policy design and development, and the necessary legal and regulatory support, and capacity building; (ii) establishment of a regulatory agency for pharmaceuticals and devices which are increasingly becoming of concern as major expenditure items, but also because of their inappropriate use; (iii) a new agency for quality control and assurance, and the accreditation of health facilities (both public and private hospitals, laboratories, out-patient clinics, pharmacies, etc; and (iv) establishment of a new M&E agency within the MOH to track progress with the implementation of the PTH, but also to become the key unit to provide key evidence in line with MOH's revised mandate and functions. Consequently, the scope and nature of the activities will encompass organizational restructuring, setting-up of new units, training of MOH personnel and public information campaign. MOH will be the implementing agency.

A.1. Restructuring of the MOH (Base Cost of € 3.12 million). This sub-component will support the reorganization of the functional and administrative structure of the MOH; provide executive management and in-service training; build its strategic planning capacity; and design a public awareness campaign. It will finance consultant services for organizational change, capacity assessment and public information campaign and both external and internal training of managerial staff.

A.2. Establishment of the National Pharmaceuticals and Medical Devices Agency (Base Cost of € 2.14 million. This sub-component will support development of the legislative and regulatory framework; in-service training of new staff; procurement of startup equipment and furniture; identifying equipment needs and revision of the technical specifications for the main quality

assurance and control laboratory; and carrying out environmental impact assessment. The equipment itself will be procured in Phase II (to be cost separately). It will finance purchase of office equipment; consultant services for organizational set up and identification of training needs and technical specifications for equipment; and both external and internal training of Agency staff.

A.3. Quality Assurance and Accreditation of Health Facilities (Base Cost of € 2.59 million). This sub-component will support the development of an accreditation and licensing system; establishment of a new Unit within the MOH; public information of the roles and functions of the Unit; identification of in-service training needs; and accreditation of the National Hygiene Laboratory. It will finance procurement of limited amount of equipment, consultant services to set up the new Accreditation System and its Unit, and training of Unit and Hygiene Laboratory personnel.

A.4. Establishing Monitoring and Evaluation Capacity (Base Cost of € 1.74 million). This sub-component will support development of a Monitoring and Evaluation Framework for the Program for Transformation in Health; establish a Unit within the MOH and develop its human resources capacity. It will finance consultant services and local and foreign training.

Project Component B – Building Capacity of the Health Insurance and Social Security Institutions (Base Cost of € 3.00 million)

This component will assist MOLSS to carry out technical work to assess and project UHI medium- and long-term costs and revenues, build the actuarial basis for revenue and cost projections, strengthen institutional capacity for strategic purchasing and contracting; develop new provider payment systems for family physicians and hospitals; complete the legislative and regulatory requirements to set up the NHIF; and train its staff on various health insurance related functions and tasks in line with their new functions, roles and responsibilities. It will finance consultant services for the needed technical assistance, namely, institutional design of the NHIF, actuarial analysis to assess fiscal sustainability; estimation of premium rates, deductibles and co-payments; identification of eligibility/exclusion criteria; and definition of the minimum service package.

Once the necessary legislative work is complete and the new social security law is enacted MOLSS will embark on a major restructuring which will realign its organizational structure along functional lines (health, unemployment, pension and social assistance). This new setup will introduce administrative autonomy to each agency with its own management board, and prevent transfer of funds from one to another for deficit reduction. Therefore this component also includes technical assistance for the social security reform in general, as it pertains to UHI and the NHIF which will be carried out in accordance with the conditionality of the proposed PPSAL operation. Accordingly, it will also finance assessment of human resources and skills mix needs and preparation of training programs and packages. MOLSS will be the responsible implementing agency

Project Component C – Reorganizing the Delivery of Healthcare Services (Base Cost of € 15.67 million)

This component will assist MOH to design, develop and pre-test new organizational models for service delivery by (i) introducing the tenets of family medicine as the basis for the provision of outpatient or primary health care services; (ii) doing away with the distinction between MOH and SSK hospitals and eventually making them autonomous; and (iii) building a new patient referral mechanism to reactive system hierarchy. Such a change can only be executed gradually, and will require cooperation and collaboration of the two line ministries and the cooperation of various stakeholders (professional associations, trade unions active in the health sector, associations of private health institutions, hospitals and insurance companies). A fourth and final sub-component will focus mostly on population health programs, namely maternal and child health, tobacco control, NCDs, etc., to help Turkey reach the related MDGs. The scope and nature of the activities will include technical assistance for in-service training, licensing and institutionalization of family medicine; design of a capitation-based reimbursement scheme; and possibly low interest loans to prospective family physicians to set up and refurbish their practice settings. The latter may include capital investment to upgrade family practitioners' offices and equipment, hardware and software procurement for cost accounting and health information network requirements. Because of the nature of the reform, pilot sub-projects will be carried out to test the various models to ensure that the new set-up in the provision and financing of health care services, i.e., family medicine, hospital autonomy, and referral system, is functionally integrated, including the proposed infostructure. This component will be carried out by the MOH.

C.1. Introducing Family Medicine for Primary Health Care (Base Cost of € 9.98 million). This sub-component will support the design and development of a family medicine based primary health care organization, including definition of task profiles for family physicians, piloting the model in a few cities; and identifying resource needs for full-scale implementation. Such a model entails family physicians working in their private settings and being paid on a capitation basis. It is hoped that the model would streamline patient referral thus leading to more appropriate care, reduced patient load in hospitals and elimination of bottlenecks in the referral hierarchy.

Such an organizational change require financial and technical support in both the design and implementation phases and could include, on the formal training side, review of curriculum, certification standards and institutionalization of family medicine and, on the organization side, legal and regulatory framework for contracting out and change in the mode of payment, definition of the standards in terms of optimal number of families/patients on family doctors' lists, services which need to be paid on a fee-for-service basis to ensure total coverage (e.g., immunization, ante-natal care, etc.), pricing of per capita based payment, and possibly low interest loans to prospective family physicians to set up and refurbish their practice settings. It will finance technical assistance for system design, training of physicians in pilot areas, actual piloting, and public information campaign.

C.2. Autonomization of Public Hospitals (Base Cost of € 2.89 million). This sub-component will support development of a autonomous hospital model; assessment of the current financial and management capacity of the public hospitals; development of accounting and performance monitoring models; training of managerial cadre; projection of future resource needs; and development of a financing plan. This sub-component will mainly finance consultant services and local and foreign training.

C.3. Developing an Effective Referral System (Base Cost of € 0.29 million). This sub-component will support the design and development of a registration system for referral and counter-referral; identification of the guidelines for patient referral and the incentive mechanisms for compliance. It will also determine the roles and responsibilities of the family physicians and assess their training needs. It will finance consultant services and training activities.

C.4. Strengthening Population Health (Base Cost of € 2.50 million). This sub-component will support assessment of health and service needs and the resources required to meet them; establishment of a small grant program for community-based initiatives; strengthen the disease surveillance system; and carry out innovative school- and community-based child health and tobacco control initiatives. It will finance consultant services for needs assessment and surveillance system setup, a small grants program and its public awareness campaign, and training activities.

Project Component D – Strengthening Human Resources Capacity (Base Cost of € 8.72 million)

This component aims at strengthening the competencies of future family practitioners and other allied health professionals, including healthcare managers. It will also support the re-activation of the school of public health which will act as an advisory and training institution to MOH, and fulfill the functions of training, research and consultancy covering the topics of public health, health policies and strategies, health services management and health financing and economics. This component will be implemented by the MOH and the MOLSS.

D.1. Health and Social Security Human Resources Policy and Planning (Base Cost of € 1.30 million). This sub-component will support establishment of an interdepartmental working group; technical work for long term human resources needs projections and identification of training needs and other development needs. It will mainly finance technical assistance to carry out these activities.

D.2. Strengthening the School of Public Health (Base Cost of € 7.42 million). This sub-component will support the development of the capacity of the SPH to conduct training courses in the field of health management and administration, health economics and financing, rational use of drugs, flagship programs, epidemiological intelligence service and population health; establishment of a training facility and library within the School of Public Health. It will finance procurement of equipment, library material, consultant services for curriculum development and training modules for each discipline and training activities.

Project Component E – Building Infostructure for Health and Social Security (Base Cost of € 15.13 million)

This component aims at building and expanding the information platform, network and user endpoints for all of the four social security agencies. During Phase I, the scope and nature of the activities will encompass design, development and piloting of the "infostructure", and training of cadres. The piloting of the "infostructure" will be aligned with the piloting of the sub-projects in Component C to ensure a fully integrated system.

E.1. Building the Health Information System (Base Cost of € 6.71 million). This sub-component will support the development of data architecture and platform; system design; development and pilot testing of software; and assessment of training needs. Procurement of all IT equipment will be carried out in Phase II. The sub-component will finance MOH's limited equipment needs for pilot testing, consultant services for system and software design and local and foreign training.

E.2. Building the Social Security Information System (Base Cost of € 8.42 million). This sub-component will support the development of data architecture and platform; system design; development and pilot testing of software; and assessment of training and resource needs for the social security system. Procurement of all IT equipment will be carried out in Phase II. The sub-component will finance MOLSS's limited equipment needs for pilot testing, consultant services for system and software design, development and local and foreign training.

Project Component F – Project Management (Base Cost of € 2.60 million). This component will support the establishment and functioning of the PMSU and the two PIUs, technical and oversight work of the IAWG and IASC and the hiring of a Project Management Consulting Firm. It will finance consultant services, workshops, publication and dissemination activities and training of project management staff.

Annex 5: Project Costs

TURKEY: Health Transition Project

Project Cost Summary by Component
(€ Million)

Component and/or Activity	Local	Foreign	Total
A. Restructuring the MOH for Effective Stewardship			
1. Restructuring of the MOH	2.43	0.70	3.12
2. Establishment of the NPMDA	0.59	1.55	2.14
3. Quality Assurance and Accreditation of Health Facilities	1.54	1.06	2.59
4. Establishing Monitoring and Evaluation Capacity	0.71	1.03	1.74
B. Building Capacity of the Health Insurance and Social Security Institutions	0.82	2.18	3.00
C. Reorganizing the Delivery of Healthcare Services			
1. Introducing Family Medicine for Primary Health Care	9.09	0.89	9.98
2. Autonomization of Public Hospitals	2.48	0.41	2.89
3. Development of an Effective Referral System	0.13	0.17	0.29
4. Strengthening Population Health	2.10	0.40	2.50
D. Strengthening Human Resources Capacity			
1. Health and Social Security Human Resources Policy and Planning	0.64	0.66	1.30
2. Strengthening the School of Public Health	4.33	3.09	7.42
E. Building Infostructure for Health and Social Security			
1. Building the Health Information System	3.05	3.66	6.71
2. Building the Social Security Information System	4.44	3.98	8.42
F. Project Management	1.63	0.97	2.60
Total Baseline Cost	33.95	20.75	54.70
Physical Contingencies	3.14	2.05	5.19
Price Contingencies	0.57	0.30	0.88
Total Project Costs[1]	**37.66**	**23.10**	**60.76**
Front-end Fee		0.49	0.49
Total Cost to be Financed	**37.67**	**23.59**	**61.26**

(Totals may not add-up due to rounding errors.)

[1]Identifiable taxes and duties are € 6.78 million, and the total project cost, including taxes and the front-end fee, is € 61.26 million. The share of taxes in the project cost is estimated at 11%.

Annex 6: Implementation Arrangements

TURKEY: Health Transition Project

The program will be implemented jointly by the Ministry of Health and the Ministry of Labor and Social Security. The existing **Inter Agency Steering Committee (IASC)** will remain in force, and will be responsible for project oversight, inter-agency coordination at the national level and overall performance. The IASC will be chaired by a designate of the MOH and will be composed of six senior officials, one representative from each SPO and the Treasury, and two from each MOH and MOLSS, the key implementing agencies involved in the project. The IASC will also be responsible for ensuring the achievement of project goals, and review of project progress in line with the objectives of the PTH. The IASC should meet at least four times a year during project implementation.

In addition, a **National Advisory Board (NAB)** will be set up from nationally reputable academia/experts and will include no more than seven members. The NAB will be chaired by the Minister of Health, and will meet 2-3 times a year on matters related to MOH's own Program for Transformation in Health and its linkages with the HTP (TORs to be defined). **Technical Working Groups (TWGs)** will address technical issues such as preparation of TORs, review of proposals and technical advice and assistance to the IASC and the Project Manager. Each TWG will be composed of up to five experts, either from Ministry staff, or from outside, as needed (TORs to be defined).

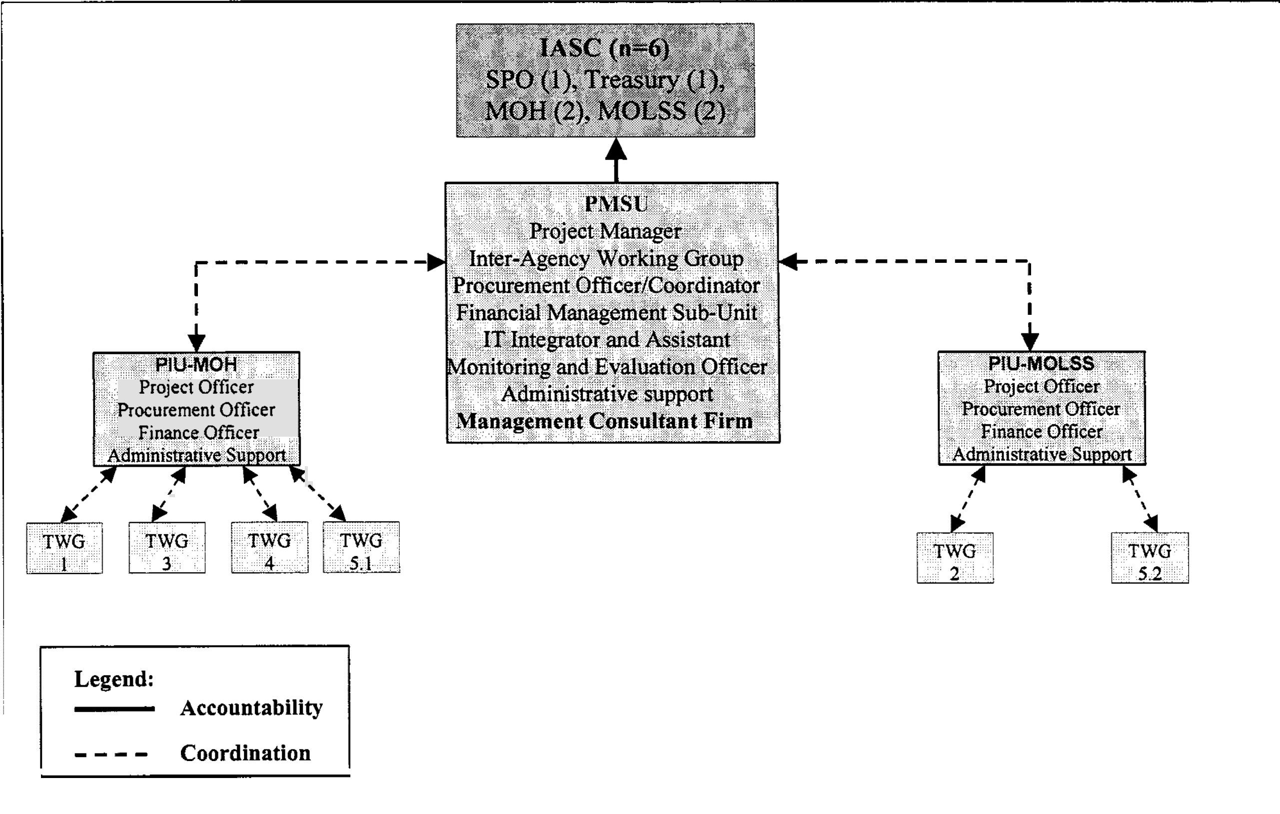
A **Project Management Support Unit (PMSU)** headed by a **Project Manager** with appropriate qualifications and experience will be jointly appointed by the MOH and the MOLSS. The PMSU will be located in the MOH, and will have the overall fiduciary responsibilities for project implementation. The PMSU will be accountable to the IASC in project management with TORs satisfactory to the Bank.

Besides the Project Manager, the PMSU will comprise: (i) a **Financial Management Sub-Unit,** composed of three MOH staff, a financial management coordinator, with overall oversight on all financial management activities, an accountant, and a disbursement officer; (ii) two procurement specialists, a civil servant **Procurement Coordinator**, with oversight on all procurement in both ministries, and responsible for overall project procurement, and a consultant **Procurement Specialist**; (iii) two IT specialists, one **IT integrator**, in charge of ensuring harmonization between the two MOH infostructure development and piloting, and an IT assistant (both consultants, TORs to be defined); (iv) a **Monitoring and Evaluation Officer,** to be solely in charge of all aspects of project's monitoring and evaluation (TOR to be defined); (v) two translators; (vi) two administrative officers; and (vii) two team assistants.

A **Project Implementation Unit (PIU)** will be established by each Ministry and will be responsible for procurement, disbursement, and accounting for ministerial level activities. Each PIU will have five staff, a Project Officer, a Procurement Officer, a Financial Management Officer and two team assistants, all civil servants. Each PIU will coordinate its fiduciary functions with the respective PMSU procurement and financial management coordinators.

An **Inter Agency Working Group (IAWG),** composed of six technical staff from both Ministries will be appointed for full time technical support to Project Manager. The IAWG will be responsible for the preparation of workplan, timing of activities, TORs, etc., in coordination with the focal points in the TWGs, as appropriate, and with technical support from the **Management Consultant Firm** (TOR to be defined) to be hired under the project.

Project Management Organizational Chart



Annex 7: Financial Management and Disbursement Arrangements

TURKEY: Health Transition Project

Project Financial Management

Summary of Financial Management Arrangements

The table below summarizes the findings and observations of the assessment of the adequacy and readiness of the project financial management arrangements at Board (please see the detailed report on file). In summary, the current financial management arrangements for the project meet the minimum Bank requirements. An Action Plan to bring the arrangements that were not fully satisfactory to the Bank has also been agreed with the PMSU.

ASSESSMENT CRITERIA	RATING	AGREED ACTION PLAN
1. Implementing Entity	Satisfactory	
2. Funds flow	Satisfactory	
3. Staffing	Marginally Satisfactory	One more person will be employed full time at the financial management sub-unit of the PMSU.
4. Accounting Policies and procedures	Satisfactory	Comprehensive draft financial management manuals are prepared.
5. Internal Audit	NA	
6. External Audit	Satisfactory	
7. Reporting and Monitoring	Satisfactory	Format of the FMRs agreed with the PMSU.
8. Information systems	Marginally Satisfactory	There is an existing accounting software. It will be customized for HTP by April 30, 2004.
OVERALL FM RATING	Satisfactory	

Country Issues

A Country Financial Accountability Assessment (CFAA) for Turkey was carried out in 2001. The CFAA report identified major weaknesses in the Turkish financial accountability, in both the public and the private sector. The CFAA concludes that to ensure that Bank funds are used for their intended purposes ring-fenced financial management arrangements are more appropriate for the implementation of Bank-financed investment projects rather than relying upon government systems.

In December 2003, the National Assembly enacted the public financial management and control law which establishes the legal framework for harmonizing and modernizing budgetary practices across all government agencies. It will reduce fragmentation and provide for a more comprehensive presentation of the budget. The law which will come to force in January 2005 will also allow for future decentralization of financial control to spending agencies.

There has also been an initiative to introduce modified accrual accounting in compliance with GFS requirements. However this took more time to complete than initially envisaged. Based in

part on the experiences from the pilots, the revised timetable for the accounting reform is as follows: (i) introduce modified accrual accounting in consolidated budget entities in 2004; (ii) begin introduction of the full accrual basis in entities outside the consolidated budget in 2004; and (iii) introduce full accrual accounting for consolidated budget entities by 2007. The government accounting standards board to be established through the PFMC law will be responsible for transforming the framework standards included in the accounting regulation into full-fledged accounting standards over time.

Audits of most Bank-financed projects in Turkey are carried out by the Treasury Controllers (TCs).

RISK ANALYSIS

	Risk	**Comments**
INHERENT RISK		
1. Country Financial Management Risk	High	Based on CFAA report
2. Project Financial Management Issues	Moderate	
3. Counterpart funds	Moderate	Secured by GoT for CY 2004
Overall Inherent Risk	Moderate	
CONTROL RISK		
1. Implementing Entity	Moderate	The PMSU is formally established.
2. Funds Flow	Moderate	Arrangements are discussed and agreed with.
3. Staffing	Moderate	Appointment of PMSU manager and key FM and procurement staff has been completed prior to Negotiations.
4. Accounting Policies and Procedures	Moderate	A comprehensive Project Financial Management Manual prepared.
5. Internal Audit	N/A	
6. External Audit	Moderate	
7. Reporting and Monitoring	Moderate	Format of the FMRs agreed with PMSU.
8. Information Systems	Substantial	Existing accounting software will be customized prior to Board
Overall Control Risk	Moderate	

Risk mitigation strategy

The changes in national financial accounting rules and practices mentioned above are not expected to affect HTP's financial management, at least in the short run. The integration of the project accounting into Government's accounting will be considered at a macro level and will not be within the scope of HTP. Therefore in order to compensate for the weaknesses identified in the CFAA, the project will be controlled and accounted for by a separate Project Management and Support Unit.

Implementing Entity

The project implementation will be carried out by the MOH and MOLSS. A PIU will be established by each Ministry, and will be responsible for daily implementation of the project,

including procurement, disbursement of counterpart funds and accounting for ministerial level activities. Overall project coordination will be carried out by the PMSU. The PMSU will have the fiduciary responsibilities for overall project implementation and will be accountable to the IASC who will be responsible for project oversight, interagency coordination at the national level and overall performance. The PMSU will be headed by a Project Manager with appropriate qualifications and experience.

The PMSU will have the following sub-units: (i) Financial Management Sub-Unit (FMSU); staffed with a financial coordinator, an accountant and a disbursement officer, and will be responsible for all project financial management activities. The FMSU will have oversight on all financial management activities carried out by their counterparts at the PIUs; (ii) Procurement Sub-Unit (PSU) will have oversight on all procurement activities in both ministries and be responsible for overall project procurement; (iii) Monitoring and Evaluation Sub-Unit (MESU) will be appointed to be solely in charge of all aspects of project's monitoring and evaluation.

Funds Flow

There will be one Special Account for the project at the Central Bank of Turkey. All payments to the contractors, suppliers and consultants will be made from this Special Account with the authorization of the Project Manager and the Financial Coordinator of the FMSU based on the payment orders of the implementing ministries. Payments will be made directly from the loan account for amounts over 20% of the authorized special account allocation.

Using the project funds (both Bank financed and counterpart financed) depends on having yearly allocations in the general government budget. These funds could be used only after they are made available by the Ministry of Finance. The responsibility for ensuring that sufficient funds are provided in the institutions budget belongs to each ministry. The payments for the counterpart funds will be made directly by the MOF's payment office at the implementing entity. The FMSU will get a copy of the payment document relating to the counterpart funds so that they are included and documented in the overall project accounting.

The PMSU could authorize the payment from the special account only after the approval of the MOF's Payment Office at the spending institution. The financial officers at the PIUs will be responsible for obtaining the approval of the MOF Payment Office at their respective ministries. They will then send a payment order to the PMSU to initiate the payment from the special account. The PMSU will have the overall responsibility for the management of the special account and will make the required payment from the special account based on the approval of the spending institution and the MOF payment office. The PIUs will be given a copy of the payment documents and the PMSU will make the required accounting entries in to the financial management system.

There is already an allocation of US$ 2 million and of US$ 1 million for the HTP in the 2004 budgets of the MOH and the MOLSS, respectively.

Staffing

The PMSU under the direct responsibility of the IASC will work as a specialized organizational unit of MOH and will act as a service provider to the implementing entities. The Financial Management Sub Unit of the PMSU will have a Financial Coordinator, a Disbursement Officer and an Accountant. The TORs for these positions are attached to the assessment report.

Given the fact that there already is a Project Coordination Unit at the MOH for the on-going Health II project, the PMSU will operate in the same premises, and benefit from the roll-over of the fiduciary system and procedures into its own management. As the current PCU staff do not have the required qualifications and the experience needed to assume the fiduciary responsibility under the HTP, they would have to receive training on World Bank financial management procedures. Moreover, a Financial Officer needs to be assigned on a full time basis.

Accounting Policies and Procedures

The project accounting will be maintained separately within the PMSU and will be on a cash basis. The Health II PCU has a computerized Financial Management Information System (FMIS) capable of recording project transactions by project components, disbursement categories and sources of funds. Different modules within the FMIS could be used for accounting for more than one project, with some minor software updates.

The PMSU has hireda short-term consultant to ensure that all financial and accounting aspects of HTP are satisfactorily administered. The consultant has developed the Chart of Accounts (COAs) suitable for HTP and will install the COAs into the current computerized financial management system by April 30, 2004. The system willalso generate the quarterly FMRs.

The consultant has prepared the draft Financial Management Manual for the project. The Manual includes: (a) the financial management system of the project including the accounting and auditing policies; (b) the role of the financial management system in the project implementation; (c) the accounting arrangements for the project, including the format and contents of the project reporting; (d) the auditing arrangements; and (e) budgeting and planning.

Internal Audit

The newly enacted Public Financial Management Law (PFMC) requires establishment of an internal control unit in each ministry. The internal control unit in each ministry will be established after an Internal Control Coordination Board is established and designated internal controllers are certified by the Board. These articles of PFMC become effective on January 1, 2005. However, at present there is not an internal control department which carries regular audits of the departments in either Ministry and therefore no reliance will be placed on internal audit.

Reporting and Monitoring

The PMSU will maintain records and ensure appropriate accounting for the funds provided. Financial statements for the project will be prepared by the PMSU. The Financial Monitoring Reports (FMRs) will be prepared quarterly, and will be submitted to the Bank no later than 45 days after the end of the quarterly period.

The FMRs will be submitted with a cover letter explaining the activities of the quarter and will include the following tables:

- Statement of Sources and Uses of Funds by categories;
- Statement of Sources and Uses of Funds by Project Components;
- Special Account Statement;
- A detailed schedule for tracking disbursements against specific consultancy contracts. The data to be included in this report will be agreed during negotiations. It is expected that the monitoring and evaluation department of the PMSU will be responsible for the preparation of this report and the PMSU will provide the required financial data; and
- Procurement reports. It is expected that the Procurement department of the PMSU will be responsible for the preparation of procurement reports and the FMSU will provide the required financial data.

The financial accounting software will be capable of producing the financial reports of the FMRs. The first draft financial reports using dummy data, satisfactory to the Bank will be prepared by the PMSU by April 30, 2004.

Information Systems

The existing accounting software that is used successfully by other PIUs in Turkey. Due to staffing problems, the PCU has not been able to use the software satisfactorily for the last two years. Currently the staff in the financial management department of the PCU are receiving training on the software. The same software will be used for HTP and the consultant who is responsible for the customization of the software for HTP will also provide continued training to the financial management staff. It is also required that the contract with the consultant will cover maintenance of the system for at least one year after customization is completed.

Strengths and Weaknesses

The main strength of the project financial management system is the centralization of all payments and their accounting at the PMSU in the project design. This will reduce the main weakness of the project which is having for the first time a new implementing agency, MOLSS, with no prior history of Bank financing, and establishing a PIU therein with no previous experience in Bank procedures.

Action Plan

At present, the financial management arrangements for the project satisfy the Bank's minimum requirements. The following action plan is proposed to address the issues that are not yet completed.:

Action	Deadline
1. Consultant with TOR satisfactory to the Bank will be hired for setting up a financial management system at the PMSU.	Done
2. The current financial management software will be customized for HTP	April 30, 2004
3. Draft FMRs will be received from the financial management software	April 30, 2004
4. A full time financial person will start working at the PMSU.	Done

Supervision Plan

During project implementation, the Bank will supervise the project's financial management arrangements as follows: (i) review Project's quarterly financial management reports as well as its annual audited financial statements and auditor's management letter; and (ii) during supervision missions, review the project's financial management and disbursement arrangements to ensure compliance with the Bank's minimum requirements. As required, a Bank-accredited Financial Management Specialist will assist in the supervision process.

B. Audit

Annual project financial statements for the project will be audited by the Treasury Controllers in accordance with International Standards on Auditing (ISA) and under TOR that is cleared by the Bank.

C. Disbursement Arrangements

The loan proceeds will be disbursed over a period of three years, under the Bank's traditional procedures including SOEs, direct payments and special commitments.

Because of the unique nature of the Pilot sub-projects, full documentation will be required for all disbursement under this disbursement category.

Table 6 sets forth the Categories of items to be financed out of the proceeds of the loan, the allocation of amount of loan to each category and the percentage of expenditures for items so to be financed in each category.

Table 6

Allocation of Loan Proceeds (EURO)

Category	Amount of the Loan Allocated (Expressed in EURO)	% of Expenditures to be Financed
(1) Goods		
(a) under Parts A, B, C, D.1, E and F of the Project	2,050,000	100% foreign expenditures, 100% of local expenditures (ex-factory cost), and 85% of local expenditures for other items procured locally
(b) under Part D.2	350,000	
(2) Consultant Services	23,750,000	78%
(3) Training	15,650,000	100%
(4) Population Health Grants under Part C.4 of the Project	1,630,000	100% of amount disbursed
(5) Pilot sub-projects under Part C.1, 2, 3, and Part E of the project	700,000	80%
(6) Incremental Operating Costs		
(a) under Parts A, B, and F of the Project	500,000	80%
(b) under Part D.2 of the Project	160,000	50%
(7) Fee	494,000	
(8) Unallocated	4,126,000	
TOTAL	**49,400,000**	

D. Special Account

The GoT will open and maintain a Special Account in Euro at the Central Bank of Turkey. The Special Account will be used following procedures to be agreed with the Bank, and will have an authorized allocation of €4.0 million. The Project Coordinator and the Financial Manager will be authorized to sign the withdrawal applications, with two signatures required. At the start of the project, the initial deposit will be limited to € 2.0 million, and the remaining portions of the authorized allocations will be requested only after cumulative disbursements from the loan reach a level of € 10.0 million. The minimum application size for payments directly from the Loan Account for issuance of Special Commitments is 20% of the Special Account authorized allocation.

Applications for replenishment of the SA will be submitted to the Bank on a monthly basis, or when the balance of the SA is equal to about half of the initial deposit or the authorized allocation, whichever comes first, and will include a reconciled bank statement as well as other appropriate supporting documents.

Use of Statements of Expenditure (SOEs): the disbursements will be made against SOE for: (i) goods costing less than US$ 100,000 equivalent per contract, except the first contract under IS and NS; (ii) consulting contracts with firms, costing less than US$ 200,000 equivalent each; (iii) consulting contracts with individual, costing less than US$ 50,000 equivalent each; (iv) training, population health grants and incremental operating expenses, costing less than US$ 100,000 equivalent each. Full documentation in support of SOEs shall be retained by the PMU for at least one year after the Bank has received the audit report for the fiscal year in which the last withdrawal from the Loan Account was made. This information shall be made available for review during supervision by Bank staff and for annual audits which will be required to specifically comment on the propriety of SOE disbursements and the quality of the associated record-keeping.

Annex 8: Procurement

TURKEY: Health Transition Project

Procurement

Procurement of goods and technical services will be done in accordance with World Bank Guidelines: *Procurement under the IBRD Loans and IDA Credits* (issued in January 1995, revised January and August 1996, September 1997, January 1999). Consulting Services, technical assistance and training would be procured in accordance with the *Guidelines - Selection and Employment of Consultants by World Bank Borrowers*, January 1997, revised September 1997, January 1999, and May 2002. The Bank's Standard Bidding Documents, Request for Proposals and Forms of Consultants' Contract will be used. A General Procurement Notice (GPN) will be published in the U.N. Development Business in May 2004.

The PMSU will have the fiduciary procurement responsibilities including monitoring, supervision and reporting. Aside from the Project Manager and Financial Coordinator, a Procurement Coordinator, together with a Procurement Officer, will oversee all procurement in both ministries. Each of the PIUs established in the ministries will have their own procurement officer who will coordinate the fiduciary functions with the PMSU's procurement coordinator. These PIUs' procurement officers and the PMSU procurement coordinator will have TORs satisfactory to the Bank. The minimum TOR requirements for the procurement consultant will be "to be familiar and experienced with World Bank procurement guidelines and procedures, and procurement under internationally financed projects".

The civil servants assigned for procurement in the implementing agencies will be sent to a training program, preferably to a program conducted by the International Labor Office (ILO) in Turin, Italy, according to their needs for further development of procurement knowledge and qualifications to ensure that all those involved in project implementation become familiar with procurement procedures and requirements under Bank-financed projects.

In general the PIUs will have the following responsibilities:

- implementation of the respective project components;
- implementation monitoring, including compliance with the relevant Bank policies, and evaluation;
- developments of Terms of Reference for the activities under their jurisdiction;
- preparation of bidding documents and contracts for works, goods and consultancy services;
- evaluation of bids;
- signing of the contracts;
- monitoring and management of contracts
- certification and/or commissioning of delivered products; and
- making payments to the contractors from their respective SA and project accounts.

Thresholds

The following thresholds are recommended. The aggregate amounts for each procurement method discussed below are shown in the footnotes to Table A:

(i) **Goods and Equipment:** Goods and equipment costing US$100,000 and more will be procured through ICB. Goods estimated to cost less than US$100,000 each may be procured through international shopping on the basis of three written quotations obtained from at least two different countries, or through IAPSO of the United Nations Development Program. Small contracts for supplies and minor equipment such as, but not limited to, furniture, locally manufactured IT hardware and software, stationeries, printing of public campaign materials and similar locally manufactured or available goods estimated to cost less than US$50,000 each may be procured under national shopping on the basis of three written price quotations obtained from local suppliers. In the procurement of IT hardware and software by IS or NS, when soliciting bids, the firms operating in Turkey registered to the Bank's Web site should be solicited in addition to the other available firms. The procurement of software licenses and medical reference materials may be conducted under direct contracting. The procedures set forth in paragraphs (a) through (e) of Article 3.7 to the Guidelines shall apply.

(ii) **Civil Works :** There is no civil works in the context of the project.

(iii) **Consultant Services, TA and Training:** Consultant's services will be selected in accordance with the Bank Guidelines issued in January 1997 and revised in September 1997, January 1999, and May 2002, and for this project, will include Quality and Cost Based Selections (QCBS), Consultant Qualifications (CQ), Least Cost Selection (LCS), and Individual Consultants (IC). QCBS selection over US$200,000 will be advertised in Development Business on-line version DG-market (Gateway) and in local media (one newspaper of national circulation, or the official gazette, and/or electronic portal of free access) from which a short list of six firms will be drawn. For contracts estimated to cost less than US$200,000, short lists may be based solely on national firms unless international firms expressed interest. Assignments of a standard or routine nature where well established practices exist will be procured following the LCS method. Contracts estimated at less than US$100,000 each for technical assistance, preparation and review of concepts notes, legal advice, study tours, quality control, publicity campaigns and similar activities agreed by the Bank will be procured following the CQ. Individual consultants will be selected in accordance with Part V of the Consultants Guidelines. Training for the PMSU and PIU staff will be conducted in accordance with a biannual training program that the PMSU and PIU will submit to the Bank for its agreement before implementation.

(iv) **Incremental Operating Costs:** The Loan will finance the incremental operations costs of the PMSU, the PIUs and those incurred by the School of Public Health, the National Advisory Board and the Health Insurance Fund. These will be incurred in accordance with an annual budget that the PMSU and the PIUs will prepare and submit to the Bank for its approval before any expenditures are incurred. The operating costs of the PMSU and PIUs will cover office equipment and supplies, utilities, communication, maintenance of equipment at PMSU and PIU offices, the cost of advertisement for procurement under the Project, travel expenses, accommodation and per diem during field trips of the above-listed agencies, workshops for

project launch and implementation, and subscription fees to international institutions; provided, however, that such expenses shall have been previously budgeted in the MOH's and MOLSS's annual budget.

Prior Review

The following prior review requirements would be applicable:

Goods

(a) All ICB packages.

(b) First IS, NS packages under each component of the Project.

(c) Each contract to be procured on the basis of direct contracting will be processed as follows: (i) prior to the execution of the contract, the Borrower shall provide to the Bank a copy of the specifications and the draft contract for its approval; (ii) the contract shall be awarded only after the Bank's approval shall have been given.

Consulting Services

(c) *Consulting Firms*: For each contract estimated to cost $200,000 or more, all TORs, draft RFPs, short lists, technical and financial evaluation reports, and negotiated draft contracts will be submitted to the World Bank for its prior review.

(d) *Individual Consultants*: All TORs, consultant's qualifications and experience, and draft contracts, for consulting assignments above US$50,000 each.

Post Review

All contracts not subject to the Bank's prior review would be subject to ex-post review, on a selective basis. One out of five contracts for goods, works, technical services and consulting services would be subject to ex-post review. Supervision missions would include a procurement specialist especially in the first year, whose main responsibility would be to conduct ex-post reviews of the procurement process and documentation, and provide his or her findings.

Table A: Project Costs by Procurement Arrangements[1]
(€ Million)

Category	ICB	NCB	Others[2]	N.B.F.	Total
1. Goods					
	2.06		0.62		2.68
	(2.01)		(0.59)		(2.60)
2. Services			33.62	0.09	33.71
			(26.06)		(26.06)
3. Training			17.16		17.16
			(17.16)		(17.16)
4. Population Health Grants			1.63		1.63
			(1.63)		(1.63)
5. Pilot sub-projects			0.91		0.91
			(0.73)		(0.73)
6. Recurrent Cost			1.04	3.63	4.67
			(0.73)		(0.73)
Total	**2.06**		**54.98**	**3.72**	**60.76**
	(2.01)		**(46.89)**		**(48.91)**
Front-end Fee					**(0.49)**
Loan Total					**(49.40)**

1/ *Figures in parentheses are the amounts to be financed by the Bank Loan. All costs include contingencies.*
2/ *Includes goods to be procured through shopping, consulting services, services of contracted staff of the project management office, training, technical assistance services, and incremental operating costs.*

Table B: Thresholds for Procurement Methods and Prior Review[1]

Expenditure Category	**Contract Value Threshold** (US$ thousands)	**Procurement Method**	**Contracts Subject to Prior Review** (US$ millions)
1. Works	N/A	N/A	N/A
2. Goods	> or equal to $100,000	ICB	2.47
	< $100,000	IS	0.30
	< $50,000	NS	0.50
	< $100,000	DC	0.42
3. Services	> or equal to $200,000	QCBS	41.23
	< $ 200.000	LCS	0.29
	< $ 100.000	CQ	0.30

[1] *Total value of contracts subject to prior review: US$ 45.51 million (63% of the total project cost).*
[1] *Overall Procurement Risk Assessment: High*
[1] *Frequency of procurement supervision missions proposed: Once every 6 months (includes special procurement supervision for post-review/audits)*

Capacity Assessment

Capacity of the Implementing Agencies in Procurement and Technical Assistance requirements

The MOH - PIU will be responsible for implementing the project components A, C, D.1, D.2 and E.1. MOLSS-PIU will be responsible for implementing the project components B, D.1 and E.2. The MOLSS has no experience in World Bank procurement. Although the MOH has been exposed to the World Bank procedures during the implementation of the First Health and Second Health Projects; the procurement performance of the Ministry was not fully satisfactory to the Bank. Both ministries are considered limited concerning Bank's procurement procedures. It has been agreed that a Management Consultant Firm will be engaged to assist and support the civil servants working for the PIUs and the PMSU. There exists a concern in launching the goods and consultant contracts until the supporting consultant firm employed after the loan effectiveness which is estimated to take six to nine months. It is suggested to employ a procurement specialist and an FMS for the PMSU and PIUs during this transition period in order to support the public officers until the consultant firm is in place. The civil servants to be assigned to the PMSU and PIUs should have proficiency in English language, and be trained in World Bank procurement procedures particularly for goods and consultant services.

The PMSU and the two PIUs will:

(i) appoint one procurement officer for each, with suitable educational background and experience in procurement and familiarity with World Bank procurement guidelines before loan effectiveness;

(ii) launch a workshop with the Bank for all civil servants involved in project implementation. At the workshop, adequate time would be spent on procurement training, the procurement book would be discussed and explained, and a half-day session would be held for those responsible for procurement decision making under this project. Immediately after Board approval, the Bank staff will prepare a procurement book containing all procurement related documents, including Standard Bidding Documents, both in hard and soft copies, and send it to the PMSU. The contents of the procurement book will be discussed during the project launch workshop; and

(iii) establish a computerized procurement monitoring system within six months of loan effectiveness.

Country Procurement Assessment Report or Country Procurement Strategy Paper status: Country Procurement Assessment Report dated June 2001.

Are the bidding documents for the procurement actions of the first year ready by negotiations? No.

Training, Information and Development on Procurement

Estimated date of Project Launch Workshop: June 2004
Estimated date of publication of General Procurement Notice: May 2004
Indicate if there is procurement subject to mandatory SPN in Development Business: YES

Domestic Preference for Goods: Yes
Domestic Preference for Works: N/A
Retroactive financing: No
Advance procurement: No
Explain briefly the Procurement Monitoring System: The PMSU and PIUs will establish a computerized procurement monitoring system.
Co-financing: No

Procurement Staffing

Indicate name of Procurement Staff or Bank's staff part of Task Team responsible for the Procurement in the Project: Ibrahim Sirer, Sr. Procurement Specialist (ECSPS).

Annex 9: Economic and Financial Analysis

TURKEY: Health Transition Project

Background

As noted extensively in the main body of the document (see, for example, Sections A1, B3, B4 and D2) and in Annexes 1 and 3, the HTP supports the health reform initiatives of the Government of Turkey as enunciated in the UAP and its sectoral spin-off, the Program for Transformation in Health. The UAP outlines the key policy issues in the health sector and targets all aspects of health care and health systems, including financing, delivery, management and organization. The cornerstones of the UAP are the separation of provision and financing of health care so as to achieve a more efficient resource allocation and use; introduction of universal social health insurance so as to ensure equity and access to health services; financial and administrative autonomy for public hospitals in order to improve efficiency and strengthen management; introduction of family medicine so as to integrate delivery of health care and ensure continuity; and a special emphasis on maternal and child health. The goals of the UAP are being realized through a series of focused measures of the government in these key areas, and the HTP is designed to support these measures in two phases spread over six years. Phase 1 of the HTP will provide support for: (i) restructuring of the MOH for effective stewardship; (ii) design of family medicine as a model for the provision of primary health care services; (iii) introduction of financial and managerial autonomy for public hospitals; (iv) establishment of the UHI fund; and (v) design of the "infostructure" for the health and social security system. This phase is estimated to cost € 49.40 million. Subject to the passage of laws related to UHI, establishment of all required social security agencies, infostructure for all social security agencies being tested, and the family medicine model being developed and tested, Phase II of HTP will be triggered, which will support full expansion of family medicine, UHI, hospital autonomy and computerization of information system for health and social security. The economic analysis of Phase I of the HTP is presented below.

Economic Analysis

Methodology

Given the technical assistance and advisory support nature of the activities in Phase I, conventional cost benefit analysis or cost effective analysis are not considered the appropriate tools for determining the economic rationale and need of the proposed project. Further, even though the benefits of the project can be qualitatively substantiated, it is difficult to assign a quantitative value, as such estimates as disability-adjusted-life-years (DALY) or quality-adjusted-life-years (QALY) cannot be determined without making very far-reaching assumptions. For all these reasons, we use the approach developed by Devarajan, Squire and Suthiwart-Narueput (DSS) and elaborated in Hammer (1996), in which the economic rationale of a health project is determined on the basis of: (i) identifying a rationale for public involvement in the project; (ii) determining what would happen in the sector if the project were not implemented; (iii) identifying the fiscal impact of the project; and (iv) acknowledge the fungibility of resources and examine the incentives facing public servants. Accordingly, the

project components are briefly described below and are evaluated according to one or more of the above-mentioned criteria.

Component A: Restructuring the MOH for Effective Stewardship

MOH and MOLSS between them control most financing and provision of health care in Turkey. They have facilities in the same towns and cities, conduct very similar kinds of procedures, their personnel enjoy the same civil servant status, and they are both core government ministries. Yet there is almost no coordination among them. With insufficient demand for multiple providers that offer the same range of services, especially in the smaller cities and towns, the net result is that many hospitals are substantially underutilized, and investment made in buildings and equipment is underused.

There is no doubt that both MOH and MOLSS have critical roles to play in the health care system in the country, given their experience, their existing investments and their respective influence in the health sector. Yet, the present responsibilities and relationships, which result in much duplication and waste in the use of resources, are the least efficient of all possible configurations and need to be altered forthwith. It is widely agreed that improved stewardship and policy-making should be the key functions of MOH, both of which are given relatively low priority at the moment. MOH is organized along specific vertical programs and specific service delivery functions in primary and secondary care, and tends to be absorbed in running day-to-day curative services. As a result, it has neither developed the capacity to focus on policy making and priority setting for the health sector, nor does it leave itself enough resources and time to focus on quality monitoring and regulation, accreditation of institutions and licensing of professionals, insurance regulation and oversight and leading public health functions and epidemiological surveillance. Redefining the role and responsibilities of MOH and equipping it carry out these functions are important prerequisites for sustaining a broad-based health sector reform.

In sum, this component has very strong justification for public involvement. If it were not implemented, the result would be absence of coordination between agencies and ministries, and absence of priority setting in planning. The fiscal impact of this component is difficult to judge. And finally, while it is difficult to judge whether the public servants will have the appropriate incentives to effectively implement this measure, we do note that it is included in the UAP and PTH, which is likely provide the necessary support for committed implementation.

Component B: Building Capacity of the Health Insurance and Social Security Institutions

Despite the well-documented inefficiencies on the production and delivery side of the existing health system in Turkey, government justification and rationale for continued and increased involvement in health financing are very strong. Besides the general theoretical appeal of a greater role for the government in financing, the existing financial coverage for health in Turkey provides a particularly compelling case for scaling-up of public efforts to ensure universal coverage. At present, insurance coverage is provided through three social security institutions: SSK, Bagkur and Emekli Sandigi, and through the Green Card program for those who do not have the financial means to purchase health insurance through any of the above. Active civil servants and their dependents are funded directly from general revenues. Private health insurance

coverage in the country is small, reaching only about 500,000 people. This system of insurance leaves many without any coverage, and with inadequate coverage for many of those who are nominally covered. Additionally, there are many who enjoy multiple sources of coverage, either by design or by circumstances. Health insurance is also a strong determinant of seeking care when ill, and those without any form of financial protection are far less likely to seek care when ill relative to those who do have some form of financial protection. Not all those who are ill are able to get treatment for their illness; in particular, the poor are significantly more likely to not get treatment when ill compared to the non-poor. The result is that there are huge disparities in health outcomes, and the health status of Turkey's population remains poor, both in absolute terms as well as in comparison with other countries at same levels of income.

An important first step toward providing financial coverage for health is the creation of a universal health insurance fund that would integrate all functions and premium collections related to health in the existing insurance agencies such as SSK, Bag-Kur and Emekli Sandigi. In addition, the health insurance fund would also combine all other financial flows of fund in the health sector, including budgetary support to MOH (except for public health care activities), financial outlays for the existing Green Card program, and health expenditures of civil servants; only annex budget flows to university hospitals will remain outside the health insurance fund. Based on the principles of solidarity and risk pooling, all citizens of the country will be covered under health insurance, with the state making premium contributions on behalf of the indigent and others unable to do so on their own behalf.

In sum, this component has very strong justification for public involvement. If it were not implemented, universal access to health services cannot be ensured. The fiscal impact of this component is likely to be adverse in the short-to-medium term, considering that the increased burden of insuring an estimated 22 million or so presently uninsured (if this estimate is, indeed, accurate) will be high, irrespective of the level and scale of the measures adopted. And finally, while it is difficult to judge whether the public servants will have the appropriate incentives to effectively implement this measure, we do note that it is included in the UAP and PTH, which is likely provide the necessary support for committed implementation.

Component C: Reorganizing the Delivery of Healthcare Services

(i) Introducing Family Medicine for Primary Health Care

There is general agreement among policy makers that, in principle, primary care should be the basis of a well-designed and performance-focused health care system. Well-designed and functioning primary care system can contribute significantly to improving health and reduced human suffering by reducing epidemiological risks of avoidable illnesses and premature deaths, and to alleviating poverty by minimizing lost production due to avoidable illnesses and premature deaths. In addition, an effective primary care system can prevent the health system from getting on to a high-cost trajectory in which enormous resources would be required for treating preventable illnesses.

In practice, however, this is often not the case, simply because primary care is not organizationally situated to have power and control over other levels of care. In many countries,

as in Turkey, specialists tend to occupy a senior position in the hierarchy of medical specialists, and primary care providers do not have the necessary standing to play a leading role in patient care and in delivery of basic health services. Any reform in the delivery of primary care would have to start by improving the relative position of primary care providers in both the medical as well as the patient community. In other words, in reaching appropriate health services to the entire population in Turkey, primary care professionals would need to be given the necessary levers to steer patient treatment, either in home-care setting or in the hospital setting, so as to ensure integration of the different health service delivery sectors.

One such way is by adopting the concept and practice of "family medicine". Family medicine physicians provide health services for the whole family, treating common illnesses across such medicine domains as internal medicine, gynecology, pediatrics, prevention and health propagation. Patients are provided with diagnostic services, laboratory services, and consultations, so that almost all services are provided under a "single-window" system. Family medicine brings the physician and members of a family into closer and more personal contact, and redefines their relationship. The physician gets to know all members of the family and their health concerns, and plays an important role in their health education, prevention of diseases, and general betterment of health.

A common characteristic of major non-communicable diseases is their multi-factorial etiology, and a few risk factors (smoking, dietary, obesity, sedentary lifestyles, excess alcohol consumption, hypertension, hypercholesterolemia, and diabetes) account for the bulk of heart disease, stroke, chronic obstructive pulmonary disease, common cancers, and accidents. For this reason, population-based interventions that integrate action on risk factors for cardiovascular diseases (e.g. smoking, diet) can have beneficial effect in the reduction of other non-communicable diseases (e.g. colon, lung cancers), and obtain economies in the cost of health care delivery. Family based medicine, with its emphasis on health promotion, prevention and education, can provide the required integration of preventive efforts. Treatment in family practice is based on complete and comprehensive diagnosis and not only depends on the immediate illness, but also on the general patient profile as well as on the general population profile.

In sum, this component has very strong justification for public involvement. Existing inefficiencies in the delivery side of the health system would likely continue if it were not implemented. As far as the fiscal impact of this component is concerned, there is potential for some savings. And finally, while it is difficult to judge whether the public servants will have the appropriate incentives to effectively implement this measure, we do note that it is included in the UAP and PTH, which is likely provide the necessary support for committed implementation.

(ii) Autonomization of Public Hospitals

The hospital sector in Turkey suffers from much inefficiency, and although some gains have been achieved during the 1990s – average hospital occupancy rate increased from 53 percent in the mid-1980s to 60 percent in 2000, while the average length of stay dropped from 6.7 days in 1985 to 5.9 days in 2000 – a large number of hospitals remain substantially underutilized. There are a large number of facilities that are too small to allow for efficient operation and effective

provision of care. The occupancy ratio of MOH district hospitals (generally hospitals with below 50 beds in a district center) and of MOH health center hospitals is particularly low and they have very long bed turn over interval, indicating that there is little justification for these small and rarely used hospitals. Many hospital managers lack the skills necessary to effectively carry out their job, and neither are they given any incentives to strive for efficiency improvements at the facilities they manage. The absence of administrative and financial autonomy, coupled with a budgeting system that largely ignores the actual amount of services provided substantially prevents hospital managers from undertaking steps to achieve efficiency gains.

Health system reforms in Turkey need to focus on improving hospital efficiency, and while some gains in efficiency can be brought about simply by reducing the number of hospital beds in many provinces, further gains will come about only by improving efficiency in the use of resources and overall management and accountability. One way to achieve this is by granting administrative and financial autonomy to all public hospitals. It is neither feasible nor desirable to simply privatize public hospitals.

Component D: Strengthening Human Resources Capacity

The health care industry is one of the largest employers in Turkey, and employs physicians, nurses, dentists, pharmacists, psychologists, health services administrators, therapists, laboratory and X-ray technicians, social workers, and other allied health workers. Yet, there is no specific Human Resources Management Program in the health sector in Turkey, and there is no consistent program of updating skills and training for new ones. Other problems include inappropriate distribution of health workers, low ratios of non-physician health workers to physicians, inadequate basic training of the health workers for service, insufficient numbers of teachers and academicians in the professional schools, inadequate supply of training materials, low professional status of non-physician professionals, inadequate salaries, promotions unrelated to performance, lack of incentives for working in rural areas and underserved areas, centralized health worker recruitment, inadequate staffing norms based on population and bed numbers rather than workload, outdated legislation on the responsibilities and authority of health personnel, absence of sufficient job descriptions, and inadequate coordination and monitoring of in-service training programs. These problems assume even more serious implications in view of the widespread changes that the health sector reforms are likely to trigger, since both UAP and PTH will result in broad-spectrum structural changes, not only in health sector financing, management and organization, but also in the delivery of services and in the interaction between patients and providers.

In order to improve the capacity in the health sector at all levels to provide the necessary support and meet the demands of the ongoing reforms, this component will support the development and strengthening of a human resources policy to ensure that a flexible and responsive health workforce is in place to carry the benefits of the reform to the people. In addition, the School of Public Health will be reinvigorated and strengthened to become a center of excellence in advocacy and training and research in the MOH.

In sum, this component has very strong justification for public involvement. If it were not implemented, the resulting disconnect between the training of providers and demands of the new system after transformation would likely result in widespread patient discontent. The fiscal impact of this component is difficult to judge. And finally, while it is difficult to judge whether the public servants will have the appropriate incentives to effectively implement this measure, we do note that it is included in the UAP and PTH, which is likely provide the necessary support for committed implementation.

Component E: Building Infostructure for Health and Social Security

The development of a comprehensive information system is the key to better management, responsive policy making and effective regulation. It will also enable the health insurance fund to better fulfill its purchasing and regulatory functions, and will link the network of health providers to purchasers and appropriate regulatory institutions. This component will support the development of an infostructure strategy, including the development of necessary supporting legislation (related to mandatory exchange of information, confidentiality, and privacy), and the essential integration tools. It will facilitate the development of standards, regulations and other mechanisms to support the integration of health information at all levels, so that common definitions and data structures are used and necessary information can be exchanged. It will also support the development and creation of a national health data center within MOH to collect and analyze key health information from all health providers and the health insurance fund. This development and integration of the information system will support the policy making and analysis role of the MOH, in addition to synchronization and standardization of information from all other health sub-systems. The effective use of health information technology in all parts of the health care sector will ensure that high quality, consistent and timely information is provided, both to support effective care and treatment as well as to inform management and decision-making processes at all levels.

In sum, this component has very strong justification for public involvement. If not implemented, policy-making would likely remain uninformed and patient management would likely be compromised. As far as the fiscal impact of this component is concerned, there is potential for some savings in the long term. And finally, while it is difficult to judge whether the public servants will have the appropriate incentives to effectively implement this measure, we do note that it is included in the UAP and PTH, which is likely provide the necessary support for committed implementation.

Evaluation

To the extent possible, all of the above components are evaluated against each of the DSS criteria, and the results are summarized in the table below. We note that it is difficult to judge the fiscal impact of *Component A: Restructuring the MOH for Effective Stewardship*; and *Component D: Strengthening Human Resource Capacity*. At the same time, we note that the fiscal impact of *Component B: Building the Institutional Capacity of the Health Insurance Fund* is likely to be adverse in the short-to-medium term, considering that the increased burden of insuring estimated 22 million or so presently uninsured (if this estimate is, indeed, accurate) will be high, irrespective of the level and scale of the measures adopted. An exercise carried out by

the Bank in collaboration with MOH and MOLSS finds that the introduction of UHI will require additional state subventions of between 3,826 trillion TL and 6,462 trillion TL in 2002 prices, depending on which other reform measures are adopted and implemented along with UHI. The study concludes that final details pending, the introduction of UHI can be a fiscally viable proposition only if there are marked improvements on the revenue side of the social security system in addition to efficiency-enhancing reforms in the health sector.

Overall, the results of the economic analysis show that the project makes sound economic sense, subject to the general caveats of passage of the necessary supporting legislation and sound implementation of all the project components.

Component	**Is there a rationale for public involvement?**	**What are the consequences of <u>not</u> implementing this measure?**	**What is the fiscal impact of this measure?**	**Are the appropriate incentives in place that would ensure that the proposed measures would be implemented?**
A: Restructuring the MOH for Effective Stewardship	Very strong justification for public involvement	Absence of coordination between agencies and ministries, and absence of priority setting in planning		Difficult to judge, but measure supported by UAP and PTH
B: Building Capacity of the Health Insurance and Social Security Institutions	Very strong justification for public involvement	Universal access will not be ensured	Very high and adverse	Difficult to judge, but measure supported by UAP and PTH
C: Reorganizing the Delivery of Healthcare Services	Very strong justification for public involvement	Existing inefficiencies likely to continue	Potential for savings	Difficult to judge, but measure supported by UAP and PTH
D: Strengthening Human Resources Capacity	Very strong justification for public involvement	Disconnect between providers training and demands of the new system after transformation likely to result in widespread patient discontent		Difficult to judge, but measure supported by UAP and PTH
E: Building Infostructure for Health and Social Security	Very strong justification for public involvement	Policy making likely to remain uninformed; patient management likely to be compromised.	Potential for savings in the long term	Difficult to judge, but measure supported by UAP and PTH

Annex 10: Safeguard Policy Issues
TURKEY: Health Transition Project

Not Applicable

Annex 11: Project Preparation and Supervision

TURKEY: Health Transition Project

	Planned	Actual
PCN review		09/22/2003
Initial PID to PIC		10/22/2003
Initial ISDS to PIC		10/03/2003
Appraisal	03/15-26/2004	03/15-26/2004
Negotiations	04/7-9/2004	04/7-9/2004
Board/RVP approval	05/20/2004	
Planned date of effectiveness	07/05/2004	
Planned date of mid-term review	03/31/2006	
Planned closing date	12/31/2007	

Key institutions responsible for preparation of the project:
Ministry of Health, Turkey, including School of Public Health, MOH
Ministry of Labor and Social Security, Turkey
State Planning Organization, Turkey
The Undersecretariat of Treasury, Turkey

Bank staff and consultants who worked on the project included:

Name	Title	Unit
Enis Baris	Sr. Public Health Specialist, Team Leader	ECSHD
Mukesh Chawla	Sr. Human Dev. Economist	ECSHD
Antonio Lim	Operations Officer	ECSHD
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Nicole Klingen	Sr. Health Specialist	MNSHD
Ibrahim Sirer	Sr. Procurement Specialist	ECSPS
Ayse Seda Aroymak	Sr. Financial Management Specialist	ECSPS
Dilek Barlas	Senior Counsel	LEGEC
Rohit R. Mehta	Senior Finance Officer	LOAG1
Jennifer Manghinang	Program Assistant	ECSHD
Selma Karaman	Program Assistant	ECCU6
Daniel Kress	Peer Reviewer	MNSHD
Christian Baeza	Peer Reviewer	LCSHD
Shiyan Chao	Peer Reviewer	AFTH1

Bank funds expended to date on project preparation:
1. Bank resources: US$ 504,900[3]
2. Trust funds: US$ 338,538 spent or committed out of a US$ 800,000 PHRD grant
3. Total: US$ 843,438

Estimated Approval and Supervision costs:
1. Remaining costs to approval: US$ 25,000
2. Estimated annual supervision cost: US$ 100,000

[3] Including preparation costs incurred prior to change of Government (US$ 162,300).

Annex 12: Documents in the Project File

TURKEY: Health Transition Project

A. *Draft Project Implementation Plan*

Project Implementation Plan, March 2004

B. *Bank Staff Assessments*

Proposal for PHRD Grant (January 24, 2003)
PHRD Grant (TF051488)
PCN Package (September 5, 2003)
Minutes of the PCN Review Meeting (October 3, 2003)
Statement of Mission Objectives
Back-to-Office Reports, Aide Memoires and Follow-up Letters to the Government
Summary of comments from Peer Reviewers
Country Assistance Strategy (CAS) (Report No. #26756-TU, Oct. 3, 2003)
Paper on Preparing for Universal Health Insurance in Turkey: Estimation of Costs Under Different Scenarios (January 2004)

C. *Others*

Social Assessment Study (2003)
Report on the Consensus Building Conference (August 2003)
Concept Note on Health Transition Project (June 2003)
MOH's Program for Transformation in Health (June 2003)
Draft Law on Universal Health Insurance (2003)
Draft Law on Social Security Institutions (2003)
Draft Law on Ministry of Health Restructuring (2003)
Draft Framework Law on Public Administration (2003)

Annex 13: Statement of Loans and Credits

TURKEY: Health Transition Project

			Original Amount in US$ Millions						Difference between expected and actual disbursements	
Project ID	FY	Purpose	IBRD	IDA	SF	GEF	Cancel.	Undisb.	Orig.	Frm. Rev'd
P082801	2004	EXP FIN 2	303.10	0.00	0.00	0.00	0.00	303.10	0.00	0.00
P059872	2003	BASIC ED 2 (APL #2)	300.00	0.00	0.00	0.00	0.00	293.00	118.58	0.00
P070286	2002	ARIP	600.00	0.00	0.00	0.00	0.00	411.22	331.22	0.00
P074408	2002	SRMP	500.00	0.00	0.00	0.00	0.00	382.55	157.66	0.00
P069894	2001	PRIV SOC SUPPRT	250.00	0.00	0.00	0.00	0.00	159.28	122.78	0.00
P044175	2000	BIODIV/NTRL RES MGMT (GEF)	0.00	0.00	0.00	8.19	0.00	5.86	3.37	0.00
P068368	2000	MARMARA EARTHQUAKE EMG RECON	505.00	0.00	0.00	0.00	0.00	300.13	299.93	52.70
P068792	2000	ERL	759.60	0.00	0.00	0.00	0.00	375.00	375.00	375.00
P009073	1999	INDUSTRIAL TECH	155.00	0.00	0.00	0.00	0.00	55.12	55.12	0.00
P009072	1998	PRIV OF IRRIGATION	20.00	0.00	0.00	0.00	0.00	1.82	1.82	1.82
P048852	1998	NAT'L TRNSM GRID	270.00	0.00	0.00	0.00	27.79	185.93	213.72	-3.60
P008985	1998	CESME WS & SEWER	13.10	0.00	0.00	0.00	2.70	5.56	8.26	0.00
P009076	1995	HEALTH 2	150.00	0.00	0.00	0.00	20.17	27.03	52.76	52.76
		Total:	3,825.80	0.00	0.00	8.19	50.66	2,505.60	1,740.22	478.68

TURKEY

Statement Of IFC's

Held and Disbursed Portfolio

In Millions of US Dollars

		Committed				Disbursed			
		IFC				IFC			
FY Approval	Company	Loan	Equity	Quasi	Partic.	Loan	Equity	Quasi	Partic.
2001	Turkish PEF	0.00	10.00	0.00	0.00	0.00	1.26	0.00	0.00
1999	Unye Cement	14.59	0.00	0.00	0.00	14.59	0.00	0.00	0.00
1999	Uzel	9.48	0.00	0.00	5.69	9.48	0.00	0.00	5.69
0/70/71/98	Viking	8.18	0.00	0.00	0.00	8.18	0.00	0.00	0.00
1995	Yalova Acrylic	2.50	0.00	0.00	1.33	2.50	0.00	0.00	1.33
1997/98	Yapi Kredi Lease	0.48	0.00	0.00	0.00	0.48	0.00	0.00	0.00
0	ALease	1.11	0.00	0.00	0.00	1.11	0.00	0.00	0.00
1998	Adana Cement	2.50	0.00	0.00	0.00	2.50	0.00	0.00	0.00
2001/03	Akbank	25.00	0.00	0.00	0.00	25.00	0.00	0.00	0.00
0/98	Alternatif Bank	1.11	0.00	5.00	0.00	1.11	0.00	5.00	0.00
1995/96/01/03	Arcelik	17.21	0.00	0.00	0.00	17.21	0.00	0.00	0.00
2000	Arcelik LG Klima	13.79	0.00	0.00	4.72	13.79	0.00	0.00	4.72
1994/97/02	Assan	25.00	0.00	0.00	0.00	25.00	0.00	0.00	0.00

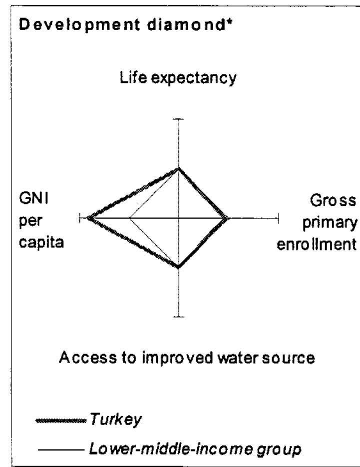
		Committed				Disbursed			
		IFC				IFC			
FY Approval	Company	Loan	Equity	Quasi	Partic.	Loan	Equity	Quasi	Partic.
2002	Atilim	6.50	0.00	0.00	0.00	5.49	0.00	0.00	0.00
2000	Banvit	15.00	5.00	0.00	0.00	15.00	5.00	0.00	0.00
0/94/96	Bayindirbank A.S	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
2002	Beko	29.08	0.00	0.00	29.08	29.08	0.00	0.00	29.08
2001	Bilgi	11.00	0.00	0.00	0.00	11.00	0.00	0.00	0.00
1994/95/96/97	Borcelik	10.00	3.21	0.00	0.00	10.00	3.21	0.00	0.00
1995/96	CBS Boya Kimya	0.00	0.65	0.00	0.00	0.00	0.65	0.00	0.00
1994	CBS Holding	4.00	0.00	0.00	0.00	4.00	0.00	0.00	0.00
1996/01	CBS Printas	0.00	0.01	0.00	0.00	0.00	0.01	0.00	0.00
1992	Cayeli Bakir	3.15	0.00	0.00	0.00	3.15	0.00	0.00	0.00
1990/93/02	Conrad	3.50	0.00	0.00	0.00	3.50	0.00	0.00	0.00
1997/98	Demir Leasing	1.11	0.00	0.00	0.00	1.11	0.00	0.00	0.00
2002	EKS	12.16	0.00	0.00	0.00	12.16	0.00	0.00	0.00
1988/93/96	Elginkan	0.40	0.00	0.00	0.00	0.40	0.00	0.00	0.00
1995	Entek	21.25	0.00	0.00	14.91	21.25	0.00	0.00	14.91
1997/98	Finans Leasing	1.11	0.00	0.00	0.00	1.11	0.00	0.00	0.00
0/99	Finansbank	5.56	0.00	0.00	5.18	5.56	0.00	0.00	5.18
1994/98/00	Garanti Leasing	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
1999	Gumussuyu Kap	4.00	0.00	3.25	0.00	4.00	0.00	3.25	0.00
2001	Gunkol	6.70	0.00	6.70	0.00	6.70	0.00	6.70	0.00
1998	Indorama Iplik	6.25	0.66	0.00	0.00	6.25	0.66	0.00	0.00
1998/00/02	Ipek Paper	16.06	0.00	0.00	0.00	16.06	0.00	0.00	0.00
1990	Kepez Elektrik	6.48	0.00	0.00	0.00	6.48	0.00	0.00	0.00
0/88/90	Kiris	10.06	0.00	0.00	0.00	10.06	0.00	0.00	0.00
1990/92	Koy-Tur	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
1991	Kula	4.93	0.00	0.00	0.00	4.93	0.00	0.00	0.00
2003	MESA Group	11.00	0.00	0.00	0.00	5.50	0.00	0.00	0.00
1993/96	Medya	0.00	0.00	4.99	0.00	0.00	0.00	4.99	0.00
2002	Milli Re	50.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
1998/02	Modern Karton	10.00	0.00	0.00	0.00	10.00	0.00	0.00	0.00
1991	NASCO	10.18	0.00	0.00	3.55	10.18	0.00	0.00	3.55
0/98	Pasabahce	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
1983/94/98	Pinar ET	6.29	0.00	0.00	0.00	6.29	0.00	0.00	0.00
1994/00	Pinar SUT	16.09	0.00	0.00	0.00	12.82	0.00	0.00	0.00
1999	SAKoSa	19.95	0.00	0.00	14.43	19.95	0.00	0.00	14.43
0/86/90	Silkar Turizm	2.65	0.00	0.00	3.01	2.65	0.00	0.00	3.01
1993/96/02/03	Sise Ve Cam	62.93	0.00	0.00	39.33	62.93	0.00	0.00	39.33
1998/02	Soktas	3.50	0.00	0.00	0.00	3.50	0.00	0.00	0.00
1999	TEB Finansal	2.22	0.00	0.00	0.00	2.22	0.00	0.00	0.00
1979/82/83/89/91/96/99	Trakya Cam	0.00	1.18	0.00	0.00	0.00	1.18	0.00	0.00
1995/99/02	Turk Ekon Bank	20.00	0.00	15.00	0.00	20.00	0.00	15.00	0.00
	Total portfolio:	514.06	20.71	34.94	121.23	454.28	11.97	34.94	121.23

FY Approval	Company	Approvals Pending Commitment			
		Loan	Equity	Quasi	Partic.
2001	Akbank	0.03	0.00	0.00	0.00
2004	Akbank BLoan Inc	0.00	0.00	0.00	0.02
2003	Cayeli Expan 2	0.02	0.00	0.00	0.00
2000	Erbakir	0.01	0.00	0.01	0.00
2002	Milli Reasurans	0.00	0.01	0.00	0.00
2004	Oyak Bank II	0.05	0.00	0.00	0.00
2003	Sisecam Exp.	0.00	0.00	0.00	0.01
2002	TEB III	0.00	0.00	0.00	0.05
	Total pending commitment:	0.11	0.01	0.01	0.08

Annex 14: Country at a Glance

TURKEY: Health Transition Project

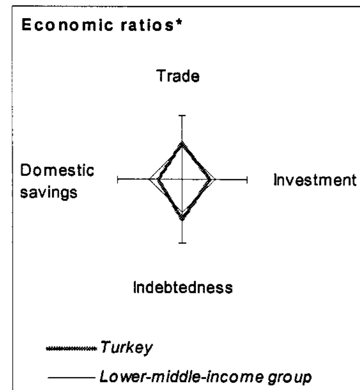
POVERTY and SOCIAL	Turkey	Europe & Central Asia	Lower-middle-income
2002			
Population, mid-year *(millions)*	69.6	476	2,411
GNI per capita *(Atlas method, US$)*	2,500	2,160	1,390
GNI *(Atlas method, US$ billions)*	174.0	1,030	3,352
Average annual growth, 1996-02			
Population *(%)*	1.7	0.1	1.0
Labor force *(%)*	2.2	0.4	1.2
Most recent estimate (latest year available, 1996-02)			
Poverty *(% of population below national poverty line)*	..	..	..
Urban population *(% of total population)*	67	63	49
Life expectancy at birth *(years)*	70	69	69
Infant mortality *(per 1,000 live births)*	33	25	30
Child malnutrition *(% of children under 5)*	8	..	11
Access to an improved water source *(% of population)*	82	91	81
Illiteracy *(% of population age 15+)*	14	3	13
Gross primary enrollment *(% of school-age population)*	101	102	111
Male	105	103	111
Female	96	101	110



KEY ECONOMIC RATIOS and LONG-TERM TRENDS

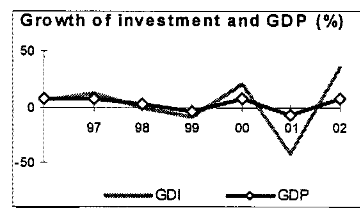
	1982	1992	2001	2002
GDP *(US$ billions)*	64.4	158.9	145.2	182.8
Gross domestic investment/GDP	17.0	23.9	16.8	21.3
Exports of goods and services/GDP	11.9	14.4	33.7	28.8
Gross domestic savings/GDP	13.8	20.9	19.2	19.6
Gross national savings/GDP	18.5	24.4	20.7	20.7
Current account balance/GDP	-1.5	-0.6	2.3	-0.8
Interest payments/GDP	1.8	2.0	3.6	3.4
Total debt/GDP	30.6	35.6	78.4	71.9
Total debt service/exports	29.4	32.1	44.0	49.0
Present value of debt/GDP	..	..	..	..
Present value of debt/exports	..	..	..	..

(average annual growth)	1982-92	1992-02	2001	2002	2002-06
GDP	5.1	2.8	-7.5	7.8	4.7
GDP per capita	2.7	1.0	-9.0	6.1	3.6

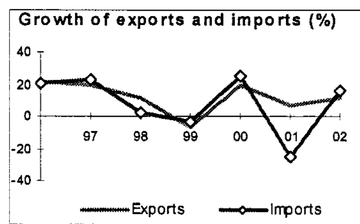


STRUCTURE of the ECONOMY

(% of GDP)	1982	1992	2001	2002
Agriculture	22.7	15.3	12.8	13.0
Industry	25.1	29.9	26.1	25.4
Manufacturing	17.7	18.9	15.8	16.0
Services	52.2	54.7	61.1	61.6
Private consumption	76.3	66.2	66.6	66.3
General government consumption	9.9	12.9	14.2	14.0
Imports of goods and services	15.0	17.3	31.3	30.5

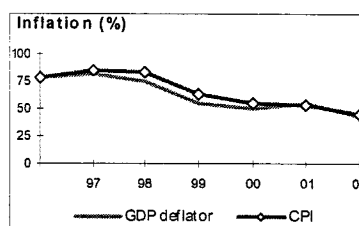


(average annual growth)	1982-92	1992-02	2001	2002
Agriculture	1.4	1.1	-6.0	7.6
Industry	7.2	2.6	-7.2	5.7
Manufacturing	7.2	3.3	-8.0	8.2
Services	4.2	3.1	-6.2	7.0
Private consumption	4.3	2.2	-9.2	2.6
General government consumption	3.4	4.4	-8.5	5.4
Gross domestic investment	5.0	1.1	-42.0	35.7
Imports of goods and services	8.8	8.3	-24.8	15.7



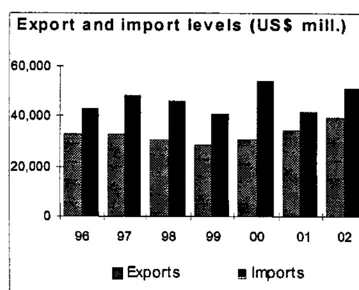
PRICES and GOVERNMENT FINANCE

	1982	1992	2001	2002
Domestic prices				
(% change)				
Consumer prices	..	70.1	53.9	44.8
Implicit GDP deflator	28.2	63.7	54.8	43.5
Government finance				
(% of GDP, includes current grants)				
Current revenue	..	19.0	29.3	28.2
Current budget balance	..	-1.3	-14.7	-4.7
Overall surplus/deficit	..	-10.7	-20.9	-12.3



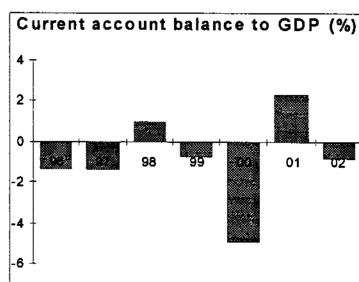
TRADE

	1982	1992	2001	2002
(US$ millions)				
Total exports (fob)	5,890	14,891	34,373	39,827
Textiles	1,145	5,603	10,344	12,066
Processed agricultural products	1,571	2,293	1,876	1,705
Manufactures	4,655	13,440	28,695	32,673
Total imports (cif)	8,843	22,871	41,399	51,270
Food	123	1,398	848	1,211
Fuel and energy	3,943	3,903	8,316	8,955
Capital goods	2,214	7,970	7,344	8,949
Export price index *(1995=100)*	..	95	76	75
Import price index *(1995=100)*	..	90	81	80
Terms of trade *(1995=100)*	..	105	94	93



BALANCE of PAYMENTS 1/

	1982	1992	2001	2002
(US$ millions)				
Exports of goods and services	7,818	23,343	50,403	54,608
Imports of goods and services	9,592	26,706	45,816	55,095
Resource balance	-1,774	-3,363	4,587	-487
Net income	-1,455	-1,670	-5,000	-4,549
Net current transfers	2,277	4,059	3,803	3,496
Current account balance	-952	-974	3,390	-1,540
Financing items (net)	1,120	2,458	-16,314	1,328
Changes in net reserves	-168	-1,484	12,924	212
Memo:				
Reserves including gold *(US$ millions)*	2,027	15,252	30,192	38,067
Conversion rate *(DEC, local/US$)*	162.9	6,881.3	1,228,367	1,509,471



EXTERNAL DEBT and RESOURCE FLOWS

	1982	1992	2001	2002
(US$ millions)				
Total debt outstanding and disbursed	19,716	56,554	113,806	131,407
IBRD	1,962	5,564	4,707	5,367
IDA	187	148	95	89
Total debt service	2,968	9,086	24,623	28,632
IBRD	209	1,207	723	708
IDA	3	6	7	7
Composition of net resource flows				
Official grants	307	506	0	334
Official creditors	762	-509	74	797
Private creditors	146	3,604	-2,187	3,811
Foreign direct investment	55	779	2,769	862
Portfolio equity	0	-1,194	-4,611	-1,180
World Bank program				
Commitments	648	686	2,200	1,650
Disbursements	500	286	1,537	1,031