9. Conclusions

Turkey has achieved considerable health status improvements since the 1980s in major health status indicators. However, although infant mortality, child mortality and maternal mortality rates have decreased, and life expectancy at birth has increased over time, the indicators are still not compatible with the current development level of the country. In addition, regional inequalities constitute a challenge for the years ahead. Improved access to health care services in recent years has contributed positively to the improvements in health status; however, for further improvements, developments in the country's socioeconomic level are also required.

In the past, the Turkish health care system was characterized by its highly complex and fragmented organizational and financing structure. The implementation of health care reforms under the HTP since 2003 has changed this structure to a great extent. The reform attempts in the Turkish health care system date back to the beginning of the 1990s. Although the pillars of the reform framework were established in that decade, the implementation process started after 2003 with the government's HTP. The reform measures include the introduction of major initiatives: a purchaser–provider split, general health insurance covering the whole Turkish population, a family practitioner scheme at the primary level of contact and more autonomous hospitals. During the 1990s, mainly as a result of political and economic instabilities, no concrete attempts were made to make these proposals a reality. In contrast, the period after 2003 witnessed a break with the past, and radical reforms were put into practice.

The health care system prior to 2003 was characterized by fragmented provision and financing systems, inequalities in access to health care by different subpopulations and a system whereby both the providers and the purchasers of the health care system were dissatisfied. Inequalities in access to health care was the major challenge to be dealt with as only a minority of the population had access to timely and relatively high-quality health care services.

The HTP undertook several measures to overcome this problem. First, all public health facilities were merged under the Ministry of Health. This was the first step taken to consolidate the provision of public health care services under one authority. This merger resulted in opening up all public facilities to the whole population and was a first step towards equalizing access to health care. The second major reform was achieved in the financing of health care services with the establishment of the GHIS, which covers the whole population. In the run-up to the full implementation of the GHIS, the benefits provided by the (fragmented) pre-existing social health insurance schemes were equalized and currently the whole population is under the same benefits package umbrella.

The third area of reform was in primary care. A pilot family practitioner scheme was introduced and this scheme was later extended to cover the whole population at the end of 2010. Under this scheme, residents are required to register on the list of a family physician, who is paid on a capitation basis. Currently, there is no compulsory referral system whereby patients are first required to refer to the primary level of care before securing access to secondary and tertiary levels, mainly because of the shortage of family practitioners who can undertake gatekeeping responsibilities. However, in the long term, establishing a referral system is seen as a prerequisite to ensuring the sustainability of the health care system. In the interim, co-payment exemptions at secondary and tertiary level facilities act as an incentive for people to first obtain a referral through a primary care physician.

The fourth area targeted for reform was hospitals. The HTP proposed to increase the administrative and financial autonomy of hospitals. However, the pace of this part of the reforms has been relatively slow, with several setbacks postponing the implementation process to sometime in the future. The major development in the hospital sector after 2003 focused on increasing the role of the private sector. Because the SSI has started to purchase health care services from both the public and the private sectors, and as population access has improved, the private hospital sector has flourished in recent years.

The major impact of the reforms can be seen in the improvements in the number of visits to health care providers in recent years. The annual number of visits per person has almost trebled, with easier access both in terms of provision and financing. The share of public health spending as a proportion of total health expenditure has also increased and OOP payments have decreased.

Within the overall framework of the reforms, payment of health care providers has also changed radically since 2003. A performance-based payment system was adopted to pay health care personnel, performance being

mainly measured by the number of services provided. This has enhanced the financial capacities of provider institutions, as providers with higher capacity utilization rates could also improve the income of their staff and their facilities. However, there are some concerns that this payment system may contribute to supplier-induced demand for services. There are also concerns about moving the system to an outcome-based payment system. That is, the system under consideration will link the outcomes of health care interventions to the payment of the provider. For example, nosocomial infection rates, success rates after surgery and rehospitalization rates will be used as inputs in the payment formula. However, this proposal is at its initial planning stage and no concrete implementation details are yet available.

Considerable improvements have been achieved in areas such as patient rights, IT, quality of health care and efficient use of resources. Special units within health care institutions that investigate complaints by patients and providers were established as part of the strengthening of patient rights. Similarly, quality units have been established in all public hospitals, also to improve this aspect of care. Although there is still room for improvement, increasing emphasis on quality can be seen as an initial and essential step. Reflecting these improvements, the satisfaction level of the population with the health care services on offer has improved over time. However, certain areas such as mental health care or long-term care still require special attention.

As can be seen throughout the various chapters of this report, Turkey has embarked on a radical process whereby all essential aspects of the health care system have been questioned and changes made. The main drive behind these changes has been stated as the need to develop easily accessible, high-quality, efficient and effective health care services for the population. Although considerable improvements have been made to this end, there are still challenges ahead. The sustainability of the health system's financing will be a major challenge facing policy-makers in the years to come, particularly in light of improved access (and, therefore, higher demand for health care services), improved technology, an ageing population and higher expectations from citizens. It is clear that the government will have to employ approaches such as HTA in order to improve efficient and effective use of resources. However, another challenge in this respect is related to the regulatory function of public agencies. In particular, the increased role of the private sector in the provision of health care services and overseeing the correct functioning of the performance-based payment system for health care personnel in public facilities require more organized and effective mechanisms of regulation.