7. Principal health reforms

Health care reform has been given the utmost importance on Turkey's policy agenda since the late 1980s. In 1989, the SPO's Master Plan Study (SPO, 1990), which was developed through a World Bank loan, introduced new concepts to the Turkish health care system. The Plan suggested splitting the functions of purchasing and provision, developing an internal market, implementing general health insurance, formulating a family medicine system at the primary health care level and giving autonomy to state hospitals. From 1990 to 1993, intensive efforts were undertaken to reshape the health care system in a way that reflected global trends and approaches. The World Bank had an important role in developing this process. The *National Health Policy* (Ministry of Health, 1993) presented the first comprehensive analysis of priority health care policies and also set out future strategies. However, a decade of political and economic instability (1993–2003) led to reform proposals that remained as blueprints with no concrete steps for implementation. Health policy projects, which were supported by the World Bank, focused on building capacity by means of training programmes, nationwide surveys (such as the NHA study) and studies on the burden of disease and cost–effectiveness. In 2003, after many years of hung parliaments, a single-party government took office and introduced a new and ambitious social and economic programme. The health care system benefited from this new environment and health care reform once again figured prominently on the political agenda. This time, however, with the government's HTP, concrete steps were taken to ensure implementation (Ministry of Health, 2003b).

7.1 Analysis of recent reforms

Table 7.1 provides a brief description of major reforms and policy initiatives implemented since 1989.

Table 7.1

Major health reforms and policy measures in Turkey, 1989–2010

Year	Description
1989–1990	Master Plan study is released, containing an analysis of the health care system and proposals for the future. Concepts such as the purchaser–provider split, internal market, family practitioners and general health insurance are used for the first time
1992	Introduction of the Green Card Scheme. Citizens under a determined poverty line are eligible to benefit from inpatient services free of charge
1993	National Health Policy document is released, analysing the current situation and identifying problems and strategies for the future
2003	Active and retired civil servants start to use private hospitals
	Legal arrangements for patient rights are put into place and hospitals start to establish patient rights units
	Contract-based appointments start for health care staff in rural and less developed regions
	A communication centre (SABIM) is established to open up ways of communicating with citizens; patient rights arrangements create authorities where patients can seek out their rights
	Total quality management is introduced within the Ministry of Health
	The individual performance-based payment system is piloted in 10 Ministry of Health hospitals
	Vaccination days are organized under the national vaccination campaign against measles
	Ambulance services offered free of charge for the first time
2004	Pilot family practitioner scheme starts in Duzce province and is subsequently extended to 23 other provinces
	Expansion of the "Extended Programme on Immunization" (including rubella, mumps and meningitis vaccinations). The number of baby-friendly hospitals is increased. New projects such as "informed mothers and healthy babies", "Turkey as Strong as Iron" and "Programme for Preventing Rickets" are launched. Community health centres are established
	Conditional cash transfers start. Grants in cash are given to the most deprived 6% of the community on condition that pregnant women and children in that community undertake the relevant medical checks
	Substantial changes are made to pharmaceutical policy regarding pricing and VAT. External reference pricing is introduced, resulting in considerable reductions in the prices of pharmaceuticals and saving the government US$ 1 billion
	VAT is reduced from 18% to 8% for pharmaceuticals
	Patients are given the opportunity to choose their physicians; the "right to choose physician" policy is also designed to encourage competition among service providers in the public sector, including Ministry of Health hospitals, for the first time
	The Reimbursement Commission is established for reimbursement decisions
	Iron supplements are distributed free of charge to pregnant women nationally
	The individual performance-based payment system begins implementation in Ministry of Health-affiliated health care facilities
2005	Green Card coverage is extended to outpatient care and prescriptions. Although initially there were no co-payments, a 20% co-payment for pharmaceuticals was introduced later in the year because of the accelerating pharmaceutical expenditure
	Transfer of public health care facilities to the Ministry of Health, apart from Ministry of National Defence and university hospitals. A purchaser–providers split is achieved by transferring SSK hospitals to the Ministry of Health
	SSK members start to purchase their prescriptions from private pharmacies in line with other social health insurance schemes
	New regulations on pharmaceutical licensing are passed by the Ministry of Health
	Vocational medical high schools, which used to be affiliated to the Ministry of Health, are transferred to the Ministry of National Education. This move contributes to the Ministry of Health being able to concentrate further on core functions
	Institutional and quality criteria are incorporated into the performance-based supplementary payment system in Ministry of Health facilities
2006	Compulsory service for doctors is re-introduced, having been abolished in 2003. The main aim is to obtain a geographical balance in the distribution of doctors, especially in rural and deprived areas of the country

Year	Description
	The Social Insurance and General Health Insurance Law is enacted, but certain articles are annulled by the Constitutional Court and implementation is delayed
	The Social Security Institution Law (Law No. 5502) comes into effect. Three of the major social security schemes (GERF, SSK and *Bağ-Kur*) are to be brought together under one new body, the SSI. Full implementation is delayed until 2008
	A system is established within SSI to monitor pharmaceutical expenditures. Work also starts to set up a system to integrate reimbursement claims and establish an electronic management system for the SSI (MEDULA)
	Parliament adopts the Law on Public–Private Partnerships For Health
	The MMR vaccine is incorporated into the routine vaccination programme
	Free primary health care services are made available to all citizens, even those not covered by any social security scheme
	Global budgeting is introduced for Ministry of Health hospitals
2007	The new Law on the Health Budget contains the following provisions: • SSK and *Bağ-Kur* beneficiaries no longer need a referral from Ministry of Health hospitals to university hospitals; • Patients suffering from chronic diseases are now allowed to refill their prescriptions at pharmacies without prior physician approval; • Fixed-price payments for outpatient and inpatient procedures based on CPT (Current Procedural Terminology) and ICD-10 are introduced in all Ministry of Health-affiliated hospitals, as well as university hospitals and private hospitals that contract with the SSI; • Hospitals contracted with the SSI are required to provide inpatient pharmaceuticals and medical devices free of charge (now covered by insurance) and are fined if patients are charged out ofpocket; and • All Ministry of Health-affiliated hospitals, university hospitals and private hospitals under contract with the SSI are required to process reimbursement claims through the MEDULA system
	New services are established to improve access to health care services, particularly for those living in remote areas, including snow-tracked ambulances, the marine ambulance system and motorbike emergency teams. Furthermore, the coverage rate for mobile health care services reaches 80%
2008	Parliament adopts the necessary amendments to the Social Insurance and General Health Insurance Law and the legislation is ratified by the President
	The GHIS begins implementation
	The DaPT-IPA-Hib vaccine is introduced into the routine immunization programme
	The Law on Tobacco and Tobacco Products, which bans smoking in closed and open public areas, is passed by parliament
	More vehicles are added to the mobile health care services stock to further improve access for people living in areas that are hard to reach in winter, including 75 snow ambulances, 4 marine ambulances and 6 air ambulances
	The new Ministry of Health Regulation on Private Outpatient Treatment and Diagnosis Centres is adopted; the provision of "need based licensing" is added and new licensing procedures are accepted by the Ministry of Health
2009	The Health Services Strategic Plan for 2010–2014 is developed by the Ministry of Health and approved
	Health System Performance Assessment study starts
	Co-payments are introduced for physician and dentist consultations in outpatient health care services
2010	Health premium payments of government employees and their dependants are devolved to the SSI
	The Draft Law on Public-Hospital associations is submitted to parliament. Once the Draft Law is enacted, secondary and tertiary health care facilities will be restructured as associations and these health care facilities will be managed by executive boards
	The Law on Full-Time Medical Practice of University and Public Sector Health Personnel is adopted, paving the way to legally enforce full-time practice of health services personnel in the public sector. However, after a challenge in the Constitutional Court, the new arrangements (as at July 2010) require only staff at Ministry of Health facilities to choose between full-time public or private practice, while staff based in university facilities can still practise in both sectors, provided that their daily full-time public duties are met first
	Big cities such as Ankara and Istanbul are included in the family practitioner scheme, which begins implementation nationwide

7.1.1 Aims and background to reforms

This section outlines the formal statements in policy documents on health care reform. In the main policy document of the government's HTP (Ministry of Health, 2003b), the Ministry of Health underlined that the programme was not designed to introduce a different approach to previous reform initiatives, and this is why the term "transformation" was preferred over "reform". The objectives of the reform measures were to achieve "effective, efficient and equitable organization, financing and provision of health care services". Effectiveness was defined as improvements in the health care status of the population. To this end, preventive services were regarded as key to attaining this objective, and decreasing maternal and child mortality was regarded as a main indicator of success. Efficiency was defined as the provision of more services with the same resources. The equity principle was defined as access to health care services according to need and contribution to the health care financing system according to income. The aim of reducing inequalities between social groups, the urban and rural population, and regions falls under this objective. The main principles of the HTP were listed as follows (Ministry of Health, 2003b).

Individuals at the centre of the system. Planning and provision of health care services should focus on individuals, their needs, demands and expectations.

Sustainability. The new system will be consistent with the conditions and resources of the country and will be sustainable in the long run.

Continuous quality improvement. This principle focuses on creating a feedback system to provide information in order to learn lessons from results and mistakes.

Participation. This principle states that during the development and implementation of the improved health care system, a constructive environment will be created with the participation of all stakeholders.

Consensus building. All segments of the health care system should work on the basis of consensus, meeting the interests of all stakeholders.

Volunteerism. This principle emphasizes that all units in the system should work together to meet its goals and objectives.

Division of power. This principle emphasizes the need to split financing, planning, monitoring and provision functions within the health care system, thus yielding more efficient and high-quality health care services.

Decentralization. Health care facilities and institutions should have less dependence on central bodies and a decentralized health care system should be established in line with contemporary governance approaches. Institutions with administrative and financial autonomy will have efficient and rapid decision-making mechanisms and will use resources more efficiently.

Competition. A competitive environment for health care providers will be established in order to advance continuous quality improvement and to decrease costs.

Based on these principles, the HTP outlined the following concrete components to be achieved (Ministry of Health, 2003b).

A Ministry of Health with planning and control functions. The programme (and subsequent policy documents) reiterate the need for the Ministry to have a predominantly stewardship function, planning and supervising both the public and the private sector. With this new structure, the Ministry of Health will focus on prioritization, quality assurance and improvement, accreditation and licensing, public health measures and infectious diseases.

A general health insurance scheme covering everyone under a single organization. This component focuses on the establishment of the GHIS where individuals benefit according to need and contribute according to their financial status.

Widespread, easily accessible and friendly health care system. The HTP emphasizes that the "socialization model" of health care was compatible with the epidemiological and social conditions of the 1960s and now needs to be reviewed to meet the challenges and problems of the 21st century. The creation of a competitive environment, which also involves the private sector in the provision of health care services, is stated as a key component of the reform strategy.

Strengthened primary health care services. This component emphasizes the introduction of a family practitioner scheme and the importance of health care services at the primary care level.

Effective referral system. Strengthening primary care services and the introduction of a family practitioner scheme is a prerequisite for an effective referral system. This component emphasizes the possible contribution of a referral system to reducing costs and outpatient visits to hospitals and also the importance of continuity of care. A patient may bypass the referral chain if she/he chooses to pay the extra cost of this preference.

Health enterprises with administrative and financial autonomy. This component focuses on restructuring public hospitals as part of a new competitive environment. In the new system, all hospitals will enter into contracts with the SSI, in competition with one another, thus requiring changes to their administrative and financial structures to operate in such an environment. Public hospitals will finance their activities with their own revenues and will be responsible for the quality and efficiency of services.

Highly motivated and skilled human resources. The success of transformation depends on the quality and devotion of health care personnel. This component requires new job descriptions for different health care professionals in line with EU requirements, a review of curricula of education programmes, a balanced distribution of health care personnel throughout the country and the introduction of incentives in human resources policies.

Academic institutions supporting the new system. This component emphasizes the need for professionals in health policy, health care administration, health economics and health care planning to undertake sectoral analyses, and to plan, research and advise on new policies. Emphasis is placed on public health and the revision of medical schools' curricula, with plans to establish a new institution for this purpose.

Quality and accreditation for effective health care services. This component focuses on establishing an autonomous "national quality and accreditation institution" to regulate registration, certification and accreditation in health care services. The institution will develop systems for the measurement of health outcomes and use these as a basis for performance measurement.

Establishment of institutions for pharmaceuticals and medical devices. This component covers the establishment of autonomous institutions that will be responsible for the regulation, registration, pricing, accreditation, certification, planning and purchasing of these two important inputs of the health care system.

Health information system. This component proposes the establishment of a health information system aimed at collecting and processing adequate data for developing health policies, identifying problems and priorities, planning health care services, assessing the quality of services and undertaking scientific research.

While the political impetus and implementation of the HTP is ongoing, a new policy cycle to strengthen the transformation process has been identified, with the following components (Akdağ, 2009).

Problem identification and diagnosis. The concept of health is related to almost every moment in an individual's life and heads the list of factors that affect social welfare. Therefore, adopting an approach that gives priority to identifying and redressing health problems that should not exist at the country's current level of development is crucial. In particular, identifying problems within the scope of defining the health care system's performance objectives is a realistic and sustainable way to improve policies. In order to establish an accurate and objective picture of the current situation, some specific criteria should be applied, including an emphasis on basic primary health care indicators, as well as indicators on protecting citizens against financial risk and citizen satisfaction.

Policy development. Following the identification of problems, health care policies should be developed to address the challenges presented, tailoring policies in accordance with domestic conditions. The HTP promotes accessibility, quality and efficiency as priority criteria during the policy development process.

Political decisions. The adoption of transformative policies in the health care sector is not only related to political will but also to establishing an effective policy strategy. Whether or not a reform measure will be adopted is related to the willingness, interest and capabilities of parties and the political strategy used. In particular, the political position of the authorities or institutions that are responsible for the implementation of particular policies is crucial, as is the support of the government headed by determined ministers. Under the HTP, the contribution of the current Prime Minister has played a significant role in implementing many radical changes.

Implementation. As in all reform processes, effective monitoring is required so that any problems may be identified and corrective measures taken. In this respect, an appropriate supervision and reporting system is required. The overriding objectives of providing effective, good quality and accessible health care services can be achieved by monitoring strategically chosen performance outputs, including those measured by primary health care indicators, indicators protecting citizens against financial risk and citizen satisfaction.

7.1.2 Policy process and reform implementation

Health care reform proposals reflected global trends in the 1990s and 2000s. In practice, the impetus for reform and the design of the reform agenda started with the involvement of the World Bank in the Turkish health care system at the end of the 1980s. Potential membership of the EU has also affected the reform

agenda and policy in recent years, with a number of legal changes being made to harmonize with EU regulations. Until the 1990s, a topdown approach was adopted, with little or no participation from different stakeholders; however, during the preparation of the *National Health Policy* document (Ministry of Health, 1993), a more participatory approach was used.

The reform proposals that preceded 2003 were not implemented mainly because of political and economic instability in the country. The 1990s and beginning of the 2000s were characterized by turmoil in both the social and economic spheres. The country went through two major economic crises and the political environment was very volatile, with unstable coalition governments. This environment considerably affected the launch and implementation of health care reforms as governments had other priorities to address. This was true for many other policy areas in addition to health care.

The Urgent Action Plan, declared by the Government on 16 November 2002, laid out the primary objectives that were identified for the health care sector under the heading "Health for All". Immediately after the Urgent Action Plan was developed, the HTP was formulated in early 2003, announced to the public and carried out under the strong leadership of the Minister of Health and the Prime Minister. Based on the strengths of the system and aiming to address its weaknesses, the content of the HTP can serve as a "model" for reforms to be undertaken in other countries with similar health care systems to that of Turkey in the pre-2003 period. The incremental steps taken to implement the HTP paved the way for major improvements to the health care system. While this process is by no means complete (see section 7.2), since 2008 both the SSI and the Ministry of Health have implemented important measures to provide Turkish citizens, most of whom have severe health needs, with reasonable access to health care services and to improve insurance coverage (see Table 7.1).

The health status of the population in Turkey has been improving rapidly in recent years and is catching up with the WHO–European Region and OECD averages in some aspects. New public health initiatives have had a considerable impact. The number of malaria cases, which was more than 10 224 in 2002, decreased to 78 in 2010. Similarly, the number of measles cases, which was 7810 in 2002, decreased to only 34 cases in 2006 and 7 reported cases in 2010, which is a direct result of the measles elimination programme (Ministry of Health General Directorate of Primary Health Care Services, unpublished data, 2009; Ministry of Health, 2011b). Free iron supplements are provided to pregnant women in order to protect infants and women against anaemia, benefiting 1 million women annually and 4 225 000 infants between May 2005 and August 2008. In addition, vitamin D, which supports bone growth

in infants, is provided free of charge, benefiting 4 020 000 infants between 2005 and 2008 (Akdağ, 2008). A rapid improvement has also been noted in the maternal mortality ratio, which was about 70 per 100 000 live births in 1998, and decreased to 16.4 per 100 000 in 2010. The IMR has decreased to 10.1 per 1000 live births in 2010 (Ministry of Health General Directorate of Mother and Child Health and Family Planning, unpublished data, 2009, 2010), from an estimated 22.8 in 2003 (Hacettepe University Institute of Population Studies, 2004). Moreover, additional immunizations were incorporated into the standard schedule of vaccinations in 2006 and 2008, and the vaccination ratio for the targeted child population at national level has improved considerably from about 78% in 2002 to 96% across the country in 2007 (Akdağ, 2008). Finally, the importance given to preventive and primary health care services and relevant studies conducted in this area have led to a major reduction in the incidence and prevalence of communicable diseases and the number of such cases reported.

In terms of citizen satisfaction with the health care system, according to the results obtained from the Life Satisfaction Survey, which is periodically conducted by TURKSTAT, overall satisfaction with health care services among the public was 39.5% in 2003, when the HTP began, and 73.04.% in 2010 (TURKSTAT, 2010d). A recent EUROPEP survey (OECD & IBRD/World Bank, 2008), which was conducted in September 2008, investigated satisfaction with primary care services in a large sample of patients across 81 Turkish provinces. In many aspects, the gap between patient satisfaction in Turkey and patient satisfaction in other European countries has almost disappeared. Although satisfaction levels had improved in most aspects of services in the provinces that had not yet adopted the new family practitioner scheme, satisfaction levels with health care services improved on a much larger scale in the 23 provinces where the family practitioner pilot scheme had been implemented, either approaching or going beyond the European average.

The full implementation of the wide-ranging structural reforms outlined in the HTP has been much slower. The challenges that lie ahead are discussed in the next section.

7.2 Future developments

Since the beginning of the HTP, significant progress has been made to realize the reform agenda. Some initiatives were delayed because of legal obstacles. For example, the most important component of the reforms, the introduction of the

GHIS, was delayed by more than a year through rulings by the Constitutional Court (see Chapters 2 and 3); however, implementation to integrate all of the social security funds began in October 2008, with the transfer of the three major schemes (GERF, SSK and *Bağ-Kur*) to the umbrella organization, the SSI. This was followed up by the transfer of the Active Civil Servants Scheme in 2010. Critical steps have been taken to implement the family practitioner scheme nationwide, public–private partnerships, the purchaser–provider split and the internal market.

The next steps in the health care reform programme will be the full implementation of the GHIS, finalizing the legal process to grant autonomy to hospitals and granting greater decentralization of powers to health facilities. In addition, the enactment of auxiliary legislative arrangements, which would further clarify the implementation of the law, is essential for the successful achievement of universal health insurance for the Turkish population. Other important components of the reform agenda, such as the completion of DRG studies to pave the way for regulating the payments made to health service providers and establishing clear contractual agreements between the SSI and providers (both public and private), are needed to improve the functioning of the health care system.

Apart from these priority areas, the current (inadequate) levels of human resources within the health care system have to be raised in order to achieve the reform programme's targets and to meet the country's needs. The gap is enormous, particularly with regard to the number of nurses and physicians. Despite the increases in employment and university admissions, particularly in recent years, neither the supply of physicians nor that of nurses has managed to reach an adequate level. Consequently, both the Ministry of Health and other relevant agencies need to take further action to address this issue as a matter of urgency. Another strategic area of concern is the implementation of a referral chain between primary and secondary care, which would contribute to gaining a greater control over costs and in some areas may even induce cost-saving efficiencies. In effect, greater use of less-expensive primary health care services, and a commensurate decrease in the utilization of more expensive hospital services, would allow the SSI to allocate payments between health care levels more efficiently. Improvements in the referral chain are expected now that the family practitioner scheme is operational throughout the country, making it more feasible to reactivate the family practitioner gatekeeping function, which was suspended because of the lack of physicians (see Chapters 3 and 6). Plans are also under way to establish a home care system, a centralized hospital

appointment system, mobile pharmacies and a drug-monitoring system; a stem cell coordination centre is also being mooted. A more systematic system to monitor and assess health care services will also be required.

In the more general public management reform proposals that accompanied the HTP, there were statements indicating that local authorities would be empowered to deliver and manage health care services and that greater administrative devolution would occur. However, such an ambitious objective has not materialized. It requires major reforms to the overall structure of public administration in Turkey, an area where historically, attempts at reform have not been successful. Therefore, it is clear that the decentralization of health care services will only ever occur in tandem with a more wide-sweeping reform of the country's public administration system.

The most challenging reform initiatives in the next few years will be the granting of autonomous status to hospitals and creating an internal market for the provision of health care services. Although the legal procedures for other major reforms are almost complete, this section of the HTP is still being discussed. At the same time, the development, implementation and improvement of health insurance, sustaining capacity building for the Ministry of Health's stewardship role, raising human resources for health to adequate levels and ensuring the financial sustainability of the health care system will need further emphasis over the next few years.

In many respects, the HTP presents a picture of the successful attempts that have been made to develop and implement major health sector reforms, including the expansion of health insurance coverage of the population through the establishment of the GHIS. According to the OECD and the IBRD/World Bank (2008), the government's strong commitment and leadership, accompanied by strong economic growth, have resulted in the implementation of long-desired reforms in the health services delivery system.