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IMPLEMENTATION COMPLETION NOTE

TURKEY

PRIMARY HEALTH CARE PROJECT
(LN. 4201-TU)

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Human Development Sector Unit
Turkey Country Unit
Europe and Central Asia Region

CURRENCY EQUIVALENTS
(as of January 15, 2001)

Currency Unit	=	Turkish Lira (TL)
US$1	=	TL1,370,000

WEIGHTS AND MEASURES
Metric System

FISCAL YEAR
January 1 – December 31

ABBREVIATIONS AND ACRONYMS

ICN	-	Implementation Completion Note
MEER	-	Marmara Emergency Earthquake Reconstruction Project
MOH	-	Ministry of Health
NGO	-	Non-Governmental Organization
OECD	-	Organization for Economic Cooperation and Development
PCU	-	Project Coordination Unit
SPO	-	State Planning Organization
UNICEF	-	United Nations Children's Fund

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TURKEY

IMPLEMENTATION COMPLETION NOTE
PRIMARY HEALTH CARE SERVICES PROJECT (LOAN 4201-TU)

A. Introduction

1. This is the Implementation Completion Note (ICN) for the Turkey Primary Health Care project, for which the Bank's Board of Directors approved Loan 4201-TU in the amount of US$ 14.5 million in June 1997. The Loan Agreement was signed in September 1997 and the Loan became effective on December 18, 1997. After twenty one months of inactivity and zero disbursements, the project was restructured and the loan's entire amount was reallocated towards financing emergency health interventions in the provinces affected by the earthquakes which shook Turkey's Marmara region in August and November 1999. The reallocation of funds was approved by the Bank's Board of Directors in September 1999, within the framework of an overall reallocation of US$ 262.3 million from eight existing loans to help provide immediate financing for repairs, reconstruction and provision of social services in the aftermath of the Marmara earthquakes. The loan was closed as stipulated in the amended Loan agreement on June 30, 2001, and an undisbursed balance of US$ 13,928,522.22 was cancelled in August 2001.

B. Background

2. The Primary Health Care Services Project was the Bank's third health sector project in Turkey. The Bank's initial intervention, the First Health project, was approved by the Board of Directors in May 1989. It prepared the grounds for the Second Health Project, approved in September 1994, and for the Primary Health Care Services Project. Both the First and the Second Health projects were still active when the Primary Health Care Services Project was approved.

3. After decades of neglect and underfunding, the Government of Turkey began to increase health allocations and evaluate the performance of its health care system in the late 1980s. The Government recognized that its health sector strategy in the past two decades had largely failed to provide adequate health services to the vast majority of Turkey's population. Basic health indicators, such as infant and maternal mortality, life expectancy and deaths due to preventable causes fell significantly below OECD averages and below those of many countries with comparable income levels. Aside from underfunding, the key deficiencies which plagued and continue to plague Turkey's health sector are (i) unequal access to health services, with the population in rural areas and in eastern Turkey having substantially less access to health care than those in urban areas and the central and western part of the country; (ii) over-emphasis on hospital care, with concurrent failure to develop an effective primary care system; (iii) lack of an effective referral system operating between primary and higher order care, (iv) vertical fragmentation and ineffective allocation of resources which, coupled with highly centralized decision making along programmatic lines, largely prevents effective coordination and service delivery, and (v) low utilization rates both doctor contacts and hospital admissions per 10,000 population, which fall substantially below OECD averages.

4. The Basic Law on Health Services adopted in 1987 was to lay the ground for much needed reforms in the health sector. The Bank's First Health Project, which followed the adoption of this law, intended to initiate sectoral reforms and lay the ground for future Bank operations to help deepen the

reforms. The First Health Project helped develop three major pieces of legislation that were to anchor the reform program and set the legal basis for a restructured and more efficiently operating public sector health care system. The draft legislation included the Law on the "Establishment and Organization of Health Financing Institutions", the Law on "Hospitals and Health Enterprises" and the law on "Primary Care Services and Family Physicians". All three pieces of draft legislation provided for piloting in two selected provinces. While funding to pilot the systems envisaged under the first two pieces of draft legislation was available under the Bank supported First and Second Health projects, a financing gap to pilot the new primary health care system envisaged in the third draft law was identified. The Primary Health Care Services Project was thus specifically designed to fill this gap and to allow for testing of a new primary health care system. However, most of the draft legislation was never submitted to Parliament and none of it was ever adopted. This had a major bearing on the implementation of the Primary Health Care Services project.

C. Project Objectives

5. The Primary Health Care Services project's original objective was to improve access to and quality of primary health care in two provinces and to serve as the basis for extending the tested primary care health reforms nation-wide. Specifically, the project aimed to (i) develop a primary health care system based on family physicians and an effective referral system supported by financial incentives and improved infrastructure; (ii) evaluate the developed primary care system in view of nationwide replication and, (iii) develop a capacity for health economic analysis in the Ministry of Health (MOH).

D. Project Design

6. The project was to be implemented in two phases. The first phase was to develop the necessary human and physical infrastructure for an effective primary care system in the project provinces by providing training, technical assistance, computer hard and software, medical equipment, furniture, teaching materials, civil works and incremental operation costs. The second phase, to be initiated upon adoption of the legislation on Primary Care Services and Family Physicians, was to include the piloting of financial incentives in support of the family physician model and an effective referral system from primary to higher order care. The project was to be implemented over a three year period and had three components: (i) improvement of primary care services through the establishment of a system of family physicians and public health centers in the two project provinces; (ii) monitoring and evaluation of the new primary care service system in view of subsequent nation-wide replication and, (iii) development of institutional capacity for health economic analysis in the MOH. Under this last component the project was to provide training and mentoring for four health economists to be located initially in the Project Coordination Unit (PCU), where their skills could be applied to evaluating and developing health reform alternatives.

7. The project was to be managed integrally with the First and Second Health projects by a PCU that had been established in the MOH when the First Health Project was launched. The PCU was to work with MOH's technical and line departments as well as with health directorate staff of the project provinces to assure effective project implementation. The PCU at one point comprised some 190 people. The PCU had been established to coordinate and in fact implement the Health I Project. Significantly, it was a structure parallel to, and separate from the Ministry of Health. As a result, the Ministry had no "ownership" of the projects and in fact saw the PCU as an entity competing with MOH.

8. These arrangements have now been changed under Health II as it was not conducive to the Bank's desire to engage the Ministry and the Government in a dialogue towards improving the performance of the sector. During the past two years, great efforts have been displayed by the Bank to encourage transferring responsibility of the project to the Ministry and reducing the role of the PCU (and its excessive complement of staff) to one primarily of project coordination. The Ministry of Health is now fully committed to the Health II Project, both for itself and for the opportunities it is now providing to have a broader dialogue with the Bank on comprehensive reforms in the health sector.

E. Project Implementation

9. Following Loan effectiveness in December 1997, the project was formally launched with a workshop attended by Bank staff in July 1998. Prior to and following the project launch workshop a limited amount of training on primary health care issues was carried out in the project provinces. The training was essentially an extension of training initiated under the Second Health project and did not require any Bank financing under the Primary Health Care Project. Apart from this limited training, the project remained largely inactive and no funds were disbursed in the twenty one months following loan effectiveness. The project's inability to take off was due to three main factors:

(i) The project concept, in particular the development of family practitioners, found little support in MOH outside the PCU. It in fact faced marked opposition from the concerned MOH line department, the Turkish Medical Association and other stakeholders, including physicians in the project provinces who feared losing job security if they were to become independent family physicians.

(ii) The Law on Primary Health Care Services and Family Physicians, as well as other health reform related legislation was never submitted to Parliament because it had limited support in the Government in general and in the MOH in particular. Because of political instability, the Parliament was not likely to adopt any legislation that would have required deep-rooted reform that inevitably would have involved winners and losers. Following the elections in the Spring of 1999, the Law would have needed to be redrafted and submitted to a new Parliament according to Turkish law. The new coalition Government and in particular the new MOH leadership were, however, not willing to push ahead with health reforms and thus never initiated the process of redrafting and submitting the legislation to Parliament. Without the law, the key element of primary health care services reform to be supported and tested under the project, namely the establishment of a system of family physicians, could not be implemented.

(iii) Growing tensions and rivalries between the PCU and MOH, particularly the line department concerned with this project (Primary Health Care General Directorate) prevented effective implementation even of those activities that would not have required passage of the law on primary health care. These tensions were brought about by changes in Government and political affiliations. They were further fuelled by the fact that the PCU had access to considerable funding and staffing capabilities and that many of its consultant staff were paid significantly higher salaries than MOH line department staff, all of which MOH line department staff resented. These tensions resulted in the PCU largely operating in a vacuum, without the necessary support from MOH staff to effectively move ahead with project activities. While this issue also affected implementation of the First and Second Health projects, it seemed to particularly paralyze the Primary Health Care Services project. Coupled with the lack of necessary support for the project concept in MOH, it led the PCU to focus its efforts increasingly on implementation of the other two

projects and ignore the Primary Health Care Services Project. The question also arises whether concurrent management of three health projects by the same PCU, particularly under a setup whether the PCU also carried out much of project implementation, was not overtaxing the capacity of the PCU.

10. From the time of the project launch workshop, the Bank supervision team recognized the dangers which the absence of legislation on primary health care services posed for the successful implementation of the project. Efforts were made to identify worthwhile primary care activities which the project could have tested and implemented in the project provinces in the absence of the law. Although supervision missions repeatedly urged MOH to develop an alternative implementation plan, the latter never materialized – a reflection of the limited support the project enjoyed in the Ministry.

F. Project Restructuring

11. In August 1999, a major earthquake hit Turkey's Marmara region and caused significant damage and loss of life. A second quake followed suit in November of the same year. After an initial cross-sectoral damage assessment by the Government and the Bank, it was decided that US$ 262.3 million from eight existing loans would be reallocated towards financing reconstruction, repairs and provision of basic social services on an emergency basis in the provinces affected by the earthquake. In the health sector, the Marmara Emergency Health Program aimed to re-establish an effective health care system in the earthquake region as quickly as possible. Bank financing for emergency activities in the health sector amounted to US$37 million, of which US$22.5 million were reallocated from the Second Health Project (Loan 3802-TU) and US$14.5 million (the entire loan amount) from the Primary Health Care Services project. Reallocation of the entire amount of the loan from the Primary Health Care Services project was justified by the fact that the project had essentially remained inactive for twenty one months and the situation was unlikely to change given the lack of commitment to health sector reforms.

G. Revised Project Objectives

12. The key objective of the restructured project was to re-establish effective provision of health services at all levels in the provinces affected by the 1999 Marmara earthquakes.

H. Revised Project Design

13. Funds from the Marmara Emergency Health Program were to finance the following activities in the region affected by the Marmara earthquakes: (i) reconstruction, rehabilitation and refurbishing of public sector health facilities; (ii) purchase of medical equipment, ambulances, mobile health units, emergency medical supplies, including drugs and vaccines and; (iii) the establishment of an epidemiological surveillance system. Project activities were to be implemented by the provincial governments with the support of concerned MOH line departments and the PCU.

I. Implementation of the Revised Project

14. Although the Marmara Emergency Health Program was designed to respond to an emergency situation, project implementation proceeded significantly more slowly than planned. With the exception of vaccines procurement through UNICEF, little progress was made with the implementation of foreseen activities during the year following the earthquake and most activities remained unfinished when the loan closed almost two years after the earthquakes. Slow implementation was due to four main causes:

(i) Cumbersome procedures surrounding the adjudication of land and the provision of land titles for sites on which new health facilities were to be constructed resulted in significant delays in the reconstruction of health facilities. In the absence of final site allocation and land titles, activities such as topographical surveys, architectural designs and procurement of works could not be initiated and without a works procurement schedule, the procurement of replacement medical equipment for these facilities could not go ahead. The land allocation issue was finally resolved in late 2000, but by the June 2001 loan closing date the tender for reconstruction of health centers had still not been launched.

(ii) MOH's 2000 budget needed to be amended to allow for financing of the emergency activities supported under the project. Due to cumbersome procedures and red tape, the amendment was only finalized in late August 2000, thus resulting in implementation delays of almost one year.

(iii) The purchase of mobile health units and ambulances was delayed by Government austerity measures. An exception to the austerity measures needed to be granted by the Ministry of Finance and the State Planning Organization (SPO). The exception was only obtained in late 2000.

(iv) Due to frequent staff turnover and internal turmoil, the PCU needed to be restructured and its overall management, procurement and financial management capacity strengthened when the Marmara Emergency Health Program was initiated. This resulted in a lack of proactiveness on the part of the PCU. Coupled with a relatively heavy procurement schedule under the Second Health project, the lacking proactiveness translated into the PCU not moving ahead with the preparation of any procurement documents as long as the above outlined issues were not resolved. This despite strong encouragement from Bank mission, which urged the PCU to prepare documents in advance of amendments/approvals discussed above to ensure that procurement could be launched as soon as the approvals were obtained. Consequently, procurement of goods and works could not move ahead at full speed once the budget and land allocation issues had been resolved.

15. By the time of the June 30, 2001 loan closing date only a small share of the activities foreseen under the program had been completed. In particular, some replacement medical equipment for hospitals and vaccines had been procured, but in fact most of these were financed under Health II. The topographical and geological surveys of sites for new health centers had also been completed. Overall, just over US$ 1 million of the initially reallocated US$ 37 million had been disbursed. Of these, only about US$ 350,000 had been funded from the loan of the Primary Health Services project.

16. In the face of slow progress by the Marmara Emergency Health Program, some of the needs for reconstruction, equipment, medical supplies and drugs were met by other donors, primarily bilateral agencies and NGOs. Their procurement regulations proved less cumbersome and they did not require land titles for the establishment of mainly prefabricated replacement health units, nor did they need MOH budgetary revisions. The financial needs of the Marmara Emergency Health Program were thus quite substantially reduced.

17. Given slow implementation progress and reduced financial needs, Bank management decided to not grant an extension on the loan closing date and the loan was closed as originally foreseen on June 30, 2001. An amount of US$ 13.93 million was cancelled following loan closure. Procurement of goods and services which had been initiated before loan closure will be financed from the reallocated

portion of the loan for the Second Health project. Reconstruction of and equipment for public sector health facilities will be financed under the Marmara Emergency Earthquake Reconstruction project from which funds have recently been reallocated for this purpose.

18. Significant efforts were undertaken by the Bank task team to help overcome the constraints faced during the implementation of the revised project and to help establish improved working relationships between a restructured PCU, concerned MOH line departments and provincial governments. While these efforts had only a limited impact on project implementation prior to loan closure, their benefits have become more visible in recent months. Both, implementation of the Marmara Emergency Health Program and that of the Second Health project (which suffered from some of the same problems) has now accelerated considerably. US$7 million worth of medical equipment have recently been purchased and installed at medical facilities in the Marmara region and procurement of ambulances and mobile health units is well advanced. Given the low progress in project implementation, however, despite more evident progress right before the closing date, the Bank team decided with management that the closing date should not be extended, but rather that activities, which procurement was advanced, should be funded under Health II and with proceeds from the Marmara Emergency Earthquake Reconstruction Project (MEER) which had unallocated funds. Accordingly, architectural and engineering designs for the civil works is about to be completed. Civil works and additional procurement of medical equipment for the medical facilities will be financed under MEER.

J. Project Outcome

19. The originally intended development objectives for the Primary Health Care Services project were clearly not achieved, which is why the loan was reallocated towards the Marmara Emergency Health Program. Slow implementation progress under the latter resulted in unsatisfactory ratings of implementation progress at the time the loan was closed. However, the project was given a satisfactory rating for the achievement of revised development objectives. While health services in the region affected by the Marmara Earthquake appear to be operational again, this is largely due to programs other than that financed by World Bank funds. Given the limited achievements under the Marmara Earthquake Emergency Program at the time of loan closure, it is questionable whether the achievement of development objectives can be rated as satisfactory. A full evaluation of these activities will have to await the completion of the entire program and will need to be carried out during the Implementation Completion Review of both the Second Health project and the relevant component under the MEER Project.

K. Lessons Learned

20. Both the experience of the unsuccessfully launched Primary Health Care Services project and that of the Marmara Emergency Health Program provide some valuable lessons for future interventions in the health sector in Turkey:

- Projects in support of sectoral reform can only be successfully implemented if they enjoy widespread support among key stakeholders both inside and outside government. The experience of the Primary Health Care Services project has clearly shown that even pilot reform activities are bound to fail if they are initiated with only limited support and if they are carried out by a unit such as the PCU, which is largely separated from the concerned line agency departments. Strong support from a wide range of stakeholders is particularly important in an environment where there are frequent government changes. Changing political leaderships tend to disown what was done by their predecessors and reform initiatives have a

higher chance of survival when they benefit from support among a wide range of stakeholders at different levels of the system. Consensus building is an ongoing process; which needs to go beyond the design and continue to the implementation phase.

- Adoption of legislation necessary for successful project implementation should be made a condition of project appraisal or of Board presentation. Allowing a loan to become effective without the necessary legal framework in place is too risky in a situation where the laws in question call for deep-rooted reform.

- Sole reliance on a PCU for project implementation is unlikely to lead to successful results, particularly in the case of reform projects. While a PCU may be required to assure overall project coordination (including procurement), concerned line agencies and other stakeholders need to be involved in project design and implementation.

- The mixed experience of the Marmara Emergency Health Program raises questions as to how effectively World Bank loan funds can be used to help provide emergency repairs and services in the aftermath of natural disasters. Procedures and requirements (particularly with respect to procurement), applicable to World Bank financed investment loans do not seem to lend themselves to provide a quick response in emergency situations. This suggests that reallocation of funds for emergency interventions under ongoing projects is of questionable value when quick action is needed. In this case, however, the delays in procurement were due to cumbersome Government procedures, rather than Bank's lengthy procurement guidelines.

ANNEX 1

BANK RESOURCES: STAFF INPUTS

Stage of Project Cycle	Planned (US $000)	Revised (US $000)	Actual (US $000)
Preparation to Appraisal	--	--	40,000.00
Appraisal	--	--	55,000.00
Negotiations through Board Approval	--	--	5,000.00
Supervision	--	--	226,000.00
Completion	--	--	1,800.00
Total	--	--	**327,800.00**