PROJECT INFORMATION DOCUMENT (PID)
APPRAISAL STAGE

Report No.: PIDA23291

Project Name	Health Sector Reform Support Project (P152799)
Region	EUROPE AND CENTRAL ASIA
Country	Turkey
Sector(s)	Health (100%)
Theme(s)	Health system performance (70%), Injuries and non-communicable diseases (30%)
Lending Instrument	Investment Project Financing
Project ID	P152799
Borrower(s)	Undersecretariat of Treasury
Implementing Agency	Ministry of Health
Environmental Category	C-Not Required
Date PID Prepared/Updated	13-Apr-2015
Date PID Approved/Disclosed	23-Apr-2015
Estimated Date of Appraisal Completion	24-Apr-2015
Estimated Date of Board Approval	22-Oct-2015
Appraisal Review Decision (from Decision Note)	

I. Project Context

Country Context

Turkey is an upper middle-income country with the world's 18th largest economy. The Gross Domestic Product (GDP) of the country reached US$786.3 billion in 2012. Private consumption accounts for more than 70 percent of GDP, and it is the main driver of economic growth, while exports make up only 26.4 percent of GDP. Domestic savings are very low (around14 percent of GDP), and thus economic growth is largely financed by external inflows, most of which are of a short-term nature and thus increase the risk of volatility.

Turkey's development over the past decade is a story of notable turnaround thanks to successfully implemented structural reforms and sound macroeconomic management. Reforms include strong fiscal management, strengthening of banking supervision, and shifting to a flexible exchange rate regime with an independent central bank responsible for inflation targeting. These reforms yielded results. Despite the global crisis of 2008-09, the Turkish economy expanded by an average of 5.2 percent during the 2002-12 period. These reforms created fiscal space that supported a large increase in both the access and quality of basic social services.

Turkey has had good performance in reducing poverty and boosting shared prosperity in the past decade. Between 2002 and 2011, extreme poverty fell from 13 percent to 5 percent, while moderate poverty fell from 44 percent to 22 percent (World Bank estimates for US$2.5 and US$5 a day respectively). The labor market has been the most important factor driving poverty reduction in Turkey in the 2000s, with around two thirds of the decline in poverty due to higher private sector earnings or higher employment rates among poor households. Other main drivers of these positive changes were social assistance and pensions. Pockets of poverty and vulnerability remain, particularly in rural areas and in the economically less advanced regions. Rural poverty rates are around twice the level in urban areas, even though the majority of the poor live in cities.

Sectoral and institutional Context

During the past decade, thanks to a major health reform, the Health Transformation Program (HTP), Turkey underwent significant improvements in the supply and demand for services which are reflected in health outcomes, trends in health financing, and health utilization rates.

The main reform elements of the HTP were: (1) the introduction of Family Medicine; (2) the unification of public hospitals; (3) the restructuring of the Ministry of Health; (4) the introduction of Universal Health Insurance and unification of fragmented social insurance schemes; and (5) the purchaser-provider split. The Family medicine system started in 2005 and was rolled out nationwide by 2010. It replaced the health center/health post structures at the primary care level with Community Health Centers and Family Medicine Centers. The unification of public hospitals transferred the managerial responsibility for the Social Insurance Institution (SII-the previous insurance scheme for the employees) hospitals to MoH structures bringing all state hospitals under one umbrella. The amended Social Security and Universal Health Insurance Law (UHI) was adopted in 2008. UHI unified the previously fragmented enrollees (active and retired civil servants, blue and white-collar workers in the public and private sectors, and the self-employed as well as green card holders) under a single institution (Social Security Institution-SSI) and made health services accessible to all, regardless of affiliation with previous health insurance schemes. A single purchaser model has been created where SSI has assumed full responsibility for all health financing functions of revenue collection, pooling, and purchasing. The Ministry underwent major restructuring in October 2011 (Statutory Decree No 663). Under the new setting General Directorates are responsible as service units for policy formulation, planning and regulatory functions of the Ministry and some previous General Directorates became affiliated agencies such as Drugs and Medical Devices Institution, Public Hospitals Institution and Public Health Institution.

The HTP was instrumental in achieving universal health coverage to enhance equity substantially and led to quantifiable ad beneficial effects on all health system goals, with an improved level and distribution of health outcomes, fairness in financing and better financial protection, and increased user satisfaction (Atun et al, Lancet 2013). By 2011, the increases in life expectancy had aligned Turkey with the average level relative to both its income and health spending per capita (graph 1). An average Turkish newborn has a chance to live an additional 3.5 years if born in 2011 as compared to 2002 (World Bank 2013). Between 2002 and 2011, life expectancy grew from an average of 71 years to 74.5 years. Relative to the selected comparator countries, Turkey’s life expectancy remains below OECD average, however under the HTP Turkey is decreasing the gap in average life expectancy at birth.

II. Proposed Development Objectives

The Project Development Objective is to contribute to improving primary and secondary prevention of selected NCDs, increasing the efficiency of hospital management, and enhancing the capacity of the MoH for evidence-based policy-making.

III. Project Description

Component Name

Public Health and Primary Care

Comments (optional)

Component Name

Increasing Efficiency of Hospital Management

Comments (optional)

Component Name

Improving Effectiveness of Overall Health Sector Administration

Comments (optional)

IV. Financing *(in USD Million)*

Total Project Cost:	135.65	Total Bank Financing:	135.65
Financing Gap:	0.00		

For Loans/Credits/Others	**Amount**
Borrower	0.00
International Bank for Reconstruction and Development	135.65
Total	135.65

V. Implementation

The project will be implemented over a period of five years. The Ministry of Health, as the overarching authority of the health sector, is responsible for implementation and oversight. Strategic guidance would be provided by the Strategic Development Presidency which would approve annual plans. The existing Project Management Support Unit (PMSU) would coordinate and facilitate the implementation of the activities and will have fiduciary responsibility. The PMSU has provided support in the implementation of past World Bank projects and would continue ensuring adequate staffing in the areas of procurement and financial management as well as monitoring and evaluation. The PMSU functioning is overseen by the Deputy Undersecretary to whom the PMSU reports. The Project Operational Manual will be developed during preparation. The financial management arrangements would build upon the arrangements under the existing project. However, a more comprehensive review of the procurement and financial management system is foreseen during preparation. The ongoing project is current on its IFR reporting and its auditing covenants and there have been no financial management issues in the Project.

The Implementing units under MOH (General Directorate (GD) of Health Research; GD of Health Information Systems; GD of Health Investments; GD of Health Promotion) and the Affiliated

Agencies (PHoI; PHeI); will be responsible for the implementing the activities and the monitoring and reporting on the results.

There is no parallel or co-financing from other international agencies of donor partners for the project. Nevertheless, there has been during preparation and will continue to be very close coordination with relevant agencies working on the health sector. In particular with the World Health Organization in the areas of health sector reform and addressing NCDs. There is no financial support in this project to the affiliated agency Social Security Institution, however there is coordination with the agency on relevant areas and ongoing dialogue on other modalities of collaboration. With regards to the support to the PPP program, the HSRSP is in close contact with the relevant partners such as the WBG, IFC and the EBRD which are financing and supporting various activities within the PPP program.

Turkey has made remarkable progress in reducing its child and infant mortality rates under the HTP. Under-five mortality fell sharply from 72 per 1,000 live births in 1990 to 15 in 2011, and infants mortality fell from 60 per 1,000 live births in 1990, to 12 in 2011 (Lancet, 2013). This rate of decrease is impressive relative to all other comparator countries (Graph 2). Between 2002 and 2012, infant mortality was more than cut in half in Turkey, while globally infant mortality decreased by approximately one-third. The decline in under-five mortality is far larger than that experienced in any of the comparator countries or country groupings. Equity in health outcomes improved as well. Infant mortality rates declined among the poorest quintiles to levels comparable to those of the richest quintiles between 1998 and 2008; from 47 per 1,000 to 12.2 per 1,000 live births (Lancet 2013).

Turkey's health expenditures increased at a faster rate than comparator countries, as did its health status indicators (Tatar and Celik, 2013). This result is particularly impressive given the lagging progress made in increasing the number of health workers and other health supply indicators. These basic comparisons indicate that while Turkey has spent relatively more on its health care sector as compared to other countries, the benefits it has gained from these resources largely justify the increased investment. The HTP reform resulted in significant improvement in health outcomes with Universal health coverage (UC) largely achieved with the adoption of the legislation and the consolidation of programs and benefit packages in 2006. Financial protection improved; Turkey had the largest reduction in Out of Pocket Spending of all OECD countries (OECD/WB, 2009).

The increase in utilization of health care services is the most explicit indicator to assess the impact of reforms on demand for health care services and user satisfaction. Physician visits per capita have more than doubled in the last decade – growing from 3.2 in 2002 to 8.2 in 2011 (MoH 2012). Currently, per capita visits are above the OECD average. This is a reflection of a number of factors, but policies to improve the accessibility of the health care system have induced demand. Both physical and financial accessibility hav e improved in Turkey. The unmet medical need of the pre-reform period should also be taken into account in interpreting this outcome.

Increases in health expenditures have been mirrored by increases in the supply of health care services in Turkey over the past ten years. Between 2002 and 2012, the overall health workforce increased by 36 percent, growing from 294,587 to 460,966 (TUIK 2013). Despite these increases, Turkey remains below average with respect to the ratio of its health workforce to its population both in comparison to other OECD countries, ECA and UMIC countries. Increasing the number of health workers in the country takes time and concurrent training initiatives in the education sector.

In order to train and recruit more health workers, the government has increased the quota for medical school entrance from 4,450 students in 2003 to 11,037 students in 2013, according to the Ankara Chamber of Doctors (Ankara Tabipler Birliği, 2013). Despite efforts to train and recruit more health workers, the possibility to do expand the supply of health workers in a dramatic way – holding quality constant – remains difficult in the short-run.

Similarly, the number of hospitals, hospital beds, primary care units, and other health infrastructure has increased under the HTP. Despite these improvements, the number of hospital beds per population remains below that of all comparator countries. Amongst OECD member countries, only Chile (2.2) had a lower number of hospital beds per 1,000 people than Turkey (2.5) in 2011 (OECD 2013). There is a decreasing trend in the number of hospital beds in OECD countries on average, which may also alter the incentives for Turkish policymakers to continue to increase the number of hospital beds into the future.

The HTP emphasized increasing the availability of scarce technology. Between 2002 and 2011, the number of MRI machines increased from 58 to 781, the number of CT Scan increased from 323 to 1088, and the number of ultrasound machines increased from 1005 to 3775 (MoH 2012). Once again, these are remarkable increases; however, the number of MRI, CT scan and ultrasound machines per population continues to remain below the levels of comparison countries. The Turkish government is now looking into ways to use health technologies more efficiently due to their relatively low levels and their increased application and accessibility.

VI. Safeguard Policies (including public consultation)

Safeguard Policies Triggered by the Project	Yes	No
Environmental Assessment OP/BP 4.01		×
Natural Habitats OP/BP 4.04		×
Forests OP/BP 4.36		×
Pest Management OP 4.09		×
Physical Cultural Resources OP/BP 4.11		×
Indigenous Peoples OP/BP 4.10		×
Involuntary Resettlement OP/BP 4.12		×
Safety of Dams OP/BP 4.37		×
Projects on International Waterways OP/BP 7.50		×
Projects in Disputed Areas OP/BP 7.60		×

Comments (optional)

VII. Contact point

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