Executive summary

Introduction

Turkey is located in the northern hemisphere and bridges Europe and Asia. The bordering countries are Greece, Bulgaria, Georgia, Armenia, the Islamic Republic of Iran, the Syrian Arab Republic and Iraq. The country has a population of 73 million, 26% being under 14 years of age in 2010. Turkey is a parliamentary democracy with a clear separation of executive, legislative and judicial powers. The 1982 Constitution describes Turkey as a democratic, secular and social state governed by the rule of law. The Turkish Grand National Assembly (*Türkiye Büyük Millet Meclisi*), or parliament, is the legislative body acting on behalf of the nation. The President, elected by the people, and the Council of Ministers (Cabinet) headed by the Prime Minister, exercise executive power. Independent courts handle judicial power. Administratively, Turkey is divided into 81 provinces headed by provincial governors appointed by the central government. Provincial governors are the representatives of all ministers at the provincial level. All ministries, including the Ministry of Health, have their own local organizations in the provinces and the heads of these organizations are responsible to the provincial governor.

Turkey has accomplished remarkable improvements in terms of health status in the last three decades, particularly after the implementation of the HTP in 2003. Major health indicators such as the infant mortality rate (IMR), life expectancy and maternal mortality have improved considerably. Average life expectancy reached 71.8 for men and 76.8 for women in 2010, with the linear improvement between 2003 and 2010 being the fastest in the WHO European Region and narrowing the gap that existed previously. The IMR decreased significantly to 10.1 per 1000 live births in 2010, down from 117.5 in 1980, while maternal mortality has declined rapidly (5.5% annually) over the last 10 years. Despite these improvements, there are still discrepancies in terms of IMR between rural and urban areas, and between different parts of the country, although these also have been diminishing over the years. The higher IMR

in rural areas can be attributed to low socioeconomic conditions, low female education levels and the prevalence of infectious diseases. The main causes of death are diseases of the circulatory system followed by malignant neoplasms.

Organization

Turkey's health care system has been undergoing a far-reaching reform process since 2003 and radical changes have occurred both in the provision and financing of health care services. Health services are financed through a social security scheme, the GHIS, which covers the majority of the population, and services are provided by both public and private sector facilities. The SSI, financed through payments by employers and employees, and government contributions in cases of budget deficit, has become a monopsonic power on the purchasing side of health care services. On the provision side, the Ministry of Health is the main actor and provides primary, secondary and tertiary care through its facilities across the country. Universities are also major providers of tertiary care in the system. The private sector has gained power over recent years, particularly after arrangements paved the way for private provision of services to the SSI.

Financing

Total expenditure on health as a proportion of gross domestic product (GDP) has risen from 2.4% in 1980 to 6.1% in 2008. The share of health expenditure from public sources as a proportion of total health expenditure was 73% in 2008. Health expenditure between 2000 and 2004 increased mainly because of reform initiatives that improved access to health care services and changes in the provider payment system. This trend has continued, with a rise in the share of public expenditure on health as a proportion of GDP from 2.9% in 1999 to 4.4% in 2008. This increase is mainly the result of improvements in the public provision and financing of health services that have decreased the share of out-of-pocket (OOP) expenditure.

Turkey finances health care services from multiple sources. Social health insurance contributions take the lead, followed by government sources, OOP payments and other private sources. According to the most recent National

Health Accounts (NHA) data, 43.9% of funds were from social health insurance in 2008, followed by 29.1% from government sources, 17.4% from OOP payments and 9.6% from other private sources.

Data on the distribution of health expenditure by types of expenditure come from the NHA study in 2000; figures for more recent years are not available. Inpatient care and public health care services, on the one hand, were predominantly paid for by public sources in 2000. On the other hand, private sources (that is, private insurance, OOP payments and other private sources) and public sources (central and local government plus social insurance funds) contributed more or less equally to outpatient services. The estimates for 2000 show that 83.1% of total current health expenditure was on personal health care services and goods, which included inpatient and outpatient services as well as pharmaceuticals and other medical goods. Nearly 60% of this expenditure was derived from government sources, with social security funds providing the largest share.

The share of OOP payments was 17.4% of total health care expenditure in 2008, with a decrease from 27.6% in 2000. The decrease can be mainly attributed to reforms that improved health coverage of the population. OOP payments can be in the form of direct payments or cost-sharing. There are both direct and indirect cost-sharing in Turkey. Direct cost-sharing occurs as co-payments for prescriptions, medical devices and outpatient care. Extra billing and reference pricing are new methods of indirect cost-sharing that were introduced after 2003. Cost-sharing exemptions exist for emergency care, intensive care and for people suffering from chronic diseases such as diabetes and cancer.

Voluntary health insurance (VHI) provides a relatively small share of health expenditure; it was estimated as 3.7% of total health expenditure in 2000. Currently, there are no complementary private health insurance schemes. Individuals or companies purchase private insurance for their employees at their discretion. Companies provide VHI for profit and currently there are no non-profit-making companies operating in the sector. Premiums, duration of insurance, coverage rules and all other rules are set within individual policies bought by the insured.

Delivery of services

A comparative analysis with other European countries clearly shows the scarcity of health care personnel in Turkey in relation to its population. In particular, while the number of physicians per 100 000 people (167 in 2010) has grown moderately but steadily since the early 1990s, it is still significantly lower than that of other Mediterranean countries such as Greece, Italy, Spain and Portugal, as well as of the average for the European Union (EU).[1] Similarly, the number of nurses per 100 000 people (156 in 2010) is the lowest among the selected countries mentioned. Despite insufficient overall numbers, a significant improvement has been made in the geographical distribution of health care personnel, particularly general practitioners (GPs), since the early 2000s. Compulsory service and strictly applied health care personnel transfer rules are used as tools to balance geographical inequalities in deprived areas.

Public health activities are mainly the responsibility of the Ministry of Health and municipalities. The Ministry mainly undertakes health promotion and prevention activities while issues such as environmental health or food hygiene are under the responsibility of other ministries and municipalities.

Recent reforms have put special emphasis on the reorganization and strengthening of primary care services. A family practitioner system was first introduced as a pilot programme and was extended to cover the whole country at the end of 2010. Family practitioners (*aile hekimi*) are GPs and family physician specialists providing primary care to the population on their lists. They are paid on a capitation basis with incentives for preventive activities. The major drawback of the system is the lack of a referral system between primary, secondary and tertiary care. In other words, patients are free to enter the system at whatever point they prefer, and the primary care level is not working as effectively as it should. However, a new system of co-payment exemptions for primary and higher level care has been implemented as an incentive for people to visit their GP first and to receive a referral to secondary or tertiary care. The main reasons underlying the lack of a compulsory referral system are the general undersupply of doctors nationwide and, in particular, the insufficient number of doctors working at the primary care level who can act as gatekeepers. Currently, outpatient care, either primary or specialist, is provided by family practitioners, hospital outpatient departments (public and private) and private practitioners.

[1] It should be noted however, that Italy and Greece, in particular, have an oversupply of doctors compared with the rest of Europe.

Hospital care is delivered by both public and private hospitals. In 2010, there were 1439 hospitals, of which 843 were owned by the Ministry of Health, 62 by universities, 489 by the private sector and the rest by other public organizations such as the Ministry of National Defence. Hospitals provide both inpatient and outpatient care. The SSI purchases health care services from both public and private sector providers. There are plans to grant autonomy to public hospitals in the future but, so far, existing attempts have not been successful. Over the years, the number of beds in acute care hospitals has increased gradually, from 145 153 in 2000 to 191 481 in 2010. The number of beds in long-term care hospitals has increased from 6841 in 2000 to 8469 in 2010.

Dental health care is provided by both public and private sector facilities, with around 70% of dentists working in the private sector. The current SSI benefits package covers dental care in both sectors, with certain restrictions in the private sector that households must cover as OOP payments.

Medicines are obtained through private pharmacies, and dispensing outpatient prescriptions from hospital pharmacies is not allowed. All SSI outpatient prescriptions are filled through private pharmacies. Pharmacy chains and provision of over-the-counter medicines in places other than pharmacies are not allowed in Turkey. However, pharmacies can sell other commercial products such as contraceptives, personal hygiene items, baby products and cosmetics.

As in other European countries, the number of elderly people is growing in Turkey, although the general demographic profile is young. As a result of rapid changes in the social structure, elderly people have an increasing need for state support and professional services. This need is met by both public and private agencies. There are a number of organizations and institutions responsible for the long-term care of the elderly and disabled. These are, mainly, the Ministry of Health, the Social Services and Child Protection Agency (SHÇEK (Sosyal Hizmetler ve Çocuk Esirgeme Kurumu)) and various initiatives in the private sector.

Turkey does not have a national policy or guidelines for palliative care. Few oncology teaching hospitals have patient-specific palliative care training in their curriculum, nor are there palliative care units in health care facilities. Similarly, the "hospice" concept is very new and there is no legal framework covering this type of organization.

Turkey has highly institutionalized mental health care, with large hospitals located regionally and community-based care is in its infancy. In 2011, the National Mental Health Action Plan was launched; as of September 2011, 26 community-based mental health centres provide services in 24 provinces across Turkey, with plans for a further 236 to be established by the end of 2016.

Reforms and future challenges

New initiatives in health care date back to the beginning of the 1990s but the real implementation phase started under the radical reforms of the HTP in 2003 (Ministry of Health, 2003b). The Program covered a number of health policy areas in both the provision and the financing of health care services. The main concrete developments since 2003 include improvements in citizens' health status; introducing the GHIS, thus enhancing the financial protection of the population; instigating a purchaser–provider split in the health care system; introducing a family practitioner scheme nationwide; transferring ownership of the majority of public hospitals to the Ministry of Health; introducing a performance-based payment system in Ministry of Health hospitals; and enhancing the accessibility of health care services of acceptable quality for the whole population.

The main challenges for the future are to implement the remaining reform initiatives; promote the decentralization of health care governance; create a more competitive environment for the operation of the health care system; and to address sustainability issues, including instigating an effective referral system from primary to higher levels of care, improving the supply of health care staff, introducing and extending public hospital governance structures that aim to grant autonomous status to public hospitals; and further improving patient rights.